PERTH AND KINROSS INTEGRATION JOINT BOARD

Council Building
2 High Street
Perth
PH1 5PH

Friday, 15 June 2018

A meeting of the **Perth and Kinross Integration Joint Board** will be held in **the Council Chamber, 2 High Street, Perth, PH1 5PH** on **Friday, 22 June 2018** at **09:30**.

If you have any queries please contact Scott Hendry on (01738) 475126 or email Committee@pkc.gov.uk.

Robert Packham
Chief Officer

Please note that the meeting will be recorded and will be publicly available on the Council's website following the meeting.

Voting Members
Councillor C Stewart, Perth and Kinross Council (Vice-Chair)
Councillor C Ahern, Perth and Kinross Council
Councillor A Jarvis, Perth and Kinross Council
Councillor E Drysdale, Perth and Kinross Council
S Hay, Tayside NHS Board (Chair)
R Peat, Tayside NHS Board
L Birse-Stewart, Tayside NHS Board

Non-Voting Members
J Pepper, Chief Social Work Officer, Perth and Kinross Council
R Packham, Chief Officer, Perth and Kinross Integration Joint Board
J Smith, Chief Financial Officer, Perth and Kinross Integration Joint Board
Dr D Carey, Independent Contractor
J Foulis, NHS Tayside
Dr C Rodriguez / Dr D Lowden, NHS Tayside (to be confirmed by the Board)

Additional Members
Dr D Walker, NHS Tayside
Dr A Noble, External Advisor to Board

Stakeholder Members
F Fraser, Staff Representative, Perth and Kinross Council
A Drummond, Staff Representative, NHS Tayside
H MacKinnon, PKAVS (Third Sector Interface)
B Campbell, Carer Public Partner
L Lennie, Service User Public Partner

Perth and Kinross Integration Joint Board

Friday, 22 June 2018

AGENDA

1   WELCOME AND APOLOGIES

2   DECLARATIONS OF INTEREST

Members are reminded of their obligation to declare any financial or non-financial interest which they may have in any item on this agenda in accordance with the Perth and Kinross Integration Joint Board Code of Conduct.

3   MINUTE OF MEETING OF THE PERTH AND KINROSS   7 - 14
INTEGRATION JOINT BOARD OF 23 MARCH 2018
(copy herewith)

4   ACTION POINTS UPDATE   15 - 22
(copy herewith G/18/90)

5   MATTERS ARISING

6   IJB MEMBERSHIP UPDATE   23 - 26
Report by Clerk to the Board (G/18/91)

7   POSITION OF CLERK TO THE BOARD AND STANDARDS
OFFICER

The Board is advised that the current Clerk, Gillian Taylor, is retiring from Perth and Kinross Council on 30 November 2018, and consequently will be resigning as Clerk with effect from 30 September 2018. The Board is asked to consider the appointment of Scott Hendry, Perth and Kinross Council as Clerk with effect from 1 October 2018.

8   REDESIGN OF SUBSTANCE USE SERVICES IN PERTH AND   27 - 72
KINROSS
Report by Chair of Alcohol and Drug Partnership (copy herewith G/18/92)

Note: There will be a Presentation on the above Item by Kenny Ogilvy, Vice-Chair of Alcohol and Drug Partnership

9   FINANCE AND GOVERNANCE

9.1 REVISION TO INTEGRATION SCHEME

The Carers (Scotland) Act 2016 came into force on 1 April 2018.

As part of the requirements of the legislation, provisions from the Act required to be incorporated into those regulations that support the Public Bodies (Joint Working) (Scotland) Act 2014. Local Authorities and Health Boards were required to revise Integration Schemes for Joint Boards to include the new list of functions and duties for delegation to the Boards.

As this was a technical amendment to the Integration Scheme, Scottish Ministers have approved these revisions made under delegated powers. The Board are asked to note the position and the updated Integration Scheme which can be viewed by clicking here.

9.5 AUDIT AND PERFORMANCE COMMITTEE - UPDATE
Verbal Report by Chair of Audit and Performance Committee

10 DEVELOPING STRATEGIC OBJECTIVES

Note: There will be a Presentation on this Item by Dr Hamish Dougall, Clinical Director.

10.4 ANNUAL PERFORMANCE REPORT 2017/18
Board Members are asked to agree that due to the timescales involved in the publication of the Annual Performance Report 2017/18 by 31 July 2018, the Chief Officer be instructed to circulate the draft report to Board Members for comment, and that a special meeting of the Audit and Performance Committee be called to approve the report prior to 31 July 2018.

11   INFORMATION
Update Papers for information:

11.1   2017/18 WINTER PLAN REVIEW   **225 - 246**
Report by Chief Officer (copy herewith G/18/99)

11.2   UPDATE ON THE IMPLEMENTATION OF THE SOCIAL CARE   **247 - 256**
(SELF DIRECTED SUPPORT) (SCOTLAND) ACT 2013 IN PERTH
AND KINROSS
Report by Chief Officer (copy herewith G/18/100)

11.3   EQUALITY OUTCOMES PROGRESS REPORT   **257 - 278**
Report by Chief Officer (copy herewith G/18/101)

11.4   TECHNOLOGY AND INNOVATION IN HEALTH AND SOCIAL   **279 - 326**
CARE
(copy herewith G/18/102)

11.5   ANNUAL REPORT FOR VOLUNTEERING IN NHS TAYSIDE 2017   **327 - 350**
(copy herewith G/18/103)

12   FUTURE IJB MEETING/BRIEFING SESSION DATES 2018

Friday 24 August 2018 - Briefing Session
Monday 24 September 2018 - Training Workshops - Standards
Commission for Scotland
Friday 28 September 2018 - IJB Meeting
Friday 26 October 2018 - Briefing Session
Friday 30 November 2018 - IJB Meeting

PERTH AND KINROSS INTEGRATION JOINT BOARD

Minute of Meeting of the Perth and Kinross Integration Joint Board held in the Council Chamber, Ground Floor, Council Building, 2 High Street, Perth on Friday 23 March 2018 at 9.30am.

Present:

Voting Members
Councillor C Reid, Perth and Kinross Council (Vice-Chair)
Councillor C Ahern, Perth and Kinross Council
Councillor E Drysdale, Perth and Kinross Council (up to and including Item 9)
Councillor X McDade, Perth and Kinross Council (up to and including Item 9)
L Dunion, Tayside NHS Board (Chair)
S Hay, Tayside NHS Board (from Item 4 onwards)
S Tunstall-James, Tayside NHS Board

Non-Voting Members
J Pepper, Chief Social Work Officer, Perth and Kinross Council
R Packham, Chief Officer
J Smith, Chief Finance Officer
J Foulis, NHS Tayside

Additional Members
L Marley, NHS Tayside (on behalf of Dr D Walker)
Dr A Noble, External Adviser to Board

Stakeholder Members
F Fraser, Staff Representative, Perth and Kinross Council
A Drummond, Staff Representative, NHS Tayside
H MacKinnon, Third Sector Interface
B Campbell, Carer Public Partner (up to and including Item 8 on the agenda)
L Lennie, Service User Public Partner

In Attendance: J Valentine, Depute Chief Executive and Chief Operating Officer, Perth and Kinross Council; G Taylor, Clerk; S Hendry, P Steel and S Rodger (all Corporate and Democratic Services, Perth and Kinross Council; D Fraser, E Devine, P Henderson, S Gunnion, V Johnson, J Cormack, and H Dougall (all Perth and Kinross Health and Social Care Partnership); and K Wilson, NHS Tayside.

Apologies: J Golden, Tayside NHS Board
Dr D Carey, Independent Contractor
Dr N Prentice, NHS Tayside
Dr D Walker, NHS Tayside

1. WELCOME AND APOLOGIES

L Dunion welcomed all those present to the meeting and apologies were noted as above.

2. DECLARATIONS OF INTEREST

There were no Declarations of Interest made in terms of the Perth and Kinross Integration Joint Board Code of Conduct.

3. MINUTE OF PREVIOUS MEETING

The minute of meeting of the Perth and Kinross Integration Joint Board of 26 January 2018 was submitted and approved as a correct record.

S HAY ENTERED THE MEETING AT THIS POINT

4. ACTION POINT UPDATE

There was submitted and noted the action point update for the Perth and Kinross Integration Joint Board as at 23 March 2018 (G/18/44).

IT WAS AGREED TO VARY THE ORDER OF BUSINESS AND CONSIDER ITEM 10.1 ON THE AGENDA AT THIS POINT

5. CHIEF OFFICER STRATEGIC UPDATE

There was submitted a report by the Chief Officer (G/18/49) updating board members on progress against tasks outlined in the rolling actions list.

Resolved:
(i)   The plans put in place for the Perth and Kinross Health and Social Care Partnership during the winter/festive period (November 2017 to March 2018) as set out in Report G/18/49 be noted;
(ii)   The progress with implementation of the Mental Health Transformation Programme, as set out in Report G/18/49, be noted;
(iii)   The progress on the implementation of the refresh of the Perth and Kinross Integration Joint Board Strategic Plan, due in 2018, and set out in Report G/18/49, be noted.
(iv)   The Chief Officer be instructed to continue discussions with Stagecoach on the provision of bus services that link with Murray Royal Hospital, Perth and provide an update at the next meeting.

6. MATTERS ARISING

There were no matters arising from the previous minute.

7.   MEMBERSHIP UPDATE

It be agreed that Dr Daniel Carey replace Dr Neil McLeod as a non-voting member of the Perth and Kinross Integration Joint Board.

8.   RECORDING OF MEETINGS

It be agreed to amend Standing Orders and liaise with Perth and Kinross Council on the recording of meetings of the Integration Joint Board for public viewing online following meetings, with recordings being retained for 12 months.

9.   REDESIGNING CARE

9.1   REVIEW OF RESIDENTIAL CARE

(i)   REVIEW OF RESIDENTIAL CARE

(ii)   SUPPLEMENTARY BRIEFING NOTE – REVIEW OF RESIDENTIAL CARE

There was submitted a report by the Chief Officer (G/18/45) providing the results of a formal consultation and options appraisal commissioned by the Board to determine the preferred alternative service delivery model for directly provided in-house adult residential care service. The report had been deferred from the meeting of the Board of 26 January 2018.

A supplementary briefing note was also submitted by the Chief Officer (G/18/46) providing supporting information in relation to the Review of Residential Care.

Motion (L Dunion and S Hay)

(i)   **The outcome of the Option Appraisal be noted and the highest scoring Option 4, Closure of Beechgrove Care Home, as set out in Report G/18/45, be approved.**

(ii)   **Perth and Kinross Council as the relevant employer to continue the engagement and progress required in consultation with the Trade Unions and employees.**

(iii)   **It be noted that the implementation of Option 4 generates a saving of £528k, leaving a shortfall in the savings target of £168k, with the Chief Officer directed to identify alternative savings options to meet the shortfall.**

(iv)   **The Chief Officer report back on the progress of the implementation of Option 4 to the Integration Joint Board in 12 months time.**

(v)   **The Chief Officer monitor and review the new model of residential care provision to ensure that it continues to align with the strategic objectives of the Integration Joint Board.**

Amendment (Councillors E Drysdale and X McDade)

(i) The outcome of the Option Appraisal be noted and Option 1, the status quo, as set out in Report G/18/45, be approved.

(ii) Perth and Kinross Council and NHS Tayside be called upon to make representations through COSLA and NHS Scotland to the Scottish Government to address the acute funding shortfall in health and social care services.

(iii) Partners be called upon to fund any remaining shortfall in 2018/19 finances at the end of that year from their financial reserves.

(iv) A further review to take place of overall budgets, as currently planned, ahead of 2019/20.

THERE FOLLOWED A FIFTEEN MINUTE RECESS AND THE MEETING RECONVENED AT 11.20AM

In terms of Standing Order 3.5, the Chair ruled that the Amendment was not competent.

Amendment (Councillors X McDade and E Drysdale)

(i) The outcome of the Option Appraisal be noted and Option 1, the status quo, as set out in Report G/18/45, be approved.

(ii) The Chief Officer be remitted to explore alternative savings options as part of the Review of Residential Care.

In terms of Standing Order 3.5, the Chair ruled that the Amendment was not competent.

Amendment (Councillors X McDade and E Drysdale)

(i) The outcome of the Option Appraisal be noted and Option 1, the status quo, as set out in Report G/18/45, be approved.

(ii) The financial deficit to be funded by Perth and Kinross Council earmarked reserves for social care for 12 months the Chief Officer be instructed to examine options for recurring funding beyond this timescale.

In terms of Standing Order 3.5, the Chair ruled that the Amendment was not competent.

In terms of Standing Order 13.1, Councillor X McDade proposed the suspension of Standing Orders 14 and 15. In terms of Standing Order 3.5, and in the absence of any competent amendments, the Chair ruled that this was not competent.

The Chair asked the voting members of the Board to indicate by a show of hands whether they were willing to support the recommendations in Report G/18/45.

Resolved:
In accordance with the Motion.

COUNCILLORS E DRYSDALE AND X McDADE, AND B CAMPBELL LEFT THE MEETING AT THIS POINT.

10.   FINANCE AND GOVERNANCE

10.1   2017/18 FINANCIAL POSITION AND FORWARD LOOK

There was submitted a report by the Chief Financial Officer (G/18/47) providing a summary of the issues impacting on the financial position of the Perth and Kinross Integration Joint Board in 2017/18, based on the 9 months to 31 December 2017.

Resolved:
The forecast financial position for 2017/18, as detailed in Appendix 1 to Report G/18/47, be noted.

10.2   2018/19 BUDGET

There was submitted a report by the Chief Financial Officer (G/18/48) seeking approval from the Integration Joint Board to the 2018/19 Financial Plan, including the budget proposals from both Perth and Kinross Council and NHS Tayside, and the 2018/19 Transformation and Efficiency Programme.

Resolved:
(i)   The proposed recurring budget offer from Perth and Kinross Council (PKC) for 2018/19, as set out in Report G/18/48, be approved, and the Chief Officer be requested to write to PKC on this basis and thereafter issue a formal direction, noting that whilst the budget proposal from PKC is considered manageable in 2018/19, it is essential that a fair settlement is agreed for 2019/20.
(ii)   The Chief Officer be requested to seek early discussions with PKC in respect of the 2019/20 budget to safeguard essential services in future years.
(iii)   The Chief Officer be requested to seek a formal proposal from PKC in relation to the Council's proposed transfer of the £538k budget for Citizens Advice Bureau, Independent Advocacy and Credit Union.
(iv)   The recurring budget offer from NHS Tayside (NHST) for 2018/19, as set out in Report G/18/48, be approved, and the Chief Officer be requested to write to NHST on this basis and thereafter issue a formal direction.
(v)   The Chief Officer to conclude discussions with NHST about the NRAC prescribing, medical locum bridging and complex car package funding.
(vi)   The 2018/19 Perth and Kinross Integration Joint Board Financial Plan, and the associated 2018/19 Transformation and Efficiency Programme, as detailed in Report G/18/48, be approved.
(vii)   The £1.2m gap in the 2018/19 Financial Plan, along with the further work being undertaken to deliver a balanced budget, be noted.
(viii)   The Chief Officer to develop proposals for the meeting of the Integration Joint Board on 22 June 2018 for a collaborative budget process with NHST and PKC for 2019/20.
(ix)   The Board passed on their appreciation to the work done by all relevant staff in the preparation of the 2018/19 budget proposals.

10.3   AUDIT AND PERFORMANCE COMMITTEE UPDATE

Councillor C Ahern, Chair of the Audit and Performance Committee of the Integration Joint Board, provided a verbal update to the Board following the [meeting of the Committee on 6 March 2018](#) focusing on areas such as strategic planning, risk management, clinical, care and professional governance and delayed discharge performance

The Board noted the position.

11.   GP PRESCRIBING FORECAST 2017/18

There was submitted a report (G/18/50) by the Clinical Director providing an update on the forecast position on prescribing for 2017/18 and the key issues impacting on performance.

Resolved:
(i)   The year end forecast overspend of £1.638m compared to the £1.687m plan, as detailed in Report G/18/50, be noted.
(ii)   The issues impacting on expenditure and the overall positive position on growth, as set out in Report G/18/50, be noted.
(iii)   The progress in implementing the GP Engagement Programme and the spend forecast for 2017/18 of £47,000 be noted. The Clinical Director to submit a revised funding request for 2018/19 and 2019/20 to the next meeting of the Board on 22 June 2018.
(iv)   The difficulties in obtaining robust management information that ties GP Practice level data to financial expenditure on a regular basis be noted, and the Chief Officer be instructed to ensure that this is resolved as soon as possible.

12.   PERTH AND KINROSS CHILD PROTECTION COMMITTEE (CPC) STANDARDS AND QUALITY REPORT 2016-2017

The Board noted a joint report by the Chief Executive and Executive Director (Education and Children's Services), Perth and Kinross Council (17/320) on the Perth and Kinross Child Protection Committee Standards and Quality Report 2016-2017. It was noted that the report had also been endorsed by Perth and Kinross Council at its meeting of 4 October 2017.

13.   WINTER PLAN 2017/18 UPDATE

The Board noted a report by the Chief Officer (G/18/51) on the Winter Plan 2017/18 Update and requested a detailed report be submitted to the Board on 22 June 2018.

14.   FUTURE MEETING DATES 2018

Friday 11 May 2018 at 9.30am – Briefing Session
Friday 22 June 2018 at 9.30am – IJB Meeting
Friday 24 August 2018 at 9.30am – Briefing Session

Friday 28 September 2018 at 9.30am – IJB Meeting
Friday 26 October 2018 at 9.30am – Briefing Session
Friday 30 November 2018 at 9.30am – IJB Meeting

15. VALEDICTORIES

The Chief Officer referred to this being the last meeting of the Integration Joint Board for both Councillor Crawford Reid, Vice-Chair, and Sheila Tunstall James and thanked them for their contribution to the work of the Board.

The Chief Officer also referred to this being the last meeting for Linda Dunion, Chair of the Board and former Vice-Chair of both the Board and previous Pathfinder Board and paid tribute to the commitment and contribution she had made in her various roles and wished her well for the future.

ACTION POINTS UPDATE
Perth & Kinross Integration Joint Board
22 June 2018

	Meeting	Minute Reference	Heading	Action Point	Responsibility	Timescale	Status
29	23 Mar 2016	Item 18(v)	Health & Social Care Joint Workforce & Organisational Development Strategy	The finalised Joint Organisational Development Plan be reviewed by the Board in June 2016 to ensure alignment with partnership priorities.	Chief Officer	~~June 2016~~ ~~March 2017~~ ~~June 2017~~ ~~Dec 2017~~ ~~Jan 2018~~ June 2018	**31/10/16** Joint OD plan been updated - due to be finalised by March 2017 and to be submitted in June 2017 **30/06/17** Update provided. – Finalised workforce plan to be rescheduled– at debrief on **11/07/17** agreed final report to be submitted Dec 2017 **Dec** Meeting reschedule to Jan 2018 – update to be included in Chief Officer Update **26/01/18** Update in Chief Strategic Update Report. – Finalised workforce plan to IJB June 2018
	30 Jun 2016	Item 10					

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ACTION POINTS UPDATE
Perth & Kinross Integration Joint Board
22 June 2018

	Meeting	Minute Reference	Heading	Action Point	Responsibility	Timescale	Status
							22.06.18 update provided in Chief Officer Update
59	04 Nov 2016	Item 14	Adult Support & Protection	Development Session to be arranged in 2017 for members on the work of the Adult Protection Committee, Child Protection Committee and Public Protection Work	Chief Officer	~~Dec 2017~~ ~~Jan 2018~~ June 2018	Jan 18 - reschedule to June 2018 **22.06.18 Agenda**
71	24 Mar 2017	Item 10 – 7.5	Chief Officer Update – Governance & Assurance	Report to be submitted to IJB June 2017 re commissioning Governance and Assurance support.	Chief Officer	~~June 2017~~ ~~October 2017~~ ~~Nov 2017~~ ~~Jan 2018~~ ~~March 2018~~ Sept 2018	**30/06/17** In progress final report to be submitted in October 2017 - October Meeting cancelled **23/03/18 Agenda Deferred to ~~June~~ Sept 2018**
76	18 Aug 2017	6.3	IJB Complaints Handling Procedure	Quarterly reports to be submitted to the IJB Audit & Performance Committee with Yearly report to be provided to the IJB.	Jane Smith	September 2018	
77	18 Aug 2017	7.1	Annual Performance Report	Requests submitted at IJB August 2017 for the 2018 Report to be more	ED/DF	September 2018	

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ACTION POINTS UPDATE
Perth & Kinross Integration Joint Board
22 June 2018

	Meeting	Minute Reference	Heading	Action Point	Responsibility	Timescale	Status
				balanced, with more data included. Member from Public Health Team to be involved and along with representation from the wider group.			
80	26 Sept 2017	4.1	Review of Day Services	Progress report to be submitted to IJB in one year.	Diane Fraser	September 2018	
85	26 January 2018	7.1	Redesigning Care - Perth & Kinross Mental Health & Wellbeing Strategy Progress Report	Draft plan with commissioning priorities for community based services	Rob Packham	September 2018	
86	26 January 2018	7.2	Redesigning Care - Perth & Kinross Learning Disabilities Progress Report	Chief Officer to provide update on progress in the implementation of the strategic commissioning plan	Rob Packham	January 2019	
88	26 January 2018	9.1	Developing Strategic Objectives – Strategic Update	Chief Officer to submit report	Rob Packham	26 June 2018	**22.06.18 Agenda (Chief Office Update)**
89	26 January 2018	9.2	Developing Strategic Objectives – Proposal to Revise Arrangements for Strategic Planning Across P&K HSCP	Chief Officer to refresh the membership of the Strategic Planning Group for approval of IJB and present a refreshed role, remit and terms of reference for these groups	Rob Packham	~~March 2018~~ Sept 2018	23/3/18 Update Included within Chief Officers report - Draft Strategic Plan Refresh to be submitted by Sept

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ACTION POINTS UPDATE
Perth & Kinross Integration Joint Board
22 June 2018

	Meeting	Minute Reference	Heading	Action Point	Responsibility	Timescale	Status
							2018
90	26 January 2018	9.4	Improving Scotlands Health: A Healthier Future – Actions and Ambitions on Diet, Activity & Healthy Weight	Future IJB development session to take place.	Rob Packham	January 2019	
91	26 January 2018	9.5	Delivering the New 2018 General Medical Services Contract in Scotland	Chief Officer to present the necessary actions to develop the Primary Care Improvement Plan to IJB for approval	Rob Packham	June 2018	**22.06.18 Agenda**
92	23 March 2018	7	Recording of Meetings	Democratic Services to take forward for next meeting	Democratic Services	June 2018	**22.06.18 - commenced**
93	23 March 2018	9.2	Budget	Chief Officer to develop proposal for a collaborative budget process with NHS Tayside and Perth & Kinross Council for 2019/20	Rob Packham	June 2018	**22.06.18 Agenda**
94	23 March 2018	9.2	IJB Financial Plan 2018/19	Full update on progress of key actions	Jane Smith	June 2018	**22.06.18 Agenda**
95	23 March 2018	9.2	3 Year Financial Plan 2018/19:2020/21	Plan to be brought forward to meeting for consideration and approval of further longer term transformation plans.	Jane Smith	June 2018	**Deferred to Sept 2018**
96	23 March 2018	10.1	Planning for Winter and Festive Season	Detailed report from previous winter plan to June meeting	Rob Packham	June 2018	**22.06.18 Agenda**

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ACTION POINTS UPDATE
Perth & Kinross Integration Joint Board
22 June 2018

	Meeting	Minute Reference	Heading	Action Point	Responsibility	Timescale	Status
97	23 March 2018	10.1	Mental Health Transformation Programme	Chief Officer to investigate and include transport as part of update in June meeting	Rob Packham	~~June 2018~~ Sept 2018	**No update available – c/f Sept 2018**
98	23 March 2018	10.2	GP Engagement Programme	Revised request for funding	Hamish Dougall	June 2018	**22.06.18 Agenda**

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ACTION POINTS RESOLVED

	Meeting	Minute Reference	Heading	Action Point	Responsibility	Timescale	Status
52	04 Nov 2016	Item 7 – 2.2	OOHs Report	Chief Officer to circulate information to Board Members in relation to test results for nurse led telephone triage within the out of hours service.	Chief Officer	~~March 2017~~ November 2017	**03/02/17**– E Devine following up this action. **06/02/17** – awaiting response – delay update until October agenda. **Oct Meeting cancelled.** **26/01/18** Update within Chief Officer Strategic Update Report. Resolved 26.1.18
53	04 Nov 2016	Item 7 – 2.4	GP Clusters	Dr D Walker to submit a briefing paper to future meeting in relation to dietetic work being undertaken at a national level.	Dr D Walker/Chief Officer Chief Officer	~~August 2017~~ ~~Dec 2017~~ Jan 2018	**11/07/17** Request at debrief meeting to c/f to Dec 2017 **Dec** Meeting reschedule to Jan 2018 26/01/18 – Agenda. Resolved 26.1.18

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72	2 Mar 2017	Item 10	Chief Officer Update	Chief Officer to feedback details to Helen MacKinnon re involvement 3rd Sector re Engagement Trans Projects.	Chief Officer	~~June 2017~~ ~~October 2017~~ Nov 2017	**03/11/17** Feedback still outstanding – **Resolved 26/01/18**
74	30 June 2017	8.1	Mental Health Service Redesign – Transformation Program	Final Report to be submitted following 3 month consultation period.	Lynne Hamilton	Jan 2018	**26/01/18 Agenda – Resolved 26/01/18**
78	18 Aug 2017	7.2	Update Report on Participation, Engagement & Communication Strategies.	New Logo approved for P&K HSCP, Strapline to inform what we are about to be developed and submitted at future meeting for approval.	HMcK	~~December 2017~~ Jan 2018	**Resolved 26/01/18**
84	26 Sept 2017	4.2	Review of Residential Care Homes	Optional Appraisal following Consultation on Options 2,3 & 4 re Residential Care Services	Diane Fraser	January 2018	In terms of Standing Order 15.4 carried forward to March meeting Resolved 23/3/18
87	26 January 2018	7.3	Mental Health Service Redesign – Transformation Program	Chief Officer to establish an inclusive process for the development of implementation plans	Rob Packham	March 2018	Resolved 23/3/18

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Perth and Kinross Integration Joint Board

22 June 2018

IJB Membership Update

Report by Clerk to the Board (G/18/91)

PURPOSE OF THE REPORT

This report updates the Board on a number of recent appointments to the voting members of the Board. It also makes proposals in terms of the appointment of non-voting members to the Board, as well as further appointments to the Audit and Performance Committee.

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1.   VOTING MEMBERS

1.1   In terms of the Integration Scheme for the IJB, the eight voting members of the Board are made up of four elected members from Perth and Kinross Council and four non-executive Board members from NHS Tayside. There have been a number of recent changes in the membership of the voting members and these are set out for information in Appendix 1. There is a current vacancy in the voting members from NHS Tayside and this will be confirmed at the next meeting of the NHS Tayside Board on 28 June 2018. In addition to this, from 1 May 2018 the Chair of the IJB is now Stephen Hay and the Vice-Chair is Councillor Colin Stewart.

2   NON-VOTING MEMBERS

2.1   The IJB also contains a number of non-voting members, set out in Appendix 1, including a Secondary Medical care Practitioner representative. Following the retiral of Dr Neil Prentice, the Board is asked to agree that Dr Douglas Lowden and Dr Cesar Rodriguez be appointed as co-members on a rotational basis.

2.2   Bernie Campbell and Maureen Summers (substitute) were appointed to the Board as Carer Representatives until May 2018. Linda Lennie and Sandra Auld (substitute) have been appointed as Service User Representatives until 31 October 2018.

In order to maintain a level of continuity on the Board for the public partners, it is proposed that both Bernie Campbell and Maureen Summers be reappointed in their respective roles for a further year until May 2019. Further proposals regarding the appointment of Service User representatives will be brought to the next meeting of the Board.

2.3   The Public Bodies (Joint Working) (Membership and Procedures of Integration Joint Boards) (Scotland) Order 2014 sets out the timescales for the appointment of non-voting members on the IJB. As a number of appointments were made at the first meeting of the IJB in November 2015, further proposals on appointments will be brought to the next meeting of the Board.

3.   AUDIT AND PERFORMANCE COMMITTEE

3.1   The constitution of the Audit and Performance Committee of the IJB sets out that four members of the Committee must be voting members of the IJB, and must include an equal number of the voting members appointed by both the Board of NHS Tayside and Perth and Kinross Council.

3.2   As Linda Dunion's term of office on the IJB ended on 30 April 2018 and Stephen Hay took up the position of Chair of the IJB on 1 May 2018, the Board is asked to agree that two further voting members from NHS Tayside be appointed to the Audit and Performance Committee.

4.   RECOMMENDATIONS

3.1   It is recommended that the Board notes the appointment of voting members by NHS Tayside Board and Perth and Kinross Council, as set out in Appendix 1.

3.2   It is recommended that the Board approves the appointment of Dr Douglas Lowden / Dr Cesar Rodriguez as non-voting / co-members of the Board.

3.3   It is recommended that the Board agrees to extend the term of office of both Bernie Campbell and Maureen Summers in their respective roles as public partners until 31 October 2018.

3.4   It is recommended that the Board approves that two further voting members from NHS Tayside be appointed to the Audit and Performance Committee of the IJB to replace Stephen Hay and fill the current vacancy on the Committee.

Author

Name	Designation	Contact Details
Gillian Taylor	Clerk to the Board	committee@pkc.gov.uk

NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

Appendix 1: Perth and Kinross Integration Joint Board Membership Update – June 2018

Perth and Kinross Integration Joint Board Membership Update – June 2018   **Appendix 1**
Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014

Category	Name	Organisation	Role and Remit	Comment
Section A Voting members (Order Section 3)	Cllr Colin Stewart (Vice-Chair)	PKC	Councillor	
	Cllr Anne Jarvis	PKC	Councillor	
	Cllr Eric Drysdale	PKC	Councillor	
	Cllr Chris Ahern	PKC	Councillor	
	Ms Lorna Birse-Stewart	NHST	Non Executive Member	
	Dr Robert Peat	NHST	Non Executive Member	
	Vacancy	NHST	Non Executive Member	
	Mr Stephen Hay (Chair)	NHST	Non Executive Member	
Section B Proxy Members (Order Section 12)	Cllr Peter Barrett	PKC	Councillor	To substitute for Voting members
	Cllr Callum Purves	PKC	Councillor	
	Cllr Tom McEwan	PKC	Councillor	
	Cllr TBC	PKC	Councillor	
Section C Non Voting members (Order Section 3)	Mr Robert Packham	NHST/PKC	Chief Officer	
	Ms Jane Smith	NHST/PKC	Chief Finance Officer (Section 95 Officer)	
	Ms Jacqueline Pepper	PKC	Chief Social Work Officer , PKC	
	Dr Douglas Lowden / Dr Cesar Rodriguez	NHST	Secondary Medical care Practitioner representative, NHS Tayside	
	Dr Daniel Carey	Independent Contractor	GP Representative, NHS Tayside	
	Mr Jim Foulis	NHST	Nurse Representative, NHS Tayside	
Section D Additional Members (Order Section 3)	Dr Drew Walker	NHST	Director of Public Health	
	Dr Alistair Noble	Independent retired GP	SACH and external advisor to the Board	
Section E Stakeholder Members (Order Section (3)	Mr Allan Drummond	NHST	Staff Representative	
	Ms Helen McKinnon	PKAVS	Third Sector representative	
	Mr Fiona Fraser	PKC	Staff Representative	
	Bernie Campbell	Public Partner	Carer Representative	Named Substitute – Maureen Summers
	Linda Lennie	Public Partner	Service User Representative	Named Substitute – Sandra Auld

Perth and Kinross Integration Joint Board

22 June 2018

Redesign of Substance Use Services in Perth and Kinross

Report by Clare Mailer, ADP Chair (G/18/92)

PURPOSE OF REPORT

The purpose of this report is to update the IJB on the redesign of substance use services and the implementation of a Recovery Oriented System Of Care (ROSC) in Perth and Kinross.

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1. BACKGROUND

1.1 The Alcohol Drug Partnership (ADP) is a strategic but non-constituted body established to oversee issues around substance use within Perth and Kinross including governance around alcohol and drugs, implementation of Government policies, implementation of local strategies, performance management, engaging stakeholders and communication with partners and the public.

1.2 The Perth & Kinross ADP was established in 2009 and succeeded the Alcohol and Drugs Action Teams (ADAT's). The Scottish Government allocates an annual budget to the P&K ADP which is channelled through and held on the ADP's behalf by the Perth and Kinross Health and Social Care Partnership. The amount of money spent on ADP activity comes mainly through four sources: the Scottish Government ADP ringfenced funds; NHS Tayside mainstream funds; Perth & Kinross Council funds; and charitable funds sourced by third sector partners. In recent years as later sections of this report will explain, the funds available for ADP work are under increasing pressure.

1.3 The Scottish Government has issued guidance that 'Recovery Oriented Systems of Care (ROSC)' should be implemented throughout Scotland. Distinguishing features of a ROSC include:-

- being person-centred
- being inclusive of family and significant others
- keeping people safe and free from harm
- the provision of individualised and comprehensive services - such as housing, employability and education
- services that are connected to the community
- services that are trauma-informed

2

The ADP undertook a Care Inspectorate validated self assessment in 2017 (see appendix 1). The findings from this, alongside local consultation and the recommendations from the Opiate Replacement Report (ORT) (2012) are being used to influence the development of a ROSC in Perth and Kinross.

1.4   Financial Environment

A breakdown of the major funding sources for substance use services in Perth and Kinross and summary of services provided is shown below.

Perth and Kinross Substance Use Services/Resources	£3.6m
Funded via ADP	£1.4m
Funded via Social Care	£0.8m
Funded via Health	£1.4m

Note – This includes the Inpatient Tayside Substance Misuse Service that is hosted in Perth and Kinross, but is a Tayside service.

The Services included within this resource are:

- Community Substance Use Service/Nursing
- Community Substance Use Social Work
- Substance Use Senior Medical (Tayside Wide)
- Inpatient Substance Use Service (Tayside Wide)
- Short to Medium term accommodation with support
- Residential and Short Breaks
- Blood Borne Virus Support (Hepatitis C & HIV)
- SMART Recovery
- CAIR Scotland Recovery & Moving On Service
- Cair Scotland The Web/Key to Change
- Tayside Council on Alcohol
- Barnardos Hopscotch Project
- Churches Action for the Homeless
- Criminal Justice Service Support
- SDS Options
- Health Intelligence (Tayside Wide)
- Website

2.   MAIN ISSUES

2.1   Perth & Kinross, Dundee and Angus Alcohol and Drug Partnerships (ADPs) all face the same challenge; to deliver systematic change in a short time in a financial environment that is under constant review and change. Collectively and individually the key elements of the challenge are:

- Funding pressures over next 3 years
- Disconnect between different providers within system of care that often results in a disjointed experience for the individuals being supported

- Need to strengthen links and create an aligned model that delivers the Recovery Oriented System of Care (ROSC) model that supports people throughout Perth and Kinross.

Any solution must deliver on:

- Improved outcomes for people
- Improved Personal Experience
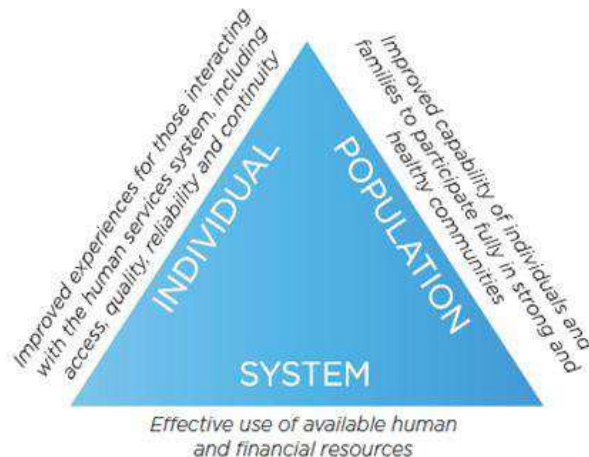- Improved Quality of Care
- Best Use of Resources

Figure 1 - Triple Aim

2.2 The development and implementation of a ROSC will be resource intensive at the outset and will require ongoing maintenance. Resources need to be moved away from maintenance and into prevention and recovery. A robust performance framework needs to be developed to evidence the effectiveness of this.

2.3 With the recent severe financial pressures it has become evident that continuing to operate using traditional models is no longer financially sustainable. This fact coupled with the improved quality of care which could be provided within a ROSC has led the ADP to establish a Redesign Project Group with membership from all key agencies, including service users and carers, to redesign substance use services in Perth and Kinross. The Redesign Project Group's aim is to support the implementation and delivery of a Recovery Oriented System of Care (ROSC) which emphasises prevention and recovery. The Redesign Project objectives are to:

1. Review and redesign the delivery of substance use services within localities to reflect strategic priorities of Early Intervention, Prevention and Recovery and the delivery of a Recovery Orientated System of Care (ROSC).
2. Adhere to the Quality Principles and Health & Social Care Standards to deliver improved person centred outcomes for individuals.

3. Deliver a service that improves outcomes for clients and their families and meets our legal and statutory responsibilities
4. Deliver a service that has the flexibility to respond to changes in demand at a service and individual level.
5. Offer an efficient and value for money service that delivers improved outcomes for individuals, families and communities and cost savings.
6. Meet the ADP strategic aims of Whole Family Approach and Whole Population.

3   PROGRESS TO DATE

3.1   An options' appraisal was carried out in early 2017 which determined the redesign should cover all substance use services in Perth and Kinross including the inpatient detox beds in Kinclaven at Murray Royal Hospital. These beds are part of the services hosted by Perth and Kinross Integration Joint Board (IJB).   People from across Tayside access these beds so any redesign requires discussions at a Tayside level. In view of this it was agreed that this workstream would be progressed separately from the redesign of community services.

3.2   An initial scoping paper is being drafted regarding the redesign of Kinclaven and a lead has been identified.

3.3   In December 2017 a two day improvement event was held with relevant stakeholders to progress the redesign of community based substance use services in Perth and Kinross (see appendix 2). Perth Prison is included in this. The following workstreams were agreed at the event:

1. Communication and Engagement
2. Processes
3. Organisational Development and Training
4. Performance Framework
5. Prevention

3.4   These workstreams meet regularly and feedback progress against key milestones to the Project Group monthly. A summary of progress to date is detailed below:

1. Communication and Engagement
An ADP communication and media strategy is being developed and a number of activities to raise awareness of Substance Use issues and services are being planned throughout Perth and Kinross along with the dissemination of information through a variety of mediums and networking events.

2. Processes
One of the key outputs to date has been the mapping of existing services and supports onto a 'pipeline' (see appendix 3) showing the type of support services currently provide and the level of complexity of intervention.   The pipeline has enabled areas of duplication and gaps in

provision to be identified. More detailed analysis is underway to identify each services key strengths and plan for how skills can be best utilised to deliver more effective outcomes for service users. This is particularly important in the current climate where there is increased demand and pressure on resources.

A gap analysis has identified areas where additional services and supports are required. This will support the review of existing Substance Use services and the realignment of services and resources to deliver the ROSC and the project objectives.

A review of referral and triage processes has been undertaken resulting in the introduction of a new multi-agency drop in assessment clinic and a revised triage process which includes workers from statutory health and social care and the third sector. The effectiveness and impact of these new arrangements are currently being evaluated.

The concepts of lead worker and client owned recovery plans are progressing along with implementing a 'recovery community' in Perth and Kinross. These enhancements will ensure people can access the pipeline at an appropriate point and navigate through it to ensure they receive the appropriate support at the appropriate time.

Once developed, the pipeline will form the core of the ROSC and ensure key substance use services are operating in an effective and coordinated manner. It will also enable more generic services that support people with substance use issues to access specialist support for people as required.

3. Training and Development
   The third workstream will review and develop training for generic workers to help ensure they have the knowledge and skills to support people with substance use issues eg motivational interviewing. Training to help workers support adults who have experienced trauma and bereavement is being rolled out.

4. Performance Framework
   Work is underway to develop a Performance Framework to be used across the three Tayside Alcohol & Drugs Partnerships (ADPs) and associated strategic bodies. A dataset has been developed in consultation with stakeholders in Dundee City, with the next stage being that the dataset will be presented to stakeholders in Angus and Perth & Kinross ADPs for their consideration. Once the indicators have been agreed, a monitoring framework will be developed in partnership with services that will facilitate quarterly reporting.

   The dataset brings together the key outcomes/indicators from the Staying Alive in Scotland Report, Quality Principles and the HSC Health & Well-being Indicators into one document and has quarterly monitoring "checkpoints". Significant consultation and discussion across Tayside has resulted in an agreement that the dataset for each area should be the

same (albeit reflecting the individual areas LOIPs etc.). The Lead Officer for the three Tayside ADPs shall adapt each Performance Framework to reflect the individual area and shall develop a Balanced Scorecard for reporting to the IJB strategic groups in each area. This work shall be completed by summer 2018.

5. Prevention
The prevention workstream is focussing on supports to prevent people developing substance use issues in the first place. This will be developed alongside, and with cognisance of, the Tayside multi-agency framework for the prevention of early initiation into substance use, as referenced within the Tayside Plan for Children, Young People & Families.

A summary diagram of the redesign project for community services is in Appendix 4.

6. CONCLUSION AND RECOMMENDATION

It is recommended the IJB
- Notes progress to date;
- Notes the proposed redesign in patient detox beds at Kinclaven;
- Approves ongoing redesign of community based substance use services;
- Instructs the Chair of the ADP to provide a further report on both reviews to the IJB in June 2019.

Author

Name	Designation	Contact Details
Clare Mailer Kenny Ogilvy	Chair ADP Vice Chair ADP	

Approved

Name	Designation	Date
Rob Packham	Chief Officer Health and Social Care	12 June 2018

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1. **IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION**

Strategic Implications	Yes / None
Community Plan / Single Outcome Agreement	**Yes**
Corporate Plan	**Yes**
Resource Implications	
Financial	**No**
Workforce	**No**
Asset Management (land, property, IST)	**No**
Assessments	
Equality Impact Assessment	**Yes**
Strategic Environmental Assessment	**Yes**
Sustainability (community, economic, environmental)	**No**
Legal and Governance	**No**
Risk	**No**
Consultation	
Internal	**Yes**
External	**Yes**
Communication	
Communications Plan	**No**

1. **Strategic Implications**

Community Plan / Single Outcome Agreement

1.1 The section below sets out how the proposals relate to the delivery of the Perth and Kinross Community Plan / Single Outcome Agreement in terms of the following priorities:

(i) Giving every child the best start in life
The ADP Strategy and Delivery Plan 2015 – 2020 notes the work that has been underway to support children with parents who are misusing alcohol and/or drugs, such as the 'Change is a Must' project. It also notes work with schools to raise awareness of the effects of alcohol and drugs in school.

(ii) Developing educated, responsible and informed citizens
The ADP Strategy and Delivery Plan 2015 – 2020 describes public awareness raising that the ADP has done to ensure that people in Perth and Kinross know where to go to get support if they are misusing drugs or alcohol.

(iii) Promoting a prosperous, inclusive and sustainable economy
The ADP Strategy and Delivery Plan 2015 – 2020 demonstrates that the ADP is endeavouring to be inclusive to people with drug and alcohol problems, and their carers, who are disenfranchised from decision making. Service user and carer involvement recognition is set out in the ADP Strategy and Delivery Plan 2015 – 2020, in relation to development of the wider workforce.

(iv) Supporting people to lead independent, healthy and active lives
A key element of the ADP Strategy and Delivery Plan 2015 – 2020 is to support people who misuse alcohol and/or drugs to lead healthier lives. Alcohol and drug misuse can have significant health impacts on people that at worst can lead to overdose and death.

(v) Creating a safe and sustainable place for future generations
The Criminal Justice element is a key part of the ADP Annual report as people who misuse alcohol and drugs can have a detrimental effect on communities in relation to anti-social behaviour and crime.

<u>Corporate Plan</u>

1.2 The ADP Strategy and Delivery Plan 2015 – 2020 is relevant to all aspects of the five objectives of the Corporate Plan and these are detailed above.

(i) Giving every child the best start in life;
(ii) Developing educated, responsible and informed citizens;
(iii) Promoting a prosperous, inclusive and sustainable economy;
(iv) Supporting people to lead independent, healthy and active lives; and
(v) Creating a safe and sustainable place for future generations.

2. Resource Implications

<u>Financial</u>

2.1 There are no resource implications

<u>Workforce</u>

2.2 The ADP Strategy and Delivery Plan 2015 – 2020 highlights training and organisational development requirements for the ADP and its partners' workforce. This is principle in relation to ensuring there is a better understanding of drug and alcohol issues and in particular, that there is understanding about the recovery agenda.

<u>Asset Management (land, property, IT)</u>

2.3 There is no asset management implications highlighted in the report. There are no implications in relation to IT at present.

2

3. Assessments

<u>Equality Impact Assessment</u>

3.1 **Equality and Diversity**
The ADP Strategy and Delivery Plan 2015 – 2020 is aimed at people in recovery and promotes social inclusion and the tackling of stigma, and is fully inclusive in its approach and does not discriminate.

<u>Strategic Environmental Assessment</u>

3.2 The Plan supports the Council's commitment to sustainable development and has undergone an appraisal through the Councils Integrated Appraisal Toolkit (IAT) (see summary report attached).

The IAT identified that there were not likely to be any negative environmental effects which will arise as a result of the implementation of this Strategy. This is because the Strategy does not present a risk to human health or the environment, and the plan does not have an effect on land use, natural or cultural heritage or landscapes.

The Strategy does have a relationship with other policy areas. For example, successful outcomes in the Strategy can have a positive impact on open spaces by reducing fear of crime and the debris related to alcohol or drug use, and to develop recovery there is a need to have transport systems which support access to services, especially in rural areas. However, other Strategies and Plans in the policy hierarchy eg relating to Greenspace and Transport will undergo separate consideration under the Environmental Assessment (Scotland) Act.

3.3 However, no action is required as the Act does not apply to the matters presented in this report. This is because the Committee are requested to note the contents of the report only are not being requested to approve, adopt or agree to an action or to set the framework for future decisions.

<u>Sustainability</u>

3.4 N/A

<u>Legal and Governance</u>

3.5 N/A

3.6 N/A

<u>Risk</u>

3.7 N/A

4. **Consultation**

Internal

4.1 ADP members

External

4.2 The draft annual report has been reviewed by the ADP membership these include:
- Voluntary Sector
- Police Scotland
- Scottish Prison Service
- NHS Substance Misuse Service
- PKC Education and Children Services
- NHS Children and Young People Services
- PKC Adult Services

5. **Communication**

5.1 The ADP Annual Report will be discussed at the Alcohol Drug Partnership and placed on the ADP website.

2. **BACKGROUND PAPERS**

. **APPENDICES**

1. ADP Care Inspectorate Evaluation Feedback 2016
2. Improvement Event write up
3. Perth and Kinross Pipeline
4. Summary diagram of Redesign of Community Substance Use Services

The Quality Principles: Alcohol & Drug Partnership (ADP) Validated Self-Assessment and Improvement
Perth and Kinross

Introduction

To support effective implementation of the Quality Principles, the Scottish Government commissioned the Care Inspectorate to undertake a programme of validated self-evaluation across Alcohol and Drug Partnerships (ADPs) in Scotland. The aim of the project was to provide an evidence-informed assessment of local implementation, measurement and quality assurance of ADP and service compliance with *The Quality Principles: Standard Expectations of Care and Support in Drug & Alcohol Services*.

To find this out we gathered the views of staff across services providing treatment, care and support and from individuals accessing drug and alcohol services. We carried out two online surveys in January and February 2016, aimed at gathering both the views of staff and users of services in relation to each of the Quality Principles. The staff survey was completed by 158 staff members and the service user survey was completed by 53 individuals.

We read the files of 10 individuals who received treatment and support from health, statutory and third sector services delivering drug and alcohol services. We met with six individuals receiving services to listen to their views about their experiences of services. We also spoke to 21 staff in these services who work directly with individuals and to members of the Alcohol and Drugs Partnership responsible for strategic planning. We are very grateful to everyone who talked to us as part of this validated self-evaluation process.

The Care Inspectorate validation team was made up of a Strategic Inspector working with an Associate Assessor with knowledge and practice experience in alcohol and drugs services and support from staff from the Scottish Drugs Forum, National Quality Development team.

In the course of the validated self-evaluation process we identified a number of particular strengths which were making a positive difference for individuals and families as well as areas for improvement. These are identified in the feedback summary.

1. Key performance outcomes

> **Quality Principle 1.**
> You should be able to quickly access the right kind of drug and alcohol service that keeps you safe and supports you throughout your recovery.

Strengths
- The Perth and Kinross ADP had exceeded the three week referral to treatment HEAT target consistently over a number of years indicating that they were delivering effective access to services for individuals who required support.
- The ADP had recently augmented its joint working arrangements to develop a formal weekly triage system involving health, social work and third sector representatives to effectively screen and allocate all referrals in to services.
- The ADP had piloted the Recovery Outcome Web (ROW) and undertaken scoping activity including development days to prepare for the wider introduction of both the ROW and DAISy across all services.
- The intelligence analyst role had strengthened compliance with the HEAT targets by ensuring that services reported data which was interrogated and benchmarked and that area for improvement were focussed on where necessary.

Areas for improvement
- Whilst there was very good systems in place to deliver on the waiting time HEAT targets, both the case file and survey analysis results highlighted that this did not always match up with individuals experiences. The ADP would benefit from further evaluation of this issue to ensure a more congruent outcome for all stakeholders.

2. Getting help at the right time

> **Quality Principle 2.**
> You should be offered high quality, evidence-informed treatment, care and support interventions which keep you safe and empower you in your recovery.

Strengths
- It was evident from the staff and service user survey results, focus groups and case file reading that service users were offered high quality, evidence informed treatment, care and support interventions.
- The Roots to Recovery Service funded by the Integrated Care Fund was impressive. It had produced up to 30 case samples of interventions they had undertaken to date and had been well evaluated. They were working very closely with the homeless service outreach team and providing very good interventions for individuals who were difficult to reach and in crisis.
- Both the survey and case file reading analysis suggested that there was good access to harm reduction services. This was also the findings from our focus group meetings with staff, although, the message from service users was much more mixed. New psychoactive substances (NPS) and naloxone awareness and training had widespread availability and the harm reduction

nurse was positively reinforcing this work. Core services were thought to do good harm reduction work while most felt that the further away from the centre you got, the less services knew about the approach.

Areas for improvement
- Whilst both the self-evaluation and staff felt that consent was built in to key operational processes and kept under review, the survey and case file reading analysis would suggest this should remain an area of focus for the ADP.
- Overall, the service users in the focus group were positive about services but there were many strong opinions voiced about how difficult it was to access NHS Addiction Services assessment pathways for ORT's. The ADP would benefit from reviewing their prescribing pathways, including GP's and assess whether this reflects a wider view of service users' experiences.
- None of the service users in the focus group said they knew about the current single point of access arrangements which needs addressed to maximise accessibility.
- There was very mixed views about in-patient detox services being reduced to one week for alcohol and after care support. The ADP needs to address the stark contrast we found between staff and service users about aftercare and post discharge support.

3. Impact on staff

Quality Principle 3.
You should be supported by workers that have the right attitudes, values training and supervision throughout your recovery journey.

Strengths
- Almost all of the service user's completing the survey said that workers had the right attitude, values and worked in a supportive way. Most, but not all the focus group agreed.
- Almost all the staff we met and who responded to the staff survey said they felt well supported by their manager which was important in the context of the complex environment in which they work.
- The ADP had positively implemented Sainsbury Recovery Model to support individual service self-evaluation and they were reporting on quality aspects to the ADP executive group through an agreed reporting schedule.
- Both the case file reading and survey analysis suggested that the high majority of workers were encouraging individuals' to connect with wider community support groups which were important to their longer term wellbeing.

Areas for improvement
- Specialist trauma services were available in mental health services and accessible through joint integrated referral pathways. There were services for children who needed them. Whilst this was positive, our focus group highlighted that the extent of frontline staffs knowledge, skills and awareness was not consistent across services and capacity for specialist services was

often limited due to vacancies in key posts. The ADP needs to continue building on the good foundation they have laid to close any gaps in provision.
- Some service users in the focus group expressed frustration about having appointments with nurses with a background in alcohol services when they were presenting with drug related issues and vice a versa. The ADP could benefit from exploring the impact of this more fully.

4. Impact on the community

Strengths
- The appointment of the Wellbeing and Recovery Project Manager to oversee the project work around the Recovery Orientated System of Care (ROSC) had delivered a number of key objectives relating to community capacity building. In particular, the Wellbeing Fair work was particularly impressive.
- The benefits of the Social Prescribing Project are discussed further in the 'Good Example' section of this feedback summary.
- There was good evidence that the ADP had laid strong foundations in terms of their community work including their ROSC activity, mutual aid, whole population approach, NPS/naloxone strategies and had strong links to other thematic groups.

Areas for improvement
- There was a lack of clarity around the permanency of the resources committed to the above projects and the ADP should continue their work to ensure projects of this nature are designed to be sustainable in the longer term.
- Whilst all of the service users attending our focus group were generally positive about their experiences of services, none of them said they knew about the Quality Principles. The ADP needs to ensure that all its stakeholders know and understand how these shape their experiences working in addiction services
- The staff survey suggests that the ADP needs to demonstrate more effectively to staff how it is improving the quality of people's lives in the wider community so they can more clearly understand the wider benefits of the roles they undertake.

5. Delivery of key processes

Quality Principle 4.
You should be involved in a strength based assessment that demonstrates the choice of recovery model and therapy is based on your needs and aspirations.
Quality Principle 5.
You should have a recovery plan that is person-centred and addresses your broader health, care and social needs, and maintains a focus on safety throughout your recovery journey.
Quality Principle 6.
You should be involved in regular reviews of your recovery plan to demonstrate it continues to meet your needs and aspirations.
Quality Principle 7.

You should have the opportunity to be involved in an ongoing review of how services are delivered throughout your recovery.
Quality Principle 8.
Services should be family inclusive as part of their practice.

Strengths
- Almost all of service users completing the survey said their recovery plan felt personal to them and was achieved in partnership with staff. This was also reflected in the service user focus groups. In most cases, these were up to date and visible in the case files reflecting sound front line working practices.
- Feedback from staff and service users we met suggested that there was a developing approach to strength based practice. This needs to continue being consolidated.
- There was a positive and distinct shift of strategic policy direction and investment from the ADP, supported by all sectors, away from traditional treatment services and towards a whole family approach. Whilst service users we met in focus groups, as well as those completing the survey, experienced this, case file reading analysis indicated that there is the potential to further strengthen this approach in key processes.

Areas for improvement
- From our case file analysis we found that the majority of recovery plans identified agreed outcomes, however, only a few recovery plans were SMART. While staff we met in focus groups gave us examples of where this is developing across individual services, the ADP still had more work to do in this area.
- There were assessments, including risk assessments, in the majority of files we looked at. Whilst general assessments were all of an adequate standard and above, improvement was required around the timing and quality of risk assessments.
- Both the survey and case file analysis showed that the ADP needs to continue focussing on ways of providing people with copies of their recovery plans to ensure they are fully involved in their support.
- Whilst the service user survey indicated a high number of individuals felt plans were reviewed to reflect changes, the case file reading analysis suggested the ADP should continue to focus on this being done at intervals appropriate to the individual's needs.
- Despite a lot of evidence of close joint working across the ADP, less than half of the case file analysis showed an appropriate level of partnership working in terms of implementing individual plans which the ADP needs to address.
- The case file and survey analysis would indicate that more work needs to be done by the ADP to highlight the role of Independent Advocacy in order that service users opportunities to self-determination is maximised.

6. Policy, service development and planning

Strengths
- The ADP was developing their governance arrangements within the local and Tayside context in which it operated. Despite the current challenges including

health and social care integration, it had sound mechanisms in place for reporting progress on its delivery plan through both the Integration Joint Board (IJB) and Community Planning Partnership and linked well to other thematic groups.
- There was a strong focus on self-evaluation through the executive group using approaches such as the Sainsbury self-evaluation framework and the Quality Academy, which both embedded the Quality Principles.
- There were a number of targeted needs assessments undertaken such as NPS, mostly completed on a pan Tayside basis. The ADP's position within this work was strong and they were proactively using the findings to commission and invest and reinvest in areas that were beginning to shift the balance of care from treatment to early interventions including the whole family approach.
- The ADP involved service users in the commissioning processes effectively enhancing their involvement in service delivery and planning. It had a traditionally strong outcome focussed approach and linked to the use of alternative funding streams promoting sustainability such as Lloyds TSB Foundation and the Integrated Care Fund.
- The ADP was confident that it was actively involved in joint financial planning processes and that the outcome of this would support their vision for the services both in Perth and Kinross and more widely across Tayside, as the need for closer work across the region was acknowledged

Areas for improvement
- Whilst the position statement and ADP focus groups we attended confirmed that there were a number of effective engagement strategies in place, both the service user survey and focus group highlighted that some individuals remained unclear about how their views routinely shaped service delivery. The ADP would benefit from having a more systematic approach to service user feedback (You Said, We Did).
- The ADP needed to refresh its commissioning plan so it was in line with the IJB's strategic plan, recent needs analysis activity and clear focus on early interventions. This is to ensure it is consistent with the needs of the population and ADP vision.

7. Management and support of staff

> **Quality Principle 3.**
> You should be supported by workers that have the right attitudes, values training and supervision throughout your recovery journey.

Strengths
- The staff survey indicated that the majority of staff received an annual appraisal or performance review in the last year which showed the ADP was supporting personal and professional development for staff.

Areas for improvement
- Both the staff survey and focus group we attended reflected positive feedback from staff about feeling well supported and regularly receiving feedback on

the quality of their work. Whilst this was positive, it was evident in only a few case files we read. Consideration on how to better reflect this support and feedback within case notes needs to be undertaken.
- The staff survey indicated that the ADP needs to continue supporting new staff to undertake induction and workforce development opportunities to ensure they have the knowledge and skills to work in a complex area.
- Whilst there had been good workforce development foundation work undertaken jointly between the ADP, other Tayside ADP's and the Scottish Drugs Forum, the learning, training and development group needs to further develop a SMART delivery and implementation plan aligned to the ROSC..

8. Partnership working and resources

Strengths
- There was evidence that there was effective collaboration with all stakeholders and across all sectors. There were joint operating procedures, performance reporting, governance as well as strategic planning and delivery arrangements.
- There were strong working relationships developing with all the other appropriate thematic groups such as Child Protection Committee, Adult Protection Committee, children and families and other public protection agendas. In addition, the ROSC, mutual aid and whole population work were also firmly rooted in strong partnership arrangements.
- The co-location of the statutory services at Highland House in Perth was consolidating the above. Staff felt that multi-agency working had really been embedded since this model was introduced. Staff felt the multi-agency single point of access and drop in centre at Highland House was helping to diminish perceptual differences amongst staff.

Areas for improvement
- The ADP was working with its stakeholders to determine the future delivery model of their existing social work services but there was much uncertainty amongst all staff groups about this. The ADP needed to ensure frontline staff were kept abreast of developments including jointly agreed plans and timescales for change.
- Whilst the ADP had progressed well with co-location and joint delivery models, many of these services were delivered from a single point in Perth. Work remained to be done to determine how these existing statutory services will be jointly deployed more widely across localities.
- Both the staff and service users we met highlighted that the ADP would benefit from developing their joint processes, for example, shared assessments, outcome tools, and recovery plans to avoid areas of duplication.

9. Leadership and direction

Strengths
- The ADP was consistently meeting and exceeding key performance targets, indicating that they were successfully delivering accessible services.

- Our focus group with the ADP chair and its members confirmed that there was effective communication around the challenges and that all stakeholder agencies felt well informed.
- The ADP was collaborative, transparent, had robust governance in place, with sound strategic planning and delivery arrangements and established working relationships with all the other necessary strategic groups.
- The ADP had evidenced a high level of innovation, commitment to self-evaluation and ongoing improvement; this culture was well supported and encouraged by the leaders we met.
- The ADP benefited from a culture within services where the majority of staff felt motivated, supported by their manager and evidenced person-centred approaches to their work. All of this was positive given the context of the demanding working environment they operated within.

Areas for improvement
- Whilst ADP members felt positive about understanding the vision for the ADP, both the staff survey analysis and focus group suggested there is more work to be done to both communicate and involve staff in future service development.
- There was a strong emphasis on partnership working amongst services. Whilst this was positive, the redesign of the social work services was causing significant uncertainty and the ADP, along with its partner organisations, needed to make sure that all stakeholders were fully involved in consultations about any new joint service delivery models.

Examples of good practice

As part of the validated self-evaluation process, we asked partners to nominate some examples of good practice which can be shown to have a positive impact on the lives of individuals, families and communities. During the onsite visit we assessed these examples to identify those which we consider would be useful to other alcohol and drugs partnerships across Scotland.

- **The Social Prescribing Project.** The Social Prescribing Project was a sound and well integrated approach that featured an appointed lead officer who had collaborated closely with a large number of stakeholders and local communities to raise awareness of addiction issues, develop mutual aid and a range of sustainable support networks. The project had also developed an evaluation framework in order to measure the positive impact the work had on communities and had demonstrated a range of positive results to date. There was good evidence that this project had strengthening community capacity across Perth and Kinross.

Perth and Kinross
Health and Social Care
Partnership

ADP – BITE WRITE UP
Thursday 14 and Friday 15 December 2017
AK Bell Library, York Place, Perth, PH2 8EP
09:00-16:30

ADP - BITE
Thursday 14 and Friday 15 December 2017
AK Bell Library, York Place, Perth
09:00 – 16:30

Group 1 – Engagement	Group 2 – Preparation
Colin Paton	Ann-Marie Kennedy
Danielle Millar	Hazel Robertson
Kathryn Baker	Laura Kerr
Ross McLennan	Sandra Campbell

Group 3 – Change	Group 4 – Completion
Anne Fleming	Alan Arundel
Maureen Donnelly	Kenny Ogilvy
Russel Goldsmith	Louise Glover
Tim Elworthy	Richard Lister

Group 5 – Reintegration	Facilitators/Support
Liam McLaughlin	Paul Smith
Pauline McIntosh	Clare Mailer
Ian Burge	Eleanor Mackintosh
Dawn Wigley	Mary Begbie
Erin Martin	

ADP - BITE
Thursday 14 and Friday 15 December 2017
AK Bell Library, York Place, Perth
09:00 – 16:30

DAY 1		
Time	**Item**	**Who**
08:45 – 09:00 -	Arrival and Refreshments	
09:00 – 09:15	Welcome and Introductions Housekeeping / Rules for the BITE	Clare Mailer / Kenny Ogilvy
09:15 – 09:45	Ice Breaker	Paul Smith
09:45 – 10:45	**Overview and Presentation:** • ADP role • Reporting Structures • ROSC • ROSC Model • Quality Principles • Redesign Process • Pipeline	Clare Mailer / Kenny Ogilvy
10:45 – 11:00	Break	
11:00 - 11:40	**Breakout Session 1:** 5 Groups for Pipeline Model Workstreams What are the current issues?	
11:40 – 12.00	Feedback from Groups	
12.00 – 12.40	**Breakout Session 2:** 5 Groups for Pipeline Model Workstreams What currently works well?	
12.40 - 13.00	Feedback from Groups	
13.00 – 14.00	Lunch	
14.00 - 14.40	Breakout Session 3: 5 Groups for Pipeline Model Workstreams What Improvements can we make?	
14.40 – 15.00	Feedback from Groups	
15.00 – 15.45	Breakout Session 1 - 4 Groups: 1. Process 2. Comms & Engagement 3. Performance Framework / Outcome, Monitoring 4. Prevention	
15.45 – 16.00	Break	
16.00 – 16.20	Feedback from Groups	
16:20 – 16:30	Summary and Close	

ADP - BITE
Thursday 14 and Friday 15 December 2017
AK Bell Library, York Place, Perth
09:00 – 16:30

DAY 2		
Time	**Item**	**Who**
08:45 – 09:00 -	Arrival and Refreshments	
09:00 – 09:30	Recap on day 1	
09:30 – 10:15	Breakout Session 1 - 4 Groups: 　1. Process 　2. Comms & Engagement 　3. Performance Framework / Outcome, Monitoring 　4. Prevention	
10:15 – 10:45	Feedback from Groups	
10:45 – 11:00	Break	
11:00 – 11:45	Breakout Session 2 - 4 Groups: 　1. Process 　2. Comms & Engagement 　3. Performance Framework / Outcome, Monitoring 　4. Prevention	
11:45 – 12:15	Feedback from Groups	
	Rest of day TBC	

What are the current issues at each stage of the ROSC?

Group 1: Engagement

- Need to recognise loss / change for workers
- Poor understanding no common understanding of what 'engagement' is and **who** does the engagement
- When does engagement become preparation? Pre-contemplation stage?
- Not necessarily taking the time to stop listen and really understand what people are saying / what are the issues for them
  - Perhaps a lack of understanding of substance misuse issues? Across the broader workforce
  - Time pressures
- We don't always understand and value the importance of effective engagement
- We have lots of missed opportunities for engagement e.g. within justice services
- P&K website not easy to find info – people don't know where to go to start to ask for help
- Need clarity about the handover to next state – handover needs to be done well and supporting needs to change the language we use to value the stage of engagement

Group 2: Preparation

- Crisis or incident is usually the reason for people accessing services – does not always lead to a wish for change.
- Chemistry /personal connection is vital to this stage – this takes time and flexibility / capacity within the service
  - We don't tend to 'check in' with people to see how they feel about their working relationships (QP!!)
- Not a lot of options available to help people plan and prepare for their recovery journey
  - (Not connected to this but need to be using the Lloyds PD / research around recovery and children)
- Lack of relationships / joint working between services results in mixed messages. Being given prior to 'Treatment / service delivery'
- Separate care plans for children and parents does not help PPL Plan
- No common baseline assessment, makes it impossible to measure progress / outcomes
- Transitions between services is difficult i.e. LD MH, Prisons etc.
- Our services are not very 'stickable' but it's important to note that this is due to capacity / resources
- Should part of the initial assessment be around the 'style' and 'type' of intervention that the person feels would be best for them i.e. nurturing opposed to direct, structured counselling or support work.
- Do we have enough services that focus on helping people to establish routines, practical support that will enable them to move towards the preparation stage
  - Goal setting
- People not being aware / knowledge of options available

What are the current issues at each stage of the ROSC?

Group 3: Change

- No access to contingency management and community detox
- In prison – access to ORT is too limited/not prioritised
- Inability to track patients' journey (outcome measures, treatment history. (IT systems)
- Nursing staff taking on non-clinical tasks and doing it badly (i.e. coordinating benefits/housing/employment)
- Currently no commissioned services for change in tier 1 & 2
- Poor links to tier 1 & 2 non-commissioned services
- Challenging accessing mental health services, palliative care
- Poor recording of co-morbidities
- Capacity within commissioned services at breaking point (monitoring quality?)
- Ensuring equality in funding across localities
- Little opportunity to create capacity
- More required to ensure optimum health of workforce.

Group 4: Completion

- Change Is a Must (CIAM) – Decision made re children, substance us worker changes – need continuity of worker
- Resource issues in wider system – e.g. housing, 'safe' temporary housing
- Resource issues core services
- Attitudes generic services
- Lack of clear pathway to other services
- Rigid process driven system – not person centred or flexible
- Lack of communication between services/supports
- lack of ability to focus resources on people who may benefit most
- blanket rules in parts of system re no-engagement – overall system ready to keep door open
- People relapsing once return to own community
- Need improved links between prison p&p and wider system
- Therapeutic interventions need to be adopted before this stage. Often underlying issues related to trauma not addressed

Group 5: Re-Integration

- Barrier with employment
- Stigma
- Lack of resources
- Lack of focus resources
- Lack of opportunity for people to re-integrate
- We are still doing rather than them being involved
- Number of problems associated housing, family etc.
- Need to create a new persona
- Benefits create barrier
- Recovery is invisible
- Lack of engagement between us and employers
- Scottish Government employment strategy not inclusive
- Support for employers
- Relapse = failure
- Flexibility of appointments
- Flexible treatment
- Lowering expectation in regards to work being carried out

What are the current issues at each stage of the ROSC?
Group 5: Re-Integration
• How to disclose gaps in employment history, criminal convictions / support needed in this area   • Lack of openness / honesty   • Isolation   • Follows you around (addiction)   • Language should be plain English and available in other languages

What currently works well at each stage of the ROSC?
Group 1: Engagement

- Keep the different options, not just one point of contact – offer different pathways i.e. Social Work, TSMS, TCA and different locations
- Phone and 'walk in' services – stigma and confidentiality
- Out of 'business' house service to be held on to.
- Continue relationships building between agencies – learning & developing a better service for clients.
- Keep staff motivated who are open to and continuing to develop change.
- Presence at Social Care & Health partnership forums/meetings – ECS

Group 2: Preparation

- Pockets of good exchange of advice and information (primarily specialist Substance Misuse Services (built on this)
- Pockets of really good practice that we should learn from e.g. CIAM Service Misuse Worker, brilliant model replicate this across Children's Services – **DON'T** dilute by expanding their area of responsibility
- Look at other areas to see if there are more examples of this
- Trauma informed practice / ACES
- Housing First model
- Naloxone
- Belief in the capacity to change
- Understanding of the significance of deprivation and poverty in this area
- Reflective and learning culture across the system
- Hold on to the successes and accept small wins
- (TCA) – aftercare monthly contact for up to a year
- Harm reduction
- IEP
- Engagement with sexual health and BBV services
- Dry Blood Spot Testing (DBST)

Group 3: Change

- Integrate but retain specialisms i.e. NHS; MH specialists; SW; psychology (- Prioritised – Training – Integration to Generic)
- Accessibility (at a cost – capacity – retention)
- Good Partnership working > (build/capitalise on this)
- Strong foundations to build on
- People **DO** achieve abstinence
- People have reduced risk
- Provide access to NHs services i.e. harm reduction; BBV; needle exchange; pain clinic; MH services
- Evidence based interventions support by clinical governance
- Evidence based pathway to other partners – (alcohol)
- Provide equity of across large geographical area
- Late night clinics to increase across for workers etc. (& early morning appointments)

What currently works well at each stage of the ROSC?
Group 4: Completion

- Joint working ECS, LD, EIP, TSMS, TCA, CAIR
- Co-location
- Shared perspective – different teams, different models – there are relationships, confidence & trust for joint working
- Professional standards & values. *Skills – committed workers willing to go above and beyond.
- Flexibility to provide brief intervention at short notice
- Period of stability whilst maintaining culture of continuous improvement
- Specialist SW support/knowledge
- Flexibility of service provision – employability > SMART recovery
- Training/education
- Sign posting
- Agreeing pathways
- The good working relationships.

Group 5: Re-integration

- A lot of agencies supporting people
- Agencies doing good work
- Local community organisations = life line
- Peer support/development of peers
- Mindspace recovery college
- Through care agencies
- Moving on service
- Recovery cases
- Work opportunities in prison
- Peer support in the prison
- Individuals in recovery involved
- Passionate staff/keen to make a difference
- SMART recovery
- Skilled workforce
- Andysman

What Improvements can we make at each stage of the ROSC?
Group 1: Engagement

- What population group are you looking to engage with?
- L&D – Too all, in relation to "engagement"
- The value of engagement – Bolton to training that is already taking place. Learning about the process
- Opportunity
  - "Needle X"
  - "Welfare Rights"
  - Chemists
  - Justice
  - A&E – PRI
  - Website re-launch – Linked to other
- Collaborative routes to engagement – Lessons from other project
  - Triage example – TCA, CAIR
- Out of hours – Working more to meet supply & demand
- Culture – Public awareness
- Communication – messages – remove the stigma & myths
- School's & other youth/young people areas – look to mental health
- Understanding **trauma** – SDF course
  - We need champions to take this forward → MI
- Develop workforce to establish recovery plans to set groups
  - Hand held records
  - Personal passports
  - Wellness & Recovery Action Plan (WRAP)
- Engage with "whole family"
- Developing & investing in peer approaches
- Time set audits to ensure that the part of the pipeline is achieving
- *everyone's job*

Group 2: Preparation

- Improved liaison across services and clarity of realistic goals to achieve outcomes
- SHANARRI / RICKTER resilience matrix wellbeing web
- Prioritise a 'whole family approach'
- More holistic approach for those using services (avoid onward referrals where possible)
- Assertive outreach (desirable) but at a minimum ensure 'stickability' to help improve outcomes for individuals
- Acknowledge that therapeutic work is hard and will be difficult to make 'attractive' to stick with a service – need to give options to help people stay engaged
- Improved joint working – make contact with people where they feel comfortable – use of different settings
- Increase service awareness of resourced and how to access provision
- Reinforce the strengths of having specialist roles / understanding and access to appropriate resources
- General improvement of awareness of substance use
- Environment we work in
- Lack of investment infrastructure
- Sharing of information between services

What Improvements can we make at each stage of the ROSC?
Group 3: Change

- Not continuing to push efficiency savings. (Now they are usually cuts).
- All services need to improve PR
- Act we invest in business infrastructure, (IT; admin functions & staffing) & systems which speak to each other!
- Needs assessed & matched to right intervention at right time & right person delivering it.
- TSMS needs to focus & invest on the prescribing interventions and the other partner agencies need to meet other needs.

Group 4: Completion

- Processes – reduce paperwork, single IT system
- Co-location
- Clearly defined roles with level of overlap (re supporting person)
- Lead worker/named person – including CJS & Prison P&P
- One person one plan
- Sharing information / data protection
- Improved pathway to 3rd sector to support re integration
- Clearer pathway for people not meeting criteria for stat. support
- Integrated care team – meetings for substance use workers/organisations (3rd sector?)
- Dedicated worker to work regularly with prisoners 1 month before release re ongoing supports
- Combine meetings- MARAC, unborn baby, NATAC, MAPPA, CCIG?

Group 5: Re-integration

- More workers in communities
- More support for reintegration
- Organisation taking on the role of work placements
- Variety of workplaces
- More support in regards to education
- More family support educate family on recovery (whole family approach)
- More emphasis on what recovery means
- Improved drug education in schools
- Early drug intervention in schools, picking up users early
- More emphasis on mental health, early criminal justice, upskill staff, deliver psychosocial such as CBT
- Link better with MH Services
- Involving people such as pharmacists / nurses
- Strengthen links between person and service such as churches
- More collaboration between people using services
- Holistic approach
- Support for individuals to access local community groups

Group 1 – Comms & Engagement	Group 2 – OD & Training
Ann-Marie Kennedy	Chris Lamont
Liam McLaughlin	Colin Paton
Maureen Donnelly	Pauline McIntosh

Group 3 - Performance & Framework	Group 4 – Prevention
Kathryn Baker	Erin Martin
Laura Kerr	Hazel Robertson
Russel Goldsmith	Ross McLennan

Group 5 – Process	
Anne Fleming	Kenny Ogilvy
Danielle Millar	Louise Glover
Dawn Wigley	Richard Lister
Ian Burge	

Facilitators / Support	
Clare Mailer	Eleanor Mackintosh
Paul Smith	Mary Begbie

Additional Information
Group 1 - Communications & Engagement

- Comms – Protocol
- Comms – Action Plan and Digital Action Plan
- Improving in some partners
- Inability to communication in the 'right language'
- At present:
  - Governance
  - Not good -
  - ADP – lack of feedback
  - Using old systems for new problems?
- Professionals really bad?
- Chose who we communicate with
- Embrace modern technology
- The way we run meetings
- Flexibility outwith 'office hours'
- Family approach
- Better liaison with families
- Communications – 1 way system
- Campaign for real English
- Maudsley Dual Diagnosis model
- Outreach / hard to reach people

Group 1 - Communications & Engagement Membership

- Comms & Engagement worker – Paul Turner
- Liam McLaughlin
- Service User –
- Third / Church Sector –
- Employers –
- Prison –
- Services –

Group 1 - Communications & Engagement GAPS

- Alcohol Briefing Interventions (ABI) training
- Motivational Interventions (MI) training
- Vulnerable People training
- Whole Family training
- Trauma training

Group 4 - Prevention

- Recognise value of engaging family / friends a earliest opportunity
- Combat damaging effects of stigma
- Acknowledge the importance of trauma and the impact of this on adult substance users
- Reinforce hope and aspiration for the future
- Brief intervention
- Promotion of self-esteem in drug / alcohol education and impact of negative consequences
- Improve awareness of specialist resources amongst universal services
- Develop of 'softer' approach to offer assistance

Additional Information
Group 5 - Processes

GAPS
- Lack of capacity to do motivational/prep work
- Lac of recording
- Group work
- Passing information
- Who does drop in?
- Naxolone
- Who does Harm Reduction
- Social Work & CAIR not in prison

Consideration:
- Explore Wellbeing Team
- Explore Relapse Prevention (WT) & Locality SW
- Recovery Plan travels with individuals
- Seek funding
  - Groups
  - CAIR relapse prevention/WRAP
  -

RESOURCES
- SW Team 0.5 WTE + 1.0 support worker
- Access generic
- CAIR 1.0 WTE
- TSMS 8.4 WTE + 3.0 HCSW

ITEM	ACTION	WHO	WHEN	COMMENTS
Group 1 – Communications & Engagement Action Plan				
1	What we need to communicate? Formalise a Communication group	ADP Partners	March 2018	This would aid Communication Strategy and feed into wider Comms & Engagement Group
2	Some gaps in communications to all services Ensure Communications are circulated amongst **all** services	ADP Services	Mid 2018	Through Comms group. Information is circulated throughout all service. Use – My P&K website / NHS StaffNet Service Manager contacts
3	How do we 'lock' people into wanting info re D&A issues? Substance Misuse effects all Services Require to ensure engagement around communication and information Link in with OD & Training Pathway	ADP Services	March 2018	OD & Training Actin Plan Link in so that all services can be targeted
4	ADP launch Lack of overall knowledge re substance issues and Services Improve knowledge and information for all services regarding knowledge around issues. Services and health	ADP Substance Misuse Services	March 2018	Increase profile of Substance Misuse and available services. Impact upon health and social impact
5	Improve use of technology around Communications & Engagement Use TEC Care to communicate and engage. Link in with Schools IT departments to improve access	ADP IT Offices	Mid 2018	Link in with Health improvement TEC Care MOMO

ADP - BITE
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ITEM	ACTION	WHO	WHEN	COMMENTS
	Group 2 – OD & Training Action Plan			
1	Ensure LD and Workforce training is standard item on ADP agenda	Delivery Groups	End March 2018 Young Persons Group already established	Ensure an agenda as opposed to commencing new group
2	Devise 2018 workforce development calendar	L McLaughlin / Partners	Mid 2018	Using existing resources to devise calendar. Ensure ROSC, SKT is incorporated
3	Implement 'toolbox talks' Topics to be decided e.g. ROSC, SKT	C Paton / Partners	April 2018	Aim to have 4 – 5 talks delivered to relevant people within 6 months of 2018
4	ADP launch Highlight role to other services	ADP Steering Group	By mid to end 2018	Continues to be some uncertainty around what ADP is and what's its role
5	Ensure ADP partnership working with Adult Protection, Child Protection and Community Safety to prevent duplication	L McLaughlin		Use other services. Vehicles to highlight and promote delivery
6	Monitor all learning and recommendation from reports. outcomes. Links in with Action 1	ADP Delivery groups	As Action 1	Monitoring and governance is lead by ADP delivery groups
7	Encourage shadowing and 'on the job' learning amongst services	All Services		ADP Shadowing Policy
8	Future internal audit to measure any success	All		Still to be further developed

ITEM	ACTION	WHO	WHEN	COMMENTS
**Group 3 – Performance & Framework Action Plan**				
1	Tayside-wide audit of current data collection demands across <u>ALL</u> services.	Laura Kerr & Russel Goldsmith	Completed end of Jan '18	Questionnaire to be sent out (LK)
2	Evaluate above action	Laura & Russel	Completed end of Feb '18	
3	Write up evaluation & present to 3 ADP chairs for comment/sign-off.	Laura & Russel		Ask Chairs to present to IJB to prompt discussion re shared system. Ideally end up with <u>one</u> system that <u>all</u> services can use & what they need for funders.
4	Develop balanced score card	Laura Kerr & ADP members		
5	Develop contract monitoring form/framework of <u>all</u> services	Laura Kerr & Liam McLaughlin		Recognising added value. Review after a year!
6	Regular contract monitoring groups for <u>all</u> services	Laura Kerr, Liam McLaughlin & contracts		
7	Establish Finance & Commissioning sub group of ADP	Laura Kerr		
8	Map RON outcomes against SHANARRI			

	Group 4 - Prevention			
ITEM	**ACTION**	**WHO**	**WHEN**	**COMMENTS**
1	Positive engagement of family and friends at earliest opportunity	All	Immediate	Separate responses required for individuals who have substance problems and for family members who make independent contact
2	Combat stigma associated with substance use	Employers (via staf communications) Trainers	?	
3	Improved understanding of impact of trauma on adult substance users	ADP members to promote		Utilise existing training models and extend access to training
4	Encourage asset based approaches to help built self-esteem across all partner agencies	ADP members		
5	Promote Belief in Recovery / Hope and aspiration for future	? Peer support		
6	Develop brief intervention opportunities	Front-line universal services		
7	Improve awareness of specialist resources amongst universal services	PKC		Make use of existing comms teams in all organisations
8	Ensure there is an appropriate services for Young People who use substances			

ITEM	ACTION	WHO	WHEN	COMMENT
	**Group 5 – Processes Action Plan**			
1	Review drop in function & staffing	A Fleming	Mar '18	
2	Review triage com	A Fleming	Mar '18	
3	Increase capacity for motivation / prep work	K Ogilvy	Mar '18	
4	Increase capacity reintegration	K Ogilvy	Mar '18	
5	Develop lead worker role	C Paton	Mar '18	
6	Develop personal recovery care plan	C Paton	Mar '18	
7	Review triage prison	D Wigley	Mar '18	
8	Scope potential for developing 'recovery community'			
9	Assessment docs & outcomes tools			
10	Need to consider needs of young person who misuses drugs & alcohol			
11	Need to consider special care need of elderly people with drug & alcohol issues			

Group 2 – OD & Training - ADP Toolbox Talks	
TOPIC:	Engagement / Methadone Awareness . . .
OBJECTIVE:	To ensure engagement . . . .
OUTCOME OF TALK:	Staff to . . . . .
KEY LEARNING POINTS:	1
	2
	3
	4
	5
ADDITIONAL LEARNING:	
ADP LEVEL COURSE	

Group 4 – Processes
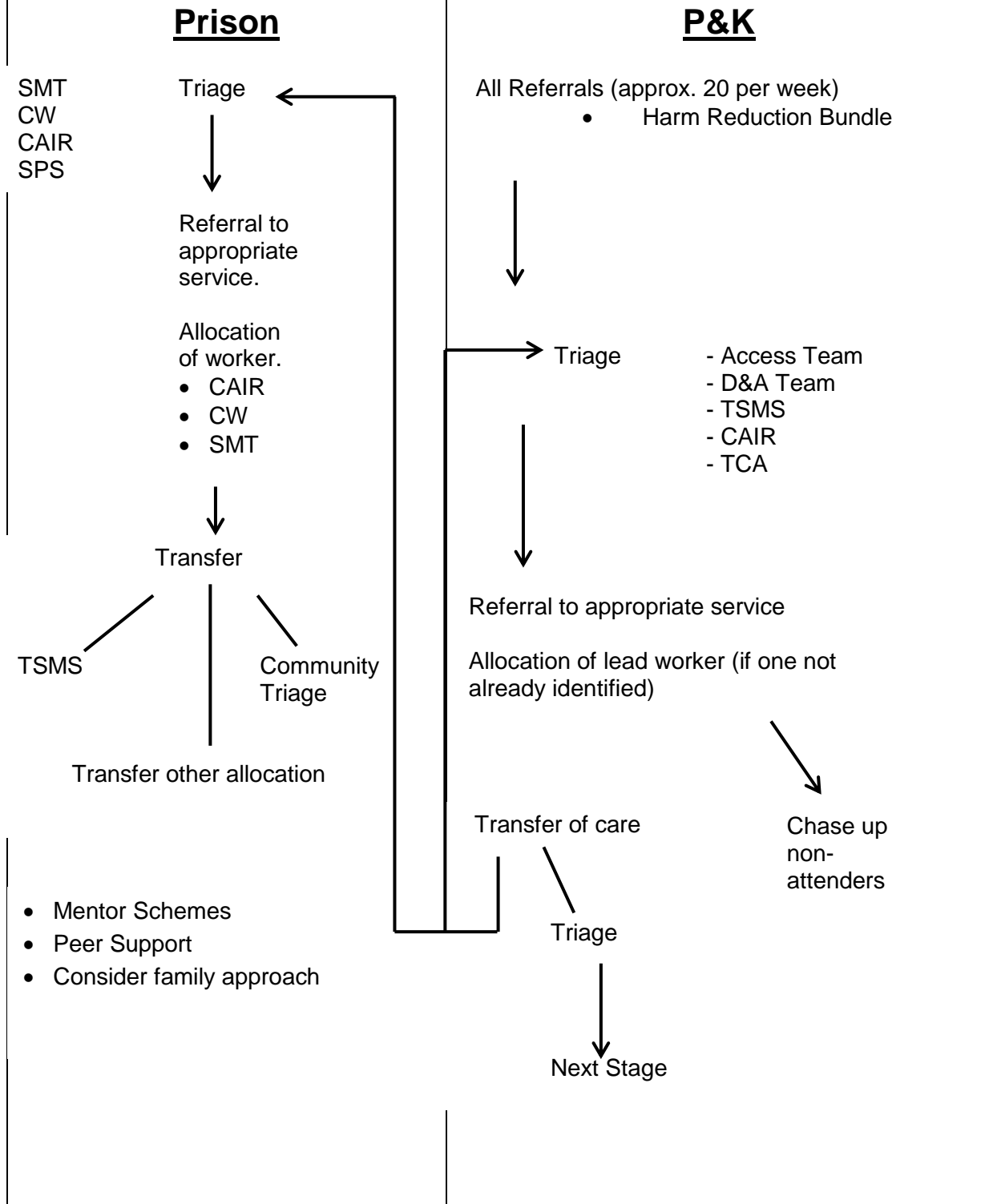
Prison

SMT
CW
CAIR
SPS

Triage

↓

Referral to appropriate service.

Allocation of worker.
- CAIR
- CW
- SMT

↓

Transfer

TSMS   Community Triage

Transfer other allocation

- Mentor Schemes
- Peer Support
- Consider family approach

P&K

All Referrals (approx. 20 per week)
- Harm Reduction Bundle

↓

Triage   - Access Team
             - D&A Team
             - TSMS
             - CAIR
             - TCA

↓

Referral to appropriate service

Allocation of lead worker (if one not already identified)

Transfer of care   Chase up non-attenders

Triage

↓

Next Stage

Risk / Issues:

- No representation from Police Scotland and Community Justice Services
- Recruitment / rete ton of staff
- Training / Workforce Development
- Data quality
- Monitoring
- Tracking of clients
- Pharmacy / prescribing capacity
- Service secs / Memo of Understanding need updated to ensure they are reflective of ROSC and WFA
- No new contracts have been issued to commissioned services, only letters of comfort.
- H2 link with other relevant groups – strategic partnerships
- Not getting enough resource to implement re-design
- Un-met needs – no capacity to cope with an increase
- Are services really accessible – how do we measure?
- Not meeting waiting list target
- Providing for non-opiate users
- Losing focus on alcohol users
- Approval for CIAM D&A Social work
- Don't take opportunity to make changes

Recovery Pipeline

Engagement	Preparation	Change	Completion	Re-integration

Kinclaven

TSMS

Access Team

D&A Team

SPS

Prison Health Services

TCA — Harm Reduction

Pharmacies

CIAM

RASAC

SPS

Access Team

TCA

Children's services

CIAM

TCA

Children's Services

CAIR

CAIR

CAIR

Locality Teams

Services for Young People

Elderly

Housing

EPICS

Hospital Discharge, A&E, GPs

Tier 4 - Residential Treatment

Tier 3 - Community Based drug assessment and structured treatment

Tier 2 - Information and advice by specialist drug services, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction services and aftercare

Tier 1- Information and advice, screening and referral to specialist drug treatment services, provided by non-drug specialists

ADP Redesign Project Diagram

Project Brief

The Redesign Project's aim is to support the implementation and delivery of a Recovery Oriented System of Care (ROSC) which emphasizes prevention and recovery. The Redesign Project objectives are to:

1. Review and redesign the ADP delivery of services within localities to reflect strategic priorities of Early Intervention, Prevention and Recovery and the delivery of a Recovery Orientated System of Care (ROSC).

2. Adhere to the Quality Principles and Care Standards to deliver improved person centered outcomes for individuals.

3. Deliver a service that meets our legal and statutory responsibilities.

4. Deliver a service that has the flexibility to respond to changes in demand at a service and individual level. (Based in the 4 tiers of intervention model)

5. Offer an efficient and value for money service that delivers improved outcomes for individuals, families and communities and cost savings.

6. Meet the ADP strategic aims of Whole Family Approach, Whole Population.

Process flow (centre)

- Stocktake of Current Activity
- Analysis of Current and Future
- Financial Savings
- Map on to Pipeline tiered model
- BITE to decide future service design including ROSC
- Establish workstreams to implement service redesign
- Workstream 1 Comms & Engagement
- Workstream 2 OD & Training
- Workstream 3 Performance & Framework
- Workstream 4 Prevention
- Workstream 5 Process
- Engagement Event with wider group of partners
- Refine workstreams based on feedback from Event
- Full implementation of redesign

CUSTOMER/SERVICE USER EXPERIENCE

OUTCOMES

1. Health - More people are healthier and experience fewer risks as a result of alcohol and drug misuse

2. Prevalence - Fewer adults and children are drinking or using at levels or patterns damaging to themselves or others;

3. Recovery - More individuals are improving their health, wellbeing and life chances by recovering from problematic drug/alcohol use;

4. Families - More children and family members who are affected by alcohol and drugs are safe, well supported and have improved life chances;

5. Community - More communities and individuals are safe from alcohol/drug related offending and anti-social behaviour;

6. Local Environment - More people live in a positive, health promoting local environment where alcohol and drugs are less readily available;

7. Services - All alcohol and drugs prevention, treatment and support services are high quality. They are continually improving, evidence based and responsive to people moving through treatment into sustained recovery.

Timeline

September - December 2017	Dec-17	January 18 - ???	TBC

September - December 2017

Activity

1. Stocktake of Current Activity
- *interviews conducted with service providers*

2. Analysis of Current and Future demand

3. Financial Savings

4. Create Pipeline ROSC model

5. Supporting documentation for BITE

Dec-17

Bite Activity

Map on to Pipeline Model

BITE to decide future service design including ROSC

Establish Workstreams to implement service redesign

January 18 - ???

Workstreams

1. Action plans developed for each workstream

2. Leads to arrange meetings with teams before each project board meeting

3. Highlight reports to be completed by leads for each Project Board Meeting

4. Project Board to track progress monthly and report to startegy group quarterly

TBC

Activity

1. Date and venue for wider engagement event selected

2. Invitees agreed by Project Board

3. Event held

4. Feedback incorporated into workstream actoin plans

- *Preparation for BITE*
- *BITE*
- *Redesign Activity*
- *Engagement & Implementation*

WORKSTREAMS

1. Comms & Engagement - Chris Lamont
- To improve the communication of ADP's role and remit to partner organisations and between members

2. Organisational Design and Training - Colin Paton
- To develop a training and development plan for ADP members and partner organisaitions

3. Performance and Framework - Clare Mailer
- To develop a robust performance framework for ADP that allows clear outcome measurement and consistency, within P&K and across Tayside

4. Prevention - Erin Martin
- To design and implement a prevention strategy for substance misuse across P&K

5. Process - Kenny Ogilvy
- To continue the redesign of processes started at the BITE, ensuring a ROSC model of service delivery is implemented woth all elements of ROSC delivered

Perth & Kinross Integration Joint Board

22 June 2018

Unaudited Annual Accounts 2017/18

Report by Jane Smith, Chief Financial Officer (G/18/93)

PURPOSE OF REPORT

This report presents the Integration Joint Board's (IJB) Unaudited Annual Accounts for the financial year 2017/18 in accordance with the Local Authority Accounts (Scotland) Regulations 2014.

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1. **BACKGROUND**

1.1 The Unaudited Annual Accounts for 2017/18 are due to be submitted to the Controller of Audit by 30 June 2018.

1.2 The Annual Accounts are prepared in accordance with the 2015 CIPFA Code of Practice on Local Authority Accounting ("the Code").

1.3 These accounts also comply with the Local Authority Accounts (Scotland) Regulations 2014 which came into force in October 2014.

2. **ANNUAL ACCOUNTS**

2.1 The regulations require an annual review of the effectiveness of the IJB's system of internal control. This requirement will be met by the approval of the Annual Governance Statement by the Audit & Performance Committee of the IJB on 19 June 2018. The Statement is set out from page 16 of the attached accounts.

2.2 The Annual Accounts include a Management Commentary. The purpose of which is to provide users of the financial statements with integrated information on management's view of performance, position and progress (including forward looking information). This is set out from page 1 of the Accounts.

2.3 The regulations require the IJB to consider the unaudited accounts at a meeting to be held no later than 31 August 2018. Best practice is for the IJB to have formally considered the Unaudited Annual Accounts prior to submitting them to the appointed auditor and making them available for public inspection.

2.4 Following consideration of the Unaudited Annual Accounts the IJB is asked to authorise the Chief Financial Officer to sign the Accounts, submit for external audit and make them available for public inspection,

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3. NEXT STEPS

3.1 The audit of the Annual Accounts will take place during July and August 2018. Audit Scotland (working with Council officers) will consider whether the Annual Accounts:

- Give a true and fair view in accordance with applicable law and the 2015/16 Code of the state of the affairs of the IJB at 31 March 2018 and of the income and expenditure of the IJB for the year then ended;
- Have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 Code; and
- Have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973 and the Local Government in Scotland Act 2003.

3.2 It is anticipated that the results of the audit will be summarised in the Draft Annual Report which incorporates the ISA260: Report to those Charged with Governance. It is anticipated that this Audit Scotland report will be considered by the Audit & Performance Committee on 25 September 2018 with the Final Annual Report on the 2016/17 Audit being considered by the IJB on 28 September 2018.

3.3 The Unaudited Annual Accounts are also available for public inspection between 2 July and 20 July 2018 (inclusive) with any objections being sent to the auditor.

4.   CONCLUSION AND RECOMMENDATIONS

4.1 The Unaudited Annual Accounts require to be submitted to the Controller of Audit by 30 June 2018 subject to approval by the IJB and authorisation by the Chief Financial Officer.

4.2 It is recommended that the IJB authorises the Chief Officer to sign the Unaudited Annual Accounts.

Name	Designation	Contact Details
Jane M Smith	Chief Financial Officer	janemsmith@nhs.net

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Perth and Kinross Health and Social Care Partnership

Supporting healthy and independent lives

Perth and Kinross Integration Joint Board

Annual Accounts 2017/18

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INTRODUCTION

This publication contains the financial statement for Perth & Kinross Integration Joint Board (IJB) for the year ended 31 March 2018.

The Management Commentary outlines key messages in relation to the objectives and strategy of Perth & Kinross Integration Joint Board (IJB) and the financial performance of the IJB for the year ended 31 March 2018. It also provides an indication of the issues and risks which may impact upon the finances of the IJB in the future and the challenges we face in meeting the needs of the people of Perthshire & Kinross.

Perth & Kinross Integration Joint Board was established as a body corporate by order of the Scottish Ministers on 3 October 2015 as part of the establishment of the framework for the integration of health and social care in Scotland under the Public Bodies (Joint Working) (Scotland) Act 2014.

The IJB has responsibility for providing social care and defined health care services for the residents Perthshire and Kinross encompassing an area of 5,000 square kilometres and a population of 150,000. In addition, the IJB provides specific health care services across Tayside by means of hosted services arrangements agreed in the Integration Scheme between NHS Tayside and Perth & Kinross Council. Perth & Kinross Council and the NHS Tayside (Health Board), as the parties to the Integration Scheme, each nominate four voting members to sit on the IJB. The Council nominates Elected Members and the Health Board Non-Executive Directors.

 A Council nominee was the Chair of the IJB until 30th September 2017 and the Vice-Chair was drawn from NHS Board Non-Executive Directors. From 1st October an NHS Board Non-Executive Director was the Chair and a Council nominee was appointed as Vice Chair. A number of non-voting Representative Members sit on the Integration Joint Board and contribute to its proceedings. These Representatives are chosen from the Third Sector, Carers, Services Users, and Council and NHS Board staff. A GP Stakeholder Member has also been appointed along with a Medical Practitioner who is not a GP.

Management support to the IJB is led by the Chief Officer. The operational structure is a composite of three principal service areas:

- Community Health / Hospital & Other Hosted Services
- Adult Social Care Services
- Inpatient Mental Health Services

The IJB has appointed a Clinical Director and a Chief Finance Officer. Corporate services including strategic planning, performance and business support services to the IJB are provided by NHS Tayside and Perth & Kinross Council.

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PURPOSE AND OBJECTIVES OF THE IJB

The main purpose of integration is to improve the wellbeing of families, communities and people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. The Integration Joint Board has approved the following Vision for the Health and Social Care Partnership as part of its approved Strategic Plan for 2016-19: "We will work together to support people living in Perth and Kinross to lead healthy and active lives and live as independently as possible in their own homes, or in a homely setting with choice and control over the decisions they make about their care and support." The Integration Scheme puts in place a framework designed to deliver the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under Section 5(1) of the Public Bodies (Joint Working) (Scotland) Act 2014. The IJB Strategic Plan sets out a number of Strategic Objectives and Policy Priorities with accompanying Implementation and Resource Plans, Performance Framework and Strategic Risk Assessment, all designed to ensure a direction of travel by the Partnership consistent with National Objectives. The Partnership's agreed Strategic Objectives are as follows:

1. Prevention and early intervention
2. Person-centered health, care and support
3. Working together with our communities
4. Reducing inequalities and unequal health outcomes and promoting healthy living
5. Making best use of available facilities, people and other resources

The plan places a lot of emphasis on the need for services and support to intervene early to prevent later, longer term issues arising, and enabling people to manage their own care and support by taking control and being empowered to manage their situation. Where this is not possible, our aim is for services to target resources where they are needed most, reducing ill health and deterioration and ultimately reducing health inequalities.

OPERATIONS FOR THE YEAR

The IJB's strategic ambitions sit alongside operational imperatives across a wide range of services. This creates a very challenging landscape to deliver major service redesign at the pace expected. However much progress has been made including:

- The development of Integrated Care Teams (ICTs) across the three localities in Perth & Kinross has continued aimed at providing targeted health and social care to restore and improve the quality of life for individuals in our communities. A Person Centered Framework has been developed for the purposes of identification of a named key worker.

- A redesign of Psychiatry of Old Age (POA) services has been taken forward increasing the Older Peoples Mental Health community based teams across Perth & Kinross allowing enhanced care in peoples homes. The enhanced teams are an integral part of the Integrated Care Team in each locality. In addition a multi-disciplinary POA Liaison Service has been established supporting wards at Perth

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Royal Infirmary and Murray Royal Hospital dementia care, diagnosis of delirium and managing cognitive impairment needs.

- During the year, the fully implemented Discharge Hub at Perth Royal Infirmary has had a significant impact on ensuring timely and appropriate discharge from hospital, improving health and well being outcomes by reducing significantly the length of stay in a hospital setting and the overall risk of a delay. Further a new Social Care 'HART' team (Home Assessment Recovery Team) has been established in further support of timely discharge and early intervention and prevention. Care Home liaison services have also been enhanced ensuring timely and appropriate discharge to care home settings. A better locality focus on Care Home Liaison has also been established.

- During the year, a full review of residential care was undertaken. In Perth & Kinross there is a decline in demand for residential care home placements in line with national trend. However demand for nursing care home placements continues to increase and further investment will be required moving forward.

- The implementation of the Carer's Act has been a significant program of work. The IJB approved eligibility criteria during the year following consultation with key stakeholders. Additional carer support workers have been recruited. Further significant investment will be required moving forward.

- The implementation of a new care home contract was completed following an extensive tendering process. The demand of care at home continues to increase however and the sector has struggled to keep pace with demand. A review of the sustainability of the current service model is required.

- During 2017/18 the significant restructure of social work and social care field work teams was completed, ensuring a shift in resources to provide early and preventative interventions. Moving forward we will be working with communities to support the work that they can do to reduce isolation and loneliness.

- We have worked closely with clinicians at Perth Royal Infirmary and with staff across Community Hospitals to develop a sustainable service model for the future with pathways that ensure appropriate capacity and flow in and out of the inpatient environments.

- As the IJB responsible for hosting In Patient Mental Health and Learning Disabilities, we have completed an extensive review of these services with options identified and a three month public consultation on proposals for the future delivery of services. The preferred option will see the relocation of all 4 General Adult Psychiatry wards at the Carseview Centre in Dundee and all Learning Disability Inpatient Wards relocated to Murray Royal Hospital in Perth.

- Across our other hosted services, the Podiatry Service has successfully implemented a move to single use instrumentation in a number of areas. Further it has undertaken a review of workforce to ensure equity of access to specialist podiatry care across each locality. Within our Public Dental Service, the provision

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of person centered care has continued with close community working to promote oral health prevention an intervention across all ages. Within Prison Healthcare, the completion of significant redesign of workforce has improved the effectiveness of service delivery including medicines prescribing.

- During 2017/18, we have provided funding to support GP capacity to work with us on quality, safe and cost effective prescribing. The program of engagement will step up further in 2018/19.

- The role of the Executive Management Team has been strengthened and this pivotal group now provides scrutiny review and support to all key transformation projects across the Partnership.

Looking forward to 2018/19, the Partnership has a number of key priorities focused on ensuring future sustainability of services:

- We will take forward the development of our Primary Care Improvement Plan aimed at ensuring that the benefits set out in the new contract for GP's are realised.

- We plan to expand Technology Enabled Care in the year ahead and enable people to choose the way their care and support are provided. This will complement our support to carers and reduce the need for Care at Home where this is appropriate.

- We will increase our support to carers through further enhanced community support, enabling people to remain at home for longer and avoiding unnecessary admissions and longer stays in hospital.

- For Inpatient Mental Health services the planning for and implementation of approved transformational changes will be taken forward. Further opportunities to deliver sustainable services will also be developed. This will include a review of the current inpatient drug and alcohol service.

- We will finalise the review of Inpatient model for Tay Ward, Stroke Services and our Community Hospitals. This forms a significant part of the wider development of a Perth & Kinross Integrated Clinical Strategy. The timescales for this will be determined by the broader NHS Tayside review of Unscheduled Care for which an Option Appraisal is to be completed by July. This will include a review of Emergency Department and General Medical Wards at PRI which form part of the IJB's large hospital set aside budget.

- There will be a further review of Psychiatry of Old Age Inpatient Services with an even greater focus on community based provision through the Integrated Care Teams in each locality.

- Within Prison Healthcare we will work with the Scottish Prison Service to consider implications of a move to Smoke Free Prisons

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PERFORMANCE REVIEW

The Scottish Government has determined a key set of performance indicators that they consider measure the progress of integration. Our performance compared to last year against each of the indicators is set out below:-

Data indicators

MSG Indicator	MSG Description	P&K Total Previous Year	P&K Current Year	P&K YTD diff from 16/17
1a	Emergency Admissions	15,128	15,021	↓ 107
2a	Unscheduled hospital bed days	111,324	102,451	↓ 8,873
3a	A&E Attendances	31,825	32,506	↑ 681
4.1	Delayed discharge bed days**	19,176	16,785	↓ 2,391
5.1	Proportion of last 6 months of life spent at home or in a community setting	88%	89%	↑ 0.46%
6.1	Percentage of population at home unsupported	98%	98%	↑ 0.03%

* Takes the last 12 months from the date shown in column D, except for MSG 5 and 6, where the previous financial year before is taken for comparison

** Changes to the calculation of delayed discharges came into effect in July 2016

Our work to ensure effective and appropriate flow into and from our hospital services has impacted positively on both levels of delayed discharge and unplanned admissions.

FINANCIAL MANAGEMENT

Background

The IJB's finances are overseen by the IJB's Chief Finance Officer with support from Finance functions within Perth & Kinross Council and NHS Tayside. This support is provided as part of overall arrangements for corporate support services whereby Perth & Kinross Council and NHS Tayside provide a range of services including, for example, Finance, Human Resources and Committee Services support without charge to Perth & Kinross IJB.

Prior to April 2016, the IJB had developed the financial governance infrastructure required to allow it to assume new responsibilities from 1st April 2016. That financial governance infrastructure continues to be reviewed and refreshed.

Analysis of Financial Statements

The main objective of the Annual Accounts is to provide information about the financial position of the IJB that is useful to a wide range of users in making and evaluating decisions about the allocation of resources.

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The 2017/18 Annual Accounts comprise:-

a) Comprehensive Income and Expenditure Statement – This statement shows that the IJB achieved a breakeven position overall.

b) Against health budgets an underlying over spend of £1.279m was reported. However in line with the risk sharing agreement agreed with NHS Tayside and Perth & Kinross Council for the first three years of the IJB, NHS Tayside devolved further non-recurring budget to the IJB to balance income with expenditure. A breakeven position for 2017/18 is therefore reported against health budgets.

c) Against Social Care budgets an underlying under spend of £2.637m was delivered. The Integration scheme sets out that under spends can be retained by the IJB as reserves following agreement with the Partners. Such agreement was not reached in relation to 2017/18 under spend. Instead Perth & Kinross Council reduced the budget to deliver breakeven and will carry forward the under spend in an earmarked reserve for Social Care.

d) Movement in Reserves – The IJB carried £1.386m reserves into 2017/18 and these reserves were fully released into the budget in 2017/18. As above, the under spend on Social Care will be carried forward by Perth & Kinross Council. Therefore the IJB is reporting no reserve.

e) Balance Sheet – In terms of routine business the IJB does not hold assets, however the movement in reserves noted above are reflected in the year-end balance sheet.

f) Notes, comprising a summary of significant accounting policies, analysis of significant figures within the Annual Accounts and other explanatory information.

The Annual Accounts for 2017/18 do not include a Cash Flow Statement as the IJB does not hold any cash or cash equivalents.

The overspend on health services has arisen across GP Prescribing and Inpatient Mental Health Services. For GP Prescribing, anticipated national price reductions on specific medicines were not realized impacting significantly on the in year financial position. For Inpatient Mental Health, nursing costs and medical costs continue to be significantly higher than budgeted. Both areas are undergoing significant review and transformation with plans in place for 2018/19 that should see a significant reduction in levels of spend.

Financial Outlook, Risks and Plans for the Future

The IJB, like many others, faces significant financial challenges and will be required to operate within very tight financial constraints for the foreseeable future due to the difficult national economic outlook and increasing demand for services.

A Financial Plan for 2018/19 is currently in development with the objective that the IJB operates within resources available. A budget settlement with Perth & Kinross Council and NHS Tayside has been agreed. Discussions are continuing with NHS Tayside in relation to Prescribing and Inpatient Mental Health (which Perth & Kinross IJB hosts on behalf of all three IJB's). However significant transformation and cost improvement plans are being developed for both areas which should support future financial sustainability.

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However both settlements present significant challenges in terms of accommodating demographic and inflationary type pressures across core services. In particular pay, price and demand pressures across social care services are estimated at £4.6m for 2018/19 with similar levels forecast for the next two years. Whilst a significant transformation and efficiency programme has been identified for 2018/19 the scope of opportunity for further major transformation across services will not be sufficient to address the level of social care pressures moving forward. Both parent bodies are facing a very difficult financial outlook. Perth and Kinross Council have set an indicative budget for the IJB for 2019/20 and 2020/21 which could see further net cuts to the budget in both years. Early discussions are taking place with NHS Tayside and Perth and Kinross Council to ensure a collective understanding of the significant challenges and to provide a forum for agreement for the IJB's budget for 2019/20 and beyond.

In addition to the recurring settlement for 2018/19, NHS Tayside have agreed to distribute non-recurring funding to the IJB to take forward a number of agreed projects for which expenditure has been delayed and will now not be incurred until 2018/19.

FURTHER INFORMATION

These Annual Accounts refer to both the Perth & Kinross IJB Integration Scheme and the Perth & Kinross IJB Strategic Plan. These can be found at:
Perth & Kinross IJB Integration Scheme:

http://www.pkc.gov.uk/media/36049/Perth-and-Kinross-Integration-Scheme/pdf/Approved_Health__Social_Care_Integration_Scheme

Perth & Kinross IJB Strategic Plan:

http://www.pkc.gov.uk/media/38714/Health-and-Social-Care-Strategic-Commissioning-Plan/pdf/2016193_strat_comm_plan_CLIENT

Perth & Kinross IJB publishes all formal Board papers at:

http://www.pkc.gov.uk/ijb
Further information regarding the Annual Accounts can be obtained from:
Chief Finance Officer, Perth & Kinross IJB, 2 High Street, Perth PH1 5PH.

CONCLUSION AND ACKNOWLEDGEMENTS

We are pleased to record that during 2017/18 the IJB has successfully delivered health and social care services to the population of Perth and Kinross and, for hosted services, to the population of Tayside. We acknowledge this has been a challenging year and the IJB's success has only been achieved through the hard work of staff employed in Perth & Kinross Council and NHS Tayside and other partner organisations.

Looking forward, while the IJB faces continuing challenging financial circumstances it also plans to continue to take advantage of the opportunities available through Health and Social Care Integration to best deliver affordable health and social care

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services for the population of Perth & Kinross.

Stephen Hay	28/9/18
IJB Chair	

Rob Packham	28/9/18
Chief Officer	

Jane Smith	28/9/18
Chief Financial Officer	

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SECTION 2: STATEMENT OF RESPONSIBILITIES

This statement sets out the respective responsibilities of the IJB and the Chief Financial Officer, as the IJB's Section 95 Officer, for the Annual Accounts.

Responsibilities of the Integration Joint Board

The Integration Joint Board is required to:

- Make arrangements for the proper administration of its financial affairs and to secure that the proper officer of the board has responsibility for the administration of those affairs (section 95 of the Local Government (Scotland) Act 1973). In this authority, that officer is the chief financial officer.
- Manage its affairs to secure economic, efficient and effective use of resources and safeguard its assets.
- Ensure the Annual Accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland act 2003).
- Approve the Annual Accounts.

I confirm that these Annual Accounts were approved for signature at a meeting of the Integrated Joint Board on 28 September 2018.

Signed on behalf of the Perth and Kinross IJB

Stephen Hay   28/9/18
IJB Chair

Responsibilities of the Chief Financial Officer

The Chief Financial Officer is responsible for the preparation of the IJB's Annual Accounts in accordance with proper practices as required by legislation and as set out in the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom (the Accounting Code).

In preparing the Annual Accounts, the Chief Financial Officer has:

- selected suitable accounting policies and then applied them consistently
- made judgements and estimates that were reasonable and prudent
- complied with legislation
- complied with the local authority Code (in so far as it is compatible with legislation)

The Chief Financial Officer has also:

- kept proper accounting records which were up to date
- taken reasonable steps for the prevention and detection of fraud and

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other irregularities

I certify that the financial statements give a true and fair view of the financial position of the Perth and Kinross Integration Joint Board as at 31 March 2018 and the transactions for the year then ended.

Jane Smith   28/9/18
Chief Financial Officer

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INTRODUCTION

This Remuneration Report is provided in accordance with the Local Authority Accounts (Scotland) Regulations 2014. It discloses information relating to the remuneration and pension benefits of specified IJB members and staff.

The information in the tables below is subject to external audit. The explanatory text in the Remuneration Report is reviewed by the external auditor to ensure it is consistent with the financial statements.

BOARD MEMBERS

At 31 March 2018, Perth and Kinross IJB had 8 voting members and 12 non-voting members as follows:

Voting Members:

Linda Dunion (Chair)	Councillor Xander McDade
Councillor Crawford Reid (Vice Chair)	Judith Golden (NHS Employee Director)
Councillor Chris Ahern	Sheila Tunstall-James (Non Executive Member)
Councillor Eric Drysdale	Stephen Hay (Non Executive Member)

Non-voting Members:

Robert Packham (Chief Officer)	Dr Drew Walker (Director of Public Health)
Jane Smith (Chief Financial Officer)	Allan Drummond (Staff Organisations Rep.)
Jacqueline Pepper (Chief Social Work Officer)	Fiona Fraser (Staff Organisations Rep.)
Dr Neil Prentice (Associate Medical Director)	Helen McKinnon (Third Sector Representative)
Jim Foulis (Associate Nurse Director)	Linda Lennie (Service User Representative)
Dr Alistair Noble (SACH and External Advisor)	Bernie Campbell (Carers Representative)

During 2017/18 the position of Chair was held by Councillor Dave Doogan until 3rd May 2017, then by Councillor Crawford Reid from 17th May until 30th September 2017, it was then held by Linda Dunion (NHS non-executive) from 1st October 2017 until 30th April 2018. The Chair is now held by Stephen Hay

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(NHS non-executive).

The position of Vice-Chair was held by Linda Dunion (NHS non-executive) until 30th September 2017, then Councillor Crawford Reid until 30th April 2018. The position of Vice-Chair is to be confirmed at the June IJB.

IJB CHAIR AND VICE CHAIR

The voting members of the IJB are appointed through nomination by Perth & Kinross Council and NHS Tayside. Nomination of the IJB Chair and Vice Chair post holders alternates between a Councillor and a Health Board representative.

The IJB does not provide any additional remuneration to the Chair, Vice Chair or any other board members relating to their role on the IJB. The IJB does not reimburse the relevant partner organisations for any voting board member costs borne by the partner. There were no taxable expenses paid by the IJB to either the Chair or the Vice Chair in 2017/18.

The IJB does not have responsibilities, either in the current year or in future years, for funding any pension entitlements of voting IJB members. Therefore no pension rights disclosures are provided for the Chair or Vice Chair.

OFFICERS OF THE IJB

The IJB does not directly employ any staff in its own right, however specific post-holding officers are non-voting members of the Board.

<u>Chief Officer</u>

The Integration Joint Board requires to appoint a proper officer who has responsibility for the administration of its financial affairs in terms of Section 95 of the 1973 Local Government (Scotland) Act. The employing contract for the Chief Financial Officer will adhere to the legislative and regulatory governance of the employing partner organisation. The remuneration terms of the Chief Financial Officer as approved by the IJB.

<u>Other Officers</u>

No other staff are appointed by the IJB under a similar legal regime. Other non-voting board members who meet the criteria for disclosure are included in the disclosures below.

Total 2016/17 £	Senior Employees	Salary, Fees & Allowances £	Total 2017/18 £
83,965	**Rob Packham** Chief Officer	86,112	86,112
69,933	**Jane Smith** Chief Financial Officer	70,539	70,539
153,898	**Total**	**156,651**	**156,651**

In respect of officers' pension benefits the statutory liability for any future contributions to be made rests with the relevant employing partner organisation. On this basis there is no pensions liability reflected on the IJB balance sheet for the Chief Officer or any other officers.

The IJB however has responsibility for funding the employer contributions for the current year in respect of the officer time spent on fulfilling the responsibilities of their role on the IJB. The following table shows the IJB's funding during the year to support officers' pension benefits. The table also shows the total value of accrued pension benefits which may include benefits earned in other employment positions and from each officer's own contributions.

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Senior Employee	In Year Pension Contributions		Accrued Pension Benefits		
	For Year to 31/03/17 £	For Year to 31/03/18 £		Difference from 31/03/17	As at 31/03/18
Rob Packham Chief Officer	12,703	13,168	Pension	1,257	24,945
			Lump sum	3,771	74,834
Jane Smith Chief Financial Officer	10,409	10,513	Pension	1,081	20,914
			Lump sum	(983)	49,679
Total	**23,112**	**23,681**	**Pension**	**2,338**	**45,859**
			Lump Sum	**2,788**	**124,513**

Disclosure by Pay Bands

As required by the regulations, the following table shows the number of persons whose remuneration for the year was £50,000 or above, in bands of £5,000.

Number of Employees in Band 2016/17	Remuneration Band	Number of Employees in Band 2017/18
1	£65,000 - £69,999	0
0	£70,000 - £74,999	1
1	£85,000 - £89,999	1

Stephen Hay
IJB Chair
28/9/18

Rob Packham
Chief Officer
28/9/18

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SECTION 4: ANNUAL GOVERNANCE STATEMENT

INTRODUCTION

The Annual Governance Statement explains Perth & Kinross IJB's governance arrangements and reports on the effectiveness of the IJB's system of internal control.

SCOPE OF RESPONSIBILITY

Perth & Kinross IJB is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively.

To meet this responsibility the IJB has established arrangements for governance that includes a system of internal control. The system is intended to manage risk to support achievement of the IJB's policies, aims and objectives. Reliance is also placed on the NHS Tayside and Perth & Kinross Council systems of internal control that support compliance with both organisations policies and promotes achievement of each organisations aims and objectives including those of the IJB. Assurance has been received from both NHS Tayside and Perth and Kinross Council as to the effectiveness and adequacy of those systems. The systems can only provide reasonable and not absolute assurance of effectiveness.

PURPOSE OF THE GOVERNANCE FRAMEWORK

The governance framework comprises the systems and processes, and culture and values by which the IJB is directed and controlled and the activities through which it accounts to, engages with and leads the community. It enables the IJB to monitor the achievement of its strategic priorities and to consider whether those priorities have led to the delivery of appropriate, cost-effective services. The system of internal control is a significant part of that framework and is designed to manage risk to a reasonable level. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of Perth & Kinross IJB's policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

GOVERNANCE FRAMEWORK

The Board of the IJB comprises voting members, nominated by either NHS Tayside or Perth & Kinross Council, as well as non-voting members including a Chief Officer appointed by the Board.
The main features of the governance framework that was in place during 2017/18 are summarised below:
- The IJB, comprising all IJB Board members, was the key decision making body. The Audit and Performance Committee considered all matters in relation to Internal and External Audit, Risk Management and Performance;

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- Strategic decision-making is governed by the IJB's key constitutional documents including the Integration Scheme, standing orders, scheme of administration, scheme of delegation to officers and financial regulations;
- The IJB's purpose and vision are outlined in the IJB Strategic Plan. Regular progress reports on the delivery of Strategic Plan priorities were provided to the IJB; The arrangements for future Strategic Planning have been agreed by the IJB including the role of the Strategic Planning Group.
- The Performance Management Strategy focuses very firmly on embedding a performance management culture throughout the IJB. Regular reporting to Board Members takes place;
- The IJB has adopted a 'Code of Conduct' for all of its Board Members and employees, a register of interests is in place for all Board members and senior officers;
- The IJB has in place a development programme for all Board Members.
- The IJB has established 3 locality planning forums, reflecting the previously agreed local planning areas;
- Financial management arrangements conform to the governance requirements of the CIPFA statement: 'The Role of the Chief Financial Officer in Local Government (2010)'. Arrangements include a robust financial planning framework and has established a Budget Review Group to ensure scrutiny of investment and disinvestment proposals.
- The role of the Executive Management Team has been strengthened.
- Increased Clinical Leadership capacity has been established.

SYSTEM OF INTERNAL CONTROL

The governance framework above operates on the foundation of internal controls including management and financial information, financial regulations, administrative procedures, management supervision and a system of delegation and accountability.

The Board uses the systems of NHS Tayside and Perth & Kinross Council to manage its financial records. Development and maintenance of the systems is undertaken by NHS Tayside and Perth & Kinross Council as part of the operational delivery of the Health & Social Care Partnership. In particular the systems include:-
- Comprehensive budgeting systems;
- Setting of targets to measure financial performance
- Regular reviews of periodic and annual financial reports that indicate financial performance against the forecasts;

The wider internal control framework includes:-
- Complaints handling
- Clinical Care Governance monitoring arrangements
- Whistle blowing
- Data Sharing
- Procedural frameworks including Scheme of Delegation; Standing Financial instructions, standing orders, scheme of administration
- Internal Audit Function

- Reliance on procedures, processes and systems of partner organisations

Due to ongoing concerns during 2017, NHS Tayside has been subject to a number of internal (e.g. Internal Audit) and external (e.g. Scottish Government) reviews. A series of actions have resulted to address identified weaknesses, with further review work ongoing. Agreed actions will be monitored locally by NHS Tayside's new leadership team and nationally. A number of the weakness's identified may have an impact on the IJB and its ability to deliver on its Strategic Objectives. In particular the IJB is reliant on strong strategic planning capacity and financial management support. As part of its own review of governance, weaknesses in both strategic leadership capacity and financial management support have been identified.

REVIEW OF ADEQUACY AND EFFECTIVENESS

Perth & Kinross IJB has responsibility for conducting, at least annually a review of the effectiveness of its governance framework including the system of internal control.

The review of the effectiveness of the framework has been informed by:-
- the work of the Executive Management Team who have responsibility for development and maintenance of the governance environment and
- the Annual Report by the Chief Internal Auditor
- Reports from Audit Scotland and other review agencies.
- Self assessment against the Delivering Good Governance in Local Government Framework 2016 Edition (CIPFA)
- Draft Annual Governance Statements for Perth & Kinross Council and NHS Tayside.

The Chief Internal Auditor reports directly to the IJB Audit & Performance Committee on all audit matters, with the right of access to the Chief Officer, Chief Financial Officer and Chair of the Audit & Performance Committee on any matter.

In addition to regular reports to the IJB's Audit & Performance Committee during 2017/18, the Chief Internal Auditor prepares an annual report to the Audit & Performance Committee including an assurance statement containing a view on the adequacy and effectiveness of the systems of internal control.
The Internal Audit Annual Report 2016/17, received by the Audit & Performance Committee on 16 June 2017, highlights findings by the IJB's Internal Audit section which indicate some weaknesses in the internal control environment. None of these are considered material enough to have a significant impact on the overall control environment and it is the opinions of the Chief Internal Auditor that the systems of internal control relied upon by the IJB provide reasonable assurance against loss.

ACTION PLAN FOR 2018/19

Significant progress has been made against the 'Transforming Governance' Action Plan agreed for 2017/18. However following a full self assessment process, refreshed actions have now been set out to further strengthen the governance

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arrangements and these will include:-

- Development of a statement of our vision and values to be developed to become front and centre of all IJB activities moving forward.
- A refreshed annual programme of training and development for IJB Board Members to be agreed.
- An effective strategy for engaging with Perth & Kinross Council Elected members around IJB aims and objectives and the financial outlook to be developed.
- Establishment a collaborative approach to budget negotiation for 2019/20 onwards with NHS Tayside and Perth & Kinross Council.
- Further development of Strategic Delivery Plans for each Care Group including leadership arrangements, performance framework, strategy for engagement with users and carers, agreed programme budget with accountability for delivery of financially sustainable services. Role of Strategic Planning Group to be reaffirmed.
- Finalise the review of risk management and development clear escalation and reporting mechanisms.
- Review of the use of Directions
- Development of Large Hospitals Set Aside arrangements in conjunction with NHS Tayside.
- Strengthen leadership and corporate support capacity through key appointments including Head of Business Planning and Performance.
- Agree appointment of Data Protection Officer for Perth & Kinross IJB and ensure compliance with General Data Protection Regulations.
- Work with the Director of Finance of NHS Tayside to develop an appropriate and effective level of finance support to budget holders tasked with taking forward significant redesign of services.

CONCLUSION AND OPINION ON ASSURANCE

While recognising that improvements are required, as detailed above, it is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the IJB's governance arrangements.

We consider that internal control environment operating during 2017/18 to provide reasonable and objective assurance that any significant risks impacting on the achievement of our objectives will be identified and actions taken to avoid or mitigate their impact. Systems are in place to continually review and improve the governance and internal control environment.

Stephen Hay	28/9/18
IJB Chair	
Rob Packham	28/9/18
Chief Officer	

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COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT

This statement shows the cost of providing services for the year according to accepted accounting practices.

2016/17			2017/18		
Gross Income	Net Expenditure		Gross Expenditure	Gross Income	Net Expenditure
£000	£000		£000	£000	£000
0	43,423	Community and Hospital Health Services	46,120	0	46,120
0	20,751	Hosted Health Services	20,970	0	20,970
0	28,190	GP Prescribing	28,467	0	28,467
0	35,448	General Medical/Family Health Services	39,678	0	39,678
0	17,672	Large Hospital Set aside	11,793	0	11,793
0	226	IJB Operating Costs	232	0	232
0	46,831	Community Care	46,808	0	46,808
0	**192,541**	**Cost of Services**	**194,068**	0	**194,068**
(193,927)	(193,927)	Taxation and Non-Specific Grant Income (Note 4)	0	(194,068)	(194,068)
(193,927)	**(1,386)**	**(Surplus) or Deficit on Provision of**	**194,068**	**(194,068)**	**0**
	(1,386)	**Total Comprehensive (Income) and Expenditure (Note 3)**			**0**

GP Prescribing costs are now separately presented in the Comprehensive Income and Expenditure Statement and 2016/17 figures have been amended to reflect this change.

Large Hospital expenditure has moved significantly from prior year. This is due to a change in methodology used to establish the amount set aside. For the 2016/17 accounts, the amount of set aside was calculated at £17.672m. This was based on the net cost attributed to occupied bed days. The net cost includes both direct and overhead costs. The changed in methodology has moved to a direct cost only and therefore reduced the set aside amount to £11.793m.

There are no statutory or presentation adjustments which affect the IJBs application

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of the funding received from partners. The movement in the General Fund balance is therefore solely due to the transactions shown in the Comprehensive Income and Expenditure Statement. Consequently, an Expenditure and Funding Analysis is not shown in these annual accounts.

MOVEMENT IN RESERVES STATEMENT

This statement shows the movement in the year on the IJB's reserves. The movements which arise due to statutory adjustments which affect the General Fund balance are separately identified from the movements due to accounting practices.

Movements in Reserves During 2017/18	General Fund Balance	Unusable Reserves: Employee Statutory Adjustment Account	Total Reserves
	£000	£000	£000
Opening Balance at 31 March 2017	**(1,386)**	**0**	**(1,386)**
Total Comprehensive Income and Expenditure	0	0	0
Increase or Decrease in 2017/18	**1,386**	**0**	**1,386**
Closing Balance at 31 March 2018	**0**	**0**	**0**

BALANCE SHEET

The Balance Sheet shows the value of the IJB's assets and liabilities as at the balance sheet date. The net assets of the IJB (assets less liabilities) are matched by the reserves held by the IJB.

31 March 2017		Notes	31 March 2018
£000			£000
1,386	Short term Debtors	5	0
1,386	**Current Assets**		0
0	Short-term Creditors		0
0	**Current Liabilities**		0
0	Provisions		0
0	**Long-term Liabilities**		0

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1,386	**Net Assets**		0
(1,386)	Usable Reserve: General Fund	6	0
0	Unusable Reserve: Employee Statutory Adjustment Account		0
(1,386)	**Total Reserves**		**0**

Jane Smith   28/9/18

Chief Financial Officer

SECTION 6: NOTES TO THE FINANCIAL STATEMENTS

NOTE 1: SIGNIFICANT ACCOUNTING POLICIES

A. GENERAL PRINCIPLES

The Financial Statements summarise the Integration Joint Board's transactions for the 2017/18 financial year and its position at the year-end of 31 March 2018.

The IJB was established under the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 and is a Section 106 body as defined in the Local Government (Scotland) Act 1973.

The Financial Statements are therefore prepared in compliance with the Code of Practice on Local Authority Accounting in the United Kingdom 2017/18, supported by International Financial Reporting Standards (IFRS), unless legislation or statutory guidance requires different treatment.

The accounts are prepared on a going concern basis, which assumes that the IJB will continue in operational existence for the foreseeable future. The historical cost convention has been adopted.

B. ACCRUALS OF INCOME AND EXPENDITURE

Activity is accounted for in the year that it takes place, not simply when settlement in cash occurs. In particular:

- Expenditure is recognised when goods or services are received and their benefits are used by the IJB.

- Income is recognised when the IJB has a right to the income, for instance by meeting any terms and conditions required to earn the income, and receipt of the income is probable.

- Where income and expenditure have been recognised but settlement in cash has not taken place, a debtor or creditor is recorded in the Balance Sheet.

- Where debts may not be received, the balance of debtors is written down

C. FUNDING

The IJB is funded through funding contributions from the statutory funding partners, Perth and Kinross Council and NHS Tayside. Expenditure is incurred as the IJB commissions specified health and social care services from the funding partners for the benefit of service recipients in Perth and Kinross.

D. CASH AND CASH EQUIVALENTS

The IJB does not operate a bank account or hold cash. Transactions are settled on behalf of the IJB by the funding partners. Consequently the IJB does not present a 'Cash and Cash Equivalent' figure on the balance sheet. The funding balance due to or from each funding partner as at 31 March is represented as a debtor or creditor on the IJB's Balance Sheet.

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E. EMPLOYEE BENEFITS

The IJB does not directly employ staff. Staff are formally employed by the funding partners who retain the liability for pension benefits payable in the future. The IJB therefore does not present a pensions liability on its Balance Sheet.

The IJB has a legal responsibility to appoint a Chief Officer and a Chief Financial Officer. More details on the arrangements are provided in the Remuneration Report. The charges from the employing partner are treated as employee costs.

Charges from funding partners for other staff are treated as administration costs.

F. PROVISIONS, CONTINGENT LIABILITIES AND CONTINGENT ASSETS

Provisions are liabilities of uncertain timing or amount. A provision is recognised as a liability on the balance sheet when there is an obligation as at 31 March due to a past event; settlement of the obligation is probable; and a reliable estimate of the amount can be made. Recognition of a provision will result in expenditure being charged to the Comprehensive Income and Expenditure Statement and will normally be a charge to the General Fund.

A contingent liability is a possible liability arising from events on or before 31 March, whose existence will only be confirmed by later events. A provision that cannot be reasonably estimated, or where settlement is not probable, is treated as a contingent liability. A contingent liability is not recognised in the IJB's Balance Sheet, but is disclosed in a note where it is material.

A contingent asset is a possible asset arising from events on or before 31 March, whose existence will only be confirmed by later events. A contingent asset is not recognised in the IJB's Balance Sheet, but is disclosed in a note only if it is probable to arise and can be reliably measured.

G. RESERVES

The IJB's reserves are classified as either Usable or Unusable Reserves.

The IJB's only Usable Reserve is the General Fund. The balance of the General Fund as at 31 March shows the extent of resources which the IJB can use in later years to support service provision.

The IJB's only Unusable Reserve is the Employee Statutory Adjustment Account. This is required by legislation. It defers the charge to the General Fund for the Chief Officer's absence entitlement as at 31 March, for example any annual leave earned but not yet taken. The General Fund is only charged for this when the leave is taken, normally during the next financial year.

H. INDEMNITY INSURANCE

The IJB has indemnity insurance for costs relating primarily to potential claim liabilities regarding Board member and officer responsibilities. NHS Tayside and Perth and Kinross Council have responsibility for claims in respect of the services that they are statutorily responsible for and that they provide.

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Unlike NHS Boards, the IJB does not have any 'shared risk' exposure from participation in Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). The IJB participation in the CNORIS scheme is therefore analogous to normal insurance arrangements.

Known claims are assessed as to the value and probability of settlement. Where it is material the overall expected value of known claims taking probability of settlement into consideration, is provided for in the IJB's Balance Sheet.

The likelihood of receipt of an insurance settlement to cover any claims is separately assessed and, where material, presented as either a debtor or disclosed as a contingent asset.

I. RELATED PARTY TRANSACTIONS

Related parties are organisations that the IJB can control or influence or who can control or influence the IJB. As partners in the Joint Venture of Perth and Kinross Integration Joint Board, both Perth and Kinross Council and NHS Tayside are related parties and material transactions with those bodies are disclosed in note 8 in line with the requirements of IAS 24 Related Party Disclosures.

J. SUPPORT SERVICES

Support services were not delegated to the IJB and are provided by the Council and the Health Board free of charge as a 'service in kind'. These arrangements were outlined in the report of Corporate Supporting Arrangements to the IJB on 23 March 2016.

NOTE 2: EVENTS AFTER THE REPORTING PERIOD

The Annual Accounts were authorised for issue by the Chief Financial Officer on 28 September 2018. Events taking place after this date are not reflected in the financial statements or notes. Where events taking place before this date provided information about conditions existing at 31 March 2018, the figures in the financial statements and notes have been adjusted in all material respects to reflect the impact of this information.

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NOTE 3: EXPENDITURE AND INCOME ANALYSIS BY NATURE

2016/17		2017/18
£000		£000
46,831	Services commissioned from Perth and Kinross Council	46,808
145,484	Services commissioned from NHS Tayside	147,028
199	Other IJB Operating Expenditure	205
3	Insurance and Related Expenditure	3
24	External Audit Fee	24
(193,927)	Partner Funding Contributions and Non-Specific Grant Income	(194,068)
(1,386)	**(Surplus) or Deficit on the Provision of Services**	**0**

Costs associated with the Chief Officer and Chief Financial Officer are included within "other IJB operating expenditure". The insurance and related expenditure relates to CNORIS costs (see note 1,H). Auditor fees related to fees payable to Audit Scotland with regard to external audit services carried out by the appointed auditor.

NOTE 4: TAXATION AND NON-SPECIFIC GRANT INCOME

2016/17		2017/18
£000		£000
(48,229)	Funding Contribution from Perth and Kinross Council	(46,924)
(145,698)	Funding Contribution from NHS Tayside	(147,144)
(193,927)	**Taxation and Non-specific Grant Income**	**(194,068)**

The funding contribution from NHS Tayside shown above includes £11.793m in respect of 'set aside' resources relating to acute hospital and other resources. These are provided by the NHS which retains responsibility for managing the costs of providing the services. The IJB however has responsibility for the consumption of, and level of demand placed on, these resources.

The funding contributions from the partners shown above exclude any funding which is ring-fenced for the provision of specific services. Such ring-fenced

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funding is presented as income in the Cost of Services in the Comprehensive Income and Expenditure Statement.

NOTE 5: DEBTORS

2016/17		2017/18
£000		£000
1,386	Perth and Kinross Council	0
1,386	**Debtors**	**0**

Amounts owed by the funding partners are stated on a net basis. Creditor balances relating to expenditure obligations incurred by the funding partners but not yet settled in cash terms are offset against the funds they are holding on behalf of the IJB.

NOTE 6: USABLE RESERVE: GENERAL FUND

The IJB holds a balance on the General Fund for two main purposes:

- To earmark, or build up, funds which are to be used for specific purposes in the future, such as known or predicted future expenditure needs. This supports strategic financial management.

- To provide a contingency fund to cushion the impact of unexpected events or emergencies. This is regarded as a key part of the IJB's risk management framework.

NOTE 7: AGENCY INCOME AND EXPENDITURE

On behalf of all IJBs within the NHS Tayside area, Perth and Kinross IJB acts as the host partnership for Learning Disability Inpatient services, Substance Misuse Inpatient services, Public Dental services/Community Dental services, General Adult Psychiatry (GAP) Inpatient services, Prisoner Healthcare and Podiatry.

The IJB directs services on behalf of Dundee and Angus IJBs and reclaims the full costs involved. The payments that are made on behalf of the other IJBs, and the consequential reimbursement, are not included in the Comprehensive Income and Expenditure Statement (CIES) since the IJB is not acting as principal in these transactions.

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The amount of expenditure and income relating to the agency arrangement is shown below.

2016/17		2017/18
£000		£000
21,228	Expenditure on Agency Services	21,348
(21,228)	Reimbursement for Agency Services	(21,348)
0	**Net Agency Expenditure excluded from the CIES**	**0**

NOTE 8: RELATED PARTY TRANSACTIONS

The IJB has related party relationships with the NHS Tayside and the Perth and Kinross Council. In particular the nature of the partnership means that the IJB may influence, and be influenced by, its partners. The following transactions and balances included in the IJB's accounts are presented to provide additional information on the relationships.

Income – payments for integrated functions

2016/17		2017/18
£000		£000
48,229	Perth and Kinross Council	46,924
145,698	NHS Tayside	147,144
193,927	**Total**	**194,068**

Expenditure – payments for delivery of integrated functions

2016/17		2017/18
£000		£000
62,005	Perth and Kinross Council	64,624
130,337	NHS Tayside	129,239
199	NHS Tayside: Key Management Personnel Non-Voting Board	205
192,541	**Total**	**194,068**

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Key Management Personnel: The non-voting Board members employed by the NHS Board and recharged to the IJB include the Chief Officer; the Chief Financial Officer. Details of the remuneration for some specific post-holders are provided in the Remuneration Report.

Perth and Kinross Council employs the council staff and Chief Social Work Officer representatives on the IJB Board but there is no discrete charge for this representation.

Balances with Perth and Kinross Council

2016/17		2017/18
£000		£000
1,386	Debtor balances: Amounts due from Perth and Kinross Council	0
0	Creditor balances: Amounts due to Perth and Kinross Council	0
1,386	**Total**	**0**

Balances with NHS Tayside

2016/17		2017/18
£000		£000
0	Debtor balances: Amounts due from NHS Tayside	0
0	Creditor balances: Amounts due to NHS Tayside	0
0	**Total**	**0**

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NOTE 9: CONTINGENT ASSETS AND LIABILITIES

A review for contingent assets and liabilities has been undertaken for the IJB and none have been identified at 31 March 2018.

NOTE 10: VAT

The IJB is not VAT registered and as such the VAT is settled or recovered by the partner agencies.

The VAT treatment of expenditure in the IJBs accounts depends on which of the partner agencies is providing the service as these agencies are treated differently for VAT purposes.

Where the Council is the provider, income and expenditure excludes any amounts relating to VAT, as all VAT collected is payable to H.M. Revenue and Customs and all VAT paid is recoverable from it. The Council is not entitled to fully recover VAT paid on a very limited number of items of expenditure and for these items the cost of VAT paid is included within service expenditure to the extent that it is recoverable from H.M. Revenue and Customs.

Where the NHS is the provider, expenditure incurred will include irrecoverable VAT as generally the NHS cannot recover VAT paid as input tax and will seek to recover its full cost as income from the commissioning IJB.

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SECTION 7: INDEPENDENT AUDITOR'S REPORT

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SECTION 8: GLOSSARY OF TERMS

While the terminology used in this report is intended to be self-explanatory, it may be useful to provide additional definition and interpretation of the terms used.

Accounting Period

The period of time covered by the Accounts normally a period of twelve months commencing on 1 April each year. The end of the accounting period is the Balance Sheet date.

Accruals

The concept that income and expenditure are recognised as they are earned or incurred not as money is received overpaid.

Asset

An item having value to the IJB in monetary terms. Assets are categorised as either current or non-current. A current asset will be consumed or cease to have material value within the next financial year (e.g. cash and stock). A non-current asset provides benefits to the IJB and to the services it provides for a period of more than one year.

Audit of Accounts

An independent examination of the IJB's financial affairs.

Balance Sheet

A statement of the recorded assets, liabilities and other balances at the end of the accounting period.

CIPFA

The Chartered Institute of Public Finance and Accountancy.

Consistency

The concept that the accounting treatment of like terms within an accounting period and from one period to the next is the same.

Contingent Asset/Liability

A Contingent Asset/Liability is either:

- A possible benefit/obligation arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain events not wholly within the IJB's control; or

- A present benefit/obligation arising from past events where it is not probable that a transfer of economic benefits will be required, or the amount of the obligation cannot be measured with sufficient reliability.

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Creditor

Amounts owed by the IJB for work done, goods received or services rendered within the accounting period, but for which payment has not been made by the end of that accounting period.

Debtor

Amount owed to the IJB for works done, goods received or services rendered within the accounting period, but for which payment has not been received by the end of that accounting period.

Defined Benefit Pension Scheme

Pension scheme in which the benefits received by the participants are independent of the contributions paid and are not directly related to the investments of the scheme.

Entity

A body corporate, partnership, trust, unincorporated association or statutory body that is delivering a service or carrying on a trade or business with or without a view to profit. It should have a separate legal personality and is legally required to prepare its own single entity accounts.

Post Balance Sheet Events

Post Balance Sheet events are those events, favourable or unfavourable, that occur between the Balance Sheet date and the date when the Annual Accounts are authorised for issue.

Exceptional Items

Material items which derive from events or transactions that fall within the ordinary activities of the IJB and which need to be disclosed separately by virtue of their size or incidence to give a fair presentation of the accounts.

Government Grants

Grants made by the Government towards either revenue or capital expenditure in return for past or future compliance with certain conditions relating to the activities of the IJB. These grants may be specific to a particular scheme or may support the revenue spend of the IJB in general.

IAS

International Accounting Standards.

IFRS

International Financial Reporting Standards.

IRAG

Integration Resources Advisory Group

LASAAC

Local Authority (Scotland) Accounts Advisory Committee

Liability

A liability is where the IJB owes payment to an individual or another organisation. A current liability is an amount which will become payable or could be called in within the next accounting period e.g. creditors or cash overdrawn. A non-current liability is an amount which by arrangement is payable beyond the next year at some point in the future or will be paid off by an annual sum over a period of time.

Provisions

An amount put aside in the accounts for future liabilities or losses which are certain or very likely to occur but the amounts or dates of when they will arise are uncertain.

PSIAS

Public Sector Internal Audit Standards.

Related Parties

Bodies or individuals that have the potential to control or influence the IJB or to be controlled or influenced by the IJB. For the IJB's purposes, related parties are deemed to include voting members, the Chief Officer, the Chief Finance Officer, the Heads of Service and their close family and household members.

Remuneration

All sums paid to or receivable by an employee and sums due by way of expenses allowances (as far as these sums are chargeable to UK income tax) and the monetary value of any other benefits received other than in cash.

Reserves

The accumulation of surpluses, deficits and appropriation over past years. Reserves of a revenue nature are available and can be spent or earmarked at the discretion of the IJB.

Revenue Expenditure

The day-to-day expenses of providing services.

Significant Interest

The reporting authority is actively involved and is influential in the direction of an entity through its participation in policy decisions.

SOLACE

Society of Local Authority Chief Executives.

The Code

The Code of Practice on Local Authority Accounting in the United Kingdom.

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Perth & Kinross Integration Joint Board

22 June 2018

2017/18 Financial Position

Jane Smith, Chief Financial Officer (G/18/94)

PURPOSE OF THE REPORT

The purpose of this report is to provide a summary of the issues impacting on the financial position of Perth and Kinross IJB in 2017/18, for the year ended 31st March 2018.

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1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:-

- Note the year end out-turn for 2017/18.

2. 2017/18 FINANCIAL POSITION

The IJB year end out-turn is an overall under spend of £1.4m.   The key drivers are as follows:

- A £2.6m under spend on Social Care and a £0.5m under spend on Hospital & Community Health. These are being offset by overspends of £1.7m on Prescribing and £1.4m on Inpatient General Adult Psychiatry of which the IJB share is £0.5m.
- Of the Social Care under-spend £1.3m is due to accelerated savings and £0.8m due to slippage in the utilisation of budget flexibility. The underlying base budget is underspent by £0.5m, of which £0.3m relates to slippage in the utilisation of complex care package funding due to delay in funding agreement and housing provision. However underlying this is a pressure on care home placements.
- The Prescribing out-turn is £1.7m overspend. This is in line with financial plan expectation.
- Within the 2017/18 financial plan, Inpatient Mental Health General Adult Psychiatry (GAP) was anticipated to overspend by £0.6m. The year end out-turn is an overspend of £1.4m. This out-turn is a £0.8m deterioration from plan and is due to medical locum spend being higher than the amount of cost pressure funding transferred along with higher than anticipated nursing costs.
- A full report on the 2017/18 Out-turn is provided at Appendix 1. The risk sharing agreement has impacted on the final reported year end position within the IJB's draft year end accounts as follows:

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	2017/18 Finance Report Out-turn £m	Impact of Risk Sharing Agreement £m	Draft Annual Accounts 2017/18 £m
Health	1.279	(1.279)	0
Social Care	(2.637)	2.637	0
Total	(1.358)	1.358	0

3. CONCLUSION

Whilst overall the IJB will report a break-even position for 2017/18, a number of underlying pressures within Inpatient Mental Health and Prescribing will require to be addressed in the 2018/19 Financial Plan.

Author(s)

Name	Designation	Contact Details
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Financial Update as at 31st March 2018

1.   OVERALL SUMMARY

The year end position at 31st March 2018 is set out in Table 1 below.

Table 1 Summary Year End Forecast as at 31st March 2018

	Budget 2017/18	Base	Savings	Total Partnership	Total IJB		Month 9 forecast Total IJB
	As at 31st March 2018	Forecast Over/(under) spend	Forecast Over/(under) spend	Forecast Over/(under) spend	Forecast Over/(under) spend		Forecast Over/(under) spend
	'£000	'£000	'£000	'£000	'£000		'£000
Hospital & Community Health	46,770	(718)	185	(533)	(533)		(500)
GMS/FHS	39,873	(195)	0	(195)	(195)		(233)
Other Hosted Services	8,506	5	122	127	(66)		14
General Adult Psychiatry	15,149	898	498	1,396	468		509
In Patient Learning Disabilities	5,856	(206)	0	(206)	(69)		(42)
In Patient TSMS	1,483	(90)	0	(90)	(30)		(23)
Prescribing	26,763			1,704	1,704		1,475
Sub-total Health Care				2,203	1,279		1,200
Social Care Services	49,561	(1,342)	(1,295)	(2,637)	(2,637)		(2,493)
Total				**(434)**	**(1,358)**		**(1,293)**

The actual out-turn on Health and Social Care Services within the IJB is an underspend of £1.358m. Of which, Health Services were £1.279m over spent and Social Care £2.637m under spent.

The Integration scheme sets out that any overspend will be met by the partner with the operational responsibility. Therefore NHS Tayside have devolved further non-recurring budget to the IJB to balance income with expenditure and allow a breakeven position to be achieved.

The Integration Scheme also sets out that under spend can be retained by the IJB as reserves following agreement with the Partners. Such agreement was not reached in relation to 2017/18 under spend. Instead Perth & Kinross Council reduced the budget to deliver breakeven and will carry forward the under spend in an earmarked reserve for Social Care. Of this £1.84m is being returned as part of the 2018/19 budget settlement. The IJB is now reliant on this funding to deliver break even in 2018/19. A further £0.7m will be held in a PKC earmarked reserve for Social Care purposes. The first call of which will be Voluntary Severance Scheme (VSS) costs from the closure of Beechgrove Care Home.

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Further analysis and commentary on the underlying financial position across each key service area including savings delivery is set out in the sections below.

2.   HOSPITAL & COMMUNITY HEALTH SERVICES

Overall Hospital and Community Health services have delivered a year end underspend of £533k. This is broadly in line with the last report to the IJB. The key drivers of this underspend are within:

- Uncommitted delayed discharge funding (£247k) allocated non-recurringly to offset overspend in inpatient beds, driven by workforce recruitment issues.
- Slippage in utilisation of Primary Care Transformation Funding (£238k).
- Medical Training budget underspend due to Junior Doctor vacancies (£141k).
- Community Hospitals in the North (£159k), mainly due to a non-recurring benefit from the non-operational status of Aberfeldy Community Hospital.

These were partially offset by overspends in:

- Psychiatry of Old Age (£111k) this is primarily due to locum consultant costs. This has now ceased. Financial balance is expected for 2018/19 through work to fill posts on a substantive basis.
- Community Hospitals in the South (£129k) due to ongoing sickness levels and incremental drift.

The Hospital and Community Health recurring savings target for 2017/18 was £763k. Of this £507k was met recurrently and £70k non-recurring. This unmet saving has been carried forward as a pressure into the 2018/19 plan.

3.   OTHER HOSTED SERVICES

The Perth & Kinross IJB share of Other Hosted Services year end position is an underspend of £66k, an improvement of £80k from month 9. This can be broken down as follows:

Services Hosted By	Month 12 Over/(under) spend	Month 12 Perth & Kinross IJB Share Over/(under)spend
	£000	£000
Perth & Kinross	127	43
Dundee	(92)	(31)
Angus	(233)	(78)
Total	**(198)**	**(66)**

Other Hosted Services within Perth & Kinross are Prison Health Care, Podiatry and Public Dental.

The key driver of overspend in Perth and Kinross is Prison Health Care due to medicine costs, however the service have a robust plan to reduce costs in 2018/19.

Other Hosted Services within Perth & Kinross had a recurring savings target for 2017/18 of £356k. Of this £143k was met recurrently and £90k non-recurring. The shortfall of £122k has been carried forward as a pressure into the 2018/19 plan.

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4.   INPATIENT MENTAL HEALTH

Learning Disability Inpatient Services
A year end out-turn of £206k under spend has been delivered, an improvement of £81k from month 9. This movement is due vacancies, skill mix and additional income from out of area placements. The Perth & Kinross IJB share is £69k.

General Adult Psychiatry (GAP)
Excluding unmet savings, the GAP year end position is an overspend of £898k. This has improved by £123k from month 9. This overspend is due to locum spend being £380k higher than cost pressure funding transferred from NHST and the number of locum sessions across Tayside being higher than the number budgeted. Nursing costs are also £675k higher than budgeted, this pressure was not predicted in the financial plan and has been driven by an increased level of patient observations and supplementary staffing costs related to sickness.

The Perth & Kinross IJB share of this overspend is £301k.

Inpatient Tayside Substance Misuse Services (TSMS)
Inpatient TSMS year end position is an under spend of £90k, this has improved by £22k from month 9. The Perth & Kinross IJB share of this underspend is £30k.

Savings Delivery
Inpatient mental Health Services had a recurring savings target for 2017/18 of £812k. Of this £315k was met recurrently. The shortfall of £497k has been carried forward as a pressure into the 2018/19 plan. This shortfall was predicted and is reliant on wider service redesign.

5.   PRESCRIBING

The year end out-turn on prescribing is a £1.704m overspend, a deterioration of £229k from month 9.

The year end position on Prescribing can be broken down as follows:

	Month12 Out-turn Over/(under) spend	Month 9 Forecast Over/(under) spend
	£000	£000
GP Practice Prescribing	1,910	1,638
Centrally Managed Prescribing Budgets	(206)	(163)
Total	**1,704**	**1,475**

The 2017/18 financial plan anticipated a £1.7m overspend on GP Prescribing. Whilst the actual out-turn is in line with plan, growth levels are lower than anticipated. However the nationally expected price reduction on Pregablin did not materialise and this has offset the benefit of the drop in growth.

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6. SOCIAL CARE SERVICES

The year end out-turn for Social care is a £2.637m underspend and can be broken down as follows:

a) Accelerated Non-Recurring Savings (£1.295m)
   Accelerated savings of £1.295m were delivered by the year end. This has increased by £225k from month 9 primarily due to the additional accelerated savings from the review of day care. For 2018/19 Social Care is required to deliver a transformation and efficiency programme of £4.62m from 1st April 2018. Throughout 2017/18 significant work has been undertaken to ensure delivery of these savings from 1st April and a non-recurring benefit has accrued in 2017/18.

b) Slippage in utilisation of IJB Reserves/Budget Flexibility (£818k)

   This is driven by slippage in the 'Shifting the Balance of Care' project (£626k) due to a delay in implementation.

c) Under spend on Base Budget (£524k)
   The year end out-turn on base budget was an underspend of £524k. The key drivers of this out-turn are as follows:

   - An underspend in Care at Home (£296k) due to staff vacancies, however this is entirely offset by an overspend on Interim Placements. These are used by clients that are awaiting care at home packages, step up or step down care or for clients ready for discharge from hospital but awaiting a care home of their choice
   - A total underspend of £348k against Direct Payments and the Self Directed Support budget due to revised spend plans.
   - A £328k under spend within complex care due to a delay in new build housing provision.
   - A £236k under spend against locality teams. This has been driven by vacancies and delays in recruitment as we move to the new locality model.

   In addition, care home placements have overspent by £509k. This includes Nursing Placements £166k, Physical Disabilities £213k and Mental Health £130k. The 2018/19 budget includes a £462k demand pressure for nursing care which recognises the 2017/18 level of demand. Also £140k has been added for increased demand in complex care packages.

Jane M Smith
Chief Financial Officer
22nd June 2018

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Perth & Kinross Integration Joint Board

Friday 22 June 2018

2018/19 Finance Update

Report by Jane Smith, Chief Finance Officer (G/18/95)

PURPOSE OF REPORT

This report sets out an update on the development of the 2018/19 Financial Plan and sets out the key financial risks to delivery of financial balance for the year ahead.

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1. **RECOMMENDATIONS**

   It is recommended that the IJB:

1.1 Note that a gap of £920k remains in the 2018/19 Financial Plan driven by Inpatient Mental Health and GP Prescribing.

1.2 Note the key financial risks that may further impact on the ability of the IJB to deliver financial balance in 2018/19.

1.3 Note the non-recurring budget to be allocated by NHS Tayside in 2018/19 to meet specific IJB funding commitments which have slipped from 2017/18.

1.4 Note the confirmation of the £1.685m Scottish Government earmarked recurring funding to meet Primary Care and Mental Health priorities in Perth and Kinross.

2. **2018/19 FINANCIAL PLAN**

2.1 At its meeting on 23rd March 2018, the IJB approved the 2018/19 Financial Plan. This has been updated to take account of further ongoing work to identify recurring an in year solution and is attached at Appendix 1.

2.2 A shortfall of £920k is reported driven predominantly by a £438k shortfall on GP Prescribing and a £427k gap on Inpatient Mental Health Services. This is an improvement of £300k from the initial plan presented to the IJB in March 2018.

2.3 For GP Prescribing our work with colleagues across NHS Tayside has identified a number of further cost improvement opportunities. However this has been offset by more prudent assumptions on expected national price changes. We still await a formal decision by NHS Tayside on the fair allocation of £1.2m additional NRAC Funding and

any share of this will help close the current gap. We have included a £0.2m share of the additional £1.2m Tayside NRAC Funding and this drives the overall improvement in the gap from £627k to £438k.

2.4 For Inpatient Mental Health a number of further opportunities to transform services and deliver cost improvement have been identified. However at this stage it is not possible to formally assess the financial benefit that may accrue. Progress to strengthen leadership arrangements is being made and this will be essential in driving forward progress. Overall the IJB's share of the gap has reduced from £497k to £438k.

2.5 The Financial Plan highlighted a significant pressure in relation to the health contribution to complex care packages that sits outside the financial plan since the budget for complex care has not been devolved to the IJB by NHS Tayside. Further work has been done to quantify this pressure, now estimated to be £440k. This is subject to discussions with the NHS Tayside Director of Finance as part of a pan Tayside consideration of the complex care budget.

3. 2018/19 FINANCIAL RISKS

3.1 The Chief Financial Officer has worked with budget holders to identify key risks to delivery of financial balance in 2018/19. Appendix 2 sets out a summary of these risks along with a risk rating and potential scope of financial impact where it has been possible to quantify at this stage.

3.2 The first Financial Monitoring Report will come to the IJB in September 2018. However it is already clear that over and above the formal gaps in the 2018/19 Financial Plan a number of high risk potential pressures have emerged that may have a significant impact on the in –year financial position.

3.3 The most significant risk is in relation to Social Work Complex Care packages. A detailed review has been undertaken of expected costs and this is now significantly higher than expected across Learning Disabilities and Mental Health. The Chief Finance Officer will support the Head of Social Work and Social Care to present the findings of the detailed review. In line with the Integration Scheme we hope there will be an opportunity to discuss with Perth & Kinross Council the provision of additional resources in-year to meet this unforeseen cost in line with the Integration Scheme.

3.4 The further significant financial risk is the reduction in demand for 84 Care Home Placements through investment in Carer's Support. A review has now been undertaken of the level of impact that the increased investment will have on demand and this is now lower than originally anticipated.

3.5 The GP Prescribing Financial Plan relies on a number of price reductions which are being negotiated nationally and are notoriously difficult to predict. Whilst we believe that prudent assumptions have been made this is still regarded as high risk. Further, in Perth & Kinross levels of growth in prescribing have been lower than across Tayside during 2017/18. Whilst a product assumption has been made around growth levels in 2018/19, again growth predictions are recognised nationally as complex due to the large number of factors than can impact including short supply medicines.

3.6 The Inpatient Mental Health Financial Plan assumes that NHS Tayside will allocate £448k of non-recurring resources to meet the cost impact of current contingency arrangements whilst the service moves to formal organisational change. The deterioration in the financial position of NHS Tayside makes it highly likely that this funding may not be allocated. In addition a further risk has emerged in relation to non-recurring funding required to support the agreed transformation of services.

4. NON-RECURRING PARTNERSHIP FUNDS

4.1 NHS Tayside have agreed to distribute non-recurring funding in 2018/19 to each of the three IJB's in relation to locally agreed projects for which spending plans have slipped. Appendix 3 sets out the funds to be distributed for 2018/19. Future management of slippage will be made through the IJB's own reserves mechanism. Spend against these funds will be reported to the IJB as part of routine monthly financial monitoring reports.

5. 2019/20 BUDGET NEGOTIATIONS

5.1 The Chief Officer, Chief Finance Officer and Chair of the IJB met with the Chief Executive of Perth and Kinross Council and the Strategic Director of Finance of NHS Tayside in early May to commence discussions on a joint approach to agreement of the IJB budget for 2019/20. This will be one of a series of meetings over 2018/19 aimed at ensuring a collective understanding of the financial challenges facing both parent bodies and the IJB itself and for discussion around the IJB's devolved budget for 2019/20 and future years.

6. 2018/19 SCOTTISH GOVERNMENT FUNDING FOR PRIMARY CARE AND MENTAL HEALTH

6.1 In May 2018, the Scottish Government confirmed earmarked recurring funding for a number of priorities. The funding will be allocated at Integration Authority level; however discussions at NHS Board level will be essential in agreeing spending plan priorities. The Perth and Kinross IJB share of this funding is as follows:

	£000
Mental Health Strategy (Action 15)	300
Primary Care Improvement Fund	1,249
Out of Hours	136
	1,685

At this stage spending plans have not been agreed and these will be developed over July and August 2018 for approval by the IJB in September 2018.

7.   **CONCLUSION**

7.1   Over and above the £920k gap in the 2018/19 Financial Plan a number of significant risks have been identified which are likely to have a material impact on the delivery of a break even position.

Appendix 1 2018/19 Financial Plan
Appendix 2 Financial Risk Register
Appendix 3 2018/19 Non-Recurring Partnership Funds

Summary Perth and Kinross Financial Plan 2018/19 (Revised as at 30th May 2018)

	Hospital and Community Health £000	Other Hosted Services £000	Inpatient Mental Health £000	GP Prescribing £000	Sub-Total Health £000	Social Care £000	Total £000
Total Expenditure Pressures	**1,325**	**562**	**3,255**	**2,828**	**7,970**	**4,615**	**12,585**
Increase/(-)Decrease to Budget from Parent Body	671	156	434	588	1,849	(1,537)	312
Savings Requirement	**654**	**406**	**2,821**	**2,240**	**6,121**	**6,152**	**12,273**
Savings/Other Income Identified	608	381	1,097	1,802	3,888	4,620	8,508
Recurring Shortfall / (-) Surplus	**46**	**25**	**1,724**	**438**	**2,233**	**1,532**	**3,765**
Other Funding:							
Non Recurring Reserves	-	-	-	-	-	1,532	1,532
NHST Bridging Finance	-	-	448	-	448	0	448
Sub-Total Other Funding	**-**	**-**	**448**	**-**	**448**	**1,532**	**1,980**
PKHSCP Financial Plan 2018/19 Shortfall /(-)Surplus	**46**	**25**	**1,276**	**438**	**1,785**	**0**	**1,785**
Perth & Kinross IJB 2018/19 Financial Plan Shortfall / (-)Surplus	**46**	**8**	**427**	**438**	**920**	**0**	**920**

IJB FINANCIAL UPDATE – KEY RISK FACTORS

	Risk Owner	Risk Rating	Potential Impact	Mitigating Action
Older People and Unscheduled Care				
Community Hospitals Fire & Safety Review Implications	ED	High	£50k	All options are being considered to ensure safety concerns are fully addressed in a way that provides best value.
Shifting the Balance of Care (Reduction of Placements) savings not deliverable	DF	High	£775k	Full review of investment plans being undertaken to ensure focus on most effective early intervention and prevention strategies.
Primary Care				
Implications of Prison Healthcare Inspection	ED	High	TBC	Formal outcome of inspection is expected in June 2018
Prison Healthcare Smoke Free Prison Implementation has unfunded cost implications (PKIJB share)	ED	High	TBC	Ongoing work with Public Health with budget being transferred between other elements of the smoking cessation framework outcome bundle. Additional funding for staffing to support on a temporary basis is being provided by Public Health.
GP Prescribing Gap in 2018/19 Financial Plan is not closed	HD	High	£438k	A number of other opportunities to improve efficiency and drive

	Risk Owner	Risk Rating	Potential Impact	Mitigating Action
				down cost are being pursued locally and at NHST Level.
Prescribing National Price Changes do not come to fruition	HD	High	£295k	This is out with our control and nationally lead. However our overall exposure is lower than in previous years.
Prescribing Level of Volume Growth is higher than anticipated	HD	High	£280k	This is being closely monitored. The growth for 2017/18 was negative at -0.19% for P&K. Significant programs of work and use of a 1% growth projection should ensure that growth is delivered to expectation
Wellbeing				
Inpatient Mental Health Gap in Financial Plan (PKIJB Share) cannot be met by additional efficiency/income/cost reduction measures.	RP	High	£427k	A number of other opportunities to improve efficiency and drive down cost are being pursued.
Unanticipated pressure on social care complex care packages for LD and MH	DF	High	£1,100k	Fully briefing prepared and discussion planned with PKC EOT in June 2018
Budget not devolved from NHST to cover known Health commitments to new/increased complex care packages (MH and LD)	ED	High	£440k	Discussion to take place with NHST Strategic Director of Finance in June 2018
Income to meet Inpatient Mental Health Contingency Costs not available from NHST (PKIJB share)	RP	High	£150k	Discussion to take place with NHST Strategic Director of Finance
Capital and other non-recurring funding necessary to implement Inpatient Mental Health Transformation Programme not available from NHST (PKIJB share)	RP	High	TBC	Urgent meeting requested with Programme Director and NHST Strategic Director of Finance.

	Risk Owner	Risk Rating	Potential Impact	Mitigating Action
Requirement to meet share of costs for new Mental Health Improvement Team (PKIJB share)	RP	High	£60k	A full costing is being pulled together for sharing with CO's/CFO's.
General				
Mobile Working etc Savings Target Social Care not deliverable.	DF	High	£86k	Meeting to review options in June 2018.
Total			£4,101k	

Perth and Kinross IJB Non-Recurring Partnership Funds 2018/19

Partnership Fund	Funding Available £000
Perth and Kinross Integration Fund	711
Primary Care Transformation Funding	209
Alcohol and Drug Partnership Funding	137
Mental Health Innovation Funding	183
Trauma and Orthopaedics Improvement	78
Total	**1,318**

Perth & Kinross Integration Joint Board

22 June 2018

Chief Officer Strategic Update

Report by Robert Packham, Chief Officer (G/18/96)

PURPOSE OF REPORT

The purpose of this report is to update board members on progress against tasks outlined in the rolling actions list.

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1.   **RECOMMENDATION(S)**

It is recommended that the Integrated Joint Board note the following updates:

- Integrated Workforce Plan
- Development of a Healthy Organisational Culture
- Mental Health Transformation Programme
- Working with Public Partners
- Strategic Planning

2.   **INTEGRATED WORKFORCE PLANNING**

2.1   On 23rd March 2016, the IJB approved its Organisational Development and Workforce Development Strategy. This Strategy made a commitment for our integrated authority to work with our parent organisations, Perth and Kinross Council and NHS Tayside, to provide the highest quality services to our service users and communities, and improve how people feel about Perth and Kinross HSCP as a place to work.

2.2   The Strategy focused on two key objectives that support the workforce to be committed, capable and engaged in person-centred, safe and effective service delivery, namely:

- Delivering a clear approach to Organisational Development and Service Improvement
- Delivering a comprehensive plan for tomorrow's workforce.

2.3   Although not an employing body the IJB recognises the people who deliver the services as its greatest asset. There is an inextricable link between the people who provide care and the people that they care for - without these people (e.g. Social Workers, Nurses, GPs, Home Care Workers, Therapists etc) there would be no health and social care services. As we face unprecedented demand on these services, increasing financial pressures, and

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a service user population with complex care needs, we must continue to ensure that our workforce have the right skills and competencies, are resilient, and feel valued, well supported and engaged.

We recognise the interdependency on our corporate support to support three key areas of work:

- Human Resources and Workforce Planning
- Learning, Education and Training
- Organisational Development and Service Improvement

2.4 National Guidance has been produced by Scottish Government to support work force planning. Three parts have been published over the past 12 months which have included a framework for improving work force planning across NHS Scotland. The second focused on a framework for workforce planning in Social Work and social care services and the third and most recent Primary Care. This plan focusses on developing, building and expanding Multidisciplinary Teams (MDTs), made up of professionals each contributing their unique skills to managing care and improving outcomes. The national guidance are key to enabling the development of our workforce plan.

2.5 The IJB have been working closely with partner organisations to develop a workforce plan in line with significant organisational change in parent organisations. The senior management team connects and collaborates with operational, professional, governance and functional groups within the HSCP and in parent organisations in order to ensure that all activity is aligned with any partnership activity.

3 DEVELOPMENT OF A HEALTHY ORGANISATIONAL CULTURE

3.1 The focus on organisational development is critical to develop an organisational culture of shared behaviours, values, and beliefs, which governs how people work collaboratively. These shared values have a strong influence on the people in the organisation and dictate how they act, and perform their jobs.

3.2 Since the establishment of the Health and Social Care Partnership (HSCP), the Chief Officer and his the Senior Management Team have taken a leading role, working with our managers and staff, to develop the Health and Social Care Partnership to develop a positive and shared culture is pivotal to our new organisation's ability to meet the demands placed upon it and in particular to maintain an engaged and motivated workforce.

3.3 The HSCP brings together a diverse workforce from two distinct and recognised organisations with established cultures and subcultures, within our wide ranging services, teams, professions and disciplines.

3.4 The HSCP will build upon the strong existing values and behaviours from our two parent organisations, whilst creating its own unique identity, brand and shared vision- that working together we can improve outcomes for the people who use our services.

3.5 Key to developing our organisational culture is supported by the IJB's Strategic Plan to provide a clear direction of travel for our organisation, and how our different services, teams and individuals all play a role in contributing to, and achieving our Vision and strategic objectives.

It is intended that the Workforce Plan will set out the arrangements that we presently have, and the arrangements we plan to put in place, to make sure that we have a workforce which is enabled and fit for purpose and able to deliver to meet current and future needs of our residents.

3.6 It will also aim to highlight the steps we will take to anticipate future workforce needs based on legislative requirements, evidence of changes in demographics, the impact of ongoing change implementation and in particular a shift towards the provision of more community based health and care services.

3.7 We start from a position of strength. We have robust workforce planning and workforce development arrangements in place in each of the parent organisations which will provide ongoing HR and Organisational and Learning and Development support to employees. This Plan sets out additional support and development activity that will be implemented in support of our new partnership arrangements.

3.8 It is recognised that workforce planning and workforce development needs are emergent and dynamic therefore development of the workforce is a core activity embedded within our planning processes and is continuous.

4.   MENTAL HEALTH
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4.1   Transformation Programme
Work continues to implement the MHLDSRT programme. There is an intention to drive more rapid progress to meet further emerging workforce challenges and the requirement to achieve financial balance. Changes to programme management will bring implementation within the responsibilities of the Operational Leadership team.

4.2   Culture
Following the HIS report, significant work has been undertaken to draw together all elements of Mental Health and Learning Disability Services across Tayside. The intention is to improve pathways of care and to consider how pathways can be broadened to support early intervention and prevention wherever people come into contact with public services and third sector organisations.

4.3   Contingency
Significant efforts are underway to support permanent solutions for staff working to support the contingency arrangements. A formal process of organisational change is followed in partnership with the individual member of staff, their manager and their staff organisation representative.

4.4   Medical Workforce
A further Deanery review of General Adult Psychiatry training took place on 3 May 2018. The Review team outlined that the Training Programme would be placed in enhanced monitoring.

5   WORKING WITH PUBLIC PARTNERS

5.1   Officers and Public Partners are working to ensure appropriate engagement of the public, service users and carers in shaping the business of the IJB. The role of members of the public, local service users and carers is embedded in the principles of local strategic planning as undertaken within the local action partnerships.

5.2   The Health and Social Care Partnership has a Strategic Planning Group to which includes members of service user and carer groups. This group sets the strategic direction for the partnership and has responsibility for the modernisation of the Strategic Plan

5.3   The Public Partners who are elected to sit on the IJB as stakeholders have a scrutiny and advisory role to ensure the business of the partnership is conducted in partnership with service users and carers across Perth and Kinross.

5.4   The public partners in Perth and Kinross IJB have expressed a desire to understand the core business of the Health and Social Care Partnership. Induction sessions for new members will be open to Public Partners and shadowing opportunities and site/service visits will be organised to ensure a closer understanding of services.

6   STRATEGIC PLANNING

6.1   A series of meetings have resulted in proposals for the future model of care in Perth and Kinross. Initially based in the requirement to modernise services and to appropriately design acute services in Perth and Kinross, this work is also linked to wider work being undertaken across NHS Tayside. The Health and Social Care Partnership is ensuring appropriate links between community and hospital services and encouraging formal review to be inclusive of the future requirements of the Perth and Kinross Community Services.

6.2   Work is progressing on target to define and align services into care groups. This will allow appropriate standardisation of services. The march strategic Planning Event provided opportunity to revisit the strategic aims of the partnership and to prepare the refreshed strategic plan for presentation to the IJB in September 2018

      April – June Development of care group strategy/ programmes of work
                 Locality Forums to develop community solutions
                 Formation of initial proposals
                 Consultation and Engagement with localities/communities

      September Draft Strategic Plan Refresh considered by IJB

Author(s)

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Perth & Kinross Integration Joint Board

22 June 2018

GP Engagement Funding

Report by Dr Hamish Dougall, Clinical Director (G/18/97)

PURPOSE OF REPORT

To seek approval for 2018/19 GP Engagement Funds to support effective GP Prescribing.

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1. RECOMMENDATION(S)

1.1 The IJB is asked to approve investment of £211k in 18/19 for the GP Engagement Programme.

2. SITUATION/BACKGROUND / MAIN ISSUES

2.1 In March 2017 the IJB approved a proposal to invest £312k/annum for a 3 year period to support additional GP time to focus on quality, safety and cost effectiveness of prescribing and transformation of unscheduled care.

2.2 The investment was regarded as an essential 'invest to save' initiative, key to improving the cost effectiveness of prescribing and bringing expenditure in line with budget.

2.3 The roll out plan for 2017/18 estimated spend of £156k. Actual spend was £41k with reasons for delay in spending as follows:

   2.3.1 It was always anticipated that finding additional GP capacity from either within or outwith GP practices was going to be a challenge in the current difficult GP recruitment climate, and so it has been the case.

   2.3.2 Lack of capacity within the HSCP team to deliver such an innovative program which has required personal visits to most of the 24 GP practices in P&K to discuss.

   2.3.3 Resistance to change from some GP practices.

2.4 Whilst financial investment in 17/18 has been lower than anticipated, the investment of time by the Clinical Director and others to set up a sustainable engagement approach, has been significant.

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2.5 Overall in 17/18 there was a 0.19% decrease in GP Prescribing expenditure in Perth and Kinross compared to an increase of 1.7% across Scotland. Whilst this cannot be directly attributed to the establishment of the GP Engagement approach, it is likely that it is a significant contributing factor.

2.6 The 2018/19 Financial Plan for GP Prescribing assumes growth in volume of 0.5% (£140k) and price growth of 1.0% (£281k) which equates to an overall increase of £321k. A step up in investment in GP Engagement will seek to ensure that this level of growth is controlled with any further improvement helping to close the current £438k shortfall in the Financial Plan.

3. 2018/19 Proposed Investment

3.1 The proposed investment for 2018/19 on GP Engagement is set out in Table 1 below.

Table1: Programme Area	2018/19 Projected Cost £
GP Capacity	121,000
Specific Projects	27,000
Other incl. Programme Management Support	63,000
Totals	**211,000**

3.2 The basis of this model is to provide a blended approach to the establishment of the team tasked with accelerating the work already being undertaken.

3.3 In order to maximise the benefits of the programme we are seeking to vary our approach to accessing GP capacity. This involves using a range of methodologies including: salaried GPs; GPs undertaking "career start" (part funded by NHS Tayside); and others on a sessional basis.

3.4 In respect to project specific costs; a number of projects are already established and will continue to be supported to ensure maximum benefits are achieved. There are other projects which are being developed and small tests of change are being undertaken to establish their viability. These projects generally require a level of pump priming investment, for example for pharmacy support staff, and once rolled out across the partnership area they will individually contribute to the overall aim of controlling prescribing expenditure.

3.5 To assist in the efficient management of this activity and following the significant start up work undertaken by the Clinical Director, the programme will now be supported by a programme manager.

4. CONCLUSION

Significant progress on prescribing costs has been made but it is recognised that challenges still remain. A more coherent and dynamic team, inducing significant GP capacity, should soon be in place to focus on this and wider quality & safety prescribing issues, and to work with GP's on their use of unscheduled care.

Author(s)

Name	Designation	Contact Details
Dr Hamish Dougall	Clinical Director	hdougall@nhs.net

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	Yes / None
HSCP Strategic Commissioning Plan	**Yes**
Transformation Programme	**Yes**
Resource Implications	
Financial	**Yes**
Workforce	**Yes**
Assessments	
Equality Impact Assessment	**No**
Risk	**No**
Other assessments (enter here from para 3.3)	**No**
Consultation	
External	**No**
Internal	**Yes**
Legal & Governance	
Legal	**No**
Clinical/Care/Professional Governance	**Yes**
Corporate Governance	**No**
Communication	
Communications Plan	**Yes**

1. Strategic Implications

1.1 Strategic Commissioning Plan

The approach being proposed in respect to investment in prescribing management impacts on the following areas.

1   prevention and early intervention,
2   person centred health, care and support
3   work together with communities
4   inequality, inequity and healthy living
5   best use of facilities, people and resources

2. Resource Implications

2.1 Financial

The Chief Finance Officer has been consulted on the drafting of this report and seeks to invest £211k in the prescribing management programme.

2.2 Workforce

This report details proposed new workforce arrangements for advancing the quality, safety and cost effectively prescribing agenda.

3.   Assessments

3.1   Equality Impact Assessment

Assessed as **not relevant** for the purposes of EqIA

3.2   Risk

None

3.3   Other assessments

None

4.   Consultation – Patient/Service User first priority

4.1   External

None

4.2   Internal

Chief Finance Officer has been consulted in the drafting of this report.

5.   Legal and Governance

5.1   None

6.   Communication

6.1   Communications with stakeholders is a key element to progressing this work both internally in respect to prescribers and externally with patients.

At a pan Tayside level staff engage with colleagues to ensure consistent prescribing communications messages are sent out. This work will continue but will be bolster by having greater capacity to influence communications which pertain more directly to Perth and Kinross.

7.   BACKGROUND PAPERS/REFERENCES

None

8.   APPENDICES

None.

Perth & Kinross Integration Joint Board

22 June 2018

Tayside Primary Care Improvement Plan 2018 to 2021

Report by Dr Hamish Dougall, Clinical Director (G/18/98)

PURPOSE OF REPORT

This report seeks approval from the Integration Joint Board for the NHST Tayside Primary Care Improvement Plan (PCIP).

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1. **RECOMMENDATIONS**

   It is recommended the Integration Joint Board:

1.1 Approve the content of the Tayside Primary Care Improvement Plan in so far as it pertains to Perth and Kinross (Appendix 1).

1.2 Endorse the programme management approach being taken in Perth and Kinross in respect to the ongoing delivery of changes to General Medical Services.

2. **SITUATION/BACKGROUND / MAIN ISSUES**

2.1 The PCIP is a pan Tayside collaboration which sets out the work being undertaken across Tayside and within each partnership area to implement the new General Medical Services contract which came into effect on 1 April 2018. Once approved by each Tayside IJB, the PCIP will be submitted to the Scottish Government for approval. The timescale for this is 1 July 2018.

2.2 The provision of GMS (General Medical Services) in Scotland is changing and the catalyst for this is the new contract for General Practitioners; "The 2018 General Medical Services Contract in Scotland. The initial draft of the GMS contract was released for consultation across Scotland in late 2017 and was approved, following feedback, in early 2018. It came into effect on 1 April 2018.

2.3 The contract offers the opportunity to refocus GP activities away from areas of work which can be undertaken by other healthcare professionals and onto delivering more holistic and person centred care as "expert medical generalists".

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2.4   What this means for patients is that they may come into contact with a wider range of professionals within GP practices as multi-disciplinary teams become more established. In turn this will free up GP time so that they can undertake work dealing with more complex and challenging patient care.

3.   PROPOSALS

Structure/Methodology

3.1   The implementation of the new contract is a large and complex undertaking requiring a whole system view of primary care; the services delivered; the professionals engaged and the dependent relationships between primary and secondary care.

3.2   There are also variances across practices in terms of how the same/similar services are delivered for patients and these need to be understood in significant detail to ensure that transitions to new arrangements can be managed seamlessly. This work needs to be undertaken in consultation with GPs at a practice level, taking into account the needs of patients and the availability of specialist staff.

3.3   In terms of service design, the contract is split into a number of key elements listed below. These elements each represent an opportunity to ensure practice sustainability is secured and patient care is improved:

- Vaccination Services

- Pharmacotherapy Services

- Community Treatment and Care Services

- Urgent Care Services

- Additional Professional Role:
    o Physiotherapy focussed on Musculoskeletal conditions
    o Community Mental Health Services
    o Community Link Worker Services

3.4   NHS Tayside has taken a lead in coordinating the drafting of the PCIP and with significant input from across partnership areas including Perth and Kinross. It is recognised however that the budget for GMS implementation is held by partnership IJBs.

3.5   It is clear that, when considering service developments, future resource requirements are better understood in some areas than they are in others. The PCIP notes the overall budget allocations for each partnership and sets out areas where more detail is known about future plans and commitments.

3.6   Within Perth and Kinross each element of the PCIP which requires funding in order to implement the GMS contract will be worked into a business case proposal before resources can be reasonably and responsibly allocated. The partnership will undertake this work using a coordinated programme

management approach by splitting the contract into is constituent elements and dealing with them as projects in their own right. In doing so it is important to understand local needs across Perth and Kinross and so each element will be considered in locality context. This work will be undertaken over the coming weeks and months with robust financial plans being developed.

2018/19 Scottish Government Funding

3.7   In late May the Scottish Government confirmed earmarked recurring funding for the Primary Care Improvement Fund for 2018/19. A total of £45.75m has been allocated to Integration Authorities across Scotland on an NRAC basis. The Perth & Kinross IJB share of this important investment is £1,249k. Spending plans are currently being developed and the overall scrutiny and approval of investment decisions will be the responsibility of Perth and Kinross Health and Social Care Partnership Executive Management Team.

3.8   The Primary Care Improvement Fund is designed as a facilitator to enable and accelerate change with the intention to directly support General practice by enabling work to shift away from practices. This income stream can be enhanced by local provision or re-configuration, but cannot be reduced and is not subject to the application of savings targets. There is an expectation that all money allocated by the Scottish Government to fund the plan each year is spent within year. Money not spent from this income stream can be carried forward – but a carry forward of unspent funding should be considered as exceptional.

3.9   It is recognised that IJB's have the ability to collaborate where appropriate at a regional level where it is acknowledged that regional development is both necessary and an efficient use of funding.

4.   CONCLUSION

4.1   The GMS contract represents an opportunity to improve the provision of primary care services across Perth and Kinross. This will be done by improving the accessibility of services to patients while allowing GPs to focus on more complex care needs.

4.2   Contract implementation is nonetheless a significant undertaking requiring a coordinated approach which takes into account the needs of all stakeholders including patients and GPs as well as the wider GP cluster groups and Localities.

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1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	Yes / None
HSCP Strategic Commissioning Plan	**Yes**
Transformation Programme	**Yes**
Resource Implications	
Financial	**Yes**
Workforce	**Yes**
Assessments	
Equality Impact Assessment	**Yes**
Risk	**Yes**
Other assessments (enter here from para 3.3)	
Consultation	
External	**No**
Internal	**Yes**
Legal & Governance	
Legal	**No**
Clinical/Care/Professional Governance	**Yes**
Corporate Governance	**Yes**
Communication	
Communications Plan	**Yes**

1. Strategic Implications

1.1 Strategic Commissioning Plan

The Primary Care Improvement Plan seeks to implement the 2018 General Medical Services Contract. Consequently this report impacts on all areas of the Strategic Commissioning Plan

1   prevention and early intervention,
2   person centred health, care and support
3   work together with communities
4   inequality, inequity and healthy living
5   best use of facilities, people and resources

2. Resource Implications

2.1 Financial

The Chief Finance Officer has been consulted on the drafting of this report.

A total of £45.75m has been allocated to Integration Authorities across Scotland on an NRAC basis. The Perth & Kinross IJB share of this important investment is £1,249k. Spending plans are currently being developed and will be brought back to the IJB for approval in September 2018.

2.2   Workforce

The Lead for Human Resources and the partnership representatives for each area affected by this work have been and continue to be engaged in this significant piece of work.

3.   Assessments

3.1   Equality Impact Assessment

Under the Equality Act 2010, PKC and NHS Tayside is required to eliminate discrimination, advance equality of opportunity, and foster good relations between equality groups. Carrying out Equality Impact Assessments for plans and policies allows the HSCP to demonstrate that it is meeting these duties.

The service re-design elements of the GMS implementation are required to consider equalities as a key element of any proposed development.

3.2   Risk

Each chapter of the PCIP will be developed into individual business case proposals which make the case for change including, amongst other elements the risks borne by taking proposals forward.

3.3   Other assessments

The following assessments will be undertaken as part of the programme management approach being proposed to manage the implementation of the GMS contract:

Measures for Improvement

Patient Experience

Health and Safety

Healthcare Associated Inspection

Benefit Realisation

Quality

IT

4.   Consultation – Patient/Service User first priority

4.1   External

N/A

4.2   Internal

The following people/roles have been consulted in the preparation of this report:
1)   Chief Officer
2)   Chief Finance Officer
3)   Clinical Director
4)   Head of Health
5)   Locality Managers
6)   Heads of Service, Service Managers, Lead Professionals and Third Sector representatives for:
        a.   Vaccination Services
        b.   Pharmacy
        c.   Urgent Care
        d.   Mental Health
        e.   Physiotherapy
        f.   Community Link Workers

5.   Legal and Governance

This is a large piece of partnership work and each element of service re-design will consider appropriate Governance arrangements.

6.   Communication

This a large piece of partnership work and each element of service re-design will require significant communications with stakeholders. This will be taken forward throughout the implementation phase of this programme of work.

7.   BACKGROUND PAPERS/REFERENCES

"The 2018 General Medical Services Contract in Scotland"

8.   APPENDICES

Appendix 1 – Tayside Primary Care Improvement Plan 2018 to 2021

Tayside Primary Care Improvement Plan

2018 to 2021

Authors
Lisa Prudom
Dr David Shaw
Dr Andrew Thomson

CONTENTS

Foreword

We are delighted to present our Primary Care Improvement Plan. This plan has been developed collaboratively between by Angus, Dundee and Perth and Kinross Health and Social Care Partnerships, NHS Tayside Board and GP Subcommittee.

The plan describes our commitment to support and deliver primary care services which meet the needs of the communities we serve both now and for the future. It represents an ambitious programme of change which places people at the heart of service delivery.

The Primary Care Improvement Plan does not sit in isolation. It is a living document that is a critical element of to the rich clinical context of strategic and transformative change taking place across Tayside and is integral to the delivery of the Integrated Clinical Strategy.

Dr David Shaw   **Dr Andrew Thomson**
Clinical Director   **Medical Secretary**
Dundee HSCP   **Tayside GP Subcommittee**
June 2018

Introduction

An effective primary care system is critical to sustaining high quality universal healthcare and is vital if we are to realise Scotland's ambition of improving the health of our population and reducing the burden of health inequalities that rests upon it. As a nation we require a strong and thriving general practice at the heart of our primary care system if we are to succeed in these goals.

The vast majority of healthcare interactions for our population start and end within primary care, with General Practices acting as a necessary and efficient gateway to decisions about referral, admission and prescribing. These decisions have a direct impact on the entire health and social care system with immense consequential resource implications.

This document describes a three year investment programme of unprecedented scale that aims to support the moving of patient care and resources into the community, the improving of quality and efficiency of healthcare delivery and the addressing of the Realistic Medicine agenda. This will ensure that we have a general practice and a primary care system that delivers high quality, effective and responsive care for our patients in the communities in which they live.

This Plan is a commitment to provide better care for our population. An effective, vibrant and fully functional primary care is essential for NHS Tayside and for the Health and Social Care Partnerships, who commission that care. It is also essential for the professions and services that deliver it. The spirit of collaboration and co-production runs through this plan and are essential to ensure its effective implementation.

National Background and Context

General practice has experienced a prolonged and unprecedented level of challenge across the UK. A sustained period of real terms decline in resource coupled with a negative portrayal of General Practice has resulted in a recruitment crisis with GP Practices; unable to match recruitment to the service with departures from it.

This challenge is set against a background of increasing demand for access through changes in societal values, an ageing demography and an increasing disease burden. Practices have not only struggled to attract sufficient doctors but also to recruit other healthcare professionals to deliver the service at the level to which they aspire. The result of this 'perfect storm' across Scotland is a wave of practices restricting their lists through closure, tightening boundaries and increasingly having to surrender their contracts due to insurmountable difficulties.

Development of the 2018 Scottish GMS contract

Recognising the severity of the situation, the Scottish Government in close collaboration with the Scottish General Practitioners Committee, developed the 2018 Scottish General Medical Services (GMS) contract. This contract seeks to both re-invigorate general practice and through fundamental service re-design create positive effects throughout Primary Care as a whole.

The 2018 GMS contract builds on re-energised core values, developing the GP as the expert medical generalist at the heart of the community multidisciplinary team. The aims of the contract are to create a dynamic and positive career for GPs; a resilient and responsive wider primary care with opportunities for all healthcare professionals to flourish; and an assurance that patients will continue to have accessible, high quality general medical services.

Scope of the Contract and supporting documents

The new contract is supported by a Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards. This MoU requires every area in Scotland to develop a Primary Care Improvement Plan (PCIP) as a collaborative process between the NHS Board, Health and Social Care Partnerships (HSCPs) and GP Subcommittee of the Area Medical Committee (GP Sub). Specific agreement is also required by the Local Medical Committee in relation to contract implementation.

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The MoU identifies six key priority areas which must be included in the PCIP:

- Vaccination Transformation Programme
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care Services (advanced practitioners)
- Community Link Workers
- Additional Professional Clinical and Non-clinical services including
  - Acute musculoskeletal physiotherapy services
  - Community Mental Health Services

The MoU represents a statement of intent recognising the roles of the Integration Authorities and NHS Boards in commissioning and delivering primary care services. Primary care service redesign and development will be in the context of delivery of the new GMS contract and accord with seven key principles:

- Safe
- Person Centred
- Equitable
- Outcome Focussed
- Effective
- Sustainable
- Affordability and Value for Money

Further key enablers for change identified are:

- **Premises** – a shift over 25 years to a new model for GP premises in which GPs will no longer be expected to provide their own premises
- **Information sharing arrangements** – reducing risk to GPs by moving to a system where GPs and their contracting Health Boards have joint data controller processing responsibilities towards to the GP patient record
- **Workforce** – a national workforce plan has been published setting out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multi-disciplinary team

The MoU covers the 3 year period, from 1 April 2018 to 31 March 2021 to which this implementation plan relates.

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Aims of the Tayside Primary Care Improvement Plan

The Tayside Primary Care Improvement Plan takes the principles detailed within the GMS contract and MoU; describing how they will be embraced and implemented by creating a better functioning, patient centred primary care that allows other healthcare professions to grow and develop while easing pressure within General Practice. This is not just to increase the sustainability of the profession, but also to release the time required for GPs to take a full part in shaping a reinvigorated primary healthcare system.

The changes that our Improvement Plan describes are the single greatest alteration to the shape of primary care in a generation. Each of the workstreams that lie within the plan is a major project in its own right. The improvements within the plan represent an opportunity for the whole of the Primary health and social care team to reshape itself; becoming more rewarding, attractive and sustainable. This will act as a catalyst for change which will reshape, refresh and re-invigorate the entire healthcare system so that our population will have timely access to the right person within their community delivering the highest quality achievable.

The PCIP will be interwoven within the Strategic Plan for each Health and Social Care Partnership (HSCP) and, to ensure the continued delivery of high quality, safe, person centred care, the transition to full implementation will happen over a period of three years.

A regional plan, locally owned

The three Tayside HSCPs (Dundee, Perth & Kinross and Angus), NHS Tayside and the GP Sub agreed to formulate a joint plan for Tayside. A single shared plan allows services to be planned at scale; to be integrated with the other major strategic changes occurring across the region's health and social care services; and assists in the aspiration of an equal standard of service across the population.

A single plan does not prevent or restrict but facilitates individual HSCPs in finding differing solutions that address the local needs of Tayside's disparate population. We strongly support an equality of outcome across Tayside that is supported by locally owned and designed solutions with regional support.

A description of how the PCIP was developed, how it will be implemented and how it will be monitored is included in the Governance section of this paper.

A Plan for General Practice

General Practice within Tayside is experiencing the same difficulties as elsewhere in Scotland. Three practices are already operated by NHS Tayside, as they were unable to sustain themselves as independent practices. Many others are struggling, particularly due to problems with recruiting new GPs. As a result many practices have, closed their lists, reduced their boundaries or reduced the scale of the services that they offer.

The PCIP aims to improve the resilience of our Tayside practices. It will do so in part by moving work and services more appropriately provided by others away from the responsibility of General Practitioners and in some cases practices.

The PCIP also aims to attract more doctors to the profession by creating a more fulfilling role for those working in it. The proposed new role for the profession is described below in the following extract from the 2018 GP Contract offer document:

"GPs are expert medical generalists who provide the first point of contact with the NHS for most people in their communities. They may deal with any medical problem, 'from cradle to grave', and by providing continuity of care to their patients, families, and communities, they contribute hugely to keeping the nation healthy.

General practice is a unique discipline. Rigorous scientific and clinical medical training and the ability to apply the evidence appropriately in community settings, places general practice at the centre of the NHS. This knowledge and skill set – when combined with the discipline's holistic, relationship based philosophy and broad generalist practice, distinguish the discipline in large measure from other medical disciplines."

The aspiration of this change in focus is that it makes General Practice a more attractive specialty to work in. The effect of this change should be to offer greater opportunities for the development of additional skills for other healthcare professions; and to make the care of patients central to an entire healthcare team working together.

The document goes on to outline the following aspiration for the new contract:

To enable and empower GPs to function as expert medical generalists, non-expert medical generalist workload needs to be redistributed to the wider primary care multi-disciplinary team, ensuring that patients have the benefit of the range of expert advice needed for high quality care.

Through delivery of this Primary Care Improvement Plan, which is interwoven with HSCP Strategic Plans, future service will be protected. This will ensure the delivery of sustainable services required to ensure our population's health and social care needs continue to be delivered.

A Plan for Our Patients - designed with our population

Throughout the development of the PCIP it has been critical to ensure that our Plan is suitable for the needs of our local populations and that the improvements it brings address the challenges our population face.

The most obvious of the many challenges that we face are those created by the shifting demographics of the population. An ever greater proportion of our community are living longer, resulting in an aging population. This brings with it an inevitable and growing burden of chronic disease accompanied by a relative decrease in the working age population. Addressing these pressures through the mobilisation of community assets and infrastructure is a priority.

Health inequality is, and will remain, a priority for NHS Tayside. We have pockets of both significant deprivation and geographic isolation within Tayside and the delivery of services to help tackle these will have to be sensitive to local needs that will vary between local populations.

Some of the priority workstreams such as Link Workers offer a vital tool in helping to address and mitigate these societal challenges that directly impact on wellbeing and the use of health resource. Delivery of enhanced and proactive care will be facilitated by freeing up GP time and through enhanced delivery within the community such as in Care and Treatment Centres.

Stakeholder Engagement

The successful delivery of the PCIP relies on it being seen as clinically necessary, clinically led and good for patients.

In implementing this plan, we place those responsible for delivering the services and the patients that they care for at its heart. Those services which are key to the implementation of the plan, along with each HSCP and GP locality clusters, are charged with ensuring that the needs and views of patients are integrated with the delivery and further evolution of the plan; and that our workforce is informed, supported and consulted in the necessary changes that must be made.

There has already been a broad focus on engagement seen throughout Tayside, both in terms of gathering and developing the views of professionals, and also facilitating local dialogue about principals and priorities for implementation. Each HSCP has undertaken surveys to help inform them of GP practice priorities for implementation of the contractual elements and this has been reflected within the priorities set within the following chapters. Implementation will be guided by local priorities with new services being made available to patients of every practice and locality at a roughly even rate with an expectation of full and universal provision by 2021.

Ongoing stakeholder engagement will be critical to successful delivery and we intend to expand further on our engagement with the public around service development as the route-map to implementation becomes clearer. Their views and experiences will guide our conversations and decisions, informing our choices for the development and prioritisation of services. We have a good track record of successful co-production which we envisage expanding upon during the implementation of the PCIP.

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Tayside's population – Understanding Health Inequalities

Introduction

Understanding our population's demography is important if we are to provide for their current and predicted health and social care demands. Many illnesses, conditions and health related behaviours are associated with age, gender or other demographic characteristics. An awareness of population distributions and attributes can help identify those likely to experience health inequalities. This will enable us to plan the most efficient and effective services for the future.

Tayside currently has 64 GP practices providing care to a population of approximately 416,000 registered patients. Over a third of our population have been diagnosed with at least one chronic disease and for a growing number they suffer from multi-morbidity. These patients often require significant numbers of clinical attendances, are on multiple medications and may require significant social care support.

With an aging population (Fig: 1), health and social care demand is set to continue to increase and, without change, would outstrip our current capacity. This improvement plan uses the information we know about our population in developing and prioritising new approaches to the provision of health and social care to ensure our ability to continue the high quality provision for our population now and in the future.

Population Structure

The estimated population of Tayside on 30th June 2016 was 415,470, an increase of 430 (0.1%) from 2015. The gender distribution was similar to previous years, with males comprising 48.6% of the population and females 51.4%

Tayside's population is distributed across three local authority areas, in 2016 there were 116,520 residents [28.0% of the Tayside population] in Angus, 148,270 in Dundee [35.7%] and 150,680 in Perth & Kinross [36.3%]. Figure 1 displays the age structure of the Tayside population and its three local authority areas for 2016.

Figure 1. Age Structure of the Tayside Resident Population, as at 30th June 2016
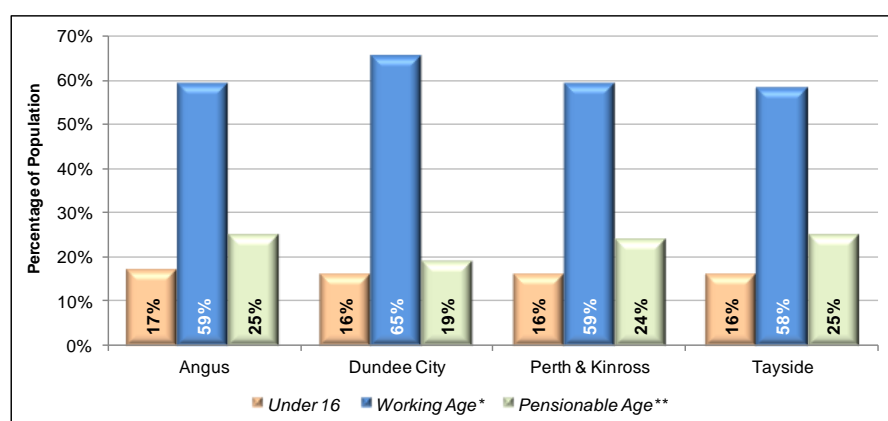
The proportions in each age category across the three local authority areas are relatively similar. However, Dundee City has a higher proportion of the population who are of working age and a lower proportion of those who are pensionable in comparison to its Tayside counterparts.

Minority Ethnic Population

The 2011 Census reported that 3.2% (13,111 individuals) of the Tayside population were of non-white ethnicity. This varied across the region with the corresponding proportions in Angus, Dundee City and Perth & Kinross being 1.3%, 6.0% and 2.1% respectively.

Deprivation

The Scottish Index of Multiple Deprivation (SIMD1) is an area-based measure of deprivation, identifying small area concentrations of multiple deprivation in a comparative manner. It combines the domains of income, employment, health, education, skills and training, housing, geographic access and crime based on a ranking system from most to least deprived. These ranks can be grouped into categories, most commonly quintiles.

While in a standard population, 20% of the population would be expected to live within each quintile, across Tayside there are large variations between the differing levels of deprivation. Figure 2 displays the population proportions residing in each deprivation quintile for all three of Tayside's local authority areas.

Figure 2. Percentage of Tayside Resident 2015 Mid-Year Population Estimate by SIMD_2016 Quintile
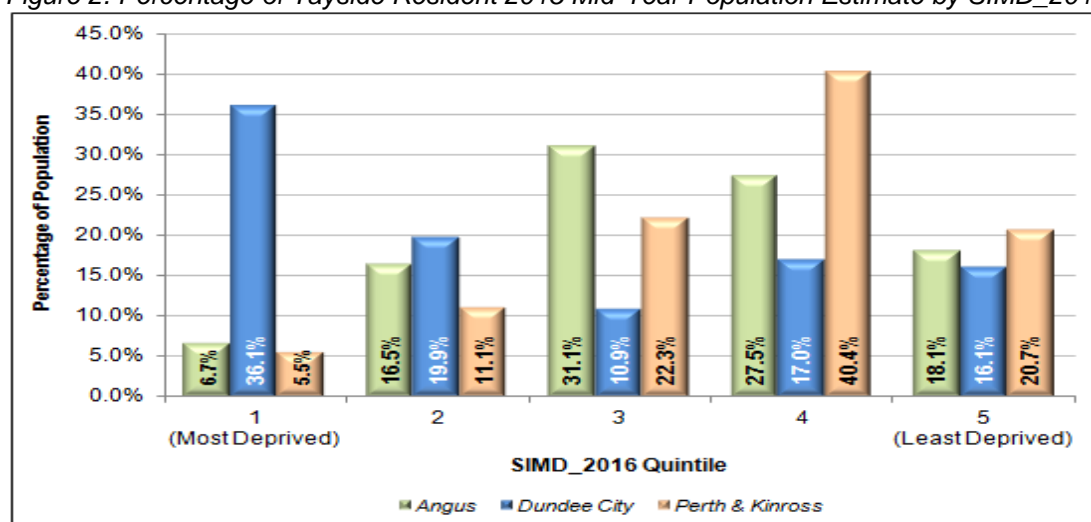
Dundee City has the greatest proportion of their residents living within the most deprived areas (SIMD Quintiles 1 and 2). 36.1% of the Dundee City population resided in the most deprived area, more than five times that compared to its Tayside counterparts.

Population Projections

The total Tayside population is projected to increase by 7.5% (N=444,763) by 2039 (2014 population estimate based). Displayed in figure 3 are the projected changes in the Tayside population, showing the variations in the differing age groups across the three local authority areas.

Figure 3. Tayside Projected Population Changes by Age Group (All Persons), 2014 and 2039
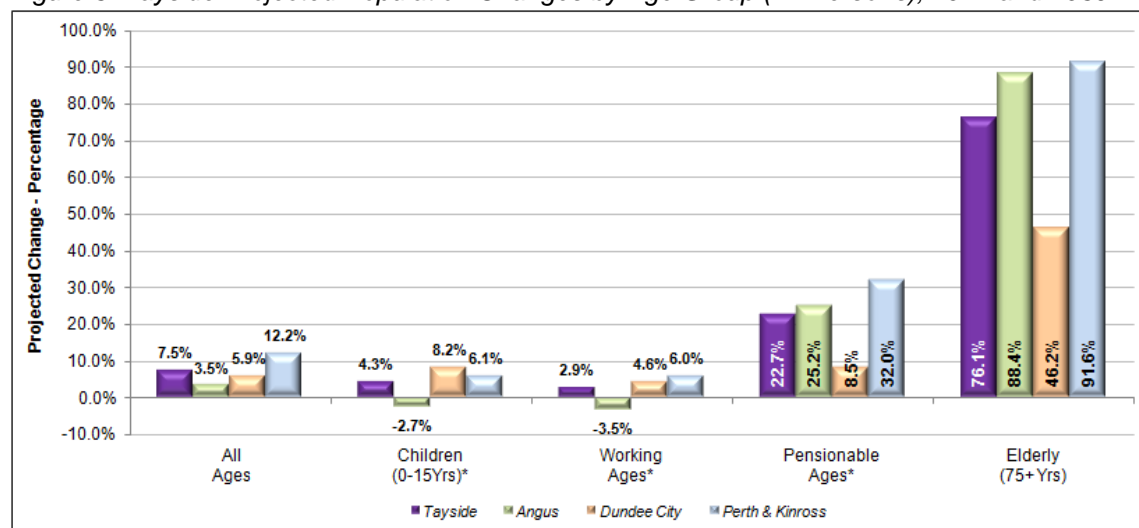
Perth & Kinross is expected to represent the largest projected population change by 2039, an increase of 12.2% (N=167,087) from the baseline estimate of 2014[2]. The other two areas are also projected to increase in total population by 2039, however by considerably less. (Angus - 3.5% (N=120,799), Dundee City - 5.9% (N=156,877)).

Of those age groups encompassed within the population of Tayside, those of pensionable age, and especially those aged 75+ years, are projected to display the greatest increase in population size by 2039 from the 2014 baseline estimate. Over the next twenty-five years, the most elderly age band, those aged 85+ years, are projected to increase by 128.7%. Of Tayside's three local authority areas, both Angus and Perth & Kinross are predicted to show the greatest increases in these elderly age groups.

Ill health

Many patterns of disease and conditions demonstrate inequalities between gender, age or geographical area. It is estimated that one in four adults (aged 16+ years) report some form of long term condition (LTC), health problem or disability and by the age of 65 nearly two thirds will have developed a LTC. Examples of common LTCs include diabetes mellitus, asthma and chronic obstructive pulmonary disease (COPD).

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Understanding health inequality

Inequalities in health are a major challenge both for the NHS in Scotland and for Tayside. Despite improvements in many other health outcomes, there has been little improvement in relative inequalities with evidence of some areas where it is increasing.

Deprived socioeconomic groups suffer lower life expectancy, higher morbidity, and much lower healthy life expectancy than their more affluent peers. Male mortality exceeds that of women; those with physical or learning disability die earlier than those without; those with mental health issues have greater morbidity and mortality than those who don't. Some rural populations with limited access to patient service suffer greater ill health than more urban communities. The reduction of inequalities is a challenging priority at national, regional and local level. This is reflected in a number of strategies and plans in Tayside and is embedded in the Strategic and Commissioning Plan of each HSCP. NHS Tayside is committed the aim of achieving health equity within a generation.

Life Expectancy and Disease expectation

Life expectancy in Tayside overall is similar to the rest of Scotland. However there is significant variation. A baby boy in Dundee can expect to live to 75.1 years, while a baby girl in Perth and Kinross can look forward to surviving an additional 7.5 years. (Figure 4)
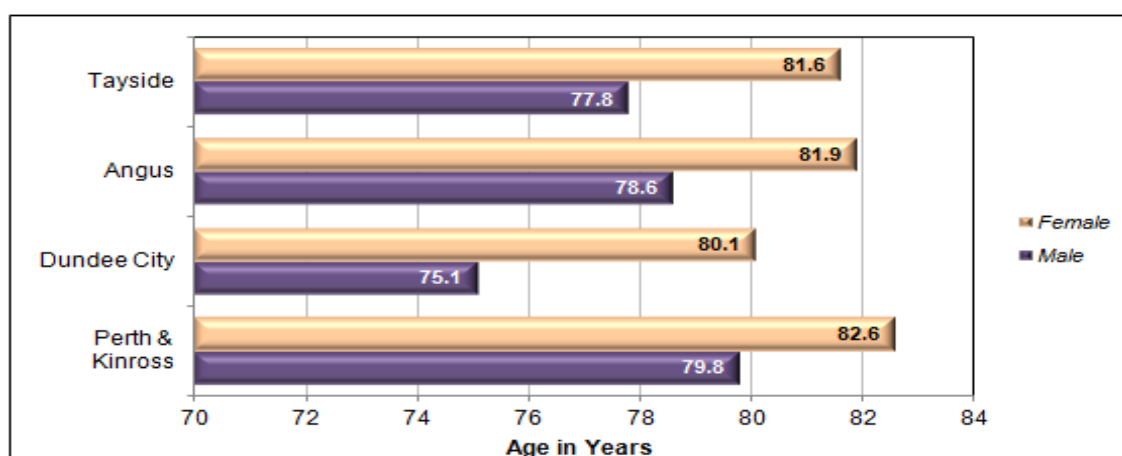
Figure 4. *Tayside Residents 'Life Expectancy at Birth' by Gender, 2013-2015*

These figures mask an even wider variation at locality level, with those in areas associated with higher levels of deprivation, having poorer outcomes across virtually all indicators of health. (Figure 5 and 6)
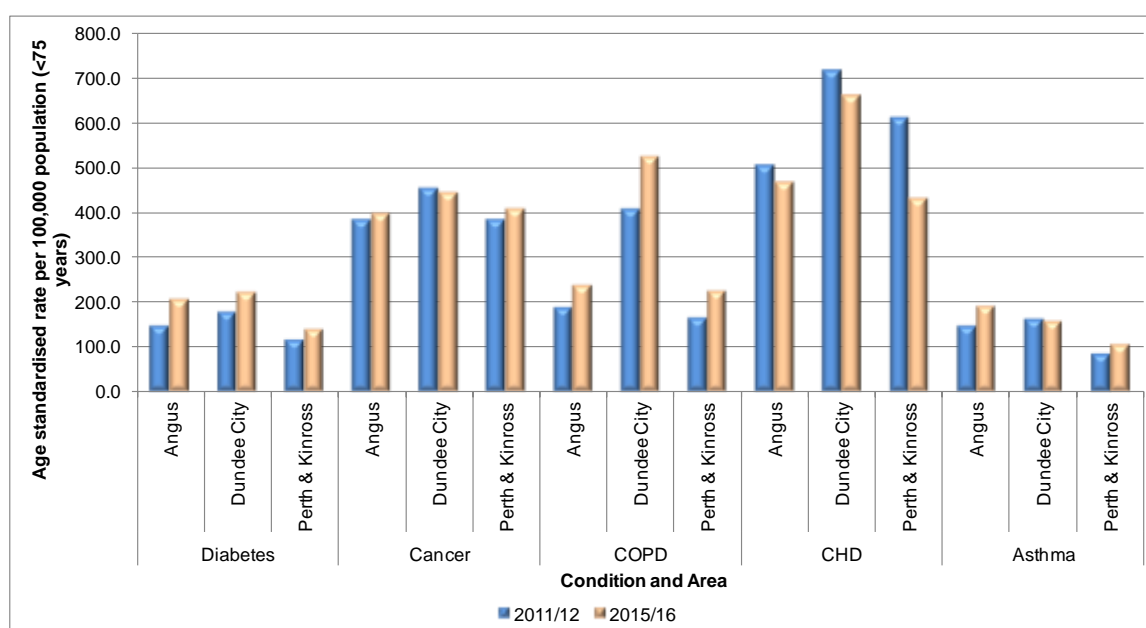
Figure 5. *Age standardised rates for those aged under 75 years for selected conditions across Tayside 2011/12 and 2015/16 (cancer registrations compare calendar years 2011 and 2015)*
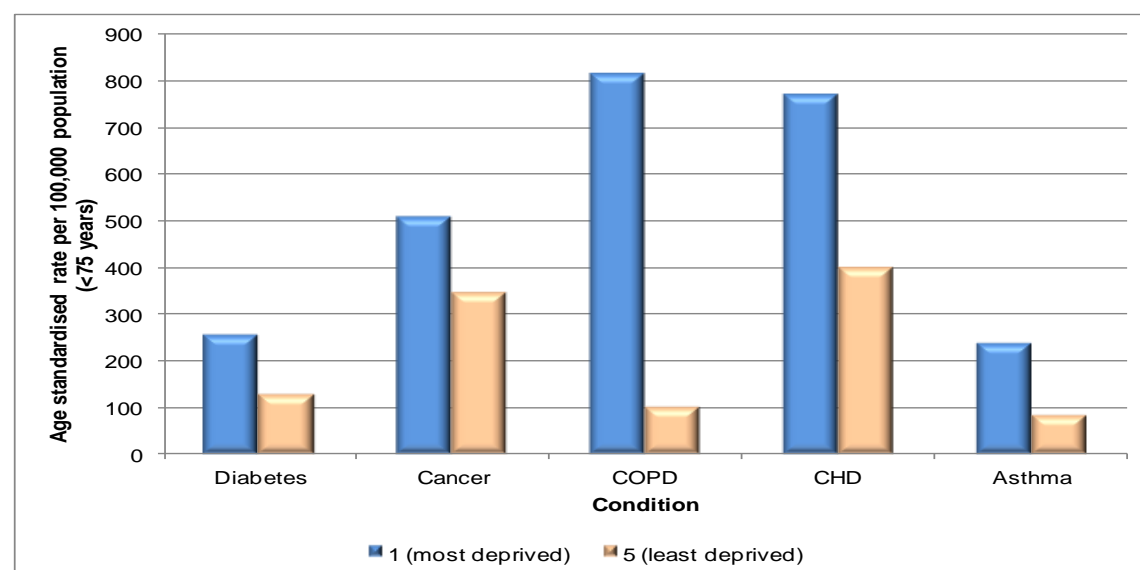
Figure 6. *Comparison of age standardised rates for the most and least deprived areas in Tayside for selected conditions 2015/16 (2015 for cancer registrations)*

Comprehensive evidence suggests that poverty causes harm through the chronic stress it causes. Unhealthy lifestyles, such as substance misuse, which help people cope with this stress, are passed on at very early ages. Teenage pregnancy is both a product of this cycle and an accelerant.

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The lifestyle and socioeconomic factors which lead to ill health are interrelated. For example someone who has lost their job and income may have chronic stress and anxiety, with this impact on their mental wellbeing having a further negative impact on their physical health, and leading to longer term unemployment due to ill health. Breaking the cycle of deprivation leading to ill health early is therefore vital for future generations.

Having a sense of worth, aspiration and confidence can protect people from such harm and gives them resilience. We will build on existing confidence, promote resilience, and rebuild aspiration within communities. This is a very different goal than just aiming for faster or closer services.

Achieving Improvement

Through improving and innovating as detailed in this plan, there is an aim to reduce the avoidable differences dramatically; reducing the years of life lost annually to poverty in Tayside. This goal requires a fundamentally different approach to health and social care, starting with embedding improvements within Primary Care.

We will promote community resilience and support co-production; helping people to plan services and to take back elements of services which do not need to be delivered by health professionals. Engaged communities, with a caring and connected society will promote patient and community enablement, not more dependency on the NHS.

Our effort will need to be tailored to the needs of local populations within Tayside to reflect the problems and supports these communities possess. We will encourage cultural change to help communities become stronger and healthier. This will happen not just within our HSCPs but through inclusion of the voluntary and third sector.

Impact on and role of Primary Care teams

The impact on practices that have populations who predominantly reside in areas of higher deprivation is well documented including by the work of the "Deep End" practices. Socioeconomic deprivation has the greatest impact in Dundee where 33% live in the most deprived 20% of the population. The resulting workload impact on supporting those with multi-morbidity from a relatively early age is hugely demanding. There has been evidence for a number of years that practices in more deprived areas should have longer appointment times but this has not been achievable. Longer term as the workload in practices shifts as a result of the investment that the PCIP brings, it is anticipated that the duration of appointment times could be increased.

General practice and the wider primary care team, as described in the new contract, is core to achieving this ambition. As the key service which supports the whole population, General Practice has a critical role from pre-conception to palliative care. The aspiration of GPs as expert medical generalists at the core of a locality based

MDT within a local community will support identifying and planning for local health needs in a way that reflects the ambitions of the Health Equity Strategy.

Tayside already has a strong infrastructure to support this approach, with well established, GP led cluster groups, actively involved in considering quality improvement work for their local population. As capacity is released within general practice there will be the ability for GP teams to become more involved in the broader aspects of planning services around communities and community needs.

Inequality is also linked to rurality, with a number of contributory factors, particularly access to services, and low incomes. By its nature, the rural aspect of this issue makes it challenging but General practice is often unique in being part of the local community. An important aim of the contract is to ensure that services are provided as locally as possible. The role of technology to provide support is a key part of that solution, and with increasing rural connectivity, is more achievable now than it has been in the past.

Supporting Primary Care

A number of roles may support practices to interrupt the cycle of health inequality. The link worker role is one component of this, but wider social prescribing support can also add value. Where practitioners can easily refer to other agencies and groups, particularly where there is supported access when required, this can impact positively on all aspects of people's lives.

Examples of work undertaken in Tayside to develop this include:

- The use of **web based information systems** to support both self referral and professional referral based on ALISS infrastructure in Angus and Perth and Kinross.
- Dundee has funded the **co-location of welfare rights officers in practices** allowing clinicians to book patients directly to see the welfare rights officer. The officer has access to relevant medical information, with the person's consent, simplifying processes for a range of financial benefits, including PIP and DSA. This work has been evaluated very positively including a reduced impact on clinician time.
- The role of **link workers**, well evaluated nationally, with a well established model in Dundee. There is a social prescribing model that is currently operating in Angus practices with developing work within Perth & Kinross. These roles will be expanded across Tayside, using a range of models which fit local needs, as one of the priority areas of this improvement plan.

The positioning of care and treatment services locally within communities will also assist by providing better and more local access to care which can be augmented by embedding other community services such as social prescribing within the same location.

Tackling inequality

Through the improvements described within this plan, as well as NHS Tayside and HSCP strategic plans, we will:

- Encourage and support a more flexible appointment length for practice appointments for those with complex, socioeconomic or disability issues
- Increase the amount of social prescribing undertaken at practice level
- Continue to develop social prescribing support through a number of teams, including link worker models, wider social prescribing support, welfare rights and volunteering opportunities
- Continue to develop mental health resources within the community supported by the resources associated with Action 15, ensuring that it is tailored to meet the needs of our deprived and vulnerable populations to improve their resilience
- Develop the links established through local planning groups, ensure we work in a coordinated way to meet local health needs
- Build in Equality Impact Assessment in to all our developments
- Promote prevention at as early a stage
- Work with local people to promote a culture of proactive community support, to improve resilience and reduce social isolation.
- Encourage GP clusters to consider how they plan for, evaluate and address inequalities for their local population.
- Actively adopt technologies which increase accessibility and affordability of services. e.g. Florence or Attend Anywhere.
- Make better use of the information available at Tayside and HSCP levels to ensure that we are targeting our resources at those most in need.

An element of the investment supporting these goals will come through existing work planned by HSCPs, local authorities and NHS Tayside. A further element will come through the investment in community link workers associated with this PCIP and the additional funds linked to the Action 15 funding stream for mental health services described in the finance section below.

However, if we are to see the greatest impact on reducing the health and social care burdens associated with inequality we need to embed the cultural changes referred to above throughout all the workstreams described within this document.

Barriers and Opportunities

This PCIP describes a radically different future for primary care from the present in which we now live. It describes an expanded workforce that does not currently exist, with competencies that we have not yet fully described, working in part from premises that have not yet been built or developed, with an IT infrastructure that is not yet readily available. Funding information is relatively limited in extent and is being released at a time that NHS Tayside is encountering significant financial strain and requirements for contraction of spend. Funding sources for the PCIP will need clearly defined with appropriate staff and resources moved across the health and social care system as services are delivered within the community in new and innovative ways. There is an opportunity for greater efficiency of resource usage through innovation and close working between clinicians and managers in a clinically led and directed service.

An additional external pressure within Tayside relates to the early adoption of the link worker scheme within Dundee. This scheme was initially funded separately by Scottish Government but is now expected to come from the resources allocated to the implementing the PCIP. The Government recognised when they made that choice that this might disproportionately impact on HSCPs that had successfully applied to this scheme and therefore gave authority to HSCPs to work jointly to manage this.

The Government have directed that HSCPs and Boards should take note that the continuation of the early adoption of the link worker scheme should be considered to be a priority, whilst leaving it up to HSCPs to decide whether there is a need to change the scope, oversight, employer or lead responsibility for these posts. Discussions regarding how this scheme will develop are ongoing.

This PCIP seeks to coordinate the activities of our 3 HSCPs, the Health Board and an array of services hosted, managed and reporting to a variety of locations across NHS Tayside in a complex reshaping of care clinically led by 13 different GP clusters with a requirement to take into account the needs and views of the 416,000 patients we all serve. The scale of the challenges we face should not be underestimated and the efficiency and speed of decision making and progress should not be fettered by blunt instruments designed for a previous era of healthcare delivery.

We have an opportunity to develop systems of care that enable patients to have access to services close to their home and to be flexible to deal with patients that may live across either Board or HSCP boundaries in a way that ensures the patient is the focus.

The HSCPs and NHS Tayside have a responsibility to monitor, evaluate and report on the impact of the plan to Scottish Government whilst the Government's reporting requirements continue to evolve.

It is almost inevitable that the outcome we will see in 2021 at the culmination of Improvement Plan will differ in part from that which we are seeking to describe in 2018.

The key opportunity this PCIP brings is a massive catalyst for change and development. Whilst envisaged as a means to improve the sustainability of General Practice, it also offers a tremendous chance for other professions to develop into new, enhanced, and more rewarding roles. It allows those in existing roles to be facilitated to develop further having their skills recognised and utilised appropriately.

The changes, and possible redeployment opportunities, arising as part of NHS Tayside's financial recovery, offers the prospect of the release of an already highly skilled workforce, largely based within Secondary Care, into the new services described within this plan. This has potential to provide us with some of the capacity to meet our new and emergent needs.

The release of General Practitioner time to develop into the role of expert medical generalist allows both health and social care services to tap into an additional clinical resource that can support our evolving multidisciplinary teams to provide better care for patients. The GP Clusters will have increasing opportunity and responsibility to shape the quality of service delivered in their locality and will be facilitated by accurate, timely and relevant information delivered through comprehensive IT and data service support, both locally and nationally.

The improvements in IT infrastructure which this plan describes represent an opportunity to ensure better, safer and more efficient communication between primary and secondary care; more local care for patients; and for more coherent specialist clinical management of complex patients by those who have the expert knowledge to do so.

There will be an opportunity to focus on ensuring the principal of 'single entry' delivering appropriate sharing for clinical and care recording reducing and eliminating the risks identified through data transcription that exists currently.

Finance and Resourcing Principles

The changes described in this Primary Care Improvement Plan offer an opportunity to reshape our local healthcare system. The development of Care and Treatment Services; enabling an efficient and safe local IT infrastructure; and the augmentation to the nursing, pharmacy, physiotherapy and other healthcare services described are a catalyst to further improve services not covered directly within the Plan but reflected in the Strategic Plans of each IJB. There is a real opportunity, over time, to move services currently delivered in hospital settings closer to where people live; and to augment social care services by linking them more intimately with healthcare provision.

While the Primary Care Improvement Fund is designed as a facilitator to enable and accelerate change with the intention to provide direct support to General Practice. This funding stream can be, and may need to be, broadened by extended local re-modelling of other services to deliver the broader strategic plan for Primary Care.

The programme of investment and improvement outlined in the Primary Care Improvement Plan will be supported by funding made available by the Scottish Government as part of the Scottish Government's overall commitment to increase Primary Care Funding by £250m by 2021/22. The General Medical Services contract document is clear in stating that the funding streams agreed with the profession are for the direct support of general practice.

Primary Care Improvement Funding has been made available at an IJB level and, while funding has only been confirmed for 2018/19, overall national funding is planned to increase from c£46m in 2018/19 to £155m in 2021/22. The funding available locally is assumed to be as follows:-

	2018/19	2019/20	2020/21	2021/22
	£k	£k	£k	£k
Angus	986	1185	2370	3340
Dundee	1355	1630	3259	4592
Perth	1249	1502	3004	4232
Tayside	3591	4317	8633	12165
Scotland	45750	55000	110000	155000

While funding has been made available at an IJB level based on NRAC weightings, locally it is acknowledged that much of the investment will provide direct support to General Practices and therefore differential weightings may be required. It is also recognised that IJB's have the ability to collaborate where appropriate at a regional level and examples of this would naturally include areas where it is acknowledged that regional development is both necessary and an efficient use of funding (e.g. development of a core process for use of Care and Treatment services or engagement of appropriate levels of professional advisory and project management support).

At this stage in the development of local plans, allocations to specific outcomes have not yet been agreed and this will remain under development and subject to local prioritisation and approval. Scottish Government have stipulated that they require a progress report, including financial details, which must be submitted by September 2018. These will include Local Medical Committee approval in relation to monies provided for direct support of general practice and the implementation of the GMS 2018 contract provisions. Costings mentioned within the workstreams should therefore be regarded as indicative rather than as confirmed.

Within overall plans issues such as impact on premises, IT and other support will be considered along with the impact of existing local commitments (e.g. "early adopter" link workers) and the cumulative impact of inflation. Specific requirements of this funding stream including it not being subject to savings measures or being used to address wider funding pressures will be adhered too.

While in the first year of the Primary Care Improvement Plan overall investment will be dependent on early clarification of plans and ability to quickly recruit to any new posts, in the longer term it will remain challenging to deliver the overall plan within available funding.

However, there is also recognition within the Primary Care Improvement Plan that additional sources of funding may also be available to provide further support including:-

- Mental Health Strategy : Action 15 funding , to improve access in settings such as Accident & Emergency, General Practice, Police custody settings and Prisons.
- GP Out of Hours Funding
- GP Recruitment and Retention Funding.

Tayside	2018/19	2019/20	2020/21	2021/22
	£k	£k	£k	£k
Mental Health (Action 15)	863	1334	1884	2511
GP OOH Funding	392	392	392	392
Recruitment & Retention	TBC	TBC	TBC	TBC

Governance

The ethos behind the Primary Care Improvement Plan (PCIP) is that it should be locally owned, reviewed and implemented whilst being regionally approved and nationally monitored.

Integrated Joint Boards are responsible for commissioning the PCIP and must be confident that it is fit for their local population and that it is being implemented equitably and effectively. All three Tayside HSCPs are committed to working together to deliver the best PCIP for the people living within NHS Tayside. The GP Sub is similarly committed to ensuring that the PCIP fosters a stronger, more sustainable primary care system for our patients.

The delivery of the PCIP will be embedded within the strategic development and improvement plans of the HSCPs and of NHS Tayside. This is essential to maximise the whole system improvement that the 2018 GMS contract offers.

Development of the Plan

Each of the different work streams outlined in the following sections was developed on a regional basis with inputs from each HSCP, NHS Tayside and with Clinical Expert support and GP Sub collaboration. A group entitled the GMS Contract Implementation & Advisory Group (GMS CIAG) was set up for this purpose. This ensured efficient use of resource and an improved ability to generate common understanding of challenges and achieve expeditious solutions.

Ongoing national and regional monitoring of the PCIP

GMS CIAG's role is not confined to the generation of the PCIP. It has an ongoing role in monitoring and evaluating the outputs of the PCIP. Each regional work stream will continue to report to GMS CIAG. GMS CIAG's membership comprises healthcare professionals and service leads; representatives of the GP subcommittee; managers and clinical directors from the Health and Social Care Partnerships; and the Associate Medical Director for Primary Care and Primary Care Department Managers. GMS CIAG should act to facilitate communication between multidisciplinary teams, ensuring that all are supporting each other through the challenge of implementing the PCIP. GMS CIAG reports on progress and barriers to progress to the Tayside Primary Care Board. Quarterly funding status reports must be brought to the Primary Care Board with funding approved also by the LMC. The Governance flow diagram below presents this structure graphically.

Updates on the PCIP's progress must be sent in periodically to the National Oversight Group. This national group is comprised of representatives from the Scottish Government; the SGPC; Integration Authorities (HSCPs) and NHS Boards. It is responsible for overseeing implementation of both the GMS 2018 Contract by NHS Boards and Primary Care Improvement Plans by HSCPs. This will include focus on delivery of clear milestones for the redistribution of GP workload and the development of effective MDT working, including with non-clinical staff.

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                    │   Scottish Government Oversight Group     │
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                    │     Tayside Local Medical Committee       │
                    │    (Approval of Implementation Plans)     │
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│ │ Asset &   │ │ Team / MDT   │ │ Urgent /   │ │ Treatment   │ │ therapy   │ │ ation   │ │
│ │ Infrastructure│ │ Working Group│ │ Unscheduled │ │ Service   │ │ Implementation│ │ Program │ │
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Local implementation and monitoring of the PCIP

Each Health and Social Care Partnership owns its own Improvement Plan and monitors it locally, reporting back to its Integrated Joint Board, and holding councils and health board to account in ensuring the timely implementation.

Professional and Care Governance is critical to the protection and improvement of high quality service delivery. Local and regional governance structures will be refreshed to ensure that they are clinically focussed providing guidance to the emergent new landscape of primary Care Delivery.

As workstreams are delivered at local level many of them will have and develop interdependencies with other services that will vary according to local circumstances. It will therefore be necessary to work with GP clusters, patients and other stakeholders in ensuring that robust, locally owned plans are developed, approved and implemented.

Cluster role in implementing and guiding the PCIP

Each HSCP has aligned its structures into locality units. Each of these has a grouping of General Practices forming a 'Cluster'. GP clusters, with identified quality leads from each GP practice (PQLs), have a clear role in quality planning, quality improvement and quality assurance. Their core functions include an intrinsic focus to improve clinical care quality for their practice populations through peer led review whilst also providing meaningful influence the local system on service function and quality. Quarterly service provision reports will be made available for review by clusters to ensure quality and consistency and reassure of service development across all areas.

Each Cluster has an identified lead GP. These Cluster quality leads are an integral part of locality improvement groups which, in turn, feed into HSCP Strategic Planning Groups responsible for service commissioning. GP clusters also feed into the local Clinical, Care and Professional Governance Forums which report to both the Integrated Joint Boards, and through the Clinical Quality Forum to NHS Tayside Board.

This model of engaging GPs within clusters, and cluster leads within HSCP structures is consistent with the contract's call for GPs to become expert clinical generalists playing a clinical leadership role in the design of services along with other professional colleagues.

Interface Issues

The PCIP is being implemented at a time when there is a wider set of changes to flows of work across Primary and Secondary systems. Inevitably without good communication across these systems we will not be able to achieve the best outcomes for our patients. A new Primary : Secondary Care interface group is being developed to address these issues.

This is supported at NHS Tayside level with the appropriate recognition and authority to influence pathways of care for patients across the Generalist / Specialist and Community / Hospital interfaces. This will assist in turn the realisation of the Primary Care Improvement Plan's core aim of maintaining and improving the quality, efficiency and effectiveness of the care delivered to our population.

Future of the PCIP

The Improvement Plan is a living document. As services develop, new staff are employed, new premises and new ways of working are developed, it is inevitable that the Plan will change. At each stage of this development, further engagement will be required, including sharing ideas and working in partnership with various staff side and professional bodies. Although this Improvement Plan is for a three year time period, it will be reviewed many times over that period, ensuring it is on track and adapting as necessary. In keeping with that ethos, the Scottish Government has mandated that there will be at least annual formal review of the Plan. Within Tayside HSCPs, NHS Tayside and the Local Medical Committee are committed to ensuring that our PCIP is current, effective and responsive to the changing needs that will emerge over this time.

Evaluation & Monitoring

We will require a robust evaluation of the implementation of the PCIP across its three year lifespan. This is partly to identify the benefits that it will bring; partly to identify where a change in priority or direction is required and partly to identify where investment needs to be focused differently.

There will need to be tests of change and pilots as part of scoping for new services. These will require review and evaluation to ensure that they are capable of being scaled up, and that adequate information is available to ensure efficient and effective development and delivery of services.

Each priority area will identify a set of 'SMART' measures and hard objectives with which to monitor progress towards implementation and drive further improvement and development.

Evaluation will involve community and staff consultation in addition to quantitative and qualitative analyses.

There is a need to provide a suitable, timely and robust project and programme management resource to each HSCP area with the allocation of adequate business development and change management resource to allow for the initiation, monitoring and evaluation of local projects.

There will need to be a fundamental bolstering of resource to support HSCPs, primary care managers, and other workstream teams through this period of implementation to allow them to adequately support the clinically led delivery of the Plan.

As identified in the MoU and further clarified in the Funding Allocation letter, there must be a commitment to adequately resource this support as well as the required professional advice and support of the GP Sub and work of the Cluster GP leads in driving forward quality improvement at local level.

Workforce

Introduction

The PCIP describes fundamental change in Primary Care. It describes change in how healthcare is delivered, who delivers it, where it is delivered and how that care is organised, communicated and contracted for.

This change in how Primary Care is provided means that there will be a necessary requirement to change the primary care workforce that we currently have into the one that we will need for the future. Our future workforce will require new and differing competencies and skills to do the new and interesting tasks that are new to how we have worked before within Tayside.

Requirement for a comprehensive workforce plan

We need a Tayside wide workforce plan that takes us from where we are to where we need to be. This necessary transition requires the development of a robust workforce development programme. This programme must ensure that we possess within our workforce the competencies, skills and scale of workforce to deliver our new future.

There is a need to develop and enhance the existing skill sets of almost all staff involved in the care of our community, from Advanced Nurse Practitioners to Paramedics, Physiotherapists to Administration team. New skills and job descriptions that have yet to be defined will undoubtedly emerge as we implement this challenging but achievable Implementation Agenda.

To support this development there is commitment to break down barriers in recruitment, facilitate the streamlining and efficiency of grading processes and develop and invest in the necessary training resources required to develop our future workforce.

Employment arrangements of our workforce

There is a separate challenge as tasks previously performed by GP contractor employed staff become the responsibility of Board and HSCP employed staff, while aspects of necessary day to day clinical direction of the workforce remains with the GP. While this presents a new operational challenge, it is nonetheless critical to the risk reduction promises within the new GMS contract for independent contractor GPs.

Development of the wider workforce

The workforce development plan, as it develops, will outline a set of developments over a wide set of professional groupings. The Improvement Plan describes fundamental changes in scale, skills, and competencies within the nursing, pharmacy, physiotherapy and paramedic professions. If that is to be delivered within the ambitious time targets we have set ourselves, then we must not only describe how we address recruitment and training; but also address the contractual, trade

union and other employment issues that will inevitably follow from the new roles, new means of employment and new skills needed from our workforce.

Developing the workforce plan: identifying the existing workforce

Recruiting, developing and retaining our workforce against a backdrop of vacancies across Tayside, retraction occurring within secondary care, demographic pressure within the workforce itself and pre-existing pressure within the healthcare environment to develop new skills and roles is challenging. This is even before we consider the new roles and needs that the PCIP will bring.

We have at present only partial knowledge of our total current workforce, with only limited information about those employed by GP practices. At present we do not have central clear current knowledge of the head count, whole time equivalents, grades or competencies of those employed within practices across Tayside
In order to plan the transformation of this workforce it is essential that we possess baseline information on the current state position. This needs to cover:

- Current roles and numbers.
- Current skills and skill gaps.
- Required staffing models for primary care based on population differences and need.

One of the first actions in planning our future workforce therefore must be finding out the attributes and disposition of our current one. This should then allow us to identify where gaps are likely to exist, and allow us to plan how to recruit and train so that we can progress towards the workforce we require. In order to do this, we plan to survey both GP practices and existing primary care services over the 2018-19 period to establish a comprehensive picture of our current state.

Developing the workforce: identifying the future need

The needs of our future workforce are necessarily dependent on the following factors:

- the scale of the services that we plan to offer
- the locations at which are staff are employed
- the models chosen of how we employ our staff
- the models chosen of how we operate our services
- the models chosen of how our services will work together
- the availability of staff
- the new needs and skills our staff require to perform their roles
- the need to recruit and retain staff
- the opportunities to use staff more flexibly across services
- the financial envelope available

In recognition of the scale of the challenge we face, GMS CIAG has set up an expert led, professionally supported working group to collate and review these factors to produce early recommendations of where change or investment is required. There will be direct input into this group from the service areas impacted upon by the PCIG. Recommendations from this group will be sent to the Primary Care Board, the HSCPs and NHS Tayside for review, consideration and necessary action and approval.

Premises

Introduction

The work performed under the new Improvement Plan will require workplaces suited to the needs of patients and staff, with IT links that support the delivery of that care, and which operate within structures that provide for the safe communication of the results of that care into the patient record and back to those who have requested that care be performed.

While there are existing premises that are owned or managed by NHS Tayside and our local councils, there will be an increasing need to provide workplaces within local communities to perform work previously done within practices. With limited capital funding we will need to make the best use of those premises we have, consider where it is practical to use space within practices, and consider where new buildings are needed.

The PCIP recognises that the provision of appropriately located and designed premises linked by an effective IT infrastructure is critical to the development and delivery of improvement of Primary Care within our communities.

GP practice estate

The new GP contract recognises that asking GPs to own their own premises or to hold a lease that may commit the practice to paying rent for decades into the future places significant risks on General Practitioners and may discourage new partners from joining the practice when older GPs approach retirement. The contract therefore states that the ownership of leases and of premises should move from GPs to Health Boards. The effect of this change will be a substantial reduction in risk for GP partners in Scotland, which should lead to a substantial increase in practice sustainability and hence result in better care for patients.

GP Owned Premises

New interest-free sustainability loans will be made available, supported by £30 million investment over the next three years. GP contractors have been informed of the priority categories for applications and requested to provide notes of interest by 25 May. The District Valuer has provided refreshed estimates of the existing-use value of GP owned premises and the intention is that these will be provided to GP contractors before the scheme opens.

The GP Premises Implementation Group have met and agreed broad principles for the loan documents. There will be discussions with BMA and NHS representatives on the detail of the loan documents with a view to all parties reaching agreement. The plan is to open the scheme once the detail of the loan documents has been agreed.

GP Premises Survey

Health Facilities Scotland has prepared the High Level Information Pack for bidders for the survey contract and an assessment panel is being identified. Health Boards have been asked to confirm that the list of properties to be surveyed is correct.

GP Leased Premises

The Scottish Government's long term strategy is that no GP contractor will need to enter a lease with a private landlord for GP practice premises. NHS Boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases with private landlords and the subsequent obligations for maintaining the premises. NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions.

There are three ways in which NHS Boards can take on the responsibility of providing a GP contractor with practice premises. These are:
- negotiating a new lease for the GP contractor's current premises, with the NHS Board as the tenant
- accepting assignation of the GP contractor's current lease
- providing alternative accommodation for the GP contractor when its current lease expires

If a lease expires before 1 April 2023, the most likely course of action is for the NHS Board to negotiate a new lease or provide alternative accommodation.

If the lease expires after 1 April 2023, NHS Boards will take on the existing lease from GPs where:
- The practice has ensured that its premises are suitable for the delivery of primary care services and are sufficient to meet the reasonable needs of its patients
- The practice has met its statutory obligations regarding the premises
- The practice has provided all relevant information to its NHS Board
- The practice has given sufficient notice to its NHS Board of its need for assistance
- The practice has registered the lease with the NHS Board
- The practice has the agreement of the landlord to the assignation of the lease (and the other necessary conditions)
- The practice has complied with its obligations under its existing lease
- The rent represents value for money

Current GP Premises Portfolio for Service Provision

GP practices currently operate a range of premises models in Tayside. The models vary in form and include large teams operating from independently leased purpose built facilities using private sector funding, wholly owned premises or mortgaged by the independent contractor, through to Board owned / leased premises.

There are 64 GP practices operating their main surgeries from 54 sites across Angus, Dundee and Perth & Kinross. With respect to sites these sites:-

- 13 are Board owned / leased premises sites
- 24 are premises leased from third party developers (including PFI)/ private landlords
- 17 are owner occupied premises

In addition to this GP practice estate there are a number of Board owned or leased premises, such as community hospitals and community care centres, embedded in the community which may be able to support delivery of the new services, specifically where there location facilitates local access for patient.

At present NHS Tayside occupy space within 37 practices supporting the delivery of community nursing services and anticoagulation clinics.

Planning for the future non-GP Primary Care estate

This Improvement Plan also describes a shift of work from General Practitioners to other healthcare professionals, many of whom will be located outside of General Practices. The Plan describes new services that will be developed; and existing services that will be enhanced. This section therefore also describes how we will ensure that we have premises fit for these new services and these new workers.

Although the Improvement Plan comes with significant resource aimed at shifting work from GPs to other healthcare professionals, it does not come with a capital allocation for the development of new premises for our new workforce to work in.

NHS Tayside has established an Assets and Infrastructure Programme Board with the purpose of developing, implementing and reviewing the regional primary care strategy for assets and infrastructure. This will pull together both national and local strands to develop a coherent strategy that provides the necessary infrastructure and premises to meet the needs identified by each of the Health & Social Care Partnerships.

NHS Tayside and our local councils own or manage a range of existing premises. However, it is recognised that the current premises portfolio is not designed to meet the needs of GMS 2018 or those of the extended multidisciplinary teams that will be

developed both within GP Practices and their localities. Premises provision has to date developed individually at a local level to meet local needs and has not been seen as part of a strategic plan.

There will be an increasing need to provide workplaces within local communities to perform work previously done within practices. With limited capital funding we will need to make the best use of those premises we have, consider where it is practical to use space within practices, and consider where new buildings are needed. It is important to realise that premises will not be replaced on a like for like basis.

There is a need for additional premises to support delivery of the services within each HSCP's improvement plan, in particular to provide locality hubs and care and treatment centres. The strategy will recognise HSCP priorities arising as a result of each of the phases in their three year implementation plans with initial delivery likely to be from existing facilities. Premises milestones will be mapped out for each phase and element during implementation of the plan.

The implementation of NHS Tayside's premises strategy will be underpinned by the national perspective which recognises that that the general practice estate needs to be considered as an integral part of the local care estates and planned for and invested accordingly, recognising that it is unrealistic to expect GP practices to fund new primary care premises.

Actions

NHS Tayside will be required to:

- Implement a detailed work programme to inform their strategy.
- Quantify the premises requirement and seek to establish optimum locations to meet the needs of the service.
- Develop a complete register of the estate available both within Health and within Social Care
- Prioritise the development of existing premises and the development of new premises to meet the needs of the Health & Social Care Partnerships

There are significant funding challenges attached to the development and implementation of the premises strategy to support delivery of services including; the need for capital investment, revenue funding to support function, space and quality surveys across GP Practices and funding to support lease transfers.

IT Infrastructure

Introduction

This PCIP describes a future where work is moved from General Practitioners and from GP practices to other healthcare professionals who may be working in other locations. This cannot proceed safely without IT systems that capture that work into the patient's core GP record.

Our IT systems need to be able to connect and communicate across primary care, and into secondary care. We need systems that can allow both primary and secondary care clinicians to appoint patients where and when they need to be seen. We need IT processes that return necessary clinical information about test results and procedures to those who have requested them.

Most medical error takes place when communication fails, and the future we are constructing will only work if our communications structure is robust. It is essential therefore that we develop safe and effective communication links that operate within safe, effective and well understood processes that work for both primary and secondary care.

This section describes the work that we are doing and the work we need to undertake to make sure that our population receives the safe, efficient and high quality healthcare it requires in the future described within this Improvement Plan.

Tayside's eHealth Programme

Tayside's eHealth programme recognises the role that technology will have in enabling the changes required to support the implementation of the GMS Contract, the NHS Tayside Improvement Plans and assist in the deliver for Primary care Transformation.

This support will cover the 6 key service areas identified in the GMS Contract:

- vaccination services,
- pharmacotherapy services,
- community treatment and care services,
- urgent care in hours services
- additional professional roles (MSK, Mental Health)
- community link worker services

The strategic aims of the national eHealth strategy remain in support of this work and are to:-

- enhance the **availability of appropriate information** for healthcare workers and the tools to use and communicate that information effectively to improve quality
- support people to communicate with NHS Scotland, **manage their own health and wellbeing**, and to become more active participants in the care and services they receive
- contribute to care integration and to support people with long term conditions
- improve the **safety of people taking medicines** and their effective use.
- provide clinical and other local managers across the health and social care spectrum with the **timely management information** they need to inform their decisions on service quality, performance and delivery
- maximise **efficient working practices, minimise wasteful variation**, bring about measurable savings and ensure value for money
- contribute to innovation occurring through the Health innovation Partnerships, the research community and suppliers, including the small and medium enterprise (SME) Sector

Key Principles

The following key principles will be used to evaluate and support implementation for the services in scope. These guiding principles, while apparent, are worth stating and include:-

- The need to provide services with access to an appropriate electronic health record to ensure relevant information is available at the point of care to aid clinical decision making.
- The solutions and systems will be prioritised against those already invested in by NHS Tayside, the North of Scotland region and nationally.
- The intention is to capture data once, but make it available for viewing and use at multiple stages in the provision of 6 key service areas – providing efficiency
- The design and build of the services should be applied consistently for Tayside, where clinically safe to do so. Variation will cause complication and result in difficulties in implementing solutions/systems and ensuring continuous improvement.
- The ability to refer and commission the services in scope of GMS contract will be phase through Primary, Secondary and Community care and likely Local Authority MDT Personnel and contractors, with Primary Care being the priority. Implied in this is Secondary and Community care will maintain an as

is position for accessing these services during the delivery of the primary care phase.

- Solutions and systems need to be clear, easy to use and have a simple ability to ensure patients are safely referred into and transferred across services. Having a consistent model for the service delivery model across Tayside will be a determining factor for this.
  Already at this early stage it is apparent that the technology to support business process will need to be provided by multiple systems. All stakeholders and users will require to directly engage with these systems.
- The ability to remain agile and flexible to emerging requirements is essential during the period of implementation and will require assessment when considering any 3rd Party providing support.

Out of Scope

Infrastructure Items – It is expected that the Primary Care Assets and Infrastructure group, will be responsible for the implementation of any infrastructure changes required to support the full GMS Implementation Programme. For the eHealth element this would be expected, where assessed necessary, items such as network capacity and coverage and End Point availability.

Current Priorities

There are five priorities for the eHealth Programme:

Priority 1 – to understand and document the business processes required to support the Tayside plan.
Priority 2 – consider the delivery model proposed by the different
Priority 3 – develop a joint mapping process to formally assess existing systems and solutions to map their ability (current and future) to support the implementation.
Priority 4 - carry out an assessment of capability or improvement necessary to support the implementation.
Priority 5 – carry out prioritised work-packages to realise changes to support delivery of solution/systems to the services in scope.

A proposed categorisation is as follows:-

Red	Supplier has no formal plan to provide this functionality in their product – i.e. not on a published roadmap
Amber	The supplier has a plan to provide this functionality or is running a test of change to help its development. Should also include functionality that is in use in other markets but has not been used in Scotland. That test of change could be in place in NHS Tayside/Scotland
Green	The supplier has the functionality in their current product set and this is working/functioning in live sites in NHS Scotland
Blue	NHS Tayside are currently using this functionality at present

Aims of Solutions and System

As well as their support of the guiding principles the solutions will be required to cover the range of high level processes detailed in *Figure 7 – High Level Business Processes*. These processes will be considered for every service level and require a significant investment in resource to understand the requirements. The processes need to be capable of being initiated by Primary Care (Phase 1) followed by Secondary and Community Care (Phase 2) and likely Local Authority MDT Personnel and contractors (Phase 3)

Figure 7 - High Level Business Processes
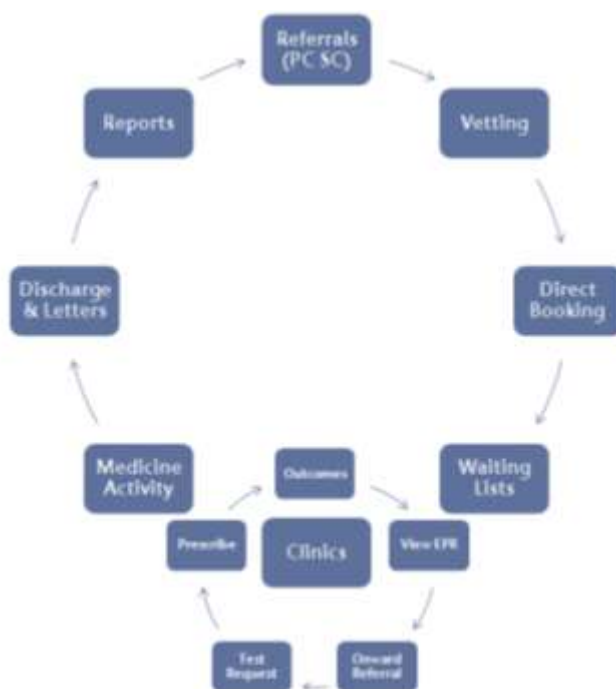
Current Projects and Early Milestones

Project Name	Project Description	Benefits	Current Status
Letham Federated Working	A solution was required to support a hub model agreed to provide MDT services to the population of Letham	• Ability to present patient details from multiple practices in a single view • Ability to record clinical updates in a system • Ability to provide these updates within the practice system in a timely manner • Presentation on the costs model associated with this working method • Information Governance model for sharing • Evaluation of benefits for this project	Test of Change **Closure**
Lochee Health Centre	The development of a 2c Practice and the merging of solutions and infrastructure to support a more modern delivery of hosted solutions, similar to a future GP IT Re-provisioning model	• Supports multi-agency working and health and social care agenda. • a blueprint for future primary care premises supporting GP IT Re-provisioning and new GP contract.	**Initiation**
Technology Care Fund	Through the national funding route for Primary Care Digital Funding. Practices are implementing, through choice, a range of technologies. These are:- **Clinical Coding** **Patient Text Reminder** **Mobile**	 • assess the ability to reduce time spend coding and filing within the existing systems • Assess the impact on reducing waste through reduction in DNA's and releasing valuable clinical time. • Ability to provide offline working and update clinical records in a timely manner	 **On Hold** **Execution** **Execution**

	WiFi	• Provide a limited WiFi canopy in GP practices for use by MDT teams and for Patient Services	**Execution**
	Patient Online Services	• Provide ability to patient to make appointment and request repeat prescriptions, without the involvement of practice staff	**On Hold**
	Patient Portal	• Provide further access to self care management information	**On Hold**
South West Angus	Test federated approach with 2 Angus practices in a virtual care and treatment centre	• Ability to present patient details from both practices in a single view • Ability to share appointments books • Ascertain solution suitability	Test of Change Request **Registration**
18/18 Care and Treatment	Requirements gathering and solution matching for Care And Treatment Services.	• Supporting access to and recording of relevant information within Care and Treatment Services in line with new GP Contract.	Test of Change **Initiation**

Other Active Projects that have dependencies

Project Name	Project Description	Benefits	Status
18/12 Extend Clinical Portal to all Pharmacies	17/92 community Pharmacies currently have pharmacists able to access clinical portal in them. This request is to roll this out fully and give access to clinical portal in the other 75 Community	• Ability to access Test results to support Pharmacy First and patients on drugs requiring monitoring eg. lithium • Ability to access Electronic discharge documentation (EDD): ▪ To support patients discharged from hospital	Initiation

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	Pharmacy premises and their pharmacists.	who receive compliance devices from their pharmacy, ▪ In NHS crisis times where bed pressures exist to help with early supported discharge from hospital for medicines (required on discharge) to be dispensed through community pharmacy ▪ Support medication review of patients in care homes ▪ Emergency supply of medication required after hospital discharge as per community pharmacy unscheduled care PGD v 23 • Ability to Access to ECS – where necessary to facilitate an emergency supply of medication under community pharmacy unscheduled care PGD v 23	

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18/06 Corporate CP Access to Staffnet	Provide access to staffnet in Community Pharmacy	To enable 18/12 Extend Clinical Portal to all Pharmacies	Initiation
17/40 Chronic Medication Service	Rollout of CMS to all Tayside GP/CP	The Chronic Medication Service aims to encourage joint working between GPs and community pharmacists to improve patient care by: • Identifying and Prioritising risk from medicines • Minimising adverse drug reactions • Address existing and prevent potential problems with medicines • Provide structured follow-up and interventions where necessary	Execution
18/67 Chronic Medication Service National Review Recommendations/Refresh	Refresh of CMS project		Request Registration
18/15 PCTP Assets and Infrastructure Dataset	Develop a comprehensive data set of information about all community based premises and their associated resources.	• Provide a solid base of comprehensive and accurate information on all aspects of GP premises and will underpin decision making process going forward.	Execution
17/139 AP Rollout (130 AP's) General Practice	Infrastructure Project to facilitate WiFI in General Practice	• To enable PC Digital WiFi Project	Execution

Enablers

The key enablers to support the implementation process mentioned below could be considered as deliverables for the Tayside Primary Care Board.

Information Governance – a data sharing arrangement needs to be put in place for the handling and control of patients' data currently retained by GPs but made available to NHS Tayside for use in clinical systems. The change required to enable this is defined in the following statement:-

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"Both General Practitioners and Tayside NHS Board ("the Board") are Data Controllers in their own rights. For data that has been agreed for share and viewable in Clinical Portal or other Board clinical IT systems, General Practitioners and the Board will be Data Controllers in Common. The responsibility for "legitimate access" to the shared data will therefore rest with the employer of staff."

Primary Care Assets and Infrastructure Group - this group is collating a data set that could be used to confirm locality approaches to providing services and solutions from the locations identified.   It is also consider that this group, following review of their data set, would be in a position to recommend and implement infrastructure improvements in order to enable the provision of services and solutions as required by the plans. Examples of this would include Network connectivity for provision of solutions, patient video conferencing, Unified Communication platforms.

GP IT Re-provisioning

The deliverables through the GP IT Re-provisioning should be considered prerequisites and need to be controlled to ensure they support the delivery of the overarching work-packages that are key to the programs objectives.   The timeline for this delivery will require NHS Tayside to adopt the services offered through the GP IT Re-provisioning programme during the three year programme.

It is also critical to successful delivery that NHS Tayside seeks to adopt single system coverage within GP Practices. Any movement from the current model will impact on timescales and budgets and will require resources to be diverted to providing the solutions necessary for the GMS implementation and will put at risk the ability to deliver this agenda.

The requirement from the GP IT re-provision must therefore be set to minimise the work associated with adopting the new model and minimise the degree of re-work associated with the test of change/current implementations. The potential scale of this work, available to be implemented from 2019, could divert significant resource and is a significant risk to all programmes of work in the scope of the GMS Contract implementation group.

Early discussion with the Primary Care IT Group, has confirmed this as a risk. A move towards a single system should be the considered as the key enabler to support the GMS implementation and reduce the risk of patient data not being available to clinical staff via electronic means.

Potential Risks

Resources – there is a risk that competing organisational priorities will result in resources having to be utilised in other projects or programmes during the 3 year period of implementation. Given the size and scale of many national programmes due to impact systems and solutions during 2018 – 2021, the risk is currently a likely (4) and would have a major (4) impact on the programme. This gives an inherent risk quantification of 16 High.

The mitigation to this is for the programme to procure dedicated programme and project management resource ensuring these resources are ring fenced for the duration of the programme. It is expected that the resourcing requirements will reduce during the 3 year period as the solutions commissioned move into a Business as Usual support model.

Dependencies – given the complexity of this programme and the number of dependencies and enablers are significant in number. Some, but not all of the dependencies are detailed in this paper, while others will be discovered as the programme moves through initiation. Key items mentioned are Data Sharing arrangements, Infrastructure Requirements, GP IT Re-provisioning etc. Given the number the likelihood of this happening is likely (4) and the impact, depending on the dependency, is moderate to major (3 – 4). This gives and inherent risk quantification of 12–16 High.

The mitigation to this is for the programme to ensure active management of the dependencies, to be clear with the responsible officers the criticality of these and to seek support of the Primary Care Transformation Board when escalation is necessary.

Supplier Management and System Maturity – there is a risk that the systems provisioned in recent periods within NHS Tayside either directly or through National Frameworks, were not specified to the requirements to be detailed as part of the GMS Contract. In addition, the agility of suppliers in the Healthcare sector to adapt and change their software has been limited either through resource challenges internal to the 3rd Party or a result of the solution being managed nationally. That said they are Healthcare system and so the likelihood of some business functionality not being available is possible (3) and the consequence moderate (3). This gives an inherent risk quantification of (9) or Medium.

The mitigation to this is to build on existing supplier relationships, leverage active procurement activities nationally, regionally and locally and provide regional pressure to suppliers where appropriate to adapt and tailor their software to the requirements. With this in mind the business requirements gather has been focussed on areas where there is suspected business process gaps e.g. Pharmacotherapy.

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Financial Risk – there is a risk that suitable funding for solutions/systems is not available to provide the needs of the services. The risk if further enhanced given that the requirements is still to be understood and translated into licencing, implementation and support costs. In addition many of the systems will go through contract re-negotiation during the period of implementation. The likelihood of this risk occurring is considered possible (3) and the consequence to provide efficient electronic working practice is major (4) – given a risk exposure of high (12)

The mitigation to this is to move through the requirement process as quickly as possible so funding can be profiled and secured.

Governance

The design, testing and implementation of solutions (systems) and infrastructure serviced by eHealth will require clear guidance and decision making from within the governance structure. This structure is set out in NHS Tayside's *Delivering Primary Care Transformation & GMS 2018 Implementation* document and is assisted by a number of specific sub groups working with operational personnel responsible for the service improvement plans.

Funding

Additional funding will need to be provided to support implementation, licensing, integration and resources to support implementation.

The detailed funding model will require refinement as the service plans are translated to a system delivery stages, so are likely to be phased over the 3 year period. An early estimate is detailed below but subject to change.

The expected funding requirements are:-

Funding Item	Nature One Off/Recurring	Description	Estimate
System Licences	One Off?	Provision of system licencing costs and use	Unable to estimate
System Implementation Costs	One Off	Provision of 3rd Party implementation services	Unable to estimate
System Integration Costs	One Off	Provision of interfacing of data item to multiple systems	Unable to estimate
Activity Reporting Development	One Off	1x Reporting Consultant	£55k
Implementation Resources	On Off	1x Programme Manager 2 x Project Manager/Business Analysts 1 x Project Administrator	£450k
System support costs	Recurring	Annual Support and Maintenance Costs	Unable to estimate

Vaccination Transformation Programme

As part of a commitment to reduce GP workload Scottish Government and SGPC agreed vaccinations will move in stages from a model based on GP delivery to one that is NHS Board delivered through the development of multi-disciplinary teams. By 2021 almost all vaccinations previously undertaken in General Practice will be delivered this way.

In NHS Tayside we have been delivering most childhood vaccinations since 2016. The changes introduced by the new GMS contract provide us with the opportunity to extend our vaccination programme, to work collaboratively with other parts of the system to design models that increase the opportunities available for our workforce by developing attractive roles and build sustainability.

Introduction

The Vaccination Transformation Programme (VTP) is a 3-year Scottish Government led programme running from April 2018 to April 2021. The VTP forms one of a number of priority work-streams within the Government's programmes for Primary Care transformation.

The VTP seeks to develop and transform vaccination administration throughout Scotland. The main drivers for the VTP include the increasing number of vaccinations and complexity of schedules, transformation of school nursing and health visiting roles, re-establishing the role of general practitioners as expert medical generalists, and re-configuration of health and social care services including the formation of Integrated Joint Boards (IJBs) and Health and Social Care Partnerships (HSCPs).

Current Position

An NHS Tayside Children's Immunisation Service was formed in 2016, becoming operational in October 2016. The service delivers routine pre-school and school age primary immunisation programmes previously delivered by general practice, health visitors and school nurses. A recent review of the service and workforce identified positive benefits achieved and identified a number of challenges and areas for development. These include recommendations around workforce (staffing, cover, retention and career development); induction, CPD, supervision; clinical practice and travel/travel costs. Routine adult immunisations some catch up/mop up vaccines for children and selective children's and adult vaccinations are administered by a range of services in primary care, community pharmacy, specialist services and private providers.

Redesign Work already underway

Members of the VT Programme met with stakeholders throughout November and March to map out and agree a potential model for future vaccine delivery in Tayside and to develop the VT programme governance structure.

Governance & Monitoring

A multi-disciplinary Steering Group oversees immunisation governance, development and service delivery. The diagram below sets out the suggested synergy between current working groups and governance structures, the newly established VTP Board, and additional new working groups that may be required.
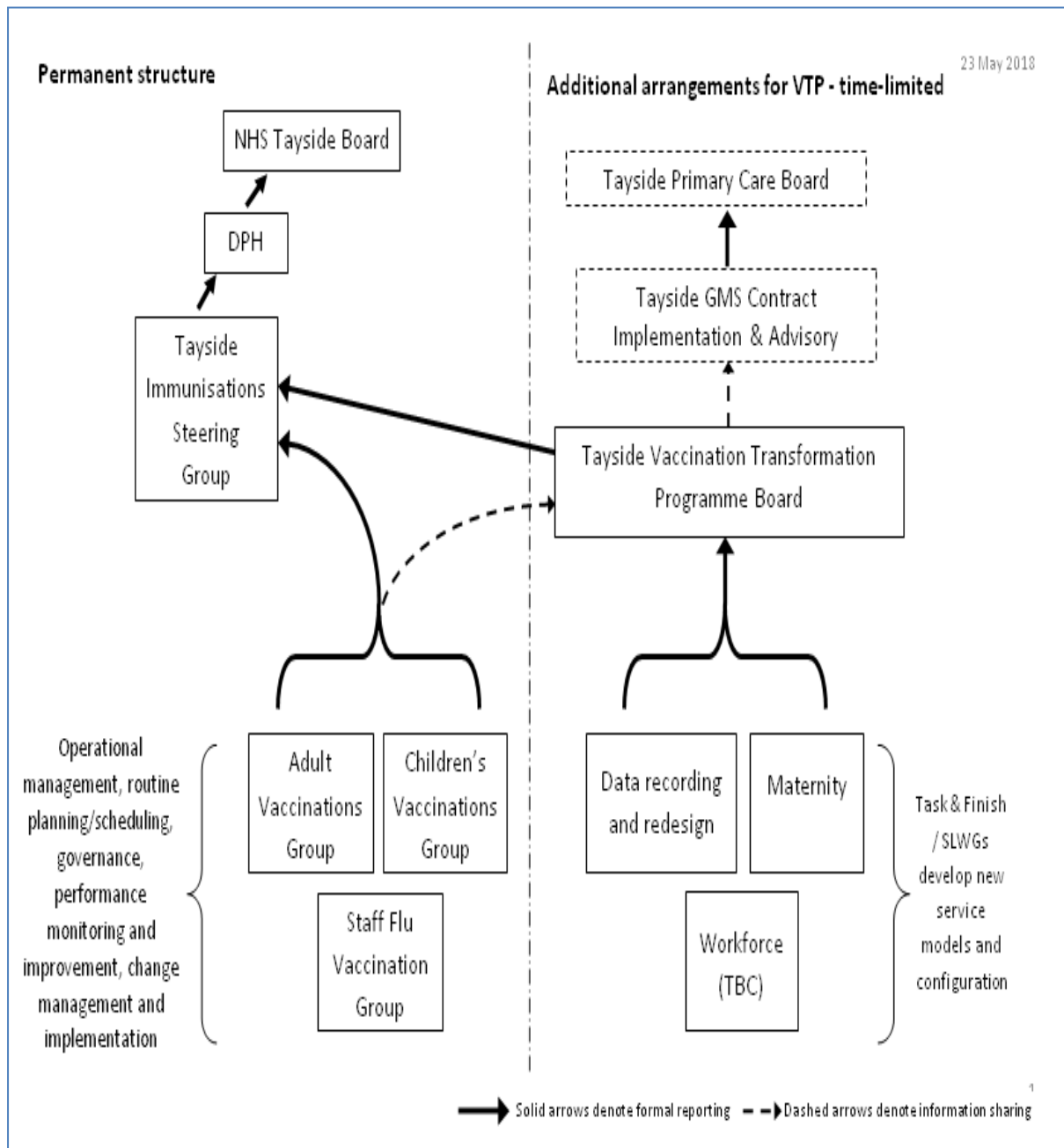
Future Vision

Following consultation, the agreed Tayside vision, is for an integrated comprehensive locality-based adults and children's vaccination service, integrated within HSCPs, operating within a single Tayside management structure. In line with IJB transformational plans, by 2021 this service should be coordinated around existing GP clusters, but with NHS directly employed staff and integrated within HSCP Care & Treatment Services (locality hubs) as part of the new model for primary care delivery.

This model provides opportunity for flexible roles, integrated service provision across primary and community care, and facilitates career development within the locality and services. Within immunisation therefore, individual staff roles may be flexible and negotiable, from dedicated child or adult vaccinators, to vaccinators for all programmes, to staff who deliver vaccines as part of a wider role. Other services and providers, including maternity, paediatrics and community pharmacies, will also have roles in delivering and contributing to specific vaccines and programmes.

Successful integration and future delivery of the VTP is dependent upon a number of factors being in place. These include integrated workforce planning between nursing, AHPs, Pharmacy and HSCPs, sufficient funding, additional resource, robust and integrated IT systems and premises.

Milestones

Year one of this Programme seeks to build on existing work undertaken within children's service delivery (0-19), with Years two & three seeking to take an integrated approach to service and workforce development in partnership with all HSCPs, GP and practice nurse services, Pharmaceutical, AHP and Nursing workforce plans therefore ensuring integrated service delivery within locality, primary care and treatment services.

The table below sets out an initial transition programme for vaccines in Tayside.

Year 1 (2018/19)	• Build resilience of the current Children's Immunisation Team and ensure that routine pre-school and school vaccines are provided in a safe and timely fashion. • Expand the remit of the Children's Immunisation Service to cover all children's vaccinations, including catch-up and mop-up doses for children with incomplete or unknown immunisation status; missed school age vaccines; children new to the UK; and immunisations of children with underlying medical conditions not routinely provided by a specialist service. Provision of adolescent booster mop-ups through community pharmacy may be considered as an interim arrangement. Pre-school influenza, travel vaccines, and those provided routinely by specialist services are specifically excluded from transitioning in Year 1.

	• Operational management of Children's Immunisation Service to remain with Children, Young People & Families Directorate. Begin to develop plans for redesign and integration within locality models and structures. • Begin to shift the responsibility for delivery of individual adult immunisations programmes away from General Practice e.g. vaccinations in pregnancy. • Expand community pharmacy administration of vaccinations for residents in Care Homes (e.g. influenza, pneumococcal, shingles) • Provide additional strategic Consultant PH leadership and project management to lead and develop and oversee the three year VTP programme. Seek to clarify any additional workforce implications within PH vaccination team.

There is less certainty as to the priorities for Years 2 and 3, as this will be shaped by Tayside VTP Board discussions, resource allocation, and the implementation of the PCIP in Tayside, as well as national progress and direction for specific vaccination programmes (e.g. Travel vaccinations and travel health advice).

Year 2 (2019/20)	• Pre-school influenza • Build on adult's service e.g. selective immunisations for at risk groups and individuals with underlying medical conditions or immunosuppression.
Year 3 (2020/21)	• Age related adult programmes (e.g. pneumococcal, shingles and influenza) • Travel N.B During the 3 year programme when it is safe and appropriate to do so, responsibility for the delivery of the majority of immunisation programmes will be transferred to IJBs.

Resource Requirements & Finance

A detailed costing of Year one of the programme has been developed and is currently being prepared for wider consultation. The cost of the first year of the programme is projected at £411k, divided between additional resource to deliver immunisations; administrative and managerial support to co-ordinate and manage the programme; and clinical input to guide it.

Barriers and Opportunities

The changes proposed for the delivery of the vaccination programme offer the opportunity for us to deliver services differently. We have the opportunity to build new and exciting roles for the team, away from purely being vaccinators. This development and broadening of the roles should help us meet some of the current difficulties and challenges we have been experiencing in the recruitment and

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retention of staff. We will also have the opportunity to build the service around the newly formed care and treatment centres, which again should help to alleviate some of the challenges around staff travel and attracting staff to the role. In order to manage the complexity of the programme and the scale of the work detailed within the workstream there needs to be significant investment in clinical leadership and programme management support.

Evaluation of the programme

The VTP board is developing a range of evaluation measures as part of the implementation phase. These will include:

- Vaccination roles for specific vaccination strands
- Measures for staff such as recruitment &retention progress
- Staff experience
- Patient and Carers satisfaction
- Prediction of vaccination wastage and error rates

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Pharmacotherapy

Introduction

The GMS Contract describes how by 2021 every practice will receive support from a new sustainable pharmacotherapy service which includes pharmacist and pharmacy technician support to the patients of every practice. This will allow GPs to focus on their role as expert medical generalists, improve clinical outcomes and support prescribing improvement work. This is in line with the professional aspirations of the Achieving Excellence in Pharmaceutical Care Strategy to integrate pharmacists with advanced clinical skills and pharmacy technicians in GP Practices to improve pharmaceutical care and contribute to the multidisciplinary team.

From April 2018, the pharmacotherapy service will evolve over a three year period with the aim that at the end of year three pharmacy teams will be integral to the core practice clinical teams delivering a consistent sustainable service. This timeline will provide an opportunity to test and refine the best way to do this, and to allow for new pharmacists and pharmacy technicians to be recruited and trained.

Over the three year implementation period, pharmacy teams will take on responsibility for:

a) Core elements of the service, including: acute and repeat prescribing, medicines reconciliation, monitoring high risk medicines
b) Additional elements of the service, including: medication and polypharmacy reviews and specialist clinics (e.g. chronic pain)

The table below set out in the new GMS Contract describes the service that NHS Tayside will have to develop by 2021.

Core And Additional Pharmacotherapy Services		
	Pharmacists	**Pharmacy Technicians**
Level one (core)	- Authorising/actioning all acute prescribing requests - Authorising/actioning all repeat prescribing requests - Authorising/actioning hospital Immediate Discharge Letters - Medicines reconciliation - Medicine safety reviews/recalls - Monitoring high risk medicines - Non-clinical medication review Acute and repeat prescribing requests	- Monitoring clinics - Medication compliance reviews (patient's own home) - Medication management advice and reviews (care homes) - Formulary adherence - Prescribing indicators and audits

	includes/authorising/actioning: • hospital outpatient requests • non-medicine prescriptions • instalment requests • serial prescriptions • Pharmaceutical queries • Medicine shortages • Review of use of 'specials' and 'off-licence' requests	
Level two (additional - advanced)	• Medication review (more than 5 medicines) • Resolving high risk medicine problems	• Non-clinical medication review • Medicines shortages • Pharmaceutical queries
Level three (additional - specialist)	• Polypharmacy reviews: pharmacy contribution to complex care • Specialist clinics (e.g. chronic pain, heart failure)	• Medicines reconciliation • Telephone triage

Current Position

Currently in Tayside medications are dealt with by a mixture of professionals within GP practices including GPs, practice admin staff and by dedicated pharmacy support. The existing locality pharmacy service is already delivering elements of the pharmacotherapy service, mainly in Levels 2 and 3 (see table below). These level 2 and 3 services will continue to be delivered over the three year implementation period.

Additional Advanced Level 2 Services

Role	Activities	Pharmacy Team Member		
		Senior Locality Pharmacist	**Locality Pharmacist**	**Senior Pharmacy Technician**
Level 2 (additional advanced)	Medication review (more than 5 medicines) Polypharmacy / medication reviews for specified groups of patients at both levels 2 and 3, either in their own home, care homes or in the practice, focusing on the priorities of NHS Tayside e.g. patients identified through DQIP2, chronic pain, older people, new patients registered to practice if complex. This may involve managing caseloads of patients on an	✓	✓	

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	ongoing basis, developing referral pathways and using Independent Prescribing when appropriate			
	Resolving high risk medicine problems	✓	✓	
	Non-clinical medication review			✓
	Medicines shortages			✓
	Pharmaceutical queries			✓

Additional Specialist Level 3 Service

Role	Activities	Pharmacy Team Member		
		Senior Locality Pharmacist	Locality Pharmacist	Senior Pharmacy Technician
Level 3 (specialist advanced)	Polypharmacy reviews: pharmacy contribution to complex care	✓	✓	
	Specialist clinics (e.g. chronic pain, heart failure)	✓	✓	
	Medicines reconciliation			✓
	Telephone triage			✓

In addition pharmacy teams are delivering locally agreed activities as detailed below, depending on resourcing and skill mix within GP clusters. These services need to be maintained over the 3 year implementation phase to promote and maintain safe, efficacious and high quality prescribing.

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Tayside Locally agreed General Practice Pharmacy Services

Role	Activities	Pharmacy Team Member		
		Senior Locality Pharmacist	Locality Pharmacist	Senior Pharmacy Technician
Medicines Safety and Governance	Provide advice on local prescribing status of medicines e.g. shared care agreements/IPTRs	✓	✓	
	Advice on actioning MHRA warnings	✓	✓	✓
	Contribution to Significant Events, IR1s, Datix, Large Scale Investigations (Care Homes), Medication Complaints, Care at Home	✓	✓	✓
	Antimicrobial Stewardship	✓	✓	✓
	Controlled Drugs Governance	✓	✓	✓
Teaching and Training	Teaching of other pharmacists and pharmacy technicians in training and foundation posts	✓	✓	✓
	GP Education on Medicines related topics	✓	✓	✓
	Mentoring of others (nurses, pharmacists and AHPs) undertaking Independent Prescriber Training	✓	✓	
	Support and train practice staff to undertake non clinical medication reviews (NCMRs) as part of the repeat prescribing system			✓
	Job Shadowing for Medical Students in GP training practices	✓	✓	✓
Facilitating Prescribing Improvement	Prescribing Support Meetings with practices to discuss prescribing data and reports, and current prescribing priorities	✓	✓	✓
	Meetings with IJBs/clusters to discuss relevant prescribing data	✓		
	Supporting Organisational Prescribing Priorities	✓	✓	✓
	Facilitating and/or undertaking prescribing audits and quality prescribing projects	✓	✓	✓
	Simple PRISMS queries			✓
	Dealing with queries from projects e.g. from patients/carers		✓	✓
General	Clinical input into Practice Meetings	✓	✓	
	Service Development e.g. Teach and Treat, ECS and Care Homes	✓	✓	✓

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The current service is delivered by 28 WTE Locality Pharmacists and 10 WTE Pharmacy Technicians in primary care across Tayside covering between 1-8 sessions per week (1x session= 0.5 day in line with GPs). There are an additional 10 WTE staff affiliated with the locality teams e.g. the ECS Pharmacy Technicians but they do not currently deliver sessions in GP practices.

Future Vision

In conjunction with the range of services to be delivered by 2021 (referenced in the introduction of this section), the GMS Contract describes the future Pharmacotherapy Service to be delivered in all regions by 2021:

GP practice - based pharmacy

- Acute, repeat & serial prescribing
- Medicines reconciliation
- Medication & polypharmacy reviews
- High risk medicines

Community pharmacy

- MAS & PHS
- CMS
- Medication review
- Monitoring, titration, & feedback
- Serial dispensing

Hospital pharmacy

- In-patient care
- Discharge
- out-patient clinic
- Specialist services
- Teach & Treat
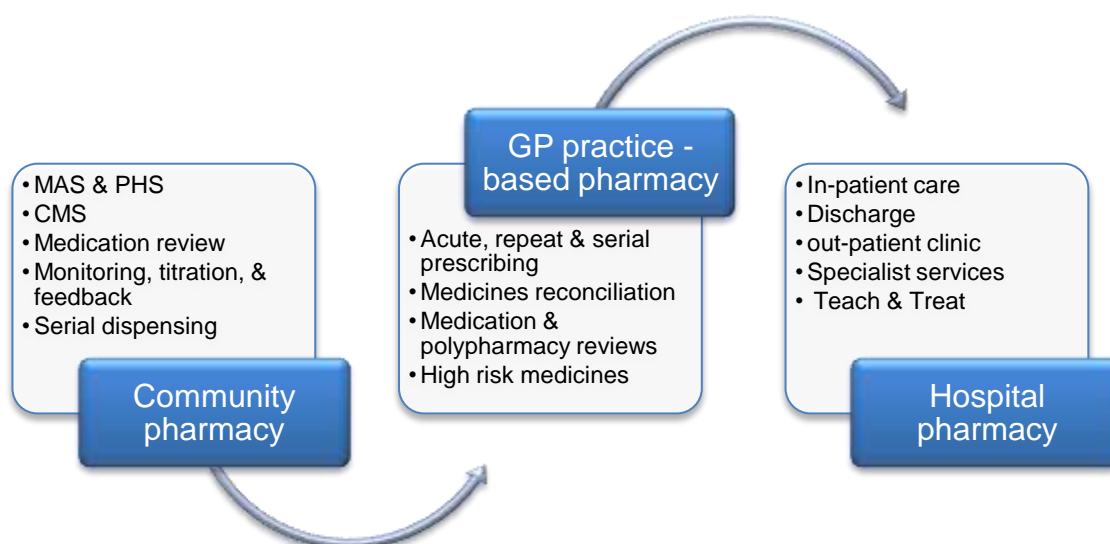
This means that over the three year implementation period, all pharmacy staff, regardless of funding source will become part of an integrated team.

Milestones

In order to continue to progress the Pharmacotherapy service, the first priority will be to undertake a Test of Change (TOC) commencing in August 2018 to scope the workload resulting from level one service and estimate the resource and skill mix required to deliver the service consistently, taking into account other drivers in addition to list size such as deprivation and demographics. The results from the test of change will inform the three year implementation programme in terms of developing the level one activities that can be delivered consistently in year one. Other level one activities will be added in years 2 and 3 as staffing resource allows with full implementation of level one service required by year 3. Arrangements for this are now underway.

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Work is also underway to make arrangements with community pharmacists to work directly with GPs to deliver patient facing care as per the requirements of PCA (P) (2017) 4. A successful pilot is currently in place in South Angus with the Monifieth, Carnoustie and Arbroath practices. The intention is to provide an arrangement of 2 days a week for each HSCP. This model has also been used in other Health Boards via Service Level Agreements. The capacity to deliver this approach at scale will need to be scoped further.

Good links will be established between the pharmacotherapy service and local community pharmacies to make full use of the clinical capacity within the chronic medication service (CMS). Community Pharmacists can carry out an annual medication review, as well regular monitoring and feedback to the GP practice for patients registered for this service. Making full use of the clinical capacity within community pharmacy can improve the pace and efficiency of delivery of the pharmacotherapy service in GP Practices.

GP Practice teams will also make full use of the other NHS Services available through local community pharmacies, such as self care advice, access to minor ailments service and Pharmacy First (currently restricted to UTI and impetigo). Further common conditions work is developing.

Resources and funding required

Funding of £922,100 was made available in 2017-18. This provided access to Pharmacists for all practices. It also provided an initial baseline of Pharmacists to support the delivery of the most appropriate skill mix, to enhance the service to the priority areas and provide pharmacists with advanced clinical skills. The funding has allowed an increase in pharmacy technicians, as well as of pharmacists within practices.

However, further funding is required to secure the required levels of staff to deliver the Pharmacotherapy Service. Guidance for pharmacy staffing in the National Health Service and Social Care Workforce Plan part 3 – Improving workforce planning for primary care in Scotland equates this to an additional 59 WTE pharmacy posts during the 3 year contract implementation period, to deliver a 52 week per year service, providing cover for annual leave and sickness.

For year 1 2018-19 this means we will be looking to recruit 11.6 WTE pharmacy posts at a cost ranging from £395-£697K depending on the preferred skill mix of post following the Test of Change evaluation (range between Band5 – Band 8a).

The table below breaks this down to individual HSCP

Total Year 1 Indicative Funding Required for additional Pharmacy Staff

HSCP	Funding Required 2018-19 (dependent upon banding)
Angus	£92K-£161K
Dundee	£166K- £293K
Perth & Kinross	£136K- £239K

Currently the administration of medicines in General Practice is undertaken by practice employed admin staff. If the Tayside service were to employ all these administration staff to deliver appropriate roles with the pharmacotherapy service, this additional resource required would equate to an additional 104 WTE band 4 staff (based on 1WTE per 5000 patients). This would amount to a total cost of £2.9Million at the end of year 3, with year 1 costs of £574K. This reflects the true hidden costs of this work. However, it is recognised that further discussion and negotiation is required to ascertain how best this area is addressed.

Total Year 1 Indicative Funding Required for Administration Staff:

HSCP	Funding Required
Angus	£148k
Dundee	£230k
Perth & Kinross	£195K

Risks and Issues

The ability to fund and recruit additional pharmacy staff including administrative support is critical to the success of the programme. Recruitment for both pharmacists and pharmacy technicians is an increasing problem. The Scottish Government target of an additional 140 Pharmacists for Primary Care in the last 2 year period has resulted in vacancies and increasing challenges to recruit to this number of posts in such a short period of time. Consideration is also currently being given to recruiting to additional foundation pharmacist posts at Band 6 to build capacity for the future within Primary Care.

There is a real risk that there is not currently the specialised workforce available in order to carry out the roles as described within the new GMS Contract and that this will not be available by 2021. Other concerns are in relation to funding and having adequate funding to develop and implement a robust and efficient Pharmacotherapy Service in Tayside within the timescales allocated. There is a risk around availability of suitable and accessible premises, space and infrastructure to deliver a Pharmacotherapy service. Other practical concerns relate to IT infrastructure and that suitable IT systems will not be available to allow the communication required between the MDT, the Pharmacotherapy service and community pharmacy.

There is a risk that if a professionally satisfying pharmacotherapy service cannot be designed it will fail to attract and retain a suitable and motivated work force. We also need to be mindful of the fact that if highly skilled clinical pharmacists have to deliver Level 1 services routinely, staff may disengage. We need to think about these issues and how we make both the service and the roles within it professionally rewarding and satisfying. The market place for pharmacy staff will be competitive and we need to ensure that Tayside is an attractive place to work. There will be substantial requirements for training and mentorship, as well as for educational and clinical

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supervision. We will need to ensure that sufficient staff are available to supervise education and training placements. We also need to explore what level of risk Pharmacists are willing/able to accept when issuing prescriptions, an area still to be explored.

Amongst some other potential unintended consequences that we must be mindful of is that if we use a greater proportion of the existing locality pharmacy resource to deliver the pharmacotherapy service, we may lose focus on prescribing efficiencies work. This may then place NHS Tayside at a potential financial risk. These practical issues will be worked through as we move through the implementation period, but it should be recognised that building a fully integrated Pharmacotherapy Service whilst providing many positive benefits to patients and staff, is not without significant challenges and difficulties which will have to be overcome in order to achieve the vision laid out by Scottish Government within the contract offer.

Engagement & Governance

A pharmacotherapy implementation group has already been established, with representation from all of the key stakeholders. This working group will feed into the GMS CIAG, which will report to the Primary Care Board.

Regular engagement with the GP Sub-committee will be essential throughout the implementation period. In view of this, they are represented on the Pharmacotherapy Implementation Group. Project support and improvement support has already been established. We also recognise that developing the Pharmacotherapy Service will require substantial staff engagement, across all sectors with workforce colleagues and staff side representatives. Patients and their interests are at the heart of everything we do. Patient engagement and public involvement both for this work stream and wider in terms of the plan overall will be a central feature of how we progress this work over the next three years.

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Community Treatment and Care Services

Introduction

Community Treatment and Care Services provide an opportunity to deliver high quality care that is located within the community where patients live.

The types of services which may be provided include:

- management of minor injuries and dressings
- phlebotomy (suggested in the contract that this is a priority in year 1)
- ear syringing
- suture removal
- chronic disease monitoring

The responsibility for providing these services will move from General Practice to HSCPs over the next three years.

This is an ambitious programme of re-design representing one of the greatest opportunities to get things right for patients so that they are seen by the right person, at the right time and in the right location. It also presents an area where we can get it right for the professionals who work in primary care by creating rewarding and satisfying careers. The Scottish Government has committed HSCPs to developing care and treatment services for patients local to where they live. By necessity Partnerships are required to meet the distinct needs of their local populations whilst at the same time recognising that a number of core principles for the redesign of services require to be retained.

Community Treatment and Care services have been designed for use by primary care. They should also be available for secondary care referrals if they would otherwise have been work load for GPs. Where Care and Treatment Services are used by secondary care, they will require funding that is in addition to that which is outlined here in the PCIP.

Current Service Provision

These services are currently delivered in a number of different ways including:

- In Practice by GPs and Practice employed staff
- Partly funded by Local Enhanced Funding streams
- In community hospitals, treatment rooms and Minor Injury and Illness Units by HSCP staff
- Elements of care and treatment services work performed in secondary care

Future Vision

By 2021 these services will be commissioned by HSCPs and delivered in collaboration with NHS Boards who will employ and manage appropriate nursing and healthcare assistant staff.

Local circumstances and demand will determine where it is most appropriate to safely situate services. In some circumstances, services may still be carried out in the Practice environment, in others the NHS Board may decide to operate these services from separate facilities. Where a separate facility is developed, this offers an opportunity to co-locate other health, social and third sector services as part of a larger community hub delivering a broad range of complementary services to the entire community.

The key aim is to allow patients convenient and comprehensive access to community treatment and care services. Where it is agreed locally that practices will continue to deliver care and treatment services then support will be provided in the form of payment of staff expenses or in the direct provision of NHS employed staff.

These changes offer a radically different future for primary care from the one in which we now live. We cannot under estimate the scale and complexity of what is required, as we design services with a workforce that currently does not exist, with competencies that we have not yet fully worked out, working from differing premises.

Core Principles

In Tayside we have agreed upon a number of core principles that are required in the future redesign of and provision of care and treatment services:

Principle 1:

- A single system facing towards secondary care

Rationale:

Secondary care does not have the flexibility or resource to identify the specific delivery mechanism in each locality area. A single system that allows tests or procedures to be ordered in a set, common fashion will have a lower error rate and a higher adoption rate.

Principle 2:

- Room for differing local implementation in different HSCP areas depending on the available resource

Rationale:

There are three main ways in which a secondary care request might be satisfied:

- Delivery of the service in a locality centre or community hospital
- Delivery of the service by NHS employed staff in a local GP practice
- Delivery of the service by a local practice at an agreed tariff

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The choice of which is the preferred route will be dependent on what resources the locality possesses. Some localities will already have staffed community hospitals or centres that can fulfil secondary requests. Some localities will not have any appropriate NHS owned resource near enough for the local community to be useful and will not have sufficient GP contractor capacity to deliver such a service from a GP practice. Local practices may however have sufficient room to embed an NHS employed staff member to deliver the service. The anticoagulant monitoring service has used this model in some practices with periodic clinics held in GP managed premises by NHS employed staff. In some localities where there is spare practice nursing capacity within practices it may be reasonable to consider either a bulk contract or item of service contract model of employing GP managed staff to deliver this service.

Principle 3:

- Diagnostic tests ordered by a clinician should return to that clinician regardless of whether they are based within primary or secondary care

Rationale:

The aim of the contract is to free up GP time in order to allow GPs to fulfil their role as "expert medical generalists". It is therefore necessary that secondary care requests are returned to secondary care for interpretation and action. The movement of work from nursing and HCA staff out of General Practice whilst retaining the responsibility of interpreting and managing the result does nothing to deliver on this objective and runs contrary to the GMC view that the ordering clinician should be responsible for interpreting the result of the test they have ordered.

Engagement and Consultation

Each HSCP has undertaken significant consultation with general practices given the need to consider local circumstances in development of services to ensure convenient and safe patient services. Results are summarised below.

Whilst scoring systems used varied considering all responses priority afforded was as follows. (1 being of highest priority and 7 being of lowest)

Task	Dundee	Perth & Kinross	Angus
Leg ulcer care	1	2	1
Wound care	2	1	2
Phlebotomy	3	5	4 =
Minor injuries	6	4	3
Ear Syringing	5	6	4 =
Suture removal	4	3	6
Chronic disease monitoring & related data collection	7	7	7

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Significant planning work has taken place within each HSCPs in relation to contract delivery and the wider implementation of local strategic plans. Regional planning around IT requirements has started. Each HSCP has established a local working group to oversee the implementation of Community Care & Treatment Services.

Whilst we recognise that phlebotomy has been identified by Scottish Government as the priority area for 2018-19, we will also be reflecting the viewpoints of our local practices and clusters.

Progress to date in each HSCP is as follows:

Dundee:

1. Complex leg ulcer clinics in place for 2 clusters with further roll-out planned.
2. Job descriptions developed and submitted to AFC to support expansion of teams.
3. Planning initiated to develop Lochee HC as a care and treatment centre.

Perth & Kinross:

1. Currently scoping phlebotomy services, leg ulcer and catheter clinics
2. Proposed service developments Aug 2018-Feb 2019 include lithium/ECG, anticoagulation, phlebotomy service introduction and pre-operative surgical assessment

Angus:

1. Initial planning progressed within Angus Care Model conversation and planning.
2. MIIU service model approved and will be implemented in 2018/19
3. Proposed service developments for 2018/19 and the 2021 vision for Care & Treatment Services in Angus available in draft pending local approval

Barriers and Opportunities

There are a number of general and specific risks presented by this complex area of redesign. Many of these services are already managed well within general practice where care is already delivered close to the patient. HSCPs will have to make decisions on the number, locations and how services will be delivered in their areas. Perth & Kinross and Angus have community hospitals that may provide possible locations for these services, but this work will need to take place in conjunction with the other complex review and change programmes taking place. Dundee has no community hospitals. This makes finding specific locations more challenging. However, there is flexibility in how we provide this model with services being delivered in a variety of different ways. Along with the changes in premises introduced by the new GMS contract, there is opportunity to do things very differently. It will be for HSCPs to consider this in their planning and implement what best suits their specific needs and local populations.

The roles of staff in supporting this work, the capacity of staff to absorb the work and the various professional standards required and how they are contracted is still to be worked out. The changes to roles will result in additional training, supervision and development of standard operating procedures. The detail of this will require input from the Nursing Directorate and will need to be negotiated with HSCPs, NHS Boards and GPs.

The intent behind establishing the care and treatment service is to relieve pressure on primary care. The service also presents opportunities to move secondary care services closer to the communities where the people who need those services live. Care and treatment services might also act as care hubs around which other community and third sector services might be constructed. The PCIP does not bring funding for either of these desirable goals and they would therefore need to be resourced from outside of this plan.

IT is one of the greatest challenges to the care and treatment service. We require IT systems that are fit for purpose and which can communicate across services, primary and secondary care and with GP practices. Safe systems that can perform this function need to be developed and rolled out. If we cannot achieve this we will not meet the intended aim of these services in providing safe, seamless care for patients and it will not result in a shift in workload from GP practices.

Urgent Care Services (in hours)

Introduction

A significant amount of GP time is used in visiting patients at home who could have their needs effectively dealt with by other health professionals. The new GMS contract and MoU describe a future model with advanced practitioners providing support as first responders for certain urgent unscheduled care presentations and home visits. The aim of this model is to free up GP time so it can be reinvested in the model of GP as expert medical generalist.

Current model

Currently almost all home visits are made by GPs. In certain circumstances nurses and advanced nurse practitioners may visit as part of enhanced community support, nursing home support or other project teams but this is very much the minority. Paramedics employed by Scottish Ambulance Service (SAS) visit and assess patients who have accessed them directly through the 999 service and may deal with some of these presentations within the community without GP involvement. However, this presents a tiny fraction of the overall workload.

Future Model

By 2021 in collaboration with NHS Boards there will be a sustainable advance practitioner service in all HSCP areas, based on an appropriate local design. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

Redesign already underway

There are two strands to our approach in Tayside for providing advanced practitioners as first responders undertaking home visits. The first is to develop and enhance the nursing teams that already have some input into visiting in the community and the second is to work with SAS to progress and grow the Specialist Paramedic Practitioner role.

Paramedics

There is real potential to further maximise the contribution paramedics and specialist paramedics make as a member of the community based multi disciplinary team. This approach is outlined in *Towards 2020: Taking Care to the Patient- A Strategic Framework for 2015-2020.* As part of the SAS national strategy, 21 specialist paramedics will be appointed to Tayside, with the first cohort already in training.

In line with this workstream, in 2018/19 it is proposed that SAS will appoint 2 wte paramedics to support tests of change to inform future modelling. This will allow the testing of service models to further develop the service. This will ensure that this test is 'ringfenced' and thus avoid any negative impact on core service provision.

Within Angus it is proposed that a paramedic will be included, as a test of change, within the enhanced community service of one Angus cluster. That will provide the potential for the paramedic to support both home visits and in practice patient reviews for patients, following an initial practice based triage. This will provide additional information regarding the effectiveness of this model of care.

Evaluation

A robust evaluation process will be detailed upon approval. This will include:

1. Qualitative data such as:
- Profile of patients seen by paramedics as part of the practice MDT response
- Place of care delivery (home/practice/clinic)
- Patient outcomes
- Impact of SAS rates of low acuity calls
- Emergency admission rates
2. Quantitative data such as:
- Patient satisfaction
- Staff satisfaction within MDT

A multidisciplinary, multiprofessional group will monitor the outcomes of these tests of change and report back to GMS CIAG, the Primary Care Board and the HSCPs.

Barriers and Opportunities

Recruitment of sufficient workforce may prove challenging. There is a concern that current paramedics may not wish to progress to these new specialist paramedic posts. GPs have expressed concern that the development of these roles may impact adversely on the current provision of SAS services.

Many practices have worked hard over a number of years to manage demand for house calls by actively supporting and encouraging attendance to the practice. Patients able to attend GP practices are seen in better conditions with better information than those at home. Introducing a responsive home visiting service may drive up demand as a more convenient option for some who could attend their practice but choose not to.

House calls are often made to the sickest and most vulnerable in society. As these patients may be medically very complex they may be better served by continuing to see the GP as the expert medical clinician who is more appropriate to deal with complex undifferentiated illness. An effective urgent visiting service needs to be able to recognise those cases that require GP input; it cannot be seen as a substitute for all GP visiting. It is vital that a GP who knows the patient is available for clinical direction and input to the visiting service if the service is to function safely.

We will require robust clinical IT systems that can provide appropriate access to the patient clinical record both to determine the clinical requirements of the patient and

to document and communicate back to practices what has been done. We also require administrative IT systems which can manage referral bookings from a range of sources.

Support is required from practices and specialist services to develop and implement new protocols and pathways. Without access to suitable training and in particular the commitment for the provision of mentorship support from the GP community whilst these staff are in training, they will not be able to progress in the competencies they will need to do their work with patients safely.

Next Steps

In addition to the national monies provided directly to SAS to support training of specialist paramedics and increase workforce for the long term, an initial short term funding of 2wte Band 6 paramedics, at a cost of £85k, will support a test of change within each HSCP area in 2018/19. This will enable models to be tested and developed with view to roll out in 2019/21.

Developing the nursing model

A further strand in providing advanced practitioners to support urgent unscheduled care presentation in hours is to augment the existing peripatetic nursing home service and the current enhanced community nursing model to visit housebound and care home patients who are not currently covered by these services.

Redesign work already underway

Within Angus, Advanced Nurse Practitioners based within the Medicine for the Elderly service have supported community nursing teams and practices within Enhanced Community Services to support complex care coordination and same day assessment in the deteriorating patient. This model has also been tested supporting triage of same day demand, including house calls, within practices.
Dundee HSCP is developing their existing nursing teams with a view to undertaking house calls and have identified four types of patients requiring acute home visiting:

Type 1: Care Home residents

Type 2: Minor illness cases

Type: 3 Acute Undifferentiated illness and long term conditions

Type: 4 Palliative patients

In year 1 they will test and develop a model that supports and enhances the existing care home team to undertake dealing with urgent/acute care of care home residents across Dundee. At the same time the existing ECS team will be trained and supported to take on acute visiting of minor illness of conditions such as urine and chest infections and falls within the elderly. This will be tested in one cluster initially. As part of the testing, a framework for ANP/specialist nurse role in GP Practice settings will be developed along with models of good practice to support people with palliative care needs.

In Year 2 all Type 1 acute visiting will be directed to the Care Home team. There will be a roll out of Type 2 visits to all clusters and localities.

In year 3 an acute visiting team made up of advanced nurse and paramedic practitioners will start to review Type 3 presentations. This testing will be phased so to ensure that any roll out is performed safely.

Additional Professional Roles

The new GMS Contract sets out a vision that by 2021 additional specialist professionals will be working as part of an extended Multi-Disciplinary Team seeing patients as a first point of contact. Not only does this free up GP time and work load, it ensures that patients see the most appropriate professional for their needs in a timely manner. We support patients receiving the right care, at the right time in the right location and believe this provides the best care and most cost effective outcomes.

In Tayside the areas where we see potential for providing additional specialist roles as part of an extended multi-disciplinary team are MSK Physiotherapy and Mental Health.

MSK Physiotherapy

Introduction

Musculoskeletal problems frequently cause repeat appointments and are a significant cause of sickness absence in Scotland. An estimated 85% of GP's musculoskeletal caseload can be safely and effectively be seen by a physiotherapist without the need for a GP referral. Presentations perhaps better dealt by MSK physiotherapy account for up to 30% of GP consultations. Dealing with these entirely within the MSK service offers the potential to improve efficiency and productivity across the health and social care pathways and systems, improve outcomes for patients and have a positive impact upon the health economy.

Current Service

Across Tayside MSK services are provided via the Physiotherapy Service with specialist input from occupational therapy, orthotics and podiatry with access routes through the Musculoskeletal and Advice Triage Service (MATs), GPs, Consultants and other health care professionals. The musculoskeletal physiotherapy services are operated from mainstream outpatient departments across Tayside with small numbers of clinics on satellite sites.

Future Service

We propose in Tayside a future service which sees first contact clinics for MSK services provided on a cluster basis across the region. Patients will use MATs or be signposted by practice staff to an Advanced Physiotherapy Practitioner who will be working as an integral member of the primary care multi-disciplinary team, there will be no need for patients to see the GP first, if at all for MSK presentations.

Redesign work already underway

Angus Model

We have already made progress in looking at how we can deliver MSK differently and support General practice. In Angus a test of change is running in Brechin Health Centre. This model, started in response to a shortage of GPs, has an Advanced Physiotherapist Practitioner embedded in the health centre team, working directly in the practice.

A number of positives have been identified by this model. These include closer working with GPs and the primary care team; participation in the MDT huddle; opportunities for joint training and sharing good practice. In common with tests that have taken place in other parts of the country we have seen that earlier intervention avoids the development of chronicity of conditions and decreases referrals to secondary care.

Crieff Model

This model is similar to the Brechin model but differs slightly in that a nurse triages patients to physiotherapy and patients are then appointed into clinics set within the GP surgery. As with the Brechin model the benefits are broadly similar in that the model provides the opportunity for closer working with GPs and the other members of the primary care team. There are opportunities for joint training, sharing good practice and early intervention. It has evidenced a similar decrease in the development of chronicity which impacts positively on secondary care referrals.

Milestones

During year 1, we plan to build on the redesign work in place and roll out the MSK model to one cluster per Partnership across Tayside. This will be rolled out further to include all clusters within Tayside by the end of 2021.

Governance

A working group lead by the Director of AHP has been established and a detailed project plan is being developed to include how this programme will be taken forward over the next 3 years. This work stream reports to the GMS CIAG, Primary Care and HSCP Boards.

A number of evaluation measures have been identified:

- Numbers seen by physiotherapist
- Impact on GP capacity
- Numbers referred to MSK services for therapy
- Onward referrals to secondary care
- Re-referral or attendance for same condition
- Prescribing
- Patient satisfaction and PROM (patient reported outcome measures)

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Finance and Resources Required

In year 1 additional funding will be needed for an initial 5.0 wte Band 7 physiotherapy posts, an approximate cost of £260k. We believe that this is achievable and realistic; we need to ensure that we attract external interest in these posts, as adopting a purely internal recruitment process would adversely affect our ability to sustain services in other areas.

Total Year 1 Staffing required for additional Physiotherapy Staff

HSCP	Staffing Required 2018-19
Angus	1.5wte
Dundee	2.0wte
Perth & Kinross	1.5wte

By 2021 we estimate that we will require approximately an additional 12 wte Physiotherapists at a cost of approximately £612k (subject to how the model continues to evolve throughout the 3 year period).

Barriers and Opportunities

By its very nature, this is an evolving programme of work. Year 1 will allow data gathering which can then inform what is required in subsequent years.   It is recognised that service redesign requires us to think differently about how services are configured and that it is not simply a question of introducing additional staff to do the same. Equitable and sustainable models must be built whilst recognising the challenges around workforce and the national shortage of physiotherapists in Scotland.

In implementing the model we will have to address issues such as premises and accommodation and work these out with relevant parties and stakeholders recognising that one size may not fit all and that some of this requires to be tailored to the specific circumstances of a locality or cluster group.   The ability to communicate effectively between IT systems in common with the redesign of other services related to this improvement plan will be a major issue to be addressed.

Mental Health

Introduction

Mental health and wellbeing affects and influences the lives of individuals, families, and communities. Mental health problems are managed mainly in primary care by general practitioners who have access to specialist expertise in a range of secondary care services.

The contract states that:
'*Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice, will work with individuals and families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression. The outcome sought is improved patient care through rapidly accessible, appropriate and timely mental health input.*'

The Scottish Mental Health Strategy (2017) supports health and wellbeing in Primary Care:

Action 15 of this strategy commits the Government to increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years there will be an additional investment of £35 million for 800 additional mental health workers in those key settings. The funding for Action 15 comes from a separate funding pot, as described in the finance section.

Action 23: Test and evaluate describes the development of effective and sustainable models of **supporting mental health in primary care,** by 2019.

Current Service

In many cases those who have a mental health or wellbeing issue will present to their GP, and much GP time involves consultations with a mental health aspect, even if this is not the primary presentation. After assessment the GP will often refer to a wide range of services within the health and voluntary sector, and can also encourage self care or signpost to online resources. A number of practices in Tayside will use link workers or the listening service to provide additional support. Navigating the options in terms of onward referral can be complex for a range of reasons, including waiting times and charges for some services.

Future Service

The future aim would be for all NHS Tayside Practices to have access to a Mental Health and Well being Service, whether Practice based or located elsewhere (e.g. within a Care and Treatment Centre). The model should be able to support people at universal level with clear pathways or routes into targeted services and onwards into specialist services for those in greatest need.

Health and Wellbeing model

Angus HSCP has tested two Health and Wellbeing models in two separate burghs over the past 18 months. Each consists of 2 part time qualified band 6-7 experienced Registered Mental Health Nurses (RMN) seconded from Community Mental Health Teams in the same locality. This ensures a good interface, sharing of local knowledge and provides supervision and support for the workers.

The workers deal with all requests from adult patients connected with:
- Distress- A better response by services to individuals in distress is seen as a key component in supporting people at risk of non-fatal self-harm, future suicide prevention and mental health services.
- Substance misuse – Trained to deliver evidence based Alcohol Brief Interventions
- Mental illness

The Pilot pathway summary (subject to some variation across the two practices):

1. The worker identifies available patient's slots each day. Receptionist and/or clinical triage allocates consenting patients to the worker instead of a GP. Nurse accesses VISION notes as well as MIDIS.

2. Worker provides a timely connection with patient to identify of immediate presenting issues. Nurse carries out first level mental health assessment, and record findings on VISION.

3. Disposal: signpost to self help, including Beating the Blues, General Practitioner, Level 1/ social prescribing, examples include Talking Services in practice, Long Term Conditions Group, WRAP Groups, Insight Counselling, Adult Psychological Therapies Service, Substance Misuse Services, Adult Community Mental Health Team or Older Peoples Community Mental Health Team.

4. The worker does not deliver any ongoing interventions themselves but can offer one follow up appointment if patients needs time to consider options available which will also test patient's motivation to change. Patient should be equipped to make ongoing referral themselves although worker can refer into services, thus reducing need for further screening. Statutory services need to accept experienced nurse referral.

Worker will record outcome of assessment and follow up within VISION.
53% of GP practices have access to 'Do You Need To Talk' delivered by NHS Tayside Spiritual Care Department. Based in Health and Social Care contexts, the Do You Need to Talk service promotes wellbeing by offering an active listening service. The service helps people explore their deepest hurts and draw strength from their own inner resources and those of the communities of support around them.

The service is a short term, early intervention model of person-centred, assets based listening with the aim of promoting personal and communal wellbeing.

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Primary Care transformation funding supported a staff wellbeing project for staff in general practice, aiming to improve wellbeing and increase resilience. The findings of this are positive.

The link worker role described in the next section is also an important aspect of supporting wider mental health and wellbeing.

Funding and Resources Required

Tayside's share of the Mental Health allocation is £863,306 in 2018/19 rising to just over £2.5 m by 2021/22.

Based on the findings of the Angus pilot work we estimate that to replicate the model across Tayside by 2021 will cost in the region of £1.9 m. However, there are variations in how each IJB sees this work progressing. Dundee propose to test a model with initial psychology assessment, rather than nursing. As learning develops the model and skill mix can be reviewed across Tayside. Depending on the findings of these tests the costs may vary quite significantly from the figure noted.

Do You Need to Talk is a key service in some but not all practices in Tayside. To support the integration of this across Tayside a further £65k would be required.

Wider redesign of services will be reviewed alongside these developments, recognising the evolving pathways and capacity issues this work both support and creates. Local planning infrastructures for mental health in each HSCP will incorporate this in to their planning processes.

Development of resources to support staff in GP Practices

Transformation funding was used to support the wellbeing of our own staff through developing the services offered through the Tayside Spiritual care Team. The funding tested the concept of and impact of a network of care for staff in the community supported by staff from the Well Being Centre. Over the test period, teams were introduced to and had access to support for resilience and wellbeing through the use of support and supervision, incorporating group Values Based Reflective Practice, Mindfulness concepts and practices, and one to one confidential support.

Workforce recruitment and retention is a key challenge for all practitioners and services delivering GP and primary care services; providing a sustainable resource to support staff would add to the attraction of Tayside as a place to work whilst supporting our existing workforce.

Based on the resource package for the test phase, this model could be supported across Tayside with £40k investment. The model implemented would enable growth and roll out of the current model and be sustainable across all 3 partnerships.

Barriers and Opportunities

Workforce availability is the main risk to this development. In Tayside particularly in its more rural areas there are significant challenges in attracting staff. Having the availability of appropriate staff with the necessary skills and attributes may take time to develop. Recruiting from within the current workforce could leave other areas depleted which could be detrimental to mental health services overall.

A major review of Mental Health Services is currently taking place within Tayside, this may provide an opportunity to meet some of the future staffing requirements for primary care mental health services.

Accommodation and IT requirements as described elsewhere in this plan apply equally to developing mental health primary care services that are integrated and part of the extended MDT.

Opportunities are available through working more closely and investing in the community based third sector and universal services as well as the digital options and choices. Governance arrangements would need to be embedded within the models and local structures.

Community Link Workers

Introduction

Social Prescribing is a term used to describe a spectrum of approaches to support clients, community members and service users to access services and activities that can help them to deal with their life circumstances. A non medical model that provides community solutions to life problems can empower patients who would otherwise have their problems medicalised with little benefit to them.

Community Link workers are non-medical practitioners aligned to practices within GP clusters. They work directly with patients to help them navigate and engage with a full range of health, social care and third sector services. They often serve socio-economically deprived communities or assist patients because of the complexity of their conditions, rurality or a need for assistance with welfare issues.

Current Service

Each locality in the region has its own specific model in place. All localities have link workers based within GP practices already and/or working closely with practice staff, albeit to different scales with Dundee being the most significant service for now.

All localities regard social prescribing as a strategic priority and work in partnership with the third sector. In Dundee, link workers are employed by NHS Tayside and are sited within the Health and Social Care Partnership whereas in P&K and Angus, staff are employed within either the local authority or Third Sector. Each service has referral mechanisms in place and is monitoring and evaluating outputs and outcomes.

Future Service

The Government is clear that each HSCP as part of their Improvement plan is required to assess the local need and develop link worker roles in every area, in line with the manifesto commitment of delivering 250 link worker roles in the life of this Parliament.

Issues and Risks

Each locality has a model that works for them. There is an opportunity to use the Primary Care Improvement Fund to scale up the work in each area, taking into consideration the HSCPs Strategic plans and own local based need assessments.

Dundee Health & Care Partnership was an early adopter for the national link worker programme and received significant resources to scale up the previous pilot. The initial pilot in 2011 ran in one practice, this was extended to a further three in 2014. Over time this has increased and following external evaluation in 2017 the service was extended further and is now available in 16 Practices.

The funding letter of 23 May spells out that the link workers already in post should be seen as a priority, however, it makes reference to HSCPs working jointly to resource early adopter link workers and that flexibility around the scope oversight, employer or

lead responsibility. Further clarification nationally is being sought and further local discussion will be required.

Angus

Community link workers, known locally as social prescribers, are sited within the third sector and embedded within general practices, working closely with the wider multi-agency team and supporting care models, such as enhanced community support. Whilst social prescribing has been available in a number of practices in Angus for some years, the model has had the opportunity to develop and undergo significant evaluation as part of the new models of care programme in two practices in Forfar since 2016. A development event is planned for August to finalise Angus service modelling for planned roll-out in 2019/21.

Perth

A partnership group has been formed to support the development of social prescribing led by the HSCP with representation from the third sector interface and the local authority. Mapping is underway at present to identify the nature and breadth or social prescribing activity in the locality

Conclusion

This PCIP describes a comprehensive reshaping of primary care that is ambitious in scope and transformative in scale. This will be delivered over a challenging three year time scale. It offers a future for our population of better quality, better co-ordinated health care, developed with the people receiving it and delivered closer to the communities in which they live.

The PCIP has been developed in partnership across the three HSCPs in Tayside and with NHS Tayside in collaboration with the services and professions that will deliver that healthcare.

The PCIP is a beginning. It represents a vision, and it is now necessary to implement that vision. The PCIP was written in collaboration and it shall be implemented in the same way. The PCIP has been designed to improve the health of our population and it must be co-produced with our population. The next phase of developing the outline plans into fully costed programmes that can be rolled out across our population has already begun.

This will require significant work from all of the partner organisations that have contributed to the PCIP. We are confident that they are fully committed to this in accordance with the MoU. It will require the evolution of new finance and accountability structures; and the rapid and effective evaluation of the new care models that are being developed and rolled out. IJBs have a key scrutiny role in discharging their role of managing the commissioning of the services described within the plan.

Inevitably there will be changes made to the plan. It is a living document, and as time goes on it will change from being an aspirational statement of the better services we aim to provide for our population to a fully realised description of a more ambitious, more resilient, more sustainable thriving primary care assisted by a vibrant general practice at its heart.

Appendix 1- Contributors

Sheila Allan	Dundee HSCP
Karen Anderson	Director Allied Health Professionals
Sandy Berry	Chief Finance Officer, Angus HSCP
Alison Clement	Clinical Director, Angus HSCP
Jim Devine	Primary Care Manager, Perth HSCP
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Julia Egan	Consultant in Public Health Nursing
Kenny Freeburn	Head of Ambulance Services
Russell Goldsmith	Health Intelligence Officer
Alistair Graham	Head of Service eHealth
Rhona Guild	Primary Care Manager, Angus HSCP
Jane Haskett	General Manager, Primary Care
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Christopher Jolly	Programme Manager, Perth HSCP
Fiona Lornie	Lead Nurse
Gail McLure	Quality and Services Manager Primary Care Dept
Jill Nowell	Head of Prescribing Support Unit
Frances Rooney	Director of Pharmacy
Bill Troup	Head of Mental Health Services, Angus HSCP
Michelle Watts	Associate Medical Director
Joan Wilson	Associate Nurse Director

Perth and Kinross Integration Joint Board

22 June 2018

2017/18 Winter Plan Review

Report by Robert Packham, Chief Officer (G/18/99)

PURPOSE OF REPORT

This report outlines the P&K Health & Social Care Partnership Winter Plan review which was shared with the Scottish Government in April 2018.

The Scottish Government was this year keen to have feedback and on the learning specific to IJBs.

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1. **RECOMMENDATION**

   The IJB should note the attached winter plan review proforma as an update on this year's P&K Health & Social Care Partnership (HSCP) winter planning performance (Appendix 1).

2. **SITUATION/BACKGROUND/MAIN ISSUES**

   This review was a beneficial exercise which helped to identify key pressures and performance, which in turn will feed into the 'National Health & Social Care: Winter in Scotland 2017/18 Report'. The lessons learned and key priorities for improvement will also be used to help develop the 'Preparing for Winter 2018/19 Guidance'

3. **PROPOSALS**

   The review has allowed the HSCP to identify key priority areas for improvement and planning for the HSCP Winter Plan activity required for winter 2018/19. Key priority areas for improvement being:

   1. Ongoing review of current Business Continuity Plans to ensure "all year" health and social care services responsiveness not just for winter planning
   2. Focussed targeting within community health & other vulnerable groups of:
      - increasing Anticipatory Care Planning (especially within Care Homes)
      - increasing seasonal Flu vaccination and Pneumococcal vaccination uptake

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- Enhanced Care & Support - further roll out and development as Integrated Care Teams from within P&K Localities
- increasing Polypharmacy Reviews (also with a focus within Care Homes)

3. Greater focus on management of long term conditions to decrease avoidable acute admissions.
4. Better defining pathways of care reducing unnecessary admissions to hospitals or care homes and better co-ordination of care provided in the community, preferably within the person's own home or home setting
5. implementing (where appropriate) flexible 7 day working

2018/19 winter planning will commence on 1st June 2018. Traditionally winter planning starts 1st October each year. Earlier planning will ensure the achievement and delivery of all improvements highlighted from the learning from the 2017/18 Winter Plan review.

4.   CONCLUSION

It has been acknowledged that the winter of 2017/18 was particularly challenging for Health & Social Care services with increased presentation of influenza like illnesses over the festive period and a prolonged incidence of adverse weather – November 2017 to April 2018.

It can be concluded from the attached winter plan review proforma that P&K HSCP performed fairly well over the 2017/19 winter period but there are clear areas for improvement and greater focus as plans are formulated for the winter period 2018/19.   P&K HSCP also require to ensure all year round business continuity and responsiveness – particularly during periods of increased system pressure and care activity.

Author(s)

Name	Designation	Contact Details
Maggie Rapley	In-patient Service Manager (MftE, Stroke, Intermediate Care, POA and AHPs)	m.rapley@nhs.net

1. **IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION**

Strategic Implications	Yes / None
HSCP Strategic Commissioning Plan	**Yes**
Transformation Programme	**Yes**
Resource Implications	
Financial	**Yes**
Workforce	**Yes**
Assessments	
Equality Impact Assessment	**None**
Risk	**Yes**
Other assessments (enter here from para 3.3)	
Consultation	
External	**Yes**
Internal	**Yes**
Legal & Governance	
Legal	**None**
Clinical/Care/Professional Governance	**Yes**
Corporate Governance	**Yes**
Communication	
Communications Plan	**Yes**

1. **Strategic Implications**

1.1 Strategic Commissioning Plan

The winter plan review highlighted where activity supported the five key deliverables within the P&K HSCP Strategic Plan:

1   prevention and early intervention,
2   person centred health, care and support
3   work together with communities
4   inequality, inequity and healthy living
5   best use of facilities, people and resources

2. **Resource Implications**

2.1 Financial

P&K HSCP was awarded a share of the NHS Tayside Winter Planning financial allocation from the Scottish Government. This covered (in full) increased staffing/medical costs to meet demand over the winter period.

2.2 Workforce

The 2017/18 winter plan was shared with the local area partnership forum inclusive of HR and Staff Side Representation. A planning group re the winter plan 2018/19 will commence in June 2018 and HR and Staff Side Representives will be invited to attend. This will be essential as we explore workforce flexible deployment and seven day working.

3. Assessments

3.1 <u>Equality Impact Assessment</u>

N/A

3.2 <u>Risk</u>

Poor planning by the P&K HSCP in respect of winter pressures will lead to a breakdown of business continuity causing negative impact on service delivery and poor care outcomes for people living in Perth & Kinross.

3.3 <u>Other assessments</u>

Key priority areas for improvement being:

1. Ongoing review of current Business Continuity Plans to ensure "all year" responsiveness not just for winter planning
2. Focussed targeting within community health & other vulnerable groups of:
   - increasing Anticipatory Care Planning (especially within Care Homes)
   - increasing seasonal Flu vaccination and Pneumococcal vaccination uptake
   - Enhanced Care & Support - further roll out and development as Integrated Care Teams from within P&K Localities
   - increasing Polypharmacy Reviews (also with a focus within Care Homes)
3. Greater focus on management of long term conditions to decrease avoidable acute admissions.
4. Better defining pathways of care reducing admissions to hospitals or care homes and better co-ordination of care provided in the community, preferably within the person's own home or home setting
5. implementing (where appropriate) flexible 7 day working

4. Consultation – Patient/Service User first priority

4.1 <u>External</u>

The 2017/18 winter plan was developed under the scrutiny of the Older People's Service Implementation Group (OPSIG) – membership includes representatives from the third sector and private care providers

4.2   Internal

The 2017/18 winter plan was developed and required to assure robustness to the Integrated Management Team and the Executive Management Team of the HSCP.

5.   Legal and Governance

5.1   The 2017/18 was shared with members of the HSCP Clinical & Care Governance Group

6.   Communication

6.1   The 2017/18 was shared widely with HSCP Care Teams

7.   BACKGROUND PAPERS/REFERENCES

N/A

8.   APPENDICES

Appendix 1 - The HSCP Review of Winter Plan 2017/18

Health & Social Care: Local Review of Winter 2017/18

NHS Board, HSCP/s	P&K H&SCP/IJB	Winter Planning Executive Lead	Evelyn Devine, Head of Health/Diane Fraser, Head of Adult Social Care

Introduction

Last year we asked for local winter reviews to be shared with the Scottish Government. This was a beneficial exercise which helped to identify key pressures and performance, which fed into the 'National Health & Social Care: Winter in Scotland 2016/17 Report'. The lessons learned and key priorities for improvement were also used to help develop the 'Preparing for Winter 2017/18 Guidance' - http://www.sehd.scot.nhs.uk/dl/DL(2017)19.pdf

To continue to improve winter planning across Health & Social Care we are asking local systems to lodge a draft of their winter review for 2017/18 with the Scottish Government to support winter planning preparations for 2018/19. Local reviews should have senior joint sign-off reflecting local governance arrangements.

We expect this year's review to include:

- the named executive leading on winter across the local system
- key learning points and future recommendations / planned actions
- top 5 local priorities that you intend to address in the 2018/19 winter planning process
- comments on the effectiveness of the wider winter planning process and suggestions as to how we can continuously improve this process. We are particularly keen to hear the views of Health & Social Care Partnerships.

Thank you for your continuing support.

Alan Hunter
Director for Health Performance & Delivery

Geoff Huggins
Director for Health & Social Care Integration

1

1	**Business continuity plans tested with partners.**
	Outcome:
	The local system has fully tested business continuity management arrangements / plans in place to manage and mitigate against key disruptive risks including the impact of severe weather.
	Local indicator(s): progress against any actions from the testing of business continuity plans.

1.1 | What went well?

- Business Continuity management arrangements/plans to manage and mitigate against key disruptions including the impact of adverse weather
- Business Continuity Team set up locally at senior management level, across HSCP/Primary Care
- Pre-planning, including planning of additional weekend staff and public holidays
- OOH GP's volunteered for extra shifts at weekends
- Many GP practices reported that they coped well with good planning
- Having knowledge of vulnerable people in the community allowed services/support to continue to be delivered utilising a good whole system winter plan.
- The stand-down was planned well

1.2 | What could have gone better?

- We could have been more responsive to known increased business following public holidays – this should be planned rather than reactive.
- Further clarity around role of Resilience Team would have helped.
- The frequency of huddles was time consuming and we needed to better identify who needed to be at which huddle
- In some cases we left interventions too late e.g. multiprofessional huddles, resource ordering

1.3 | Key lessons / Actions planned

- 4 by 4 cars picking staff up – we need to review the process and poor telephone signal arrangements to be reviewed
- Business Continuity Plans – all services to ensure BCP's are reviewed, relevant and fit for purpose and are available on Staffnet/ERIC
- Consideration of volume of information requests during snow/adverse weather and identify most appropriate people to collate information.
- Resilience planning and Site management need to ensure representation within any event planning or after review events.
- Local BCP and pressure planning needs to be led by the right people – skill based not role based
- We need to better develop teams all year round to cope when pressure hits

2	**Escalation plans tested with partners.**
	Outcome:
	Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes.
	Local indicator(s):
	• *attendance profile by day of week and time of day managed against available capacity*
	• *locally identified indicators of pressure (i.e.) % occupancy of ED, utilisation of trolley/cubicle, % of patients waiting for admission over 2, 4 hours*
	• *all indicators should be locally agreed and monitored.*

2.1	**What went well?**

As per Section 1

2.2	**What could have gone better?**

- Earlier decision making.
- Advanced planning - capacity, staffing, escalation triggers
- Planning in relation to bed management – community hospitals
- Outpatient Services continued – might have freed up staff – there was mixed messages as to what to step down. We also require to ensure we increase admin support when stepping down clinics to enable fast contact to patients.

2.3	**Key lessons / Actions planned**

- Action/Planning around Resources – workforce, duty manager/on call and timing
- Review/further develop triggers, action cards and escalation plans
- One Plan for system pressures
- Single point for resilience planning
- Early decision making required
- Escalation to other agencies, working with partners/GPs in times of system pressure

3	**Safe & effective admission / discharge continues in the lead-up to and over the festive period and also in to January.**

Outcomes:
- *Emergency and elective patients are safely and effectively admitted and discharged over the Christmas - New Year holiday period.*
- *The numbers of patients receiving elective treatment reduces and the risk of boarding medical patients in surgical wards is minimised.*
- *Patients do not have unnecessary stays in hospital; hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January.*

Local indicator(s):
- *daily and cumulative balance of admissions / discharges over the festive period*
- *levels of boarding medical patients in surgical wards*
- *delayed discharge*
- *community hospital bed occupancy*
- *number of Social Work assessments including variances from planned levels.*

3.1 | What went well?

- Discharge Hub in PRI - admission and discharge processes improving – discharge rate maintained despite reduction in beds. Only one delayed discharge in PRI on New Years Eve.
- Additional GP/medical cover for community hospitals in P&K and clinical director input facilitated increased capacity and flow with discharges and transfers from PRI.
- Additional AHP Services, Ambulance and Pharmacy over the weekends facilitated discharges and allowed ongoing assessment and treatment which resulted in optimal lengths of stay
- Enhanced Community Support (ECS) helped keep people at home
- Social Work covering 7 days and Public holidays – supported discharge
- Care at Home, Reablement and Rapid Response support for discharge and prevention of admission
- Limited annual leave authorised for internal care at home and reablement services in Dec to increase capacity over festive period
- GP Call Handling overnight – prevention of admission
- SAS support for discharge – especially to community hospitals

3.2 | What could have gone better?

- Enhanced Community Support requires to be available in all localities – this continues to be rolled out
- No definition of how step down capacity would be used – also no criteria for why you would not send for interim placements when no care at home available
- Transport availability for quick turnaround of discharges – we need to use third party volunteering also

3.3 | Key lessons / Actions planned

- Consideration of 7 day working of service ie Pharmacy, AHP

- Consideration of vacancy impact - if not optimal for business as usual then consider impact in times of pressure
- Consideration of availability of interim placements or additional home care to facilitate discharges
- Continue to develop and improve Discharge Hub in PRI
- Continue to roll out ECS

| 4 | **Strategies for additional surge capacity across Health & Social Care Services** |

Outcomes:
- *The risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised.*
- *The staffing plans for additional surge capacity across health and social care services is agreed in October.*
- *The planned dates for the introduction of additional acute, OOH, community and social work capacity are agreed and that capacity is operational before the expected surge period. It is essential that additional capacity is developed alongside appropriate arrangements to create a safe and person centred environment.*

Local indicator(s):
- *planned additional capacity and planned dates of introduction*
- *planned number of additional staffed medical beds for winter by site and the planned date of introduction of these beds;*
- *planned number of additional intermediate beds in the community and the planned date of introduction of these beds;*
- *levels of boarding.*
- *planned number of extra care packages*
- *planned number of extra home night sitting services*
- *OOH capacity*
- *planned number of extra next day GP and hospital appointments*

| 4.1 | **What went well?** |

- Health and Social Care Partnerships adapted with additional measures to prevent delayed discharges, improve flow, enhance social provision
- Social work available over festive period – 7 day working and public holidays covered. Social work Hospital Discharge team were in over the festive period including public holidays and weekend.
- Authorisation of funding for care home placements and interims approved during festive period
- Enhanced specialist liaison services to reduce emergency admissions from care homes and support discharge from hospital to care home
- Additional GP/medical cover for community hospitals, including weekend ward rounds, in P&K and clinical director input facilitated increased capacity and flow with discharges and transfers from PRI
- Additional AHP Services, Ambulance and Pharmacy over the weekends facilitated discharges and allowed ongoing assessment and treatment which resulted in ultimate lengths of stay
- SAS support for discharge

| 4.2 | **What could have gone better?** |

- Staffing – forecasting an overview across Tayside and resource planning eg annual leave time out
- Support for staff resilience – impact on health and attendance at work
- Risk reliance on good will of staff

4.3	Key lessons / Actions planned

- Ensure responsiveness particularly at weekends – will require a planned approach to increasing staffing levels

5	**Whole system activity plans for winter: post-festive surge / respiratory pathway.**

Outcomes:
- *The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. Hospital models will include flows between front doors, receiving units, and downstream wards.*
- *Monthly Unscheduled Care Meetings of hospital triumvirate, including IJB Partnerships and SAS (clinical and non-clinical) colleagues.*

Local indicator(s):
- *daily number of cancelled elective procedures;*
- *daily number of elective and emergency admissions and discharges;*
- *number of respiratory admissions and variation from plan.*

5.1	**What went well?**

- The monthly NHST unscheduled care boards and P&K Acute Care/HSCP interface meetings allowed for better winter planning this year.

5.2	**What could have gone better?**

- Covered in sections above

5.3	**Key lessons / Actions planned**

- Covered in sections above

6	**Effective analysis to plan for and monitor winter capacity, activity, pressures and performance**

Outcome:
- *NHS Boards have, and use, a range of analysis to effectively plan for and monitor winter capacity, activity, pressures and performance at board and site levels.*

Local indicator(s):
- *Agreed and resourced analytical plans for winter analysis.*
- *Use of System Watch*

6.1	**What went well?**

- NHS Tayside response

6.2	**What could have gone better?**

- NHS Tayside response

6.3	**Key lessons / Actions planned**

- NHS Tayside response

7	**Workforce capacity plans & rotas for winter / festive period agreed by October.**

Outcomes:
- *Rotas and workforce capacity plans for all disciplines are agreed for the winter (and particularly the 4 day festive holiday) period by October to underpin safe and effective health and social care. This should encompass all relevant health and social care services.*
- *Maintain discharges at normal levels over the two 4 day festive holiday periods.*
- *Right level of senior clinical decision makers available over the two 4 day festive holiday periods.*

Local indicator(s):
- *workforce capacity plans & rotas for winter / festive period agreed by October;*
- *effective local escalation of any deviation from plan and actions to address these;*
- *extra capacity scheduled for the 'return to work' days after the four day festive break factored into annual leave management arrangements;*
- *number of discharges on each of the 4 day festive holiday periods compared to number of normal daily discharges.*

7.1	**What went well?**

- Health and Social Care Partnerships adapted with additional measure to prevent delayed discharges, improve flow, enhance social provision
- Specialist Nurses changed ways of working to support pressures
- Increased senior management presence over the four day festive period – enhanced leadership and decision making
- Celebration of staff efforts and dedication to ensure service provision remained ie sleeping on site, etc, through Communications
- Increased Social work capacity over festive period

7.2	**What could have gone better?**

- Time taken to approve funding bids and time taken for staff to be appointed was too long
- Support for staff resilience – impact on health and attendance at work
- Risk reliance on good will of staff
- Consistent AHP cover over weekends

7.3	**Key lessons / Actions planned**

- Consideration of up skilling and induction plan for providing cover in alternate area

8	**Discharges at weekends & bank holidays**

Outcome:
- *Patients are discharged at weekends and bank holidays to avoid unnecessary stays in hospital and to improve flow.*
- *Robust planning and decision making midweek to support discharges for patients over a public holiday weekend for example Immediate Discharge Letters (IDLs), Pharmacy Scripts, Transport and Equipment to minimise delays.*

Local indicator(s):
- *% of discharges that are criteria led on weekend and bank holidays;*
- *daily number of elective and emergency admissions and discharges*
- *discharge lounge utilisation*

8.1	**What went well?**

- Additional AHP Services, Social Work, Ambulance and Pharmacy over the weekends to provide 7 day working allowed for discharging at the weekends – particularly to community hospitals
- Health and Social Care Partnerships adapted with additional measure to prevent delayed discharges, improve flow, enhance social provision
- Introduction of Ward rounds over weekends at Community Hospitals

8.2	**What could have gone better?**

- Definition of how step down capacity would be used
- Overnight planning

8.3	**Key lessons / Actions planned**

- Escalation to other agencies, working with partners/GPs in times of system pressure

9	**The risk of patients being delayed on their pathway is minimised.**

Outcomes:

- *Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream speciality wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflect the arrival patterns and potential waiting times for assessment and/or transfer/discharge.*
- *Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital. There is early engagement with SAS for ambulance discharge and transfer.*
- *Medical and Nurse Directors provide monthly report on ward by ward, in/out balance, daily discharge progress and performance.*

Local indicator(s):

- *distributions of attendances / admissions;*
- *distribution of time to assessment;*
- *distribution of time between decision to transfer/discharge and actual time;*
- *% of discharges before noon;*
- *% of discharges through discharge lounge;*
- *% of discharges that are criteria led;*
- *levels of boarding medical patients in surgical wards.*

9.1	**What went well?**

- NHS Tayside Response

9.2	**What could have gone better?**

- NHS Tayside Response

9.3	**Key lessons / Actions planned**

- NHS Tayside Response

10	**Communication plans**

Outcomes:
- *The public and patients are kept informed of winter pressures, their impact on services and the actions being taken.*
- *Effective local and national winter campaigns to support patients over the winter period are in place.*
- *Staff are engaged and have increased awareness of the importance of working to discharge patients over the two 4 day festive holiday periods.*

Local indicator(s) :
- *daily record of communications activity;*
- *early and wide promotion of winter plan*

10.1	**What went well?**

- Communication to public, patients and staff on access arrangements over festive period
- Good communication via Vital Sign re preventing infection

10.2	**What could have gone better?**

- NHS Tayside response

10.3	**Key lessons / Actions planned**

- NHS Tayside response

11	**Preparing effectively for norovirus.**

Outcome:
- *The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised through the effective implementation of the HPS Norovirus Outbreak Guidance (2016/17).*

Local indicator(s):
- *number of wards closed to norovirus;*
- *application of HPS norovirus guidance.*

11.1	**What went well?**

- NHS Tayside response

11.2	**What could have gone better?**

- NHS Tayside response

11.3	**Key lessons / Actions planned**

- NHS Tayside response

12	**Delivering seasonal flu vaccination to public and staff.**
	Outcome:
	• CMO uptake targets for seasonal flu vaccination for those aged 65 and above, at risk groups and front line staff are delivered in accordance with CMO Guidance.
	Local indicator(s):
	• % uptake for those aged 65+ and 'at risk' groups;
	• % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.

12.2	**What went well?**

- NHS Tayside response

12.3	**What could have gone better?**

- NHS Tayside response

12.4	**Key lessons / Actions planned**

- NHS Tayside response

13	Additional Detail

Include detail around when this review is likely to be considered by the Boards senior management team.

- Review by P&K IJB – June 2018

14	Top Five Local Priorities for Winter Planning 2018/19

Review of Business Continuity Plans

Focussed targeting within community health & other vulnerable groups:
- Increase ACP (esp. within Care Homes)
- Increase Flu Vac and Pneumococcal vac uptake
- AFT/ECS further roll out and development
- Increase Polypharmacy Reviews

Decrease failure demand interventions - Management of Long Term Conditions to decrease avoidable acute admissions.

Defined Pathways of care for not admitting, how can it be managed in the community/home setting

15	Views on Wider Winter Planning Process & Suggestions for Improvement

- Introduce 7 day working of service ie Pharmacy, AHP – Planning group in place to explore this – April 2018

Perth & Kinross Integration Joint Board

22 June 2018

Update on the implementation of the Social Care (Self Directed Support) (Scotland) Act 2013 in Perth and Kinross

Report by Robert Packham, Chief Officer (G/18/100)

PURPOSE OF REPORT

The purpose of this report is to update the IJB on the Perth and Kinross response to the Audit Scotland Report on Self Directed Support (SDS).

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1.   RECOMMENDATION(S)

It is recommended that the Integration Joint Board:

- Notes the response to the Audit Scotland Report on Self Directed Support
- Notes progress to date in implementing SDS in Perth and Kinross.
- Instructs officers to provide an update in 12 months' time.

2.   BACKGROUND

2.1   In 2013 The Scottish Parliament passed a new law on social care support, the Social Care (Self-directed Support) (Scotland) Act 2013. The Act gives people a range of options for how their social care is delivered, beyond just direct payments, empowering people to decide how much ongoing control and responsibility they want over their own support arrangements. The Act places a duty on councils to offer people four choices as to how they receive their social care support.

Option 1:   This is usually called a Direct Payment.   The Council pays money directly to the individual to arrange their own support by employing care staff or by buying services from one or more organisations. This gives them the greatest level of control.

Option 2:   The individual directs their own support, from an organisation of their choice and the Council manages the payment of the invoices.

Option 3:   The Council can arrange the support on the individual's behalf.

Option 4:   Any mix of the above options.

The Act also places a duty on authorities to provide support and information to help people make informed choices regarding their support.

1

3.0 PROGRESS TO DATE

3.1 In Perth and Kinross we have focused on two key outcomes

1. Developing a confident, competent workforce to support delivery of a personalised approach through the application of Self-directed Support (SDS)

2. Improving choice and control to improve outcomes for service users

Workforce:

During the early implementation of SDS, we were very clear that success was dependent on cultural change and establishing new models of working. To support this, a robust learning and development programme has been developed with managers and staff with input from people who have used services. An evaluation of the SDS learning and development programme in late 2015 found that staff reported that:

- Their practice has improved in relation to developing an outcome focussed approach
- They understand their statutory duties
- They are confident in supporting people to identify their personal outcomes and the options available to them

The ongoing learning and development programme is a mixture of formal training, online material, learning lunches and work based learning. The work based learning has been highly valued, providing an opportunity for staff to share practice, reflect and learn from each other.

In tandem with this training and staff development we were clear that it was vital to establish a culture and operational processes which gave staff permission and encouragement to work collaboratively with service users to develop support plans that met people's outcomes.

Therefore it was agreed to shift power to the front line and staff now have delegated authority to approve individual weekly care packages as follows

Social Work Assistant & Occupational Therapist Assistant	up to £100.00
Social Worker & Occupational Therapist	Up to £200.00
Deputy Team Leader	Up to £300.00
Team Leader	Up to £400.00
Service Manager	Over £400

Staff have responded positively to this new approach. Regular monitoring and scrutiny, by local managers, has ensured that resources have been utilised appropriately.

Improving choice and control to improve outcomes for service users

The table below shows a significant increase in the percentage of people choosing options 1 and 2 for their support over the past four years.   This suggests the choice and control for people regarding their support is increasing in Perth and Kinross.

	Oct 2014	Oct 2018
Percentage People with options 1 and 2	7.9%	19%

Significantly 86% of service users confirmed that they had achieved the goals set out in their outcome focused assessment.

Establishment of Health and Social Care Partnerships

The Public Bodies (Joint Working) (Scotland) Act 2014 required NHS Boards and Councils to establish new Health and Social Care Partnerships. In Perth and Kinross this major structural and organisational change has absorbed significant managerial time and there has been increased pressure to deliver the required support to minimise delayed hospital discharge. Alongside this we have just undergone a major retendering for most of our care at home support. Over 90% of our care at home service is now delivered by external providers. A number of transformation projects have been undertaken to deliver further savings due to a reduction in resources.

The successful implementation of SDS relies on providers from the independent and voluntary sectors being able to deliver services in a different way. This brings significant challenges, particularly in relation to recruitment and developing new models of delivery. We are working in partnership with providers to support them to deliver support which meets the needs of individuals. There are tensions for service providers between offering flexible services and making extra demands on their staff. At the same time, there are already challenges recruiting and retaining social care staff across the country owing to low wages, antisocial hours and difficult working conditions.

Notwithstanding Foundation Living Wage policy, in Perth & Kinross all service providers are experiencing recruitment and retention issues. This issue inevitably has an impact on the capacity of existing providers to offer flexible services.

New Opportunities arising from creation of Health and Social Care Partnerships

Locality Working

The Perth and Kinross Health and Social Care Partnership have established three localities as the main conduit for the delivery of local health and social care support. This restructure and the appointment of locality leads have led to a renewed focus on place and greater engagement with local residents and community resources. These changes have created the opportunity for new conversations to take place between Health and Social Care Staff and local people to discuss a broader way of supporting people beyond a service model. We have invested in a team of four community engagement workers to support closer links between local community organisations and locality staff.

Participatory Budget

Your Community, Your Budget, Your Choice was the branded title for the first Perth and Kinross Health and Social Care Partnership community based Participatory Budget initiative. In late 2016 over £66,000 was made available to three communities. The aim was to provide funding to local community organisations to enable them to develop vital preventative provision and reduce the demand on specialist services. By providing small sums of money, a range of local conversations developed and some existing supports were sustained and a number of new provisions developed. This year the Health and Social Care Partnership have contributed £90,000 to a new round of participatory budgeting which is being run in collaboration within the local Community Planning Partnership areas. This is a further opportunity to place the challenges and opportunities of providing local support as a central local issue.

Increase Awareness & Choice of SDS

Within Perth and Kinross we have recognised that a key opportunity to increase awareness and choice for people requiring additional support lies in working with local enterprise development organisations. A number of these organisations had limited understanding of the opportunities available in the social care sector to deliver high quality localised support to people accessing SDS. For a number of years we have been working with Growbiz and this led to the creation of the Care and Wellbeing Cooperative. The Co-op was also successful in gaining Scottish Government Self Directed Support Innovation Funding.

The Care and Wellbeing Co-operative provides care, support and wellbeing activities to communities in rural Perthshire. Its 29 members are micro/community enterprises which offer personalised, flexible, local and creative support including care at home, palliative care, befriending, creative writing, swimming, gardening, health walks, dance, complementary therapies. The Care and Wellbeing Co-operative represents an enterprising response to

the promotion of SDS helping develop the social marketplace and offering greater choice to rural communities.

In line with the Equalities Policy it is crucial to ensure all communities are given the support and information around the 4 Options underpinned in the SDS Act. At an appropriate level for them to be able to make informed choices, particularly around Option 1, Direct Payments.

Data Collection

The Auditor General in his evidence to the Scrutiny Committee suggested that "more reliable data is needed on the number of people choosing each of the SDS options".

In Perth and Kinross we are very aware that simple statistical information on the uptake of each SDS Option package only tells part of the story. To fully understand impact more qualitative evaluation of the experience of service users accessing all four options is required. For example, services designated as option 3 may in fact offer a level of choice and control. However some services designated as option 2 may not offer the extent of choice and control which is desirable. In short, there needs to be an evaluation/review of implementation to inform our understanding, and set a platform for the next phase of SDS development.

4.   **CONCLUSION**

In summary, good progress has been made, especially in relation to workforce development.   Increasing numbers of people are being supported by options 1 and 2 suggesting greater choice and control and the vast majority of people state their support helps them achieve their desired outcomes.

However there are capacity issues, particularly in rural areas of Perth and Kinross which can restrict choices available to people regarding their support. Actions have been taken to try and address this such as the work of the Care and Wellbeing Co-operative, the recent tendering for Care at Home providers and implementation of an enhanced hourly rate in Highland Perth and Kinross.

The Scottish Government has a role to support the sharing of knowledge and to promote dialogue around commissioning questions. Supporting the further development of front line practice, planning/consultation, commissioning and other support input for partnerships around SDS development should be a key shared agenda for the Government and Partnerships.

Author(s)

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NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

1. **IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION**

Strategic Implications	Yes
HSCP Strategic Commissioning Plan	**Yes**
Transformation Programme	**No**
Resource Implications	
Financial	**Yes**
Workforce	**Yes**
Assessments	
Equality Impact Assessment	**Yes**
Risk	**No**
Other assessments (enter here from para 3.3)	**No**
Consultation	
External	**Yes**
Internal	**No**
Legal & Governance	
Legal	**No**
Clinical/Care/Professional Governance	**Yes**
Corporate Governance	**No**
Communication	
Communications Plan	**No**

1. **Strategic Implications**

1.1 Strategic Commissioning Plan

This report supports the following outcomes of the Corporate Plan in relation to the following priorities:

1. Prevention and early intervention
2. Person centred health, care and support
3. Work together with communities
4. Inequality, inequity and healthy living
5. Best use of facilities, people and resources

2. **Resource Implications**

2.1 Financial

There are no direct financial implications arising from this report.

2.2 Workforce

There are no workforce implications arising from this report.

3. Assessments

3.1 Equality Impact Assessment

Under the Equality Act 2010, PKC and NHS Tayside is required to eliminate discrimination, advance equality of opportunity, and foster good relations between equality groups. Carrying out Equality Impact Assessments for plans and policies allows the HSCP to demonstrate that it is meeting these duties.

The Equality Impact Assessment undertaken in relation to this report can be viewed by clicking http://www.pkc.gov.uk/EqIA

This report has been considered under the corporate Equalities Impact assessment process (EqIA) with the following positive outcomes expected following implementation of this strategy:

- Improved outcomes, support, independence, choice and control for individuals and carers;
- Support access to jobs, services and amenities in local communities;
- Improved health and wellbeing – both physical and mental health - and improved access to care for all.

3.2 Risk

There are no direct risks arising from this report

3.3 Other assessments

4. Consultation – Patient/Service User first priority

4.1 External

This strategy has been informed by the 'Join the Conversation' engagement in 2015 which included service users' feedback about their frustrations of lack of availability and flexibility of care available to them.

4.2 Internal

5. Legal and Governance

There are no direct legal implications resulting from this report

6. Communication

There is no communication plan associated with this report.

7. BACKGROUND PAPERS/REFERENCES

There are no relevant background papers relevant to this report.

8.   APPENDICES

Appendix 1 – link to Audit Scotland Report on Self Directed Support

Link to Scottish Government report in Self Directed Support:

Self-directed Support: 2017 progress report

Perth and Kinross Integration Joint Board

22 June 2018

Equality Outcomes Progress Report

Report by Robert Packham, Chief Officer (G/18/101)

PURPOSE OF REPORT

To provide the Board with an annual update to the Equality Outcomes Report which was required to be published by all Integration Joint Boards by 30 April 2016.

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1. RECOMMENDATION(S)

It is recommended that the Board notes the strong basis for continuing Joint Equalities activity and notes the first annual progress report in relation to the Integration Board Joint Equality Outcomes.

2. SITUATION/BACKGROUND / MAIN ISSUES

The public sector equality duty (Equality Act 2010) came into force in Scotland in April 2011 – this is often referred to as the general duty. Scottish public authorities must have 'due regard' to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations.

The Public Bodies Specific Duties lay out that all Scottish Public authorities must publish a report on mainstreaming the equality duty; a set of equality outcomes; employee information; gender pay gap information (for authorities with more than 20 staff) and a statement on equal pay (for authorities with more than 20 staff).

The Integration Joint Board is now classed as a public body under the regulations, albeit with less than 20 employees, and must therefore; publish a set of equality outcomes and a Mainstreaming Report (2016-2020) by 30 April 2016 which it did.

The Integration Joint Board Equality Outcomes and Mainstreaming Report were shared in draft format with the Community Equality Advisory Group (CEAG) at their meeting on 18 February 2016. The CEAG comprises of a range of equality interest groups and individuals working across all of the equality characteristics (including both local and national organisations). This progress report will also be shared with CEAG members when approved.

The Integration Joint Board Equality Outcomes and Mainstreaming Report (2016-2020) were shared with the Equalities and Human Rights Commission (EHRC) during their preparation and whilst they have made it clear that they are not currently resourced to provide bespoke feedback on draft equality outcomes / mainstreaming reports ahead of the April 2016 publication date they did provide some informal feedback which has been taken into account both now and for the reporting period ahead.

Members of the Strategic Planning Group recently took part in a facilitated workshop in relation to race equality and integration. This was part of the Scottish Government's project with CEMVO (Council for Ethnic Minority Voluntary Organisations) and the outcomes of this workshop will be taken forward through the Integrated Strategic Planning process.

3.   **PROPOSALS**

Both NHS Tayside and Perth & Kinross Council have published their next 4 year mainstreaming report and equality outcomes (2017-2021) and have their own respective organisational reporting and governance structures which will still be required in the future. These were updated recently in accordance with legislative requirements.

The Integration Joint Board Equality Outcomes have been established to ensure there remains an element of consistency with the equality outcomes which were in place for each organisation at that time.

There are 5 Equality Outcomes which were agreed by the Integration Joint Board and they were cross-referenced as appropriate to the equality outcomes for NHS Tayside and Perth & Kinross Council at that time.

It was proposed that progress in response to these Equality Outcomes was reported on an Annual Basis to the Integration Joint Board using an agreed format which evidences the outputs / actions, timeframes, targets or other measurement criteria to address any specific inequalities. This format has been agreed between both organisations and is included in this report.

The agreed Integration Joint Board Equality Outcomes are detailed in full in Appendix 1.

4.   **CONCLUSION**

It is recommended that the Board notes the strong basis for continuing Joint Equalities activity and notes the first annual progress report in relation to the Integration Board Joint Equality Outcomes.

Author(s)

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NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

EQUALITY OUTCOMES

Background

The public sector equality duty in the Equality Act 2010 came into force in Scotland in April 2011 – this is often referred to as the general duty. Scottish public authorities must have 'due regard' to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations.

The Public Bodies Specific Duties lay out that all Scottish Public authorities must publish a report on mainstreaming the equality duty; a set of equality outcomes; employee information; gender pay gap information (for authorities with more than 150 staff) and a statement on equal pay (for authorities with more than 150 staff).

The Integration Joint Board is now classed as a public body under the regulations, albeit with less than 150 employees, and must therefore; publish a set of equality outcomes and an Equality Mainstreaming Report by 30 April 2016.

This report outlines the proposed Equality Outcomes for the Health and Social Care Integration Joint Board in Perth and Kinross.

Services within health and social care integration

The services provided by the new partnership will include services provided by Perth & Kinross Council and NHS Tayside as set out in the table below. A key challenge for the partnership will be to ensure services are integrated and meet the needs of people with protected characteristic(s) and communities in our localities and make the shift towards prevention and early intervention.

Services currently provided by Perth & Kinross Council	Community Services currently provided by NHS Tayside	Hospital Services currently provided by NHS Tayside (for planning purposes)
• *Social work services for adults with physical disability and older people* • *Services and support for adults with learning disabilities* • *Mental Health Services* • *Drug and Alcohol Services* • *Adult Protection and*	• *District nursing services* • *Substance misuse services* • *Primary medical services* • *General dental services* • *Ophthalmic services* • *Community geriatric medicine* • *Primary medical services to*	• *Accident and Emergency services provided in a hospital* • *Inpatient hospital services relating to the following areas:* - *general medicine;* - *geriatric medicine;* - *rehabilitation medicine;* - *respiratory medicine; and psychiatry of learning disability.* • *Palliative care services provided in a hospital*

Domestic Abuse • *Carers Support Services* • *Health Improvement Services* • *Housing Support Services* *(in Sheltered Housing)* • *Aids and adaptations equipment and telecare* • *Residential care homes/nursing care home placements* • *Care at Home* • *Reablement services Respite and day care*	*patients out-of-hours* • *Community palliative care services* • *Community learning disability services* • *Community mental health services* • *Community continence services* • *Community kidney dialysis services* • *Public health promotion* • *Allied health professionals* • *Community hospitals*	• *Inpatient hospital services provided by GPs* • *Services provided in a hospital in relation to an addiction or dependence on any substance* • *Mental health services provided in a hospital, except secure forensic mental health services* • *Pharmaceutical services*

The following services are currently planned and delivered on a pan-Tayside basis, and are included in the Integrated Functions. The Perth and Kinross Integration Joint Board will host these services on behalf of the other Tayside Integration Joint Boards:

• *Learning disability inpatient services*
• *Substance misuse inpatient services*
• *Public dental services/Community dental Services*
• *General Adult Psychiatry (GAP) inpatient services*
• *Prisoner healthcare*
• *Podiatry*

Current Position

Both NHS Tayside and Perth & Kinross Council have published existing equality outcomes and mainstreaming reports. The equality outcomes for each organisation remain relevant and are noted below.

NHS Tayside Equality Outcomes (Extract from [NHS Tayside's Mainstreaming Report and Equality Outcomes 2017-2021](#))

NHS Tayside currently has four equality outcomes (2013-2017). A decision was taken through the Equality and Diversity Steering Group in December 2016 that NHS Tayside will continue to work on meeting the requirements of the current equality outcomes so further progress can be made for each outcome.

The learning from NHS Tayside and the Equality and Human Rights Commission Section 23 Agreement (2014-2016) requires to be embedded into meeting the objectives of the current equality outcomes, this will allow NHS Tayside to build an infrastructure with robust systems and processes in place for equality and diversity so NHS Tayside can monitor and show continuous improvement in delivering on meeting the current outcomes.

Equality Outcome 1 - We will ensure that care is person-centred and meets the service needs of people with relevant protected characteristic(s).

Equality Outcome 2 – Data Collection and Monitoring Patient Diversity Information

Equality Outcome 3 – Accessible Information and Inclusive Communication

Equality Outcome 4 – Workforce Data Collection and Equality of Opportunity in Employment Policy and Practice

Perth & Kinross Council Equality Outcomes (Extract from [Equalities Outcomes Progress Report](#))

Each service in the Council has a Business Management and Improvement Plan (BMIP) which annually reports on progress and performance, including specific actions which have been progressed to meet one or more of the Equality Outcomes, thus ensuring a fully mainstreamed approach. The responsibility for this lies with lead service equality contacts in each individual service. Additionally, everyone working for, or with Perth & Kinross Council has responsibility for promoting equality of opportunity in their everyday business activity, be it through day-to-day service delivery, strategic planning systems, service support or partnership work.

Equality Outcome 1 – The Council will ensure its services are accessible to individuals and community groups with relevant protected characteristics

Equality Outcome 2 – Individuals and community groups with relevant protected characteristics in Perth and Kinross will have opportunities to participate and influence Council decisions

Equality Outcome 3 – Employees in Perth & Kinross Council will have opportunities to achieve their full potential in an equal opportunity workplace

Equality Outcome 4 – Individuals and community groups with relevant protected characteristics in Perth and Kinross will have opportunities to be involved in community activities and events in the area

There is clearly some correlation between the respective equality outcomes from each organisation and in addition all must satisfy at least one aspect of the General Duty of the Equality Act, 2010, namely:

- *Eliminate discrimination, or*
- *Advance equality of opportunity, or*
- *Foster good relations between communities*

By setting Equality Outcomes for the Health and Social Care Integration Joint Board in Perth and Kinross we have strived to ensure that there is an element of consistency with the existing equality outcomes for each organisation and how they are reported.

Health and Social Care Integration Board Equality Outcomes

Equality Outcome 1 – Health and social care partners will ensure that care is person-centred and services are accessible to individuals and community groups with relevant protected characteristics *(Cross reference to NHS Tayside Equality Outcome 1 and PKC Equality Outcome 1)*

Equality Outcome 2 – Individuals and community groups with relevant protected characteristics in Perth and Kinross will have opportunities to participate in and influence Integration Joint Board decisions *(Cross reference to PKC Equality Outcome 2)*

Equality Outcome 3 – Employees in health and social care partner agencies will have equality of opportunity in employment policy and practice *(Cross Reference to NHS Tayside Equality Outcome 3 and PKC Equality Outcome 3)*

Equality Outcome 4 – Data collected, information provided and communications issued by health and social care partners will be accessible and inclusive *(Cross reference to NHS Tayside Equality Outcomes 2 and 3)*

Equality Outcome 5 – Individuals and community groups with relevant protected characteristics in Perth and Kinross will have opportunities to be involved in community activities and events in the area relevant to the work of the health and social care partnership *(Cross reference to PKC Equality Outcome 4)*

Each of these outcomes will contribute towards the ensuring the overall Health and Wellbeing Outcomes within the Joint Strategic Plan are achieved.

Progress in response to these Equality Outcomes will be reported on an Annual Basis to the Integration Joint Board using an agreed format which evidences the outputs / actions, timeframes, targets or other measurement criteria to address any specific inequalities.

	Equality Outcome 1 – Health and social care partners will ensure that care is person-centred and services are accessible to individuals and community groups with relevant protected characteristics *(Cross reference to NHS Tayside Equality Outcome 1 and PKC Equality Outcome 1)*		
	Context: Many people do not know how to get help from the Partnership. Many people do not know which services the Partnership provides or whether those services are available for them. Many people face barriers such as living in rural areas where transport and internet connectivity may be more difficult to access or because their age may prevent them having access to services. Some communities or individuals may not seek help if information is not available in relevant formats or community languages (for people with disabilities or minority ethnic groups)and may struggle at first point of contact if interpreting support is not available to them.		
	Relevant Strategic Plan Priorities: *Prevention and Early Intervention* *Person centred health, care and support* *Inequality, inequity and healthy living*	***Relevant Protected Characteristics: Age,** *Disability, Gender reassignment, Race, Religion or Belief, Sex, Sexual Orientation*	**Relevant Aspects of General Duty:** *- Eliminate Discrimination* *- Advance equality of opportunity* *- Foster Good Relations between communities*
	Action	**Evidence of Progress (Year 2 update as at 31 March 2018)**	**Delivery timescales and future actions**
PKC	All clients assessed by the Social Work Early Intervention and Prevention team are subject to an individual needs assessment	Client details recorded on SWIFT system	Ongoing
PKC	All staff in the Council have access to Council Guidance and Standards on Translation, Interpreting and Communications in other formats for use as required	Perth & Kinross Council monitor usage of Language Line (telephone interpreting support) and Language Base (face-to-face interpreting/translation support) Main service usage (Housing/Homelessness and Welfare Rights) Main Language usage – Polish, Arabic, Romanian	Ongoing
NHS	To ensure that all staff within the IJB are aware of their responsibilities in relation to identifying and meeting the reasonable adjustment needs of patients with communication requirements.	It is important that all staff know that it is not an option or choice to have an interpreter, but a legal requirement to provide an interpreter to ensure the delivery of fair, equitable and non-discriminatory services for patients that are safe, effective and person centred. NHS Tayside, as part of an ongoing Improvement Plan in relation ensuring achievement with the Equality Act 2010, have progressed the following	Reinforce the key message to all staff who have contact with patients and members of the public, about the importance of staff undertaking and completing the Interpretation and Translation LearnPro module.

pieces of improvement work:

• Development of an Interpretation and Translation LearnPro module (which is highlighted to all staff during corporate induction) and now has a robust monitoring system in place to record the uptake of the Interpretation and Translation LearnPro module. The activity is being reported on a quarterly basis.

• To continue to influence education providers about the importance of interpreting services, ensuring that undergraduate training programmes incorporate learning about interpretation and translation services.

• The NHS Tayside Communications Team has worked with partners across Tayside to explore how a collective message about the importance of securing interpreters is delivered across the population of Tayside. The BSL Act now provides a useful driver to continue to progress this work.

• Further cohorts of Equality and Diversity Champions have been trained. Equality and Diversity Champions have a key role in raising awareness, supporting staff and signposting them to relevant information about interpretation services. There are currently 22 Equality & Diversity Champions in Perth & Kinross HSCP.

| NHS | To ensure that all services within the IJB are able to provide reasonable adjustment needs of patients with communication requirements. | A mapping exercise was completed with staff and service users and an algorithm developed about how to contact Interpretation and Translation Services within NHS Tayside. This algorithm was developed into a Standing Operating Procedure which now forms part of NHS Tayside's Interpretation and Translation Policy. Yellow posters were developed and distributed in all wards, General Practice (GP) surgeries and within community health and primary care services. A survey was sent to Registered Nurses in the community and a follow up survey is planned for September/October 2016 with GP practices to ensure the posters are still being displayed. There are ongoing awareness sessions for staff on Interpretation and Translation Services and on the Interpretation and Translation Policy and its application. | |

| | | Regular audits are undertaken to test staff members' understanding around the content.
Ongoing monitoring will continue through regular auditing with a six monthly audit report which will be monitored and reviewed by NHS Tayside's Interpretation and Translation Operational Group.
Information regarding the Online Relay Service was communicated to all staff. This is available on Staffnet and on NHS Tayside's Facebook page.
Mobile phones are now available and used by staff to communicate by text with the deaf community. | |

	Equality Outcome 2 – Individuals and community groups with relevant protected characteristics in Perth and Kinross will have opportunities to participate in and influence Integration Joint Board decisions *(Cross reference to PKC Equality Outcome 2)*		
	Context: Some individuals or community groups may be under-represented in different parts of the local community and may not have the same opportunity to have their 'voice' heard or understand how they can put their points of view forward.		
	Relevant Strategic Plan Priorities: *Person centred health, care and support* *Inequality, inequity and healthy living* *Work together with communities* *Making the best use of available facilities, people and resources*	**Relevant Protected Characteristics: All*	*Relevant Aspects of General Duty:* *- Eliminate Discrimination* *- Advance equality of opportunity*
	Action	**Evidence of Progress (Year 2 update as at 31 March 2018)**	**Delivery timescales and future actions**
PKC	Undertake consultation events with equalities groups as part of strategy/policy development	Continuation of a Safe Place programme of meetings for adults with disabilities in partnership with Centre for Inclusive Living. 2017/18 sessions focussed on Self-Directed Support; Access to Ambulance services; Access to social care services. Establishment of a new Equalities Governance Structure reporting to the Community Planning Partnership Executive Officer Group - this involved	

		Perth & Kinross Council and NHS Tayside membership of the 2 key groups (Equalities Strategic Forum and Community Equalities Advisory Group)	
		Continued participation in the Multi-Agency Working Group (and associated sub-groups) in relation to migrant workers	
		Continued monitoring of actions in relation to the Gypsy/Traveller Strategy 2013-18 which is currently under review and will be reported to Housing and Communities Committee in May 2018	
		Monitoring of those voluntary organisations which have a Service Level Agreement that work specifically with an equality protected characteristic group	
		Syrian Refugee Multi-agency group established to support new families resettled here. New joint project with Angus Council has just been commissioned to provide community integration support for families.	
		Continued engagement with Perth Islamic Society regarding relocation to new Mosque	
		Us and the Housing Group for people with learning disabilities continues	
		Homeless Voice Group continues	
		Regular tenant participation continues	
		Investment made through the Integrated Care Fund and Carers Information Strategy for development worker to specifically work with minority communities and individuals to provide information and signposting to appropriate services (PKAVS Minority Communities Hub)	

		Community Engagement Workers recruited through PKAVS who are linking with communities across P&K, and this includes minority groups	The feedback feeds into the Strategic Plan.
NHS		Locality participation framework which includes ensuring engagement with minority groups.	Local Action Partnerships now in place

	Equality Outcome 3 – Employees in health and social care partner agencies will have equality of opportunity in employment policy and practice *(Cross Reference to NHS Tayside Equality Outcome 3 and PKC Equality Outcome 3)*		
	Context: As major local employers the Council and NHS wishes to play their part in encouraging a thriving, expanding local economy with suitable employment opportunities and development opportunities for staff and a diverse workforce which reflects the local population.		
	Relevant Strategic Plan Priorities: *Making the best use of available facilities, people and resources*	*Relevant Protected Characteristics: All*	*Relevant Aspects of General Duty:* *- Eliminate Discrimination* *- Advance equality of opportunity*
	Action	**Evidence of Progress (Year 2 update as at 31 March 2018)**	**Delivery timescales and future actions**
PKC	Provision of an employment support service (**Employment Support Team**) which will assist people with Learning Disabilities, Autism, Acquired Brain Injury, or Mental ill Health to access employment opportunities. Percentage of people with LD, MH, ABI, ASD accessing service who become paid PKC employees because of the actions of the service.	9 people (13% of the total number in paid employment)	Ongoing programme
	Percentage of people with LD, MH, ABI, ASD accessing service who take up a PKC voluntary position.	25 People (45% of the total number of people supported in voluntary/work experience) 14 of these people are in projects directly supported by EST such as Working Roots and Green2Go.	
	Ensure equality issues are a key element of staff learning and development programme	**PKC training and events:** Revised Programme introduced January – March	Ongoing programme

2018
Anti-Sectarianism (online abuse)
HIV Awareness
LGBT Awareness
Disability Communications

Immigration, Asylum and Discrimination
Andy's Man Club
Cultural Awareness (South Asian)
Cultural Awareness (Eastern European)

	Equality Outcome 4 – Data collected, information provided and communications issued by health and social care partners will be accessible and inclusive *(Cross reference to NHS Tayside Equality Outcomes 2 and 3)*		
	Context: People who cannot speak English or have limited understanding of English will have access to effective and inclusive communication which will meet their individual needs. Inclusive communication means we will share information in a way that everyone will understand and enable people to express themselves in the way they find easiest. Inclusive communication is written information, online information, telephone and face to face information. *We will provide and publish information in an accessible format that is easy to understand, in different languages, easy to read and in plain language. for all* *The partners will monitor, collect, record and analyse appropriate data on protected characteristics.*		
	Relevant Strategic Plan Priorities: *Person centred health, care and support* *Inequality, inequity and healthy living* *Making the best use of available facilities, people and resources*	**Relevant Protected Characteristics: All*	*Relevant Aspects of General Duty:* *- Foster Good Relations Between communities* *- Advance equality of opportunity*
	Action	**Evidence of Progress (Year 2 update as at 31 March 2018)**	**Delivery timescales and future actions**
PKC / NHS	Ensure internal and external communications are provided in accessible formats if required	We have a Communications Plan which is equality proofed for both electronic and written communications.	Ongoing
	With regards data collected, ensure	Race/Ethnicity is continuing to be collected at above	

race/ethnicity of patient is recorded.	Scottish average and at our bi-annual meeting with Information Services Division (ISD) at NHS National Services Scotland they had no issues around NHS Tayside's ethnicity data collection please see link attached for published report (August 2017).	
Ensure that all patient / client information leaflets and publications are in an accessible format and is made available in different languages.	NHS Tayside has a wealth of healthcare information in printed format. Making this information accessible to people whose first language is not English is important. Some literature is available through NHS Inform and NHS Tayside Board translates information for patients on an individual basis. Three core patient information leaflets have been produced in Polish and BSL (NHS Tayside's top two languages), they are: - Coming into Hospital - Food and Fluids - Going to Theatre. Further leaflets will be agreed based on usage and with input from the deaf and Polish communities. Individual leaflets are translated on request.	
Employment monitoring now includes the protected characteristics of religion or belief and sexual orientation.	Percentage of employees updated their personal details to include religion or belief or sexual orientation since May 2014 - • Religion or Belief – 19.3% Sexual Orientation – 19.4%	Ongoing

	Equality Outcome 5 – Individuals and community groups with relevant protected characteristics in Perth and Kinross will have opportunities to be involved in community activities and events in the area relevant to the work of the health and social care partnership *(Cross reference to PKC Equality Outcome 4)*
	Context: Context: An increased migration to the area in recent years has seen the local population become more diverse. We want everyone to have the opportunity to be fully involved in events and activities which take place in the area

	Relevant Strategic Plan Priorities:	*Relevant Protected Characteristics: All*	*Relevant Aspects of General Duty:*

			- *Foster Good Relations Between communities* - *Advance equality of opportunity*
	Prevention and early intervention *Inequality, inequity and healthy living* *Work together with communities* *Making the best use of available facilities, people and resources*		
	Action	**Evidence of Progress (Year 2 update as at 31 March 2018)**	**Delivery timescales and future actions**
PKC	Co-ordinate annual programme of 'see me' activities (mental health anti-stigma campaign)	The Council committed to the 'See Me In Work' programme in 2017 and an Action Plan is in place	Annual programme
	Co-ordinate multi-cultural events programme in partnership with PKAVS Minority Communities Hub and MECOPP Gypsy/Traveller Carers Project	Annual multi-cultural Events Programme in place: • Diwali • Eid • Chinese Autumn Mooncake Festival • Chinese New Year • Polish St. Nicholas Day • Wellbeing Mela (co-ordinated by Gypsy/Traveller community) • Gypsy/Roma/Traveller Holocaust Memorial Day Exhibition held January 2018	Ongoing programme of events
PKC	Co-ordinate programme of LGBT History month events	LGBT History month programme of community and internal staff events held February 2018	Ongoing programme
PKC / NHS	Co-ordinate minority ethnic community lunch club programme in partnership with PKAVS Minority Communities Hub and MECOPP Gypsy/Traveller Carers Project	Regular programme of activities continues for minority ethnic community lunch clubs programme in place	Co-ordinate minority ethnic community lunch club programme in partnership with PKAVS Minority Communities Hub and MECOPP Gypsy/Traveller Carers Project
	Provision of funding towards the SAINTS (Saints Academy Inclusion Through Sport) Project	Increased sporting opportunities and activities for those with learning disabilities, autism or mental wellbeing issues – ongoing programme.	Ongoing programme

		Now part of St. Johnstone Community Trust also delivering Street Sports and Football Memories (as well as Show Racism the Red Card)	
	Contribute to the Stonewall Good Practice Programme for Public Services	Now part of Stonewall Diversity Champions programme – annually assessed LGBT+ Development Group in place to identify specific actions, improvements, events or initiatives which are required for our LGBT+ community to ensure that our services are inclusive, safe and welcoming for anyone who needs to access them or who live in or comes to visit Perth and Kinross.	Ongoing programme
		Through PKAVS participate in events such as carers and participatory budgeting.	
		TullochNet is a network which offers guidance support to minority groups in the community (particularly those who are vulnerable and those from more deprived areas)	
		Perth and Kinross "Your Community" website.	
PKC		Continuation of a Golf Memories group for adults with dementia which has involved them being able to meet weekly at a Golf Driving Range to hit a golf ball and reminisce	Ongoing programme

1. **IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION**

Strategic Implications	Yes / None
HSCP Strategic Commissioning Plan	
Transformation Programme	
Resource Implications	
Financial	
Workforce	
Assessments	
Equality Impact Assessment	
Risk	
Other assessments (enter here from para 3.3)	
Consultation	
External	
Internal	
Legal & Governance	
Legal	
Clinical/Care/Professional Governance	
Corporate Governance	
Communication	
Communications Plan	

1. **Strategic Implications**

1.1 Strategic Commissioning Plan

This section should set out how the proposals relate to the delivery of the Perth and Kinross Strategic Commissioning Plan

1 prevention and early intervention,
2 person centred health, care and support
3 work together with communities
4 inequality, inequity and healthy living
5 best use of facilities, people and resources

2. **Resource Implications**

2.1 Financial

The Chief Finance Officer must be consulted on all proposals with financial implications. No report with such implications should be presented at a meeting when this has not been done and it should be explicitly stated that the Chief Finance Officer has been consulted, and has indicated agreement with the proposals.

This section should state the specific amount of revenue and capital funding required in the current financial year and the full year effect of any future funding and how that will be met. Detail should be provided of where the financial provision has been made e.g. the Revenue Budget / Capital Programme or a special monies allocation.

All reports should contain clear and unambiguous financial information. It could also be helpful to provide an outline of the budget or overall investment in this area of activity.

2.2 Workforce

The Lead for Human Resources and Partnership Representatives must be consulted on all proposals with workforce implications.

All reports should contain adequate workforce information such as workforce planning issues, skill mix, recruitment and retention, training and development issues.

3. Assessments

3.1 Equality Impact Assessment

Under the Equality Act 2010, PKC and NHS Tayside is required to eliminate discrimination, advance equality of opportunity, and foster good relations between equality groups. Carrying out Equality Impact Assessments for plans and policies allows the HSCP to demonstrate that it is meeting these duties.

This section should reflect that the proposals have been considered under the Corporate Equalities Impact Assessment process (EqIA) with the following outcome:

(i)   Assessed as **not relevant** for the purposes of EqIA
(ii)   Assessed as **relevant** and actions taken to reduce or remove the following negative impacts: (add summary points only here)
(iii)   Assessed as **relevant** and the following positive outcomes expected following implementation: (add summary points only here).

3.2 Risk

This section should set out the key risks associated with the proposals which have not been addressed elsewhere in the report, including any implications for the corporate risk management process, and also the controls required to mitigate those risks as follows:

Risk Description:

Current Rating of Likelihood

Current Rating of Consequences

Actual control level and main control tools

Target control level

Tolerance control level

3.3   Other assessments

The following headings should be included in the report where relevant:

Measures for Improvement – a list of the measures that will be monitored as part of the implementation of the service change

Patient Experience – details of how you intend to improve the experience of hospital and community patients and demonstrate a positive impact that will be measurable.

Health and Safety - Major Health & Safety implications should be included.

Healthcare Associated Inspection - This heading must be included with adequate detail if the report will impact on Healthcare Associated Infection in NHS Tayside.

Benefit Realisation – details of the benefits should be noted here.

Quality – Quality improvements should be included here.

IT – any significant IT implications should be included.

4.   Consultation – Patient/Service User first priority

4.1   External

This section should detail who has been consulted outwith the Partnership in the development of the proposals and the preparation of the report, and also the views of the consultees.

4.2   Internal

This section should detail who has been consulted within the Partnership (other than the statutory officers already mentioned previously), including elected members, in the development of the proposals and the preparation of the report, and also the views of the consultees.

5. **Legal and Governance**

5.1 *The Head of Legal Services must be consulted on all proposals with legal implications. No report with such implications should be presented at a meeting when this has not been done and it should be explicitly stated that the Head of Legal Services has been consulted. Where appropriate, this section should set out clearly set out the legal basis for the proposals*

5.2 *This section should also include details of the Governance arrangements in place.*

6. **Communication**

6.1 *Where appropriate, this section should set out the communications which will be undertaken in implementing the proposals, including the key target audiences and the communication methods.*

7. **BACKGROUND PAPERS/REFERENCES**

This section should list the documents that have been relied on in preparing the report, other than those committee reports already referenced within the main body of the report. All documents must be kept available by the author for inspection by the public for four years from the date of the meeting at which the report is presented.

8. **APPENDICES**

This section should list the appendices to the report.

Health and Sport Committee
Comataidh Slàinte is Spòrs

Technology and innovation in health and social care

Report No. G/18/102

Contents

Health and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport.

http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/health-committee.aspx

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Ash Denham
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Miles Briggs
Scottish Conservative
and Unionist Party

Alex Cole-Hamilton
Scottish Liberal
Democrats

Jenny Gilruth
Scottish National Party

Emma Harper
Scottish National Party

Alison Johnstone
Scottish Green Party

Ivan McKee
Scottish National Party

David Stewart
Scottish Labour

Sandra White
Scottish National Party

Brian Whittle
Scottish Conservative
and Unionist Party

Introduction

1.   At our meeting on 18 April 2017, we agreed to undertake an inquiry into both Technology and Innovation in Health and Social Care.

2.   Digital technology has the potential to change the face of health and social care delivery. We want to find out what is being done to realise that potential and to build a picture of how innovative an NHS we can expect to see in 10 years' time.

3.   We wanted to understand the key opportunities in innovation and the use of technology in health and social care over the next 10 years and the extent to which this will lead to significant change how services are managed and delivered. We had identified that technology and innovation could help deliver a more efficient, responsive and patient-centred health and social care service. We wanted to see progress had been made and what barriers still exist in Scotland and identify potential health and economic benefits.

4.   Our inquiry proved timely, allowing us to consider the Scottish Government's draft digital health and social care vision and look forward to their forthcoming strategy.

5.   We issued a general call for written views seeking views on the successes and failures of existing telecare and telehealth strategies and the opportunities future developments might present. We also wanted to hear about barriers to innovation in health and social care. We received 81 responses in total. SPICe colleagues produced a summary of written responses.

6.   This was followed by oral evidence at three meetings. We heard from stakeholders on 3 October and 31 October and then on 7 November we took evidence from the Cabinet Secretary for Health and Sport.

7.   On 21 November, following the evidence session on 7 November we received a letter from the Cabinet Secretary for Health and Sport providing further information on electronic patient records.

Strategies

8.   Two principal Scottish Government technology strategies have preceded the forthcoming three year Digital Health and Social Care Strategy (The Digital Health and Social Care Strategy), which is expected in spring 2018, and these were of significant interest to us and stakeholders.

Digital Strategy

9.   In March 2017 the Scottish Government published A Digital Strategy for Scotland in March 2017. This aims to "ensure that Scotland is recognised throughout the world as a vibrant, inclusive, open and outward-looking digital nation". It also comments "The Scottish Government will create the conditions which encourage continuous innovation and improvement in our public services".

Health and Social Care Delivery Plan

10. The Scottish Government's Health and Social Care Delivery Plan, published December 2016, noted:

   "Digital technology is key to transforming health and social care services so that care can become more person-centred. Empowering people to more actively manage their own health means changing and investing in new technologies and services, by, for example enabling everyone in Scotland to have online access to a summary of their Electronic Patient Record. The time is right to develop a fresh, broad vision of how health and social care service processes in Scotland should be further transformed making better use of digital technology and data. There is an opportunity to bring together all IT, digital services, telehealth and telecare, business and clinical intelligence, predictive analytics, digital innovation and data use interests in health and social care".

11. Whilst our report focusses on the Scottish Government's Draft Digital Health and Social Care Vision and the upcoming Digital Health and Social Care Strategy the earlier Digital Strategy for Scotland and the Health and Social Care Delivery Plan are integral to the new strategy's success. The Delivery Plan sets out how the Scottish Government aims to transform health and social care services and these themes are looked at in our report. The Digital Strategy for Scotland sets out the foundation for a change that without we will not have the infrastructure to make the desired changes and again the themes run through our report.

12. During the inquiry we found technology in health and social care diverged into two distinct albeit related areas. The first is IT and systems and the need for them to work, and work together. The second area was the use of technology to transform the way medicine is practiced and delivered to patients. This could be through new gadgets that are used in surgery or monitoring devices that can be used by patients at home. Although technology split into two different contexts they are both required to operate an efficient and effective health and social care service. We see both as being required to transform the health and social care service so a move can be made away from secondary care. Innovation permeated through all aspects of the inquiry, whether IT related or fresh ideas on new ways of working.

Success of previous strategies

13.   The following sections of the report will take a brief look back at the successes of the previous strategies. We will then consider the Scottish Government's draft vision for health and social care 2017-2020 and then focus on the forthcoming strategy and what we believe should be included in it.

14.   Many responses to our call for views noted the Scottish Government has been following an appropriate strategic direction and some noted the approach taken in Scotland has received international recognition. [1] The willingness to approach new ways of working and having a strategy for Scotland and not just for the Scottish Government were praised.

15.   Edinburgh Medical School noted the 2014-17 strategy was ambitious, and although some targets had been missed, progress had been made in a number of areas. [2] Chest, Heart and Stroke Scotland noted existing strategies have led to exploration of digital solutions for health and social care services which are particularly valuable in remote or rural communities. [3]

Communication and leadership

16.   Many submissions welcomed the establishment of the Digital Health Institute and the Scottish Centre for Telehealth and Telecare . Improvements in the delivery of national programmes of work were also noted with improved communication, visibility and oversight coming from the e-health Strategy Board.[i] The contribution of the Clinical Change Leadership Group [ii] was also noted.

17.   We heard that previous strategies have supported people to manage their own health and wellbeing and interact with NHS Scotland and their GPs. The Royal Pharmaceutical Society in Scotland commented there have been successes "resulting in improved patient journeys, better use of skills mix and sharing of essential information between health professionals" such as direct referral service for community pharmacists to out of hours and NHS mail. [4]

18.   Many were supportive of the Technology Enabled Care Programme (TEC), which aims to resource evidence-based interventions and develop the infrastructure to implement successful, evidence-based eHealth solutions at scale. Argyll and Bute Health and Social Care Partnership (HSCP) commented the TEC programme has enabled it to try different ways of working including integrating their telecare and home health monitoring service together and testing new technology. [5]

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[i] The eHealth Strategy Board aims to ensure the alignment of eHealth Strategy with key policy statements.

[ii] The Clinical Change Leadership Group (CCLG) was established to bring together senior clinicians from across NHS Scotland, who are involved in eHealth and who provide clinical advice to the national eHealth Programme Board.

Telehealth

19.   Various submissions saw programmes such as the Telecare Development Programme and redesign of NHS inform and NHS24 infrastructures as being successes from previous strategies.

20.   Developments in telehealth/ telecare, video conferencing and virtual clinics were welcomed by many. The benefits of using telemedicine for people living in remote and rural communities, including the islands, were highlighted by Parkinson's UK in Scotland. [6] NHS Dumfries and Galloway highlighted the benefits of telehealth such as reducing staff travel time, patient travel time and improved supervision and support for remote and island clinicians. [7]

21.   Specific examples highlighted to us, were monthly respiratory consultant/specialist nurse virtual clinic consultations between Caithness General Hospital and Raigmore in Inverness [8] and work in Argyll and Bute where obstetrics patients are able to remotely "attend" the consultant clinic and remotely link with their midwife.

22.   Telehealth and telecare were seen by the Royal College of Emergency Medicine Scotland as one way to reduce emergency hospital admissions. They note home monitoring can improve outcomes and decrease hospital admissions for patients with diabetes, hypertension and heart failure and chronic obstetric pulmonary disorder (COPD). [9]

23.   We applaud these initiatives and seek to build upon these in the later part of this report.

Health data and electronic records

24.   Of great interest to us was data recording and the sharing of information.

25.   The Farr Institute, SPIRE (GP data) and the Scottish Health Research Register (SHARE)[iii] were highlighted as developments in health data. The ability (and future) potential to link data at patient level from different sources was seen as a key strength along with the ability to share data across sectors and services.

26.   Advances in data sharing were also recognised. There have also been developments such as access to the Key Information Summary and the emergency care summary and electronic referrals to hospital. The PACS system which centralised x-rays and CT scans was also highlighted.

27.   We note and welcome the changes proposed in the new GP contract to make the GP and health board joint data controllers.

[iii] The Scottish Health Research Register is a register of patients willing to allow their data and spare blood to be used to identify them for research projects and anonymised genetic research.

Draft Digital Health and Social Care Vision 2017-2020

28. In advance of the Scottish Government finalising their Digital Health and Social Care Strategy they have published a draft vision. The draft vision was produced in consultation with a wide range of stakeholders with the intention that general views, ideas and feedback from the vision will help shape the final strategy.

29. The draft vision for the new Digital Health and Social Care Strategy notes:

   "As a citizen of Scotland: I have access to the digital information, tools and services I need to help maintain and improve my health and wellbeing. [10] I expect my health and social care information to be captured electronically, integrated and shared securely to assist service staff and carers that need to see it, and that digital technology and data will be used appropriately and innovatively to help plan and improve services, enable research and economic development and ultimately improve outcomes for everyone." [11]

   The new Digital Health and Social Care Strategy is now due for publication in spring 2018.

30. The draft vision sets out its intentions to:

   • Move from organisational-centred developments and architecture to placing the citizen at the centre;

   • Make better use of data –both health & social care and citizen-generated –for decision support, service delivery, planning and research;

   • Start to develop digital ecosystems around the individual, home & place;

   • Create a permissive culture through improved leadership, workforce development and rebalancing our approach to risk;

   • Foster a fertile environment for innovation and economic growth;

   • Contribute to social care reform and supporting delivery of health & social care integration;

   • Build on what we have, and spreading what works;

   • Use guiding principles such as Citizen-centred; Data-Driven; Flexible; Familiar; Facilitative; Innovative; Safe & Efficient; Open.

Response to the draft vision

31. Our call for views sought responses on how well the Scottish Government's draft vision addresses the future requirements of the NHS and social care sector and whether there were any significant omissions in it.

32.   Justene Ewing[iv] commented the vision is appropriate, realistic and safe but "doesn't address some of the very tough challenges and decisions that need to be made" and is limited in its potential ambition. [12] National Services Scotland thought the vision "appears to take a safe approach and stops short of making any tough decisions about priorities, funding trade-offs, architectural platforms or on the level of convergence required to support transformation objectives". [13]

33.   The Digital Health and Care Institute considered the draft vision was not definitive or strong enough in its wording. They wanted it to address the core barriers and opportunities around data sharing to support real progress over the coming years. [14]

34.   More generally, some considered the vision should also specify how it links to and supports the realisation of the Health and Social Care Delivery Plan and major strategies such as Realistic Medicine.

35.   We pick up some of these general themes in the next section.

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iv Justene Ewing is the former Chief Executive Officer of the Digital Health & Care Institute

Developing the Digital Health and Social Care Strategy

36.   The strategy aims to be person-centred, make better use of data, be innovative and contribute to social care reform.

37.   Our call for views also sought responses on what key opportunities exist for the use of technology in health and social care over the next 10 years, what actions are needed to improve the accessibility and sharing of the electronic patient record, and views on what the barriers to innovation in health and social care are. The following sections look at some of the areas highlighted to us in more detail, and contain our recommendations on what should be covered in the strategy.

The need for a national approach

38.   A number of submissions highlighted to us a disconnect between Scottish Government strategies and local delivery. This was considered by some to have contributed to slow adoption of mobile devices and medical technologies.

39.   Some respondents felt variations at NHS board level hampered the delivery and implementation of the eHealth strategies. The Information Commissioners Office (ICO) noted the implementation of strategies has been impacted by an imbalance of decision making between technical leaders and clinical leaders. [15]

40.   Edinburgh Medical School advised "Different information governance policies across Scotland's 14 health boards has led to a piecemeal approach to implementation. There should be a national IT governance policy". [16]

41.   The Scottish Social Services Council suggested current eHealth and telecare strategies are predominantly clinical and health orientated and would benefit from a greater focus on social service and social care. [17]

42.   We believe there are a number of services which should be delivered from the centre more efficiently, balancing cost and quality, on a "once for Scotland" basis. We consider services which fall into this definition include those which would benefit from:

- simplified and standardised delivery

- increased compliance and consistency

- improved quality of service and support for staff

- improved customer service

- greater opportunities for sharing good practice, skills and expertise

- improved reporting and management information

- cost efficiencies through economies of scale

43. The Scottish Lifesciences Association, commented:

> The current approach leads to siloisation. We are a tiny country. The NHS in Scotland looks after a population that is smaller than that of Yorkshire, and the current approach is not optimal, at least in terms of the uptake of new technology.

Source: Health and Sport Committee 03 October 2017, John Brown, contrib. 238[1]

44. Parkinson's UK noted decisions to release the majority of funding to NHS boards has led to significant inequalities in the provision and coverage of eHealth across the country. [18]

45. We note a disconnect between Scottish Government strategies and local delivery and unwanted variation between NHS boards. We would welcome information on how the Scottish Government intends to move towards a national approach for technology and innovation and information on how this will incorporate social care.

46. We also recommend the Scottish Government takes a "once for Scotland" approach to the implementation of its forthcoming Digital Health and Social Care Strategy. The responsibility for the success of this Strategy lies with the Scottish Government and as such they must take the lead strategic role in its delivery.

Implementation

47. NHS National Services Scotland noted the strategy needs to make explicit choices on "how" delivery will be enabled. They commented it should be clear and be specific around IT infrastructure/platform strategy, digital patient engagement, internal digital workplace, data analytics, research/academic support, new innovation and integration, IT/eHealth workforce. [19]

48. Scottish Health Innovations Ltd explained it would be useful for the vision to include a narrative of how it is going to be actioned both internally and externally. [20]

49. The ALLIANCE advised the lack of a business plan to support the implementation of previous eHealth strategies has hindered the delivery these strategies. They gave an example from the previous strategy of an aim for at least 90% of GP practices to offer online booking of appointments and repeat prescription ordering by 2017. However, there was no detailed plan to accompany this and it appears in the absence of any measurements this target will not be met. [21]

50. The Scottish Government in evidence to the Committee acknowledged the absence of an implementation plan for the previous strategy. They confirmed that its intention was to have a national governance group for its forthcoming Digital Health and Social Care Strategy. Geoff Huggins, Director for Health and Social Care Integration at the Scottish Government detailed this group would monitor implementation of the strategy according to clear milestones. [22]

51.   We are pleased to hear there is an intention to include an implementation plan within the strategy. This is essential to ensure progress is made in delivering technology and encouraging innovation within health and social care.

52.   We recommend the implementation plan include proposals on how delivery of the areas noted above by NHS National Services Scotland will be met.

Engagement

53.   Meaningful engagement with all stakeholders is a necessary requirement for any successfully strategy. We were therefore disappointed this was a criticism of previous strategies.

54.   The Royal Pharmaceutical Society in Scotland noted a lack of communication and engagement with all relevant stakeholders was a failure in existing strategies. [23] The Mental Health Foundation commented there needs to be considerable work to create a more enabling policy environment for NHS and allied staff. They also note patient and clinical engagement remains low. [24]

Person-centred

55.   The draft vision intends a move from organisational-centred developments and architecture to placing the citizen at the centre.

56.   We were advised most were supportive of the aspirations in the draft vision around placing the citizen at the centre and various suggestions were made about who should be involved. Chest, Heart and Stroke Scotland note the draft vision needs to reflect a move towards care in the community, supported self-management and more effective communication between sectors and professionals. [25]

57.   We heard there needs to be more reference to patient and citizen groups and involvement of people with lived experience. Concerns were raised by medConfidential and the Open Rights Group that the vision statements fail to position the individual at the centre of the NHS. They believe that a truly person-centred approach would be to empower patients to control their own information. [26]

58.   Mydex CIC commented that the "Scottish Government's strategy and Parliament's legislation continue to take an organisation-centred approach to health and care". [27]

59.   Whilst we agree a person-centred approach is required we are clear of the need to ensure identifiable medical data is always protected from commercial use.

60.   NHS National Services Scotland noted other perspectives need to be considered including those from health and care delivery organisations and from enterprise, research and innovation organisations. [28]

61.   We were advised the role of the independent sector and carers should be considered along with more reference to social care and third sector. The Care Inspectorate noted:

> It is not just about ICT systems that are in use in health boards, or indeed in the 31 integration authorities. There are some 4,000 individual care service providers for adults across Scotland, and those organisations are commissioned by integration authorities but are not part of integration authorities.

Source: Health and Sport Committee 31 October 2017, Rami Okasha, contrib. 39[2]

62. The ALLIANCE echoed the need for a person-centred approach, advising that people who access the services also need to be at the heart of the process. They believe this results in solutions being identified that address real rather than perceived needs. [29]

63. The importance of co-design of services is an issue that has been raised with us in other inquiries we have conducted. In both our reports Looking ahead to the Scottish Government Health and Sport Draft Budget 2018-19: A call for greater transparency and Are they involving us? Integration Authorities' engagement with stakeholders we raised concerns about lack of engagement by integrated joint boards with their stakeholders.

64. We noted:

> Stakeholders are not embedded in decision-making processes across all IAs and at all stages in determining the approach taken to delivering local services. This must be improved.

Source: Are they involving us? Integration Authorities' engagement with stakeholders

65. Engagement is required for the successful implementation of any strategy. We note the vision seeks to place the citizen at the centre and expect the Scottish Government to engage with all relevant stakeholders, including service users, clinicians and the social care sector. We would welcome details on how Government plans to develop their engagement strategy and how they are going to ensure the citizen is at the centre from conception to implementation.

66. We believe it is imperative a person-centred approach should empower patients to control their own information, including how this is used. We would welcome information on what action the Scottish Government is taking to allow people control of their own information.

67. With the move to integration authorities and a vision for a move to community based care it seems both logical and imperative that a single information governance system must include social care organisations and hospices. Can the Scottish Government advise how they intend this to happen?

Leadership and Innovation

68. We heard of a need for more focused and firmer leadership to drive change. NHS National Services Scotland commented that leadership is required, at all levels, which fosters a true co-design/co-production environments and breaks down the

barriers between organisations and budgets. [30] Diabetes Scotland note there has been a lack of forward planning at both national and health board level. [31]

69. During evidence we were advised by the Scottish Government of the creation of a new role - the Chief Clinical Information Officer. They advised the role "will be the pinnacle of how we disseminate standard practice and try to get this once-for-Scotland approach deployed in a truly once-for-Scotland way." [32]

70. The Cabinet Secretary for Health and Sport further advised:

> The chief clinical information officer will be, if you like, at the pinnacle of driving these changes forward; they will play a strategic role in driving the strategy forward and making sure that there is pace to its delivery.

Source: Health and Sport Committee 07 November 2017, Shona Robison, contrib. 37[3]

71. The proposal to have a Chief Clinical Information Officer/ Clinical Director of eHealth was welcomed by NHS NSS. [33]

72. The new role of a Chief Clinical Information Officer seems to be a positive step forward. We would be grateful if the Scottish Government could provide further information on the role including, how many posts will be created, how the post will operate in relation to lines of accountability and where the post will sit within the NHS.

Culture and Trust

73. Another issue raised by witnesses during discussion of the future strategy was the suggestion there may be cultural barriers to the successful development and implementation of a new strategy.

74. The Royal College of Emergency Medicine noted "innovation is most often characterised by creativity, lack of scale and significant risk of failure. This means individuals must be encouraged and empowered to be innovative and failure must be tolerated, and indeed welcomed, as integral to ultimate success". [34]

75. The Care Inspectorate commented there appears to be reluctance and resistance in some partnerships to adopt technological innovations. [35] This was also identified by Alzheimer's Scotland who considers there is cultural resistance within partnerships to embrace technology and innovation to support and facilitate patients who want to use technology enhanced care to self-manage their long term conditions. [36]

76. The Mental Health Foundation also noted a pervasive risk adverse culture which they believe represents a real barrier for new technologies. [37] NHS National Services Scotland advised "we should be comfortable with failure as not everything will evaluate successfully through an innovation process". [38]

77. Scottish Health Innovations Ltd believes existing strategies have "missed the opportunity to effectively promote innovation as a core activity within NHS Scotland and recognise the entrepreneurial talent within our health service and the drive of innovation from within". [39]

78. During this inquiry we have heard of a reluctance to adopt new ways of working in the NHS, with staff worried about reprisals should they fail or worse, in some instances, for simply challenging the established order. We believe it is essential the new strategy encourages and empowers risk taking. This is the only way real change in the way technology and innovation is viewed, rolled-out and accepted will occur. Can the Scottish Government advise how the strategy will encourage a more enterprising spirit and innovative culture in the NHS and social care towards technology and innovation and encourage widespread acceptance and uptake?

79. Clinician buy-in is essential to the success of any new technology or innovation. Given this can the Scottish Government please advise how they plan to ensure such buy-in both with the development and delivery of the strategy?

Lack of scaling up

80. We were advised there is currently a lack of a strategic approach to technology and innovation within the NHS and social care. Issues were raised with us around the adoption and spread of new technologies, in particular medical devices.

81. A key theme which emerged in evidence related to difficulties scaling-up new technologies and rolling out projects across Scotland. The issue appears to be one of limited uptake of technology enabled health and social care initiatives and a lack of deployment at scale.

82. Highland and Island Enterprise noted "to date there has been a low level of large scale innovative technology deployment and commercial return within the NHS. It is generally accepted technology is widely available and is not a barrier. The challenge is to provide better access and progression for SMEs through the commercial, procurement, health economics and eHealth phases to enable scalable deployment within the NHS". [40] This view was echoed by PA Consulting and Crohn's and Colitis UK .

83. The Royal College of GPs Scotland commented it is often the case best practice is not developed and adopted across the board whilst Community Pharmacy Scotland advised innovative projects do not often get scaled up beyond board level despite being clearly suitable for national roll out. [41]

84. NHS National Services Scotland believes there is not enough focus on scaling up and widespread adoption and they commented there would be benefits of allowing a default "opt-out" position rather than a default "opt-in" when successful innovations are identified. [42]

85. Perth and Kinross HSCP noted "at times there has been a lack of clear direction from the centre. With too many people trailing, piloting or conducting tests of change and not much seems to be collated and rolled out as a national initiative". [43]

86. The Royal College of Emergency Medicine (RCEM) commented there has been limited uptake of technology enabled health and social care initiatives. [44] This view was echoed by South Lanarkshire HSCP who stated that lack of deployment at scale and programmes demonstrating best practice/ outcomes have not been advanced/ adopted widely. [45]

87. Edinburgh Medical School commented that telecare has been shown to be effective in the management of congestive cardiac failure and diabetes but progress in implementing technologies for these conditions have been limited and patchy. [46]

88. Strathclyde Institute of Medical Devices commented "I think we are very bad at implementing our own technology in Scotland". [47] Professor Thuemmler[v] added "what is lacking is a comprehensive policy approach in Scotland…we have a very difficult process for trialing such new technologies and implementing them, and that has economic implications". [48]

89. We note in the NHSScotland's Chief Executive Annual Report 2017-18 an example of innovation and technology:

> An example of the potential for remote monitoring is provided by NHS Lanarkshire. A 90-day test of change ran from March-May 2016...The study demonstrated that remote monitoring of blood pressure improves efficiency and supports clinical decision-making. Most people find it easy to use and would use it again if required. Fifteen months after the 90-day test started, the pathways remain intact with around 1,000 patients benefiting in total. A further analysis of the 820 patients who had used the service estimated that the number of clinical contacts avoided was over 3,200.

> Source: NHSScotland Chief Executive's Annual Report 2016-17 pg 36

90. The report provides an excellent example of good innovation and technology in the NHS showing the possibility of freeing up a great deal of clinicians time. However, it does not indicate whether this successful pilot was rolled-out elsewhere.

91. One of the other reasons suggested for the lack of scaling-up was that at present any new technology or innovation requires to be adopted on a board by board basis - 14 or 22 times.

92. We were disappointed to hear of the difficulties encountered when scaling-up new technologies and rolling out projects across Scotland. We would welcome information on how the Scottish Government envisages the shift to a national strategic approach.

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v Prof Christoph Thuemmler is a Professor at Napier University, Edinburgh

> 93. Under a "once for Scotland" approach we recommend a default "opt-out" position when successful innovations are identified, as suggested by NHS National Services Scotland.

Medical Devices

94. New medical devices were a specific area where the issue of lack of scaling up was raised. A small number of new devices go through an assessment with the Scottish Health Technologies Group (SHTG) however once approval is granted it is up to the developer to go to each NHS board to sell this.

95. Scottish Lifesciences Association stated:

> Even if a company has SHTG endorsement or a big green tick from the innovative medical technology assessment, it still has to sell most products board by board.
>
> Source: Health and Sport Committee 03 October 2017, John Brown, contrib. 289[4]

96. NHS National Services Scotland advised:

> A new piece of technology is normally picked up by clinicians. If a national organisation is involved, technology has a better than average chance of being adopted, but governance of the adoption of new technology is, by default, at the board level.
>
> Source: Health and Sport Committee 03 October 2017, Andy Robertson, contrib. 230[5]

97. We were also made aware that even once a device has been adopted by the NHS there were still issues in the deployment of the device. Scottish Lifesciences Association advised:

> Where we find a barrier is after that, even when the NHS has bought a new device. We have specific examples of that barrier; in one case, NHS procurement bought 30,000 devices that were better for patient outcomes and cheaper than existing products, but then they were put in a warehouse in Lanarkshire and there was silence.
>
> Source: Health and Sport Committee 03 October 2017, John Brown, contrib. 179[6]

98. We were told the innovation support landscape is confusing for innovators from the third and private sectors. The Alliance advised there was a need to join up and demystify the innovation support landscape. They commented it could be difficult for innovators to understand and navigate the landscape so they can identify and apply for relevant funding/support for their innovation. [49]

99. Justene Ewing noted "there has been no recognition of the process of adoption and scaling of digital health and care solutions" she goes on to suggest that there should be "one front door to innovation through organisations like NSS". [50] NHSNSS also noted there is a "lack of a named body accountable for the rapid scaling up of successful innovative technologies". [51]

100. Having heard the need for a central body with responsibility we were surprised to hear the following from Strathclyde Institute for Medical Devices that although it had produced a full business plan for a National Centre for Medical Technology this had not been implemented. It explained that the Scottish Enterprise and the Scottish Funding Council had: "declared a lack of funds available for this sector". Strathclyde Institute for Medical Devices added that the "response from Scottish Enterprise to Medtech Sector needs has been directed mainly at increasing exports not investment in the innovation pipeline." [52]

101. A further issue that was suggested as adding to the problems with embedding technology in the NHS was clinician buy-in. We were advised that even if a product has gone through assessment and shown to be cost reducing if clinicians did not want to adopt the technology it would not happen.

102. Strathclyde Institute of Medical Devices advised:

> I have to say that we tend to get kick-back from front-line clinical people. That is partly because digital medicine, e-health and personal monitoring are very challenging. They challenge both the clinician and the patient—and they monitor both, too. If a community group tries to introduce something without having a mandate for doing so and several nurses in the group do not want to use it, it will never be adopted. There will be no uniformity, and it will be very difficult for that group to get the business change mechanism.

Source: Health and Sport Committee 03 October 2017, Professor Connolly, contrib. 203[7]

103. Scottish Lifesciences Association agreed clinician buy in was a barrier at present:

> There are two barriers, one of which is called clinician autonomy: the doctor can take the decisions that she or he thinks are the right ones for the patient, no matter what. You might say, "This new way of doing it is much better and it costs half as much", but the doctor might say, "That doesn't matter. This way works, I know it works and I am not going to change my mind." That is not an insurmountable barrier, but you have to know that it is there in order to work out how to get past it.

Source: Health and Sport Committee 03 October 2017, John Brown, contrib. 264[8]

104. The majority of those who gave evidence believed having some level of national strategic approach to the commissioning and distribution of new technology would help alleviate these issues, with the Scottish Government having a level of oversight. Witnesses felt such oversight and guidance would help boards understand the benefits of new technology and how it could benefit them. It was also believed national guidance would ensure parity in boards and for patients across the country.

105. Professor Thuemmler noted:

> In my opinion, what is lacking is a comprehensive policy approach in Scotland

Source: Health and Sport Committee 03 October 2017, Professor Thuemmler, contrib. 178[9]

106. Scottish Health Innovations Ltd noted:

> Attacking this more at national level might lift some of those barriers.

Source: Health and Sport Committee 03 October 2017, Elaine Gemmell, contrib. 200[10]

107. We were pleased the Scottish Government recognised this issue and agreed a national approach was required. The Cabinet Secretary for Health and Sport advised:

> we need to move away from doing things 14 or—if we include the national boards—22 times. We need to move from board-level implementation towards a once-for-Scotland national system. We are looking at how we do that and the implementation plan will set that out, but it may require the Government to do more from a strategic point of view, and that may mean that we hold more of the resources in order to be able to do that on a once-for-Scotland approach.

Source: Health and Sport Committee 07 November 2017, Shona Robison, contrib. 11[11]

108. Another way it seems possible to help the adoption and spread of medical devices would be to have this included in a strategy. We understand a group was set up by the Scottish Government in 2016 to devise a Medical Devices Strategy for NHS National Services Scotland[vi]. We understand that work was undertaken with IRIC, SHTG and industry representatives, although a strategy has not yet been published.

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109. The introduction and implementation of proven medical devices appears to be over complicated. We would welcome information on the medical devices strategy and whether it will be incorporated into the digital health and social care strategy.

110. We would also welcome information on what consideration the Scottish Government has given to the establishment of a central body to co-ordinate technology and innovation.

Funding

111. In a time of tight finances, some were concerned by the lack for funding of technology and innovation. Concerns around investment and resources were raised. There is a need for both funding and a cohesive Scottish wide framework. The dispersion of eHealth finances to local level was considered by some to have made it difficult to direct the necessary finance/resource at larger projects and the separation of budgets and lack of integration/ co-ordination was believed to have resulted in siloed services.

112. Tensions have also been identified between routine activities and innovation. The Digital Health and Care Institute notes the "eHealth leads have operational responsibility for maintaining a complex set of legacy systems. The strategies and

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vi file:///C:/temp/
Sara%20Davies%20Development%20of%20a%20Medical%20Device%20Strategy%20(1).pdf

developmental work around digital health and care place an unrealistic demand on this group to lead and progress next generation digital infrastructure, when they are barely resources to maintain the status quo". [53]

113. NHS National Services Scotland advised "we put 2 per cent of our NHS revenue into IT, but the US, where Apple and some of the bigger companies are, is at 6 per cent and above. In general, we are struggling to keep the lights on with the complexity that we already have. Innovation brings another layer that will need to be funded and supported from a change management point of view". They went on to further note "It [funding] inevitably needs to increase... We are at the stage at which you have to invest more in IT to get returns in your business. That is not to say that the NHS has to spend more, but I think that we have to spend more on technology and innovation in order to fund the service transformation that has to take place. [54]

114. Parkinson's UK in Scotland note "In addition to wider funding issues in the NHS, there are major issues with funding for technological support." [55]

115. The Scottish Partnership for Palliative Care commented there is "often insufficient resources to manage periods of transition from old ways of doing things to new ways (e.g. where there is a time lag between investment required to innovate and eventual payback/saving)". [56]

116. The Scottish Government also advised some details on the proposed funding process for the strategy:

> 🔳 We are re-prioritising existing spend in order to be more effective with that and, if more spend is required to deliver the strategy, we will set that out as part of the budget process.
>
> Source: Health and Sport Committee 07 November 2017, Shona Robison, contrib. 53[12]

117. In relation to funding and the need for budgetary control changes to implement any change Scottish Lifesciences Association noted:

> 🔳 One idea with which we have toyed is that boards should be given, dare I say it, an aspiration—I will not use the word "target". Somehow or other, the adoption and spread of innovation should be part of what boards are expected to do and, if they do not do it, questions should be asked. At the moment, that does not really happen.
>
> Source: Health and Sport Committee 03 October 2017, John Brown, contrib. 264[8]

118. We have concerns about the absence of financial information on how the strategy will be funded. We recognise spending will require some re-prioritisation, however it seems clear that initially additional transformational funds will be required. We recommend a financial framework accompanies the strategy and would be grateful if the Scottish Government would advise how it intends to fund transformation.

University collaboration

119.   Collaboration with Universities is common in many fields however we heard this link
has not been used as extensively as the sector would like in relation to innovation
and technology.

120.   Professor Theummler advised

> We need to somehow build those collaborations with the skills that we have in
> Scotland. We have excellent universities with departments that have skills that
> could be more than useful to development and implementation but we are not
> making enough use of those skills and resources that we have. It is important
> that we bring together the resources and skills that we have in Scotland to
> manage the processes.

Source: Health and Sport Committee 03 October 2017, Professor Thuemmler, contrib. 263[13]

121.   The Strathclyde Institute of Medical Devices believed there was a need for better
funding of university collaboration, advising:

> I would ensure that the innovation pipeline from university through to the NHS
> is properly funded, as the university end, in particular, is neglected.

Source: Health and Sport Committee 03 October 2017, Professor Connolly, contrib. 297[14]

122.   Collaboration with universities, and other organisations outwith the NHS, can only
enhance knowledge and production of technology and innovation. We would be
grateful if the Scottish Government would advise its approach to enhancing and
delivering such co-operation.

Data Sharing

123.   As well as the issue of development and implementation of technology a central
strand to our inquiry was the huge variation in the systems for recording data within
NHS Scotland. For example, mental health, primary care and maternity services
use different programmes to record and access patient information.

124.   Probably without exception in every inquiry and piece of work we have undertaken
the sharing of data has been raised as both a barrier and an impediment. From
prisons to pharmacists, from GPs to emergency care we have heard about the
inability to share data. Frustrations are widespread across health and social care,
many based on peoples understandings of lack of understandings of data protection
rules.

125.   A common ask was for all registered health professionals directly involved in patient
care to have appropriate read and write access to a patient's health record and that
any new digital strategy enables appropriate information sharing. The Royal College
of GPs Scotland note there has been a "real failure" to move on from the continued
use of multiple incompatible systems and various platforms used across the NHS.
For example, GP systems are not compatible with those used by district nurses". [57]

126. During our inquiry into Healthcare in Prisons a constant theme was concerns about the IT system used in prisons. Virtually every person we spoke to and many submissions highlighted concerns about the lack of a comprehensive clinical information system providing access to records. Provision in prisons was described as being "not fit for purpose".

127. The Information Commissioners Office (ICO) cautioned that access by third parties to the patient record must be on a need to know basis with each request justifying why access is necessary. Consideration must be given as to whether the patient is to be contacted at each such request to provide their consent or whether one of the other conditions for processing is to be relied upon.

128. However, it should also be noted the ICO advised during oral evidence:

> That the legislative framework is set up to allow for the free movement of personal information. A lot of our work in Scotland, particularly in health, involves saying to people, "Can you share? Yes, you can." The Data Protection Act 1998 is a framework for safe and secure sharing of information; it is not the barrier that a lot of people think that it is.

Source: Health and Sport Committee 31 October 2017, Maureen Falconer, contrib. 26[15]

129. We heard that linking and access to information systems remains a key issue for most front line staff. We also heard problems with developing electronic records and data sharing. It was noted, despite improvements in secondary care, progress in sharing data is still slow and lags well behind most industrial countries.

130. The Care Inspectorate commented it is the norm that health staff do not have access to individuals' social care records and vice versa. They note social work and social care staff "constantly express the profound hope that health and social care integration and the creation of Health and Social Care Partnerships would generate significant improvements in joining access to records and electronic information sharing generally". [58]

131. The Royal College of Emergency Medicine noted the Scottish Government has a significant opportunity to improve patient record sharing across health and social care systems. They believe integrating all NHS systems will allow NHS professionals to provide patients with appropriate care and after care in a timely fashion and improve communication and the integration of services. [59]

132. Chest Heart and Stroke Scotland noted the full integration of health and social care needs underpinning by the joining up of data between (and within) the two systems and better recognition of the role the third sector plays in providing health care and support. [60]

133. Justene Ewing agreed and believes:

> Access to data and the information governance issues must be addressed, with inconsistent and often misaligned understanding of the 'rules' creating distinct disadvantages in progressing innovation and the ability to enable deep and meaningful insight across the system which empowers leadership teams and professionals to deliver deeply enhanced outcomes and for patients to experience significant improvements in outcomes [61]

134. Whilst many of the issues arose from concerns around data protection some of them were as a result of systems in different areas of health and social care not being compatible or direct access to all not provided.

135. For example, the Royal College of Emergency Medicine explained that in Ayrshire they had only received access to the portal system in the past 12 months whilst Glasgow had had access for some time before this. They explained in an emergency department it was "invaluable to have access to the most up-to-date clinicians' opinions, the emergency care summary and the KIS. It is much faster and that is better. Has everywhere that needs it got it? Not everywhere has." [62]

136. The Royal Pharmaceutical Society of Scotland advised:

> Pharmacists can access the emergency care summary, but they have to do it through NHS 24; there is no direct access even though that has been promised since 2014. We have to phone NHS 24 to gain access and often there are extra phone calls, which cost extra time. We have lobbied for a long time on that point.

Source: Health and Sport Committee 31 October 2017, Aileen Bryson, contrib. 42[16]

137. The Digital Health and Care Institute commented that guidance only goes so far. They go on to note "other governments have mandated and resourced more comprehensive common data exchange and integration approaches that have allowed them to accelerate beyond Scotland when it comes to realising the benefits of broader data sharing". [63]

Interoperability

138. We were advised there was a view current strategies have failed to create NHS wide interoperability standards which would allow the seamless integration of a large number of devices and allow larger patient autonomy. Justene Ewing noted there has been limited success in relation to interoperability and the current strategy fails to recognise the emerging consumer digital health markets and the ability to make use of the data and information many citizens have readily available within their own control. [64]

139. We did hear interoperability of systems does not necessarily stop data sharing. The Care Inspectorate advised:

> ...the lack of interoperability does not prevent effective systems from being put in place to support access to those systems for different professionals, and there is some evidence of examples where that is working, although I appreciate that that is a workaround, rather than a solution to the problem.

Source: Health and Sport Committee 31 October 2017, Rami Okasha, contrib. 39[2]

140. Strathclyde Institute of Medical Devices commented that underpinning IT systems hampers professionals from exchanging information with ease, creating a healthcare system that is fragmented and inefficient. [65]

141. Problems with interoperability between health and social work were also raised by the Care Inspectorate and Argyll and Bute HSCP.

Emergency care and other summaries

142.   The national Emergency Care Summary (ECS) system was rolled out nationally in 2006. It has several distinct components, with a degree of overlap. Current medication and allergies information is uploaded from all NHS Scotland GP IT Systems into ECS. ECS content is made available to many emergency, unscheduled and out-of-hours teams covering a range of scenarios.

143.   The electronic Palliative Care Summary was rolled out in 2010 as an extension of ECS. Palliative Care information is contained as a distinct section of a patient's ECS record.

144.   The Key Information Summary (KIS) was rolled out in 2013 as a further extension of ECS. The KIS dataset contains information including a patient's demographics, medical history, current situation, Self Management Plan, Anticipatory Care Plan, resuscitation preferences, Preferred Place of Care, and Palliative Care arrangements. Again, KIS information is contained as a distinct section of a patient's ECS record.

145.   Anticipatory care plan (ACP) information is also included in the KIS section under "Special Notes" and coded information.

146.   Access to the ECS and the additional components vary. Some people can access the ECS but cannot access the ACP. This is clearly a barrier to the delivery of good timeous care and to the continuity of care.

147.   The Scottish Government's existing eHealth strategy 2011-2017 highlights the importance of palliative care, the ePCS and the KIS in supporting the sharing of key information from anticipatory care plans. The vision was to ensure everyone who needs an ePCS or KIS, has one in place and accessible by the right people at the right time to support a patient's care wishes.

148.   We heard detail about the number of systems rolled out, it would appear in a piecemeal fashion, in the last 10 years and equally of the failure to provide access to key personnel for each of them. This, alongside repeated failures to provide promised access, paints a sorry picture of the approach to IT that has been taken.

149.   For example we were astonished to learn about the lengths pharmacists have to go to to access vital perhaps lifesaving information. The Royal Pharmaceutical Society of Scotland advised they can only access the emergency care summary through NHS24 and if they wish to access the portal to check a patient record they must have the patients permission. This is not always possible if a relative or carer collects the prescription. [66]

150.   It is worth noting the Welsh Assembly Government announced they will give Welsh community pharmacists access to the Welsh GP records from April 2018 and that English community pharmacists have had access to the Summary Care Records since June 2015.

151.   MND Scotland highlighted the need for District Nurses and allied health professionals to be given access to upload information into the eKIS. [67]

152. Not only can independent Scottish hospices not link with NHS IT systems but these hospices have rolled out electronic patient record systems that are all slightly different. [68]

153. We note Commitment 7 of the Scottish Government's Strategic Framework for Action on Palliative and End of Life Care states: "We will improve the ways that information is recorded and shared by seeking to ensure that the requirements for future e-Health systems support the effective sharing of individual end of life/ Anticipatory Care Planning conversations and care preferences, while also addressing the need for improvement in the systems that are currently used".

Read and write access to records

154. The need for read and write access to patient records was highlighted to us. It was said access was required across the health and social care arena. Areas particularly highlighted to us were community pharmacy, out-of-hours services, social care settings and hospices.

155. The lack of read and write access to a patient's electronic health record by community pharmacists is seen as an "urgent patient safety concern" by the Royal Pharmaceutical Society in Scotland. [69]

156. Marie Curie noted any future system that effectively manages anticipatory care planning information needs to include patient access, read and write access for all professionals who need it including social care, out of hours staff, care homes, hospices and district nurses with robust data protection and governance safeguards. [70]

157. The interoperability of IT systems is both essential and fundamental if the Scottish Governments draft vision is to be achieved. We were disappointed to learn that the portal has not been rolled-out across all health boards. The strategy must ensure all systems held by all parts of the health and social care sector are interoperable and we would welcome detail of the timescale to achieve this.

158. We recommend any cross-cutting technology, if it is to effectively join up health and social care, must include the social and community care sector and hospices and would expect to see this in the strategy.

159. We were disappointed prisons have been omitted from ongoing IT developments for the wider NHS and recommended this was now addressed and rectified as a matter of urgency. Can the Scottish Government please confirm if prison IT will be included in the new strategy?

160. Can the Scottish Government advise if they anticipate any legal barriers to making systems interoperable and the timescale to deliver this?

Single platform

161. We heard various examples of how data could be shared effectively, however the most repeated was the suggestion of a single platform or central spine. The Digital Health Institute Scotland highlighted international examples of good practice from Estonia, Finland, Galicia and Holland. They believe Scotland could learn from these countries and that there are tangible actions that could be taken. They commented on the principle of creating data once and using a central bridge or spine (using the example of xroad) and believe that this approach would have big savings in terms of time and resources. [71]

162. Argyll and Bute HSCP believe there would be significant benefits from the procurement and development of a single platform nationally that will link to and communicate with existing systems. [72]

163. NHS 24 commented that the ideal state would be a single source record, accessible by the individual and shared across the NHS. [73] This view was echoed by Strathclyde Institute of Medical Devices. [74] South Lanarkshire HSCP commented that a national portal would be useful which was used across primary and secondary care to ensure real time access to patient records by relevant health and social care professionals. [75]

164. The Digital Health and Care Institute agreed with a central spine idea, advising:

> Other countries have adopted the principle of creating data once; they say, "You can have your own data base, your own system and your own software package"—so there can be huge diversity—"as long as you share it in a central bridge." There is one bridge, and everyone has to connect to that bridge. That is a technical solution that is entirely feasible now
>
> Source: Health and Sport Committee 31 October 2017, Chaloner Chute, contrib. 122[17]

165. The Digital Health and Care Institute went on to advise:

> DigitalHealth.London has done it across all the trusts in London; there is one bridge, to which everyone connects. That includes patients—the patient can connect to the bridge, see who is looking at their data and withdraw consent if they feel that someone is misusing their data or using it in a way that is not in line with their wishes. That is the patient empowerment, citizen rights and data protection win.
>
> Source: Health and Sport Committee 31 October 2017, Chaloner Chute, contrib. 124[18]

166. We were pleased to hear the Scottish Government were working with the idea of a single platform for data:

> The big question is how quickly we can move to that new style of architecture—you described it as a spine or a platform, and that is a good way of understanding it. The building blocks of such systems are in place in other industries and other businesses, but it takes time to build the architecture...In effect, there will be a two-part process. The first part is to build the new platform and the second is to work across the system to bring the data and the existing systems there safely on to it.

Source: Health and Sport Committee 07 November 2017, Geoff Huggins, contrib. 48[19]

167.   We agree the best way forward for data sharing is through a single platform, or spine, for data that other systems connect into and we note witnesses and the Scottish Government are in agreement. Can the Scottish Government advise whether it has had discussions with other countries regarding the use of a single platform?

168.   Can the Scottish Government advise what work is being undertaken to procure such a system and when they anticipate it will be functional?

Ownership and control of data

169.   Another linked area that came up repeatedly through our inquiry was the ownership health data and whether there was an opportunity for this to be owned by the individual. At present data is generally held by GP practices, with the GP as the data controller. The Information Commissioner's Office advised:

> The NHS has formally set up GP practices as data controllers, which makes them the legal entity with regard to the personal information that they use and process in any shape, manner or form.

Source: Health and Sport Committee 31 October 2017, Maureen Falconer, contrib. 73[20]

170.   We heard there is variation across the country in terms of who GPs will share information with. Some are happy to share with colleagues in community pharmacies but not with out-of-hours services. Others won't share with anyone. This is rightly perceived as a public safety issue. The Royal College of Emergency Medicine Scotland noted:

> Every single GP out-of-hours system in Scotland cannot access the data for that practice's patients, which is just insane. An out-of-hours GP goes to see a patient and cannot find out anything about them, so they do the safest thing, which is probably to admit them to hospital. Out-of-hours services cannot even access care.

Source: Health and Sport Committee 31 October 2017, Dr Chung, contrib. 40[21]

171.   The Information Commissioner's Office advised:

> we will tell GP practices and so on that they can share, by and large. The issue is all about proportionate and appropriate sharing to the appropriate person and looking to the data protection framework to be allowed to do that. Too often, that approach is seen as too hard; people do not understand it. Consent is seen as the be-all and end-all; people will say, "If I don't have consent, I can't do anything with this information and I can't share it." That could not be further from the truth.

Source: Health and Sport Committee 31 October 2017, Maureen Falconer, contrib. 73[20]

172. One suggestion we heard many times was the idea that citizens owned and controlled their own data. The Digital Health and Care Institute noted "The data controller should be the citizen". [76]

173. Argyll and Bute HSCP noted the importance of having a person facing system allowing individuals access and ownership to their own health and care records. With the added ability for people to enter their own health monitoring data which could be shared with health professionals.

174. The Royal College of Emergency Medicine Scotland also believe data should be owned by the individual, and highlighted that patients are often surprised that clinicians in emergency departments do not have access to their records:

> I say that we should be more radical and let the patient own their own data. The patients already think that we know everything about them. They come to an emergency department and say, "It's all in my record, doctor." We have to say, "We don't know what's in your record. We don't know anything." They think that we are joking, or that we are lazy and do not want to look, because they are used to information about every other aspect of their life being shared...If we gave a patient options and said, "Do you want a smart card with your data on?" lots of people would take it. They would say, "I know where my records are and then I can give it to you and you will know where my records are."

Source: Health and Sport Committee 31 October 2017, Dr Chung, contrib. 40[21]

175. Many people identified individual access and control of data as a powerful way of assisting behaviour change and an area where improvements could be made, with the Royal Pharmaceutical Society in Scotland noting patients wanted more access to their own health records and health information. [77]

176. The Scottish Government were in agreement with the Royal College of Emergency Medicine Scotland that patients expect health professionals to have their data, noting:

> Most patients would expect health professionals to have enough information about them to share in order to deliver the best-quality care for them, and I think that most patients would not have an issue with that.

Source: Health and Sport Committee 07 November 2017, Shona Robison, contrib. 47[22]

177. The Scottish Government also agreed with the proposal for citizen owned data. They advised:

> The starting point of the work that we do is that the individual owns their own data. However, the situation is complicated, because the NHS in some shape or form or other bodies will be the data controller...We think, therefore, that one of the key components of transformation is not only putting the person front and centre in the strategy but prioritising the use value of data for individuals, because once people are able to use their data, they will manage their health in a different way. Indeed, that has been the experience in all other areas. We therefore agree with the proposition that you have highlighted.

Source: Health and Sport Committee 07 November 2017, Geoff Huggins, contrib. 65[23]

178. In line with witnesses we believe that citizens are best placed to own their own data. We recommend that the strategy provides information on the actions the Scottish Government is taking to move closer to this position and the timescales for its delivery.

179. We understand any change to data control will not happen overnight. Can the Scottish Government advise what work will be done with GPs to ensure they are aware of the correct rules under data protection in relation to proportionate and appropriate data sharing?

Procurement

180. A significant barrier to innovation in health and social care highlighted to us related to existing procurement procedures. NHS National Services Scotland commented the biggest barriers to widespread adoption were traditional models of IT procurement along with resistance to co-design and co-production. [78]

181. CONSARD Ltd commented NHS Scotland currently lacks an explicit intent and provision within national procurements to support the emergence of more localised solutions adapted to local clinical priorities and governance structures. [79]

182. Alzheimer's Scotland stated the current procurement framework disadvantages more bespoke technologies from being provided where they are not being bought in large numbers by commissioning bodies. [80]

183. It was noted by the Scottish Lifesciences Association "The fact that much NHS procurement is "siloised" in boards. This leads to situations where, even if a board does buy an e-health system from a Scottish company, there is no assurance that other boards will do so, despite the advantages of a uniform approach. There is an urgent need to implement a "once for Scotland" procurement process for e-health and other products and services". [81]

184. The Scottish Government noted it was working to resolve this issue:

> 🔸 I think that we have mentioned previously to the committee the procurement challenges that we face. The minute that we scale things up, it becomes tougher...However, we are now able to take things forward more efficiently by doing things once, through having single contracts with software and hardware suppliers. Sharing things is certainly how we want to proceed.

Source: Health and Sport Committee 07 November 2017, Graham Gault, contrib. 56[24]

185. We note the challenges highlighted and the Scottish Government approach of doing things once and hope this will remove many of the concerns we heard about. We trust this new approach to procurement covers all aspects raised with us while retaining a necessary degree of local flexibility in appropriate circumstances and look forward to confirmation particularly around the challenges of co-design and co-production.

Evaluation

186. We heard from a number of submissions that the success of the existing Scottish Government's strategy is extremely difficult to measure and quantify. Professor Theummler noted there are only experimental implementations and no standard applications that can be evaluated with health economic tools. [82] Others commented that no clear performance indicators were specified and the strategies should require to quantify and demonstrate improved outcomes. It was also suggested that clear evidence of positive outcomes and benefits realisation should have been made mandatory

187. We were pleased to hear from the Scottish Government this will be addressed in the new Strategy:

> 🔸 Yes, they will be measured. I am a firm believer in having milestones. We do not start off by saying, "We're going to go from there to there, and we'll see if we get there in five or 10 years' time". We need to plot a course and have milestones—where we expect to be in a year's time in terms of infrastructure, systems and governance—and to plot a course based on very clear milestones and the outcomes that we expect to achieve along the way.

Source: Health and Sport Committee 07 November 2017, Shona Robison, contrib. 55[25]

188. When giving evidence to the Committee the Cabinet Secretary for Health and Sport indicated "I see no reason why we could not produce a yearly report either to the Committee or to the Parliament if that would be in line with your thinking". [83]

189. We note the concerns raised around the scaling up and implementation of new and successful innovation and technology and the Scottish Government's intention to have clear milestones for the strategy.

190. We welcome the Scottish Government's commitment to having clear milestones for the strategy. We believe that at the outset the Scottish Government must include performance indicators to quantify and demonstrate improved outcomes.

191. We look forward to seeing the implementation plan and look forward to receiving updates on the delivery of the strategy, as offered by the Cabinet Secretary for Health and Sport. We would hope our report will assist in the development and scope of such a plan.

Conclusion

192. When we agreed to carry out this inquiry we thought we would be investigating ways of modernising the health and social care sector through the use of modern and ground-breaking technology and innovative and fresh ways of working. We expected to hear many stories of cutting-edge technology making dramatic changes in the way the sector works. We did not expect to hear of a culture that was reluctant to adapt new ways of working and where innovation is not encouraged and heavily out-dated IT systems still cause major barriers.

193. It is no surprise that in a system where decisions are made on a board by board basis that there is little leadership on technology and innovation. Often the boards or specialities that show strength in technology and innovation are only by a clinician who has a personal interest. This cannot continue. The Scottish Government must take ownership and ensure the nature of the NHS changes to welcome new and innovative ways of working. Only by having a "once for Scotland" approach can any meaningful changes happen.

194. It is no longer acceptable in this age that our health service is still using multiple incompatible systems and various platforms. In all our work we have heard repeated concerns around data sharing and interoperability. Nurses, pharmacists, allied health professionals, social care services, primary care services, prison health services and more all highlighting the fact they do not have timely access to relevant health records. This is an area the Scottish Government must tackle urgently to ensure appropriate medical care can be given in the right place at the right time. Work must be done to update systems so they can interact, whilst work must also be carried out to ensure data protection requirements and opportunities to share data are better understood.

195. We were also disappointed to hear of slow uptake in the use of technology in the sector. The public obviously has an appetite for new technology - the global market for wearable technology is forecast to grow to around six billion U.S. dollars by 2018. [84] People are wearing technology that can track their movements and record their heart rate on an increasingly frequent basis. The NHS and social care sector should be embracing and using this type of technology more.

196. The uptake of technology in the NHS that offers remote monitoring and new, time and cost saving ways of working seems very slow and inconsistent. This seems surprising when people so readily use such equipment in their personal lives for health and other areas such as banking. More must be done by the Scottish Government to increase the use of technology across NHS boards and social care. This cannot be left to be agreed on a board by board basis. Such a piecemeal process leads to increased variation in health outcomes across Scotland. We expect the use of technology should also lead to a reduction rather than an increase in health inequalities.

197. We believe the new strategy provides an opportunity for the Scottish Government to lead the way and radically develop the way technology is used in the NHS and

social care. It also presents an opportunity to ensure innovation in health and social care flourishes and that Scotland is a leader and is not left behind. It is essential the Scottish Government is bold and offer strong leadership on how and when this will be achieved.

Annexe A - Minutes of meeting

4. Technology and Modernisation in the NHS (in private): The Committee considered and agreed its approach to the inquiry.

3. Technology and Innovation in Health and Social Care: Neil Findlay and Brian Whittle made a declaration of interest, the full details of which can be viewed in the Official Report of the meeting.

The Committee took evidence, in a round table format, from—

- Alex Matthews, Digital Health and Social Care Lead, Scotland, PA Consulting;

- Professor Christoph Thuemmler, Edinburgh Napier University;

- Zahid Deen, Digital Health and Care Strategic Lead, Health and Social Care Alliance Scotland (the ALLIANCE);

- Elaine Gemmell, Head of Project Management, Scottish Health Innovations Ltd;

- Professor Patricia Connolly, Director, Strathclyde Institute of Medical Devices;

- John Brown, Director of Policy, Scottish Lifesciences Association; and

- Andy Robertson, Director of IT, NHS National Services Scotland

5. Technology and Innovation in Health and Social Care (in private): The Committee considered the evidence heard earlier in the meeting.

1. Technology and Innovation in Health and Social Care: The Committee took evidence, in a round table format, from—

- Professor Brian McKinstry, Professor of Primary Care eHealth, University of Edinburgh;

- Dr Juliet Spiller, Consultant in Palliative Medicine, Scottish Partnership for Palliative Care;

- Rami Okasha, Executive Director of Strategy and Improvement, Care Inspectorate;

- Stephen Whiston, Head of Strategic Planning and Performance, Argyll & Bute Health and Social Care Partnership;

- Dr David Chung, Vice President, Royal College of Emergency Medicine Scotland;

- Aileen Bryson, Practice and Policy Lead, Royal Pharmaceutical Society Scotland;

- Chaloner Chute, Chief Technology Officer, The Digital Health and Care Institute; and

- Maureen Falconer, Regional Manager Scotland, Information Commissioner's Office

4. Technology and Innovation in Health and Social Care (in private): The Committee considered the evidence heard earlier in the session.

25th Meeting, 2017 (Session 5), Tuesday 7 November 2017

1. Technology and Innovation in Health and Social Care: The Committee took evidence from—

- Shona Robison, Cabinet Secretary for Health and Sport, Geoff Huggins, Director for Health and Social Care Integration, Scottish Government, and Graham Gault, General Manager, Information and Communications Technology, NHS Dumfries and Galloway and Head of eHealth, Scottish Government.

3. Technology and Innovation in Health and Social Care (in private): The Committee considered the evidence heard earlier in the session.

3rd Meeting, 2018 (Session 5), Tuesday 23 January 2018

5. Technology and Innovation in Health and Social Care (in private): The Committee considered a draft report and agreed to consider a revised draft at its next meeting.

Annexe B - Evidence

Written evidence

- TINN001 Kelly Coote

- TINN002 PA Consulting

- TINN003 Bernadette Bell

- TINN004 Brian Griffiths

- TINN005 Michelle Duffy

- TINN006 Professor Christophe Thuemmler

- TINN007 Ideas for Ears

- TINN008 MS Society Scotland

- TINN009 CONSARD Ltd

- TINN010 Edinburgh Medical School

- TINN011 Audit Scotland

- TINN012 Marie Curie

- TINN013 British Dental Association

- TINN014 Chest Heart & Stroke Scotland

- TINN015 Scottish Partnership for Palliative Care

- TINN016 Care Inspectorate

- TINN017 Mental Health Foundation

- TINN018 Alzheimer Scotland

- TINN019 Roche Diagnostics Ltd

- TINN020 medConfidential and Open Rights Group

- TINN021 Argyll and Bute Health and Social Care Partnership

- TINN022 Scottish Social Services Council

- TINN023 The Health and Social Care Alliance Scotland (the ALLIANCE)

- TINN024 Perth and Kinross Health and Social Care Partnership

- TINN025 MND Scotland

- TINN026 Smart Energy GB

- TINN027 Mydex CIC

- TINN028 Scottish Council on Deafness

- TINN029 Highlands and Islands Enterprise

- TINN030 Royal College of Emergency Medicine

- TINN031 Scottish Health Innovations Ltd

- TINN032 Ieso Digital Health

- TINN033 Tactical Wireless Ltd

- TINN034 Macmillan Cancer Support in Scotland

- TINN035 JDRF

- TINN036 Strathclyde Institute of Medical Devices at the University of Strathclyde

- TINN037 Arthritis Research UK

- TINN038 NHS Education for Scotland

- TINN039 NHS24

- TINN040 Scottish Lifesciences Association

- TINN041 Crohn's and Colitis UK

- TINN042 Glasgow City Health and Social Care Partnership

- TINN043 RCGP Scotland

- TINN044 InterSystems

- TINN045 Scottish Care

- TINN046 Royal College of Nursing Scotland

- TINN047 Royal Pharmaceutical Society in Scotland

- TINN048 National Pharmacy Association

- TINN049 Tunstall

- TINN050 Diabetes Scotland

- TINN051 NHS National Services Scotland

- TINN052 Open University

- TINN053 Community Pharmacy Scotland

- TINN054 East Lothian Health and Social Care Partnership

- TINN055 Information Commissioner's Office

- TINN056 Patients Know Best

- TINN057 Digital Health and Care Institute

- TINN058 Parkinson's UK in Scotland

- TINN059 NHS Dumfries and Galloway

- TINN060 Justene Ewing

- TINN061 BT Scotland

- TINN062 Collaborative response from the health professions working in primary care

- TINN063 Anonymous 1

- TINN064 Stirling Council

- TINN065 NHS Greater Glasgow and Clyde

- TINN066 Healthcare Improvement Scotland

- TINN067 Carers Trust Scotland

- TINN068 South Lanarksire Health and Social Care Partnership

- TINN069 BMA Scotland

- TINN070 NHS Orkney

- TINN071 British Healthcare Trades Association Scotland

- TINN072 Reform Scotland

- TINN073 Bill Buchanan

Additional Written Submissions

- Health and Social Care Alliance Scotland (the ALLIANCE)

- Scottish Lifesciences Association - Innovation Centres

- Scottish Lifesciences Association - Adoption and spread of new technologies

- Professor Christoph Thuemmler

- Scottish Partnership for Palliative Care

- Strathclyde Institute of Medical Devices

- Scottish Health Innovations Ltd

- Scottish Health Technologies Group

- Cross Party Group on Inflammatory Bowel Disease

- Letter from the Cabinet Secretary for Health and Sport

Official Reports

- Tuesday, 3 October - Roundtable evidence from stakeholders

- Tuesday, 31 October - Roundtable evidence from stakeholders

- Tuesday, 7 November 2017 - Evidence from Cabinet Secretary and officials

[1]   Health and Sport Committee 03 October 2017, John Brown, contrib. 238,
http://www.scottish.parliament.uk/parliamentarybusiness/report.aspx?r=11133&c=2029538

[2]   Health and Sport Committee 31 October 2017, Rami Okasha, contrib. 39,
http://www.scottish.parliament.uk/parliamentarybusiness/report.aspx?r=11166&c=2034622

[3]   Health and Sport Committee 07 November 2017, Shona Robison, contrib. 37,
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[4]   Health and Sport Committee 03 October 2017, John Brown, contrib. 289,
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[5]   Health and Sport Committee 03 October 2017, Andy Robertson, contrib. 230,
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[6]   Health and Sport Committee 03 October 2017, John Brown, contrib. 179,
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[7]   Health and Sport Committee 03 October 2017, Professor Connolly, contrib. 203,
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[8]   Health and Sport Committee 03 October 2017, John Brown, contrib. 264,
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[9]   Health and Sport Committee 03 October 2017, Professor Thuemmler, contrib. 178,
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[10]   Health and Sport Committee 03 October 2017, Elaine Gemmell, contrib. 200,
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[11]   Health and Sport Committee 07 November 2017, Shona Robison, contrib. 11,
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[12]   Health and Sport Committee 07 November 2017, Shona Robison, contrib. 53,
http://www.scottish.parliament.uk/parliamentarybusiness/report.aspx?r=11182&c=2037277

[13]   Health and Sport Committee 03 October 2017, Professor Thuemmler, contrib. 263,
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[14]   Health and Sport Committee 03 October 2017, Professor Connolly, contrib. 297,
http://www.scottish.parliament.uk/parliamentarybusiness/report.aspx?r=11133&c=2029597

[15]   Health and Sport Committee 31 October 2017, Maureen Falconer, contrib. 26,
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[16]   Health and Sport Committee 31 October 2017, Aileen Bryson, contrib. 42,
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[17]   Health and Sport Committee 31 October 2017, Chaloner Chute, contrib. 122,
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[18]   Health and Sport Committee 31 October 2017, Chaloner Chute, contrib. 124,
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[19] Health and Sport Committee 07 November 2017, Geoff Huggins, contrib. 48,
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[20] Health and Sport Committee 31 October 2017, Maureen Falconer, contrib. 73,
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[21] Health and Sport Committee 31 October 2017, Dr Chung, contrib. 40,
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[23] Health and Sport Committee 07 November 2017, Geoff Huggins, contrib. 65,
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[24] Health and Sport Committee 07 November 2017, Graham Gault, contrib. 56,
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1   PA Consulting, Roche Diagnostics and Justene Ewing written submissions

2   Edinburgh Medical School written submission

3   Chest, Heart and Stroke Scotland written submission

4   The Royal Pharmaceutical Society in Scotland written submission

5   Argyll and Bute Health and Social Care Partnership written submission

6   Parkinson's UK in Scotland submission

7   NHS Dumfries and Galloway written submission

8   Michelle Duffy written submission

9   Royal College of Emergency Medicine written submission

10   Digital Health and Social Care Strategy 2017-2020 - Wellbeing

11   Digital Health and Social Care Strategy 2017-2020 - Improving services

12   Justene Ewing written submission

13   NHS National Services Scotland written submission

14   Digital Health and Care Institute written submission

15   Information Commissioner's Office written submission

16   Edinburgh Medical School written submission

17   The Scottish Social Services Council written submission

18   Parkinson's UK in Scotland written submission

19   NHS National Services Scotland written submission

20   Scottish Health Innovations Ltd written submission

21   The ALLIANCE written submission

22   Health and Sport Committee Official Report, 7 Nov 2017

23   The Royal Pharmaceutical Society in Scotland written submission

24   The Mental Health Foundation written submission

25   Chest, Heart and Stroke Scotland written submission

26   medConfidential and the Open Rights Group written submission

27   Mydex CIC written submission

28   NHS National Services Scotland written submission

29   Health and Sport Committee Official Report 3 Oct 2017

30 NHS National Services Scotland written submission

31 Diabetes Scotland written submission

32 Health and Sport Committee Official Report 7 November 2017 COL 8

33 Health and Sport Committee Official Report 3 October 2017

34 Royal College of Emergency Medicine written submission

35 The Care Inspectorate written submission

36 Alzheimer's Scotland written submission

37 The Mental Health Foundation written response

38 NHS National Services Scotland written response

39 Scottish Health Innovations Ltd written submission

40 Highlands and Islands Enterprise written submission

41 RCGP Scotland and Community Pharmacy Scotland written submissions

42 NHS National Services Scotland written submission

43 Perth and Kinross Health and Social Care Partnership written submission

44 The Royal College of Emergency Medicine written submission

45 South Lanarkshire Health and Social Care Partnership written submission

46 Edinburgh Medical School written submission

47 Health and Sport Committee Official Report 3 October 2017 COL 27

48 Health and Sport Committee Official Report 3 October 2017 COL 27

49 The ALLIANCE written submission

50 Justene Ewing written submission

51 NHS National Services Scotland written submission

52 Strathclyde Institute of Medical Devices written submission

53 The Digital Health and Care Institute written submission

54 Health and Sport Committee Official Report 3 October 2017 COL 40-41

55 Parkinson's UK in Scotland written submission

56 The Scottish Partnership for Palliative Care written submission

57 RCGP Scotland written submission

58 Care Inspectorate written submission

59 Royal College of Emergency Medicine written submission

60 Chest Heart and Stroke Scotland written submission

61 Justene Ewing written submission

62 Health and Sport Committee Official Report 31 Oct 2017

63 The Digital Health and Care Institute written submission

64 Justene Ewing written submission

65 Strathclyde Institute of Medical Devices written submission

66 Health and Sport Committee Official Report 31 Oct 2017

67 MND Scotland written submission

68 Health and Sport Committee Official Report 31 October 2017 COL 12

69 The Royal Pharmaceutical Society in Scotland written submission

70 Marie Curie written response

71 Digital Health and Care Institute written submission

72 Argyll and Bute Health and Social Care Partnership written response

73 NHS24 written submission

74 Strathclyde Institute of Medical Devices written submission

75 South Lanarkshire Health and Social Care Partnership written submission

76 Health and Sport Committee Official Report 31 October 2017 COL 15

77 The Royal Pharmaceutical Society in Scotland written submission

78 NHS National Services Scotland written submission

79 CONSARD Ltd written response

80 Alzheimer's Scotland Ltd written submission

81 Scottish Lifesciences Association written submission

82 Professor Christoph Thuemmler written submission

83 Health and Sport Committee Official Report 7 November 2017 COL 17

84 https://www.statista.com/statistics/302482/wearable-device-market-value/

NHS Tayside

ANNUAL REPORT FOR VOLUNTEERING IN NHS TAYSIDE

2017   **Report No. G/18/103**

Tracey Passway, Clinical Governance and Risk Management Team Lead

1. Introduction and Summary

This is an annual report for volunteering in NHS Tayside. NHS Tayside is committed to volunteering with around 1,000 volunteers providing a range of roles across acute services, in community settings and in people's homes. Well-embedded governance arrangements are in place for volunteering with a Volunteering Policy which was updated this year, a forum for Voluntary Services Managers to meet, a consistent process for recruiting volunteers and an agreed framework for evaluating the service. Plans for moving forward have been directed by recent publications including 'Realising Realistic Medicine' (Scottish Government, 2017) and 'A National Clinical Strategy for Scotland (Scottish Government, 2016), also Government directives such as the response to the publication of Kate Lampard's report for the Department of Health: Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile (Department of Health, 2015).

2. Facts and figures in NHS Tayside

NHS Tayside has 858 'registered' volunteers on the national electronic Volunteer Information System (VIS) who are recruited directly by NHS Tayside to provide a variety of roles across acute services, in community settings and in people's homes. There is a natural turnover of volunteers, 87 applications are in progress, with currently 27 awaiting placement. In addition there are other volunteers who are not registered on VIS who support NHS Tayside including Public Partners, and volunteers who are registered with volunteer organisations such as the Royal Voluntary Service, the Chest Heart and Stroke Association, and the British Red Cross.

NHS Tayside is open to involving volunteers from a wide range of backgrounds, and provides additional support, including mentoring and peer support, as required. The diversity of the volunteer team is monitored through information routinely collected on gender, age, sexual orientation, disability, ethnicity and religion. This mechanism will identify any action required on the part of underrepresented groups, although at present it is felt that the composition of the volunteer team is relatively close to that of the local community.

From returned forms over the period October 2016 – August 2017 156 volunteers were recruited by NHS Tayside. 124 (79%) are female with 32 (21%) being male. For females, the highest proportion of volunteers comes from the 20-29 age group. For males, the highest proportion is by far the 60+ age group. A significant proportion of females (15%) are under 20 years of age and 22% are aged 20-29.

The number of volunteers within NHS Tayside who consider themselves to have a disability is 9 (6%) - 6 long-term illness, 1 sensory impairment, 1 learning disability and 1 other.

Volunteers described their ethnic origin as 88% of white origin, 6% Asian origin and 3% of black origin.

2.1 Volunteer Roles

There are a diverse number of roles for volunteers across NHS Tayside. Some of these are shown below. Volunteers complement the work of staff and are not used as a substitute for paid work.

Drivers	Peer support workers	Tai Chi
Breast feeding support	Spiritual care support	Art therapy
Complementary therapists	Craft sessions	Befrienders
Tea/coffee trolleys	Administration	Hand massage
Meaningful activities	Health information	Health Fund Shop
Welcoming/way finding	Obtaining feedback	Public Partners

2.2 Voluntary Service Managers

Seven Voluntary Service Managers (VSMs), who are employed by Tayside NHS Board, support Volunteering across Tayside.

VSMs within the Health and Social Care Partnerships are increasingly working with their social care colleagues who also have volunteer remits, and all VSMs are also linking more closely with third sector voluntary organisations.

Voluntary Service Managers receiving the Investing in Volunteers Award, left to right:

Alan Gibbon, Senior Chaplain
Susan Hamill, VSM
Tracey Passway, Clinical Governance and Risk Management Team Lead
Derek McFarlane, VSM
Linda O'Neill, VSM
Karen Thomson, VSM
Jane Laahs, VSM
Val Ewan, VSM
(Jimmy Orr, VSM, absent)

2.3 Where Volunteers Are Placed

858 registered volunteers are supported by 7 Voluntary Service Managers (VSMs) and other staff, with management responsibility for volunteers, across acute services, each of the three Health and Social Care Partnerships, primary care and also Roxburghe House and Cornhill McMillan Centre. These VSMs support volunteers, staff and service managers and promote volunteering services across NHS Tayside.

369 volunteers are registered within Dundee, including Ninewells Hospital, Kings Cross Community Centre, Armistead, Royal Victoria Hospital, Roxburghe House, Glenlaw House, Kingsway Care, Dundonald Day Centre, Carseview Centre, Young People's Unit and Strathmartine Centre.

158 volunteers are registered within Perth and Kinross, including Perth Royal Infirmary, the Community hospitals, Cornhill McMillan Centre and the community.

272 volunteers are registered within Angus, and provide support within Stracathro Hospital, the MacMillan Daycare centres, Arbroath Community Hospital and Whitehills Community Centre.

65 volunteers are registered within 'NHS Tayside'; these volunteers provide roles Tayside wide including the Spiritual Care volunteers and breastfeeding buddies. There are 33 Public Partners.
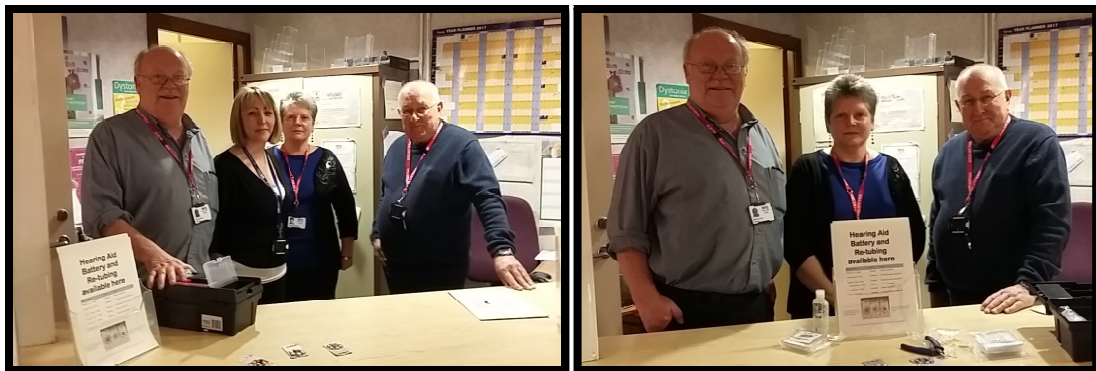
NHS Tayside Health Shop Volunteers

2.4 Spiritual Care Volunteers

NHS Tayside Department of Spiritual Care offers volunteering within the hospital setting as well as within GP surgeries throughout NHS Tayside. There are currently 13 volunteers working in an inpatient setting with 15 within GP Surgeries. In Dundee volunteers have also been utilised to facilitate peer to peer volunteer support, leading to groups. Five volunteers are currently waiting to be placed and 13 are in training. Training for volunteers working in an inpatient setting has been reviewed in 2017, and volunteers have been part of that review process and in the future will be more actively involved in the support of new volunteers.

2.5 Young Volunteers

Younger people continue to come forward to volunteer looking for insight and experience of being involved in busy NHS environments. Volunteering can help improve communication and listening skills, self confidence and enable young people to meet new people and learn new skills. Young volunteers often volunteer to: support university applications; enhance CVs or improve employment prospects. NHS Tayside warmly welcomes the input of young people which undoubtedly enhances the experience for patients and families and supports staff.

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2.6 Public Partners in NHS Tayside

Volunteers within NHS Tayside also include people who contribute to participation and engagement agendas. In particular these include the NHS Tayside Public Partners. Supported by the Public Involvement Team, these are people who give freely of their time to contribute to the development and planning of service changes. Whilst not providing a service, they are supported with induction and training in line with participation standards.

2.7 Volunteer Drivers

Volunteer drivers play an essential part of healthcare provision across Tayside. Roxburghe House in Dundee provides on average 100 single drives for patients per week. This is one aspect of volunteering that the NHS does rely on. For many people if they had to pay to attend appointments the costs would preclude them from accessing health services and compromise their health, particularly for services like dialysis or cancer therapies, when patients need to attend the hospital 3 or 4 times per week. If transport costs were provided by statutory services the costs would be phenomenal.

NHS Volunteer Drivers in Angus provide on average 48 single drives each week to Macmillan Day Care Centres. Voluntary Action Angus volunteer drivers now provide transport to hospital appointments for patients who cannot use public transport and have no alternative way of getting to their appointment; this service was previously provided by NHS volunteers.

The team of drivers within Perth and Kinross provide a valuable service throughout rural Perthshire for some of the most vulnerable patients thus enabling them to attend community support projects, hospital appointments, Anxiety Management and Psychiatry of Old Age group therapy sessions. During the recent interviews for the Investing in Volunteers re-accreditation drivers were happy to highlight the positive impact their voluntary involvement with local health services has on them.

Volunteers drove in excess of 16,000 miles taking patients to and from Day Care and for Cornhill Macmillan Centre appointments alone.

2.8 Peer Support Volunteering

Work has been ongoing this year to progress peer support volunteering in NHS Tayside. Three services have been prioritised: Renal, Parkinson's and Mental Health. There was already a well established breast feeding buddy support service which has expanded further in 2017.

2.9 Breast Feeding Peer Support

The Health Promoting Health Service (HPHS) and Maternal and Infant Nutrition Framework (MINF) require NHS Tayside to implement a breastfeeding peer support programme. Since 2007 a breastfeeding peer support buddy programme has been established which recruits, trains and supervises volunteers and complies with Investing in Volunteers (IiV) standards.

In April 2017 a Perth & Kinross volunteer co-ordinator was appointed, funded by NHS Tayside Community Innovation Fund and MINF, to help support Facebook enquiries and to establish and support breastfeeding groups in the community. 16 new volunteers have been recruited and trained and three new breastfeeding groups have been established in Perth & Kinross. This is an innovative approach to supporting local communities to support local mothers with breastfeeding.

5

In Dundee 10 new breastfeeding peer supporters were recruited in 2017 and trained to provide support to breastfeeding mothers in the postnatal ward in Ninewells Hospital. A closed Facebook page is also supported by the trained volunteers, offering out of hours support to breastfeeding mothers.

In Angus 4 breastfeeding peer supporters have been trained who provide on-line peer support via a closed Facebook page.

2.10 Renal Buddy Volunteers

This role, which was established several years ago, has provided an invaluable service to renal patients. The number of active volunteers has depleted and it was decided to re-launch the service. In partnership with the renal nurses and existing volunteers the role was reviewed. Information about the revival of the role was shared at the renal patient conference earlier in the year. A number of those attending were interested in hearing more about the role and becoming a Renal Buddy. An information afternoon brought around 15 people together to do this and a number of them are now going through recruitment and training.

2.11 Parkinson's Buddy Volunteers

In partnership with the national charity Parkinson's UK in Scotland, a Parkinson's nurse and a person with Parkinson's, a volunteer role has been scoped out. Initial work was done to establish the value of such a role. People with Parkinson's and their carers responded by saying they would value having someone to talk to about the condition at various times. To date 2 volunteers have come forward to be part of the pilot group. Recruitment and necessary training is now progressing. The initial pilot will run for 6 months then be reviewed. It is hoped to also recruit a volunteer who is a carer during the pilot. Providing support by both people with Parkinson's and their carers to people with Parkinson's and their carers will provide an all round enhancement to the service. Training for both of these initiatives will take place early in 2018.

2.12 Mental Health Peer Support Recovery Volunteers

In collaboration with Dundee Voluntary Action and the Scottish Recovery Network progress is being made to enhance support from mental health peer support recovery volunteers within inpatient settings, see section 5.3. The role of peer support recovery volunteers was raised at the Cross Party Group for Volunteering held in the Scottish Parliament and forms part of the current Mental Health and Learning Disability Service Redesign Transformation Programme; both local and strategic approaches are being taken to progress volunteering within mental health services.

2.13 Patient Feedback Volunteers

NHS Tayside currently has students volunteering to obtain feedback from patients after they have been discharged, over the telephone, and share this with clinical teams. There are currently 15 patient feedback volunteers covering 15 inpatient wards across Ninewells and Perth Royal Infirmary to collect feedback. The wards are finding this feedback invaluable and having an enthusiastic and committed volunteer to collect this has ensured the feedback is available and collected on a routine basis. Improvements wards have made in response to feedback have been reducing jargon when talking with patients; giving time for patients to clarify plans for when they leave hospital; checking in with patients to ensure they and their families are aware of, understand and feel involved in the decisions about their care and treatment.

6

Also in 2017, spiritual care volunteers supported NHS Tayside to test methods of obtaining patient feedback from patients with cognitive impairment. There were seven methods that were used during the testing phase and the volunteers participated in refining the methods and tools by initially testing them in community support groups for people with cognitive impairment. The results of these tests have been integral to shaping how to ensure feedback is effectively obtained from patients who are seldom heard.
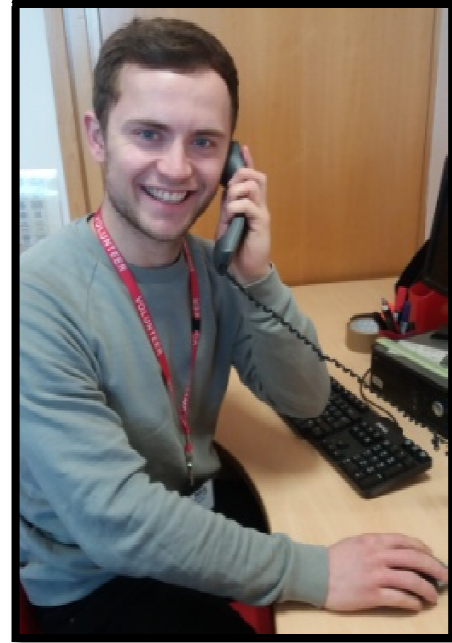
Patient Feedback Volunteers

2.14 Ninewells Gift Shop

The Gift Shop at Ninewells is run by volunteers on behalf of Tayside Health Fund. Presently the Gift Shop has 19 volunteers; many have supported this for a number of years. The Gift Shop is open 10am – 4pm Monday to Friday. The Gift Shop Facebook page provides up to date information on what is available in the shop. A table outside the shop is available and donations of used books are on sale. This year to date the shop has made approximately £30,000.

A section has been introduced on the Staffnet pages under Hot Links – Fundraising and Donations. Staff can access information about the gift shop and volunteering there.

Ninewells Gift Shop, Level 9

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2.15 Health Shop

The Health Shop in Ninewells Hospital opened in 1995 to provide relevant and easily accessible information in an informal and non-threatening atmosphere. The role of staff and volunteers within the Health Shop is to respond to requests for health promotion and disease management information which helps people to make healthier choices for themselves. Staff and volunteers are able to signpost to local and national organisations and sources of support to help people manage their condition and be better supported for everyday challenges. The Health Shop also provides a focal point for various health weeks and topics that volunteers are encouraged to participate in.

Since 1995, the Health Shop in Ninewells has expanded greatly due to the high demand for information provided. There are also smaller 'Shops' managed from the Ninewells site in Perth Royal Infirmary; Links Health Centre, Montrose, and Whitehills Health Centre, Forfar. The Health Shop Manager provides input to information points in Brechin Health Centre, Academy Health Centre, Forfar, and Abbey Health Centre, Arbroath.

The Ninewells Hospital Health Shop, located on the concourse, is supported by volunteers. Presently there are 5 volunteers. Following an initial pilot in Whitehills, Forfar, Ninewells Health Shop volunteers have been trained in changing tubing and batteries in hearing aids. This will support the work carried out at Audiology clinics. The service began in Ninewells in November 2017 and will be reviewed in March 2018.

This year the Health Shop has run 2 successful Heartstart Discovery training courses for volunteers. Due to their success further courses are planned for 2018.

Heartstart Discovery Training 2017

2.16 Radio Lollipop

Radio Lollipop provides play activities in ward 29 in Ninewells Hospital in the evenings. There are 13 active volunteers with 4 more currently going through the application process. Volunteers who are no longer active on the ward provide vital support with fundraising. At present there are 2 or 3 volunteers on the ward each evening Monday to Thursday; this is a great increase in volunteering numbers since the start of the year, and reflects on the increased activity on the ward for the children.

Fundraising has been successful, closing the year with a reasonable bank balance. This year there has been a quiz night, a bingo night, a car boot sale, a bag pack and a bucket collection. The co-coordinator has also given 4 talks to groups and received donations for these. Radio Lollipop in Dundee requires around £2,000 per year to

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cover costs. Overheads include telephone and broadband for the radio (there is a radio at each bed space), liability insurance, t shirts, new games for the children, prizes, materials for crafts as well as this year the radio as it had to be sent to the manufacturer for repair costing £175.

The children and volunteers had great fun over Halloween Week, dressing up and had the staff and children telling jokes for a prize. Radio Lollipop volunteers continue to have a good relationship with the staff, patients and parents.

One of the patients appeared on Children in Need and an email was received from his mother thanking them for keeping his spirits up on the ward.

Radio Lollipop's Festive Fun

3. Assurance and Governance

The Nurse Director has overall responsibility for Volunteering in NHS Tayside. Strategic responsibility for volunteering has not been delegated as a function to the integration authorities and therefore continues to be provided collaboratively with leadership from the Health Board. There continues to be closer collaboration between the three Health and Social Care Partnerships, the Health Board, and the Third Sector Interfaces within the three localities to ensure a joined up approach to volunteering across health in Tayside.

3.1 Volunteer Working Group

The Volunteer Working Group meets quarterly, and membership includes the VSMs, and also other NHS staff who support volunteers and representatives from the three Health and Social Care Partnerships and Volunteer Centres. Volunteer coordinators from other organisations such as the Royal Voluntary Service also attend the meetings. The national lead for volunteering, based in Healthcare Improvement Scotland, has also attended and contributed to a number of meetings this year. A member of the Area Partnership is also a member of the Volunteer Working Group and contributes to discussions and activities. The Volunteer Working group oversees achievement of actions within the Volunteering Improvement Plan. A number of initiatives are planned for 2018.

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3.2 Volunteering Policy

The NHS Tayside Volunteering Policy was reviewed and updated this year by the Volunteer Working Group in accordance with the document control policy. Changes made to the Policy include retention of records guidance and the section on Employee Supported Volunteering has been removed on discussion and agreement with colleagues in Human Resources. Finally a section has been added that includes contacts for local Third Sector Interfaces (TSIs) and reflecting greater partnership working.

3.3 Investing in Volunteers

 Tayside NHS Board was successful in achieving reaccreditation this year for the award of Investing in Volunteers Award. Investing in Volunteers (IiV) is the UK quality standard for good practice in volunteer management. Achievement of IiV offers assurance of the quality of ongoing management support provided to volunteers.

IiV Award 7th December 2017, Professor John Connell, Chairman and Ann Hislop, IiV Manager, Volunteer Scotland

3.4 Recruitment and Monitoring, Systems and Processes

All NHS Tayside volunteers are registered locally onto a national database 'Volunteer Information Scotland' (VIS). Hard copies of volunteer records and files are kept locally with the VSM who supports them in NHS Tayside.

NHS Tayside volunteers undergo robust recruitment and selection procedures which are consistent across the organisation.
- volunteers submit an application form
- the form includes details of two referees who are contacted and provide references
- volunteers undergo Disclosure or Protection of Vulnerable Groups (PVG) checks commensurate with their role
- volunteers undergo occupational health clearance
- informal interviews are held
- volunteers are provided with written information about NHS Tayside's expectations and what volunteers can expect from NHST
- volunteers are given a name badge and volunteer lanyard to identify them as a volunteer
- risk assessment and training are provided according to the role
- corporate induction to NHST is provided

Volunteers receive local induction training as an absolute minimum. Additional training is provided for volunteers, for example some volunteers may attend

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corporate induction, but this is not mandatory. Some volunteers may attend optional events such as dementia awareness training days. Quarterly meetings are held at Ninewells for volunteers, and each meeting has an education or training element, for example hand hygiene awareness or support for having difficult conversations with patients. Provision of training for volunteers in Social Care is unknown but it is envisaged that greater links can be made between third sector organisations with volunteers, and the training they provide. A part of the Lampard Report (Department of Health, 2015) is the recommendation that all volunteers should be required to undergo formal refresher training in 'safeguarding' at the appropriate level at least every three years; suitable adult and child support and protection training is being sought to achieve this both locally and nationally.

4. Links with Third Sector

This year has seen the development of the national programme: Clear Pathway. NHS Tayside has had a representative on this group and the outputs are expected early in 2018. Clear Pathway is a collaborative project to support safe, effective and person centred volunteering in NHS settings, with the focus on volunteers from third sector organisations. The programme was developed in response to the publication of Kate Lampard's report for the Department of Health: Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile (Department of Health, 2015). A Scottish Government Department letter DL(2017) 7 was published in May 2017 with a number of actions for Boards, including some that were relevant to Integration Joint Boards.

NHS Tayside has a number of arrangements with third sector organisations who provide services delivered by volunteers. Examples of these include:

- Bliss Scotland who support premature and sick babies and their families on the Neonatal Intensive Care Unit
- Lippen Care volunteers who support palliative care patients in Strathmore Hospice and the Forfar and Kirriemuir community and who provide additional resources for Angus palliative care patients through fundraising
- Radio Lollipop who provide play activities on the children's ward
- British Red Cross who provide drivers
- Royal Voluntary Service who support patients being discharged home from hospital.
- Chest Heart and Stroke working with people who have had a stroke and are still in hospital

4.1 Volunteers in other health settings

Within communities there is a wealth of volunteering associated with community involvement initiatives and projects using an asset based approach. Volunteers contribute to improving health either directly via NHS projects, for example there are NHS Walking Group Leaders, NHS Healthy Living Group Leaders, NHS Be Brain Active Café, NHS Seated Exercise Facilitators. Volunteers also support health more indirectly through, for example, healthy living initiatives in communities, community cafes, walking groups, organisations offering transport services, organisations offering befriending and food banks.

The three TSIs play a key role in supporting volunteers in other health settings, working closely within the Health and Social Care Partnerships and Tayside NHS Board.

5. Dundee Health and Social Care Partnership

The development of volunteering opportunities plays a crucial role in helping Dundee Health and Social Care Partnership to meet its vision that "Each citizen of Dundee will have access to the information and support that they need to live a fulfilled life". The Partnership is working with volunteers and voluntary organisations across the city to co-produce and co-create services and supports, which enable people to live healthy independent lives. The role that every volunteer in the city plays is acknowledged and appreciated, and also recognise that volunteering itself builds capacity of individuals and communities in Dundee to live fulfilled lives.

Volunteers work with in in-patient and out-patient settings over 12 locations, hospitals, day care/health care centres and in the community across Dundee, including Mental Health, Learning Disabilities, Medicine for the Elderly, Old Age Psychiatry, Complex Paediatric Disabilities and Brain Injury. They support Nursing Staff, Occupational Therapy, Physiotherapy, and Speech and Language Therapists by assisting with the days planned activities. Meeters and greeters provide a friendly face for all patients and visitors attending the centres.

Within 2 areas there are Therapet Visitors, which the Partnership is fortunate to have. Therapet dogs come along with their owners to cheer and comfort the patients. Nursing staff and visitors are also delighted when the dogs visit.

Therapet

This year the Partnership has been working alongside Dundee and Angus College. Students who are studying Health and Social Care and Access to Nursing Courses are placed at Royal Victoria Hospital, giving them valuable volunteering experience for their course work.

The provision of hearing aid support in the community will be spreading to Dundee following implementation in Angus.

March this year saw the end of the Befriending Project for people with a learning disability due to the retirement of the Clinical Nurse Specialist and the volunteers who were University Students coming to the end of the course work.

The Partnership is extremely fortunate to have a tremendous group of conscientious and enthusiastic people who have made a regular commitment to patients and clients and are very fortunate in that the staying powers of the volunteers has been high and the commitment exceptional.

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5.1 Volunteering in Palliative care settings in Dundee

The Voluntary Service continues to make a valuable contribution to the work of the Specialist Palliative Care facilities at Roxburghe House, Macmillan Day-care and the Community here4U service. The Community Volunteer Service is designed to help and benefit some of the Palliative Care patients who are managing to live at home. This part of the service continues to expand and many more referrals are coming from the Chronic Obstructive Pulmonary Disease (COPD) service which is resulting in a backlog of referrals for cancer patients.

The Complementary Therapy Service is also expanding with the addition of several new therapists. There has been a major recruitment drive this year. This has resulted in the service now having little or no vacancies at the moment. All volunteers are trained, supported and encouraged to develop closer involvement with patients, their relatives, carers and friends and also further complement the work provided by professional staff. A series of new training events are planned for 2018 and will be in collaboration with the in- house Education Service led by the Specialist Nurse Lecturers. The service is currently using the 'Volunteer Impact Assessment toolkit' to get feedback from both volunteers and staff on the impact of volunteering.

The Health and Social Care Partnership continues to support and develop volunteering opportunities through its "Community Capacity Building" workstream using Integrated Care Funding.

5.2 Community Cars

Community Cars is a volunteer-delivered door-to-door transport project for elderly and vulnerable people living across Dundee who are at risk of social isolation due to lack of accessible transport. It enables people to access medical appointments, social activities and day to day activities for example shopping, thus supporting their independence and wellbeing. In addition Community Cars develops and trains a team of volunteers, adding to the rich skills base of volunteers across the city. Demand for the service is high – currently there are 69 active members and 58 on the waiting list. During the period May 2016 – November 2017 3,672 journeys have been undertaken, users have been driven over 12,000 miles, and 3,015 volunteer driver hours have been contributed via the scheme. Of the people supported, 11 have dementia, 29 have hearing loss/are deaf, 39 have mobility issues, 10 suffer from conditions relating to strokes, 4 are registered blind, 7 have diabetes, 5 have high blood pressure, 6 have arthritis, 2 are amputees, and 5 are users of wheelchairs.

A recent user survey conducted on behalf of the service by a third party found a 97% customer satisfaction rate with the service, with the only negative feedback coming from customers on the waiting list who expressed the view that the service should have more drivers to meet demand. In response the Co-ordinator has actively focused on driver recruitment, increasing the driver pool by a third.

5.3 Peer to Peer Mental Health Support

The NHS Tayside Volunteer Strategic Lead has worked closely with the Mental Health Networking Coordinator at Dundee Voluntary Action and the Network Manager at the Scottish Recovery Network, supported by funding from Dundee Health and Social Care Partnership to progress mental health peer support recovery volunteers within inpatient settings. Collaborations culminated in a co-designed event that was held in November 2017 and attended by 45 people. The event was positive and ideas for taking forward will be progressed in 2018. A six week training course for people who have lived experience of mental health difficulties and who wish to

use their experience to help and support others is being delivered by DVA with taster sessions being provided to support those considering signing up to the full training.

5.4 Home from Hospital Service

The Royal Voluntary Service introduced a Home from Hospital Service in Dundee supporting older people aged 65yrs+ with their transition back into their homes and communities after a hospital stay.

With the support of over 50 trained volunteers a bespoke support service is offered to older people targeting outcomes related to:
1. prevention of ongoing health and social care provision
2. reducing readmission to hospital
3. improving the rehabilitation and socialisation of service users
4. enabling access to wider facilities, social opportunities and support services

Working with multiple hospitals in Dundee alongside a range of health professionals, the service has developed a successful and effective service that offers older people much needed support with discharge from hospital. There have been strong relationships built with Royal Victoria Hospital, Bluebell Intermediate Care Unit Hospital and Ninewells Hospital staff to ensure there has been a steady increase in referrals to the service reaching 80 older people per year.

The service is now very busy and in its third year has gained momentum and continues to grow. Over the last 12 months the service has expanded dramatically, supporting approximately 80 older people with 700+ service user interactions and over 5000 hours of volunteer time.

The service has been close to capacity more recently and is currently exploring ways as part of RVS Service redesign to reach older people more effectively. This process currently includes scoping and piloting a new On Ward Service to further maximise the impact of the service.

5.5 Making Recovery Real

The Making Recovery Real in Dundee partnership has just released its first film - Making Recovery Real in Dundee (One City, Many Recoveries). This records the personal stories of recovery from people who have their own lived experience of mental health difficulties, and shares the unique experiences of participants and their journey to recovery. The aim of the resource is to promote recovery and support recovery for others.

5.6 Chest Heart & Stroke Hospital One to One

Chest Heart & Stroke Hospital One to One: under the supervision of the Speech and Language Therapist working with people who have had a stroke and are still in hospital. Volunteers are involved in activities to help the person work on their communication skills e.g. reading a newspaper, making conversation, discussing hobbies and interests.

5.7 Community Companions

Community Companions is a befriending service for adults who experience or have the potential to experience social isolation and/or loneliness. The emphasis is placed on creating a friendship between the volunteer and the person in need of support, which makes the matching process crucial. Companions visit their match (Companionee) once a week for an average duration of 2 hours. It is up to both parties how they spend the time, whether it is going out for a coffee, joining in with a

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social group or staying in for a chat. There are various activities that the volunteers and their Companionees participate in and all are person-centred for both parties. The project adopts an assets based approach, which encourages both the Companion and the Companionee to learn from one another as well as use their skills and knowledge to benefit others within their community.

Community Companion Social Cafes are held within care homes and sheltered complexes in 7 locations throughout Dundee. Participants decide on the format of the café. Some groups get involved in an activity or a debate, others join in with some exercise and others merely enjoy the company of one another. Within a 10 month period a total of 555 people attended the cafes and associated events.

The Community Companion Project was acknowledged by care homes in the Care Inspectorate report for the positive affect it had on residents.

These befriending services support transformation of the way respite care is being developed. Carers or the person they care for can use the service to take time away from the care situation, giving both individuals a break. This has the ongoing effect of reducing stress on other services.

New models of befriending are being developed, including intergenerational befriending.

Community Companions currently has 28 active volunteers with a further 3 who have recently completed training and an additional 5 volunteers due to start their training. Throughout the year the highest number of volunteers has been 32, with the addition of the intergenerational work this will increase the capacity of the project.

There are currently 23 matches, 8 café volunteers and 1 media volunteer. This provides approximately 50 volunteer hours per week at present.

5.8 Care Home Volunteering

Volunteer Dundee has developed a programme to support the development of a framework for volunteering within care homes (public, private and Third Sector). As a result of the project a number of care homes will have achieved the Volunteer Friendly Award.   Care homes have been supported to develop and implement policies and procedures to support best practice and have been provided with bespoke training for care home staff. As a result care homes have reported an increased confidence in taking on volunteers and can evidence progress towards creating meaningful roles and the allocation of internal resources.

"*Preparing the various folders aided my understanding of the processes and how to recruit and support volunteers*"

"*I now have increased skills to ensure that the volunteers (+ staff and residents) get the most out of the experience*"

"*I have a much clearer understanding, increased confidence and motivation. Moved from an idea to now actually recruiting volunteers*"

"*Community spirit has been strengthened and supported as staff and volunteers work together with our residents*"

5.9 Dial – OP

Dundee Health and Social Care Partnership continues to support Dial-OP. Building on its existing resources and identified community needs, Dial-OP has diversified its lines of work into three strands:

- **Information helpline** - a one-stop shop that individuals, community workers and associates turn to for trusted information on local services and resources.
- **Blether Buddies** – a telephone companionship service that provides a telephone call from trained volunteers. Phone calls take place on a weekly basis and create an opportunity for lonely and vulnerable people to engage in an ordinary conversation and re-connect with their community.
- **Morning Call** – a short daily telephone call on week days that offers lonely and vulnerable adults reassurance, connectivity and, if required, reminders for appointments or commitments of a different nature.

Dial-OP Information helpline is achieving its long-standing ambition to be a proven point of contact for community members, workers and organisations within and out with the Dundee area. Year on year more people are reaching out to Dial-OP through the telephone helpline. For the period April to October 2017, 222 people had engaged with the service – a 3.5% increase in contacts compared with the same period last year.

Dial-OP Telephone Befriending has recently rebranded as Blether Buddies after a consultation period with volunteers, service users and the wider community in order to better reflect the nature of the project. Blether Buddies has experienced a period of growth over the past months and currently sustains 12 weekly friendship calls. An additional 7 referrals have been received and are being currently processed.

Dial-OP Morning Call saw its first intervention in January 2017. Calls are flexible and depend on the requirements of the service users. 32 outreach calls are made daily by staff and volunteers from Monday to Friday, and reminders are also given to service users where requested.

Through the work of Dial-OP, support is provided to the people in Dundee by keeping them informed, connected and valued. This activity enables individuals to:
- easily access community information and support offered locally
- maintain and build on their existing networks or create new ones
- increase their sense of confidence and self-worth
- reconnect with their community
- provide reassurance to themselves and their families
- encourage social participation
- achieve positive outcomes related to health and wellbeing
- maintain independence and quality of life

5.10 Sources of Support Volunteer Programme

Sources of Support (SoS) Volunteer Programme enables individuals who experience poor health as a result of socio-economic factors or personal circumstances to receive the support they need to attend appointments or access community-based resources. The purpose of the service is to offer community-level support that helps people overcome any barriers they face when accessing a new and unknown environment. Barriers include, but they are not limited to, lack of confidence and self-esteem, anxiety, low mood and lack of motivation, and poor mobility.

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Clients referred to the project are linked to a volunteer who offers the practical and emotional support that they require in order to be able to take part in social activities, community groups, or attend non-medical appointments.

Those who are referred and successfully engage with the project benefit from the following:

- Increased opportunities for social participation, particularly amongst those most deprived and marginalised
- Reduced levels of anxiety and stress-related reactions, including outbursts of anger and panic attacks
- Increased reassurance and self-confidence in accessing services and joining activities
- Improved range, choice and supported access to non-medical sources of support
- Increased engagement in health-related activities beyond the support offered
- Greater ability to take control and better manage their condition

In addition to the established induction training and mental health and suicide-prevention courses, volunteers are given the opportunity to attend relevant awareness-raising sessions and training events that further inform their role and responsibilities and contribute to their personal/professional development. At this stage, the project has 11 volunteers eager to support individuals in their journey towards positive health and wellbeing outcomes.

6. Angus Health and Social Care Partnership

There are currently 272 active Angus NHS volunteers with another 24 recent applicants awaiting return of their Disclosure. Their ages range from 16 – 87. The volunteers come from a wide range of backgrounds and they all bring different skills, knowledge, abilities and life experience to the volunteer team. Additional support is sometimes needed to facilitate the safe and appropriate placement of volunteers with challenging disabilities such as blindness but every effort is made to enable inclusion.

Angus NHS Volunteers continue to support patients in ward environments, the Midwifery Unit and in outpatient areas in Arbroath Infirmary, Susan Carnegie Centre, Montrose Infirmary, Mulberry Unit, Stracathro Hospital, outpatient clinics and hearing aid support sessions in Whitehills Health and Community Care Centre, Forfar, and Montrose and Arbroath Health Centres.

Many of the ward volunteers also assist with infection control audits and obtain patient feedback for, "How Are We Doing?" reports, thereby providing a more independent level of assurance. Volunteers also provide patient support in health related community projects such as the Hearing Aid Support volunteer service, Breastfeeding Buddies and other health related initiatives.

Dedicated volunteer drivers provide transport for patients attending the Angus Macmillan Day-Care Centres in Arbroath Infirmary, Whitehills HCCC Forfar and the Macmillan Centre at Stracathro. Additional complementary therapists, hospitality volunteers, receptionists and an activity volunteer were recruited when the new Arbroath unit opened. After training, they joined the existing volunteer team to enable the provision of therapeutic input in all locations.

When Angus acute psychiatric services needed to temporarily relocate from the Mulberry Unit at Stracathro Hospital to Carseview in Dundee, their Peer Support volunteers agreed and have continued to travel with staff members to Carseview to continue their valuable input and minimise disruption for the patients.

The service in Angus is fortunate to have a very large number of 5th and 6th year pupils from local schools supporting patients as ward volunteers. They talk to

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patients who have few visitors, play dominoes with patients, help them complete menus and assist staff serve meals and teas. Most of these volunteers work with the service for one or two school years before going to university or into employment but as one cohort moves on there are always more pupils eager to join. The patients find their input refreshing, staff appreciate their help and the pupils gain valuable people skills, self confidence and an insight into potential NHS careers together. Knowledge and skills are also enhanced through attendance at a range of training sessions. Schools and universities rate this volunteer experience highly.

The successful pilot of the twice weekly Volunteer Hearing Aid Support Service at Whitehills, Forfar, has now been extended and a weekly service is being provided at the Links Health Centre, Montrose, and Abbey Health Centre, Arbroath. It is planned that this service will be implemented in other locations.

Launch of the Montrose and Arbroath NHS Volunteer Hearing Aid Support Service

7. Perth and Kinross Health and Social Care Partnership

Perth and Kinross Health and Social Care Partnership works closely with the TSI at Perth and Kinross Association of Voluntary Services (PKAVS) and the area's dynamic third sector to deliver its ambitions. The Partnership is committed to working with local people to build on the skills, knowledge and resources of individuals and communities to co-produce creative solutions for the future.

Volunteers make up a large proportion of the third sector workforce through a wide range of formal volunteering roles, peer support and informal participation. Approximately 39,000 adults are involved in formal volunteering roles and contribute an estimated 5.5 million hours per year to the communities of Perth and Kinross.

7.1 Perth College Art Students

Within Perth, there is a continued partnership with staff and students who have been designing murals to enhance patient areas within Psychiatry of Old Age in-patient areas at Murray Royal Hospital. It has been useful for the students to gain an understanding of some of the difficulties and challenges older people face.

7.2 Rohallion Secure Care Clinic, Murray Royal

Volunteers are continuously involved within this challenging area. The Volunteer Psychology Assistant role has been extremely successful where the service were specifically looking to provide a volunteer opportunity for a fourth year undergraduate or psychology graduate with an interest in pursuing a career in Forensic Psychology and this will continue with further recruitment.

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7.3 Moveahead Community Development (Adult Mental Health)

The volunteer roles include Book Group Volunteers, Art Facilitator, Creative Writing Facilitator, Social Buddies and Activity Volunteers. Volunteers regularly discuss local social opportunities with people, facilitating their exit strategy following this support. Such support is an initial step to prepare people to consider longer term social opportunities and contact will last for a maximum of 6 months. People are sign-posted to a range of local opportunities and activities based on their needs in conjunction with MoveAhead staff.

Most volunteers have experienced mental health difficulties themselves and have benefited from the support MoveAhead provides. As their personal recovery progresses they in turn have been able to take on a role which in some cases has resulted in paid employment. They continue to work really hard in partnership with MoveAhead to deliver local services to people in the community. Their commitment and dedication is greatly appreciated and MoveAhead could not provide the level of service they do without this voluntary involvement.

7. 4 Community Empowerment

In 2017, Perth and Kinross HSCP has been working to inspire and support citizen involvement in the planning, design and delivery of services and support in communities. This has included the development of public and professional partner roles for people who use services, carers, third sector and community members, to bring diverse expertise and experience to roles in strategy, governance and work in localities. The Partnership involves volunteer stakeholders at different levels in its work. This ranges from health and wellbeing groups in communities where people can contribute to joint community action, to more formal involvement in the Partnership's governance through the Integration Joint Board.

7.5 Participatory Budgeting

As part of the Partnership's Communities First transformation project, a Participatory Budgeting project called 'Your Community, Your Budget, Your Choice!' took place in Craigie, Rattray and Crieff. 47 project proposals for ideas to support health and wellbeing in these areas were received from a range of voluntary organisations and groups. 1,562 local people voted for projects they felt would deliver the care and support required in their community. 21 projects were fully funded and a further 20 part-funded. Initiatives receiving the highest number of votes included adapted bikes for the disabled, Home Start volunteer course and the Crieff Tuesday Club.

7. 6 YourCommunityPK

A new social media channel, 'YourCommunityPK', has been established to enable a partnership approach to sharing information, good news stories and encouraging online interaction with communities. Within a few months, the channel already has over 1,800 followers between Facebook and Twitter. Video case studies included third sector services such as Royal Voluntary Service, and 'Tales of a Grandson', which shares how performance art is being used in residential homes to improve the wellbeing of residents. These digital platforms have been a particularly effective way of promoting the rich volunteering opportunities available within communities.

7.7 Third Sector Services

Perth and Kinross has a wide range of commissioned third sector services and non-commissioned voluntary activity that supports health and wellbeing outcomes for local people. Services includes areas such as support for unpaid carers, mental health and wellbeing, learning disabilities, older people, community transport, information, advice, advocacy and equalities.

A snapshot of volunteering hours taken in 2017 across a small sample of 12 third sector organisations identified that 867 volunteers were giving an incredible 45,000 hours of support to support adult health, care and wellbeing each year.

7. 8 Active Communities

The Live Active Leisure (LAL) Active Communities programme was designed to develop and deliver sustainable physical activity provision for inactive adults with co-morbidities to increase levels of physical activity to improve physical, social and mental health, and wellbeing. 2 principal outcomes are delivered aligned with the National Health & Wellbeing Outcomes:

- reducing isolation and improved health and wellbeing of communities
- working with communities to increase the number of accessible and sustainable physical activity interventions.

The LAL Wellbeing Team have supported the building of skills and knowledge at a community level, focusing on walking and strength and balance programmes that provide significant benefits to support older adults, in particular, to live independently. There have been 18 community based health walk programmes operating during 2017, including 2 new ones. Self-led strength and balance programmes also take place, led by community volunteers and partner services such as sheltered housing and care homes.

In 2017 there has been a significant focus on up-skilling volunteers in relation to specific health needs and issues in response to emerging needs and priorities. 23 walk leaders attended dementia training and 18 attended Macmillan Move More cancer awareness training resulting in dementia and cancer friendly status being achieved for 7 Stride for Life walks with provision in each locality.

There are 40 active Stride for Life project walk leaders and 15 students support strength and balance activity in care settings. 6 strength and balance groups/walking football are led and self-sustained by volunteers. Approximately 275 participants have benefited from increased activity levels, links to health awareness and screening and more social connections directly supported by volunteers.

7.9 Development of Time Banking

Over recent years, the Partnership has invested in the development of Time Banks; an informal, volunteering-based model that enables community members to offer each other some form of help or support in direct response to local needs.

In 2017, the TSI at PKAVS supported two Time Banks in Aberfeldy, and Blairgowrie and Rattray, to become independently constituted under volunteer committees and take forward their own goals as self-sustaining organisations. At the point of transfer in the autumn, the two Time Banks had over 150 volunteers between them and had enabled the exchange of over 4,200 hours of help and support in communities since their inception.

8. Partnership working across Health and Social Care and Third Sector Interfaces

The 10 volunteering principles referred to in last year's report were coproduced by working with the three Third Sector Interfaces across Tayside.

10 Volunteering principles agreed across Tayside

1. **Fairness:** Volunteers are treated fairly with robust policies in place to support this.
2. **Equality:** Volunteers are treated equally. Volunteering is open to all and demonstrates diversity.
3. **Inclusion:** Volunteers feel part of their organisation, and understand how their role fits in with the work of the team they volunteer with.
4. **Reimbursement:** out-of-pocket expenses are covered.
5. **Support and Development:** Volunteers are supported, invested in and have opportunities for personal development and access to training. Volunteers have a support worker or supervisor. This is adequately resourced and benefits the recipients of volunteering.
6. **Valued:** Volunteering contributions in terms of time, skill and impact are recognised. The contributions of volunteers are celebrated at the grass roots and at Board level.
7. **Realistic expectations/appropriate roles:** Expectations are realistic in terms of ability to recruit and retain volunteers and what is expected of them.
8. **Be effectively engaged:** Volunteers are informed about areas they are working in and have influence.
9. **Safety:** Volunteers are secure and supported in their working environment, physically and emotionally.
10. Volunteering is a resource that is unpaid, open and accessible and enriches the lives of individual human beings.

Over 2017 there has been greater collaborative working across health and social care, the TSIs and the Health Board. All three Health and Social Care Partnership Clinical Care and Professional Governance Forums across Tayside have discussed the implications of the Lampard report (Department of Health, 2015) on volunteering. The TSI Lead from Perth and Kinross and the Health Board Strategic Lead for volunteering presented jointly at the Perth and Kinross Forum, and in presenting a joint perspective helped to raise awareness of volunteering and quality assurance in the partnership forum environment. Within Angus there was an event held in September: Bringing it Altogether: A Strategic Volunteering Event. The event was attended by 50 delegates from across the voluntary and statutory sectors. A conclusion from the event was that whilst there is a genuine passion to volunteer within Angus, this needs to be better supported by both voluntary and statutory organisations. The outcome from the event is that the information will be the foundation of a local volunteering strategy that is taken forward as a Partnership Strategy by a group from different agencies and interests. In Dundee there are regular discussions about volunteering and presentations from third sector organisations; funding from the Partnership to Making Recovery Real is supporting progress with recruiting mental health peer support recovery volunteers in the inpatient setting.

9. Celebration of volunteering

In June 2017 NHS Tayside celebrated Volunteer Week with a stand in the Concourse at Ninewells and a celebration of volunteering in the Steeple in Dundee.

NHS Tayside Volunteer Week

A number of volunteers were presented with long-service awards from Tayside NHS Board Chairman Prof John Connell:

20+ years awards

15+ years awards

10+ years awards

5+ years awards

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10. Cross Party Group on Volunteering

Tayside has representation on the Cross Party Group on Volunteering which was approved by the Standards, Procedures and Public Appointments Committee at the end of 2016. The Cross Party Group has helped increase the profile of volunteering within government meetings and has helped in supporting Scottish Government and joint working opportunities. The Tayside representative raised the value of peer support recovery volunteering in mental health and the need for more links to be made at a strategic level, for example within the Scottish Government Mental Health Strategy. The theme of Volunteering in 2017 was the Golden Thread which worked well throughout the year. The theme for next year will focus on inclusion and loneliness.

11. Plans For 2018

Tayside NHS Board will continue celebrating the contribution of volunteering in 2018 and completion of the actions contained within the 'Volunteering Improvement Plan 2018' will continue to strengthen and further develop volunteering across health in Tayside.

Volunteers have a clear role in helping patients to better manage their own conditions and this is a key driver for health. Initiatives around peer support volunteering will expand over 2018 and more conditions will be considered. Work is also planned to evidence the economic benefits of volunteering locally and this evidence base will be used to expand the Volunteering Service. Outputs from the Clear Pathway project will progress and closer relationships will form between all stakeholders across Tayside concerned with volunteering and health with the 10 Volunteering principles being at the core of developing a Tayside wide volunteer strategy.

A key theme from Scottish Government for volunteering in 2018 is inclusion and loneliness. Across Tayside a number of volunteer initiatives support these aims; a new initiative 'No one Dies Alone' taken from the Compassionate Inverclyde Programme will also be explored in 2018. Additionally more emphasis will be considered in 2018 around the actual act of volunteering in itself being a motivator for some people to reduce their own loneliness and isolation. Other actions within the Volunteering Improvement Plan 2018 include supporting volunteers through adult protection training, appropriate supervision and escalation routes. In 2018 processes for how volunteers are enabled to give feedback on health services will also be reviewed.

Finally, having successfully achieved the Investing in Volunteering reaccreditation again in 2017, Tayside NHS Board will continue to provide safe and effective volunteering opportunities that benefit people who are being cared for or who are receiving services, staff, and volunteers themselves. NHS Tayside Board will continue to work collaboratively with all key partners across the volunteering landscape.

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12. References

Scottish Government, 2017. Realising Realistic Medicine,
Scottish Government, 2016. A National Clinical Strategy for Scotland,
Department of Health, 2015. Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile,

13. Report Sign Off

Thanks to all Voluntary Service Managers and other colleagues who have contributed to this annual report, including administrative support.

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