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Aberdeen City Health & Social Care Partnership
A caring partnership

To: Councillor Len Ironside CBE (Chairperson); and Jonathan Passmore MBE (Vice-Chairperson); and Councillors Cameron, Donnelly and Young; and Rhona Atkinson, Dr Nick Fluck and Professor Mike Greaves (NHS Grampian Board Members); and Mike Adams (Partnership Representative, NHS Grampian), Jenny Gibb (Professional Nursing Adviser, NHS Grampian), Jim Currie (Trade Union Representative, Aberdeen City Council (ACC)), Bernadette Oxley (Chief Social Work Officer, ACC), Kenneth Simpson (Third Sector Representative), Howard Gemmell (Patient and Service User Representative), Gill Moffat and Faith-Jason Robertson-Foy (Carer Representatives), Dr Stephen Lynch (Clinical Lead, Aberdeen City Health and Social Care Partnership (ACHSCP)), Dr Satchi Swami (Secondary Care Adviser, NHS Grampian) and Judith Proctor (Chief Officer, ACHSCP).

Town House,
ABERDEEN, 8 November 2016

INTEGRATION JOINT BOARD

The Members of the **INTEGRATION JOINT BOARD** are requested to meet in Committee Room 2 - Town House on **TUESDAY, 15 NOVEMBER 2016 at 10.00 am.**

FRASER BELL
HEAD OF LEGAL AND DEMOCRATIC SERVICES

B U S I N E S S

DETERMINATION OF EXEMPT BUSINESS

1 Members are requested to determine that any exempt business be considered with the press and public excluded

STANDING ITEMS

2 Minute of the Previous Meeting - 30 August 2016 (Pages 5 - 16)

3 Business Statement (Pages 17 - 22)

ITEMS OF BUSINESS

4 Review of Audit and Performance Systems Committee Terms of Reference (Pages 23 - 30)

5 Period Five Finance Report (Pages 31 - 46)

6 Financial Reserve Strategy (Pages 47 - 54)

7 Performance Report (Pages 55 - 108)

8 Strategic Plan's Indicative Timeline (Pages 109 - 152)

9 Grampian Winter Planning (Pages 153 - 218)

10 Three Year Civil Contingency Plan (Pages 219 - 228)

11 Empowerment, Engagement and Participation Strategy (Pages 229 - 246)

12 Social Work in Scotland - Audit Scotland Report (Pages 247 - 308)

FOR NOTING

13 Minute of Audit and Performance Systems Committee - 11 August 2016 (Pages 309 - 314)

14 Draft Minute of Audit and Performance Systems Committee - 25 October 2016 (Pages 315 - 322)

15 Minute of Clinical and Care Governance Committee - 16 August 2016 (Pages 323 - 330)

16 Draft Minute of Clinical and Care Governance Committee - 1 November 2016 (Pages 331 - 334)

17 Corporate Risk Register (Pages 335 - 364)

ITEMS THE BOARD MAY WISH TO CONSIDER IN PRIVATE

18 Drugs and Alcohol Retendering (Pages 365 - 374)

19 Bon Accord Care Report (Pages 375 - 378)

20 Transformation Progress Report (Pages 379 - 432)

WORKSHOP SESSION

21 Finance Workshop

Website Address: http://www.aberdeencityhscp.scot/

Should you require any further information about this agenda, please contact Iain Robertson, 01224 522869 or iairobertson@aberdeencity.gov.uk

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Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Minute of Meeting

30 August 2016
Community Health and Care Village, Aberdeen

Present: Councillor Ironside CBE (Chairperson); Jonathan Passmore MBE (Vice Chairperson); and Councillors Cameron (for item 14), Donnelly and Jean Morrison MBE (as substitute for Councillor Young); and Rhona Atkinson, Dr Nick Fluck and Professor Mike Greaves (NHS Grampian Board members); and Jenny Gibb (Professional Nursing Adviser, NHS Grampian), Kenneth Simpson (Third Sector Representative), Gill Moffat and Faith-Jason Robertson-Foy (Carer Representatives), Dr Howard Gemmell (Patient/Service User Representative), Dr Stephen Lynch (Clinical Lead, Aberdeen City Health and Social Care Partnership (ACHSCP)) and Judith Proctor (Chief Officer, ACHSCP).

Also in attendance: Alex Stephen (Chief Finance Officer, ACHSCP), Tom Cowan (Head of Operations, ACHSCP), Kevin Toshney (Acting Head of Strategy and Transformation, ACHSCP), Angela Scott (Chief Executive, ACC), Anne MacDonald (Audit Scotland for item 8), David Pfleger (Director of Pharmacy and Medicines Management, NHS Grampian for item 12), Gail Woodcock (Integrated Localities Programme Manager, ACHSCP, for item 13) and Iain Robertson (Clerk, ACC).

Apologies: Councillor Young and Jim Currie.

In attendance for workshop: Dr Alastair Palin (Clinical Director, Mental Health Services and Deputy Medical Director, NHS Grampian) and Claire Wilkie (Service Manager, ACHSCP).

The agenda and reports associated with this minute can be located at the following link:-
http://committees.aberdeencity.gov.uk/ieListMeetings.aspx?CommitteeId=516

Please note that if any changes are made to this minute at the point of approval, these will be outlined in the subsequent minute and this document will not be retrospectively altered.

OPENING REMARKS

1. The Chair opened the meeting and welcomed Rhona Atkinson onto the Board as a voting member representing NHS Grampian. He also advised that a new microphone system was now in place for meetings at the Community Health and Care Village and outlined the procedure for operating the microphones to participate in discussions. Thereafter the Chair proposed to amend today's agenda to consider item 8 (External Audit Report on Aberdeen City IJB) after item 6 (Period 3 Finance Report).

The Board resolved:-

(i) to welcome Rhona Atkinson onto the Board as a voting member representing NHS Grampian; and

(ii) to amend today's agenda and consider item 8 (External Audit Report on Aberdeen City IJB) after item 6 (Period 3 Finance Report).

DETERMINATION OF EXEMPT BUSINESS

2. The Chair moved that agenda item 14 (Expansion of Interim Bed Position) of today's agenda (item 15 of this minute) be considered with the press and public excluded.

The Board resolved:-

In terms of Section 50(A)(4) of the Local Government (Scotland) Act 1973, to exclude the press and public from the meeting during consideration of the aforementioned items of business so as to avoid disclosure of exempt information of the classes described in paragraphs 6 and 8 of Schedule 7(A) of the Act.

MINUTE OF PREVIOUS MEETING

3. The Board had before it the minute of the previous Board meeting of 28 June 2016.

The Board resolved:-

To approve the minute as a correct record.

BUSINESS STATEMENT

4. The Board had before it a statement of pending business for information.

The Board resolved:-

(i) to remove item 9 (Integrated Management Structure) from the Business Statement; and

(ii) otherwise note the statement.

APPOINTMENT OF MEMBER TO AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

5. The Board had before it a report by Judith Proctor (Chief Officer, ACHSCP) which proposed to appoint a new member to the Audit and Performance Systems (APS) Committee.

The report recommended:-
that the Board –
(a) Note the appointment of Rhona Atkinson to the IJB, replacing Sharon Duncan; and
(b) Approve the appointment of Rhona Atkinson to the APS Committee.

The Vice Chair noted that the process for appointing a new member to the APS Committee had been followed as per the Board's standing orders but requested that officers review the process with regards to appointing members to IJB committees and report back to the Board's next meeting on 15 November 2016.

The Board resolved:-
(i) to note the appointment of Rhona Atkinson to the IJB, replacing Sharon Duncan;
(ii) to approve the appointment of Rhona Atkinson to the APS Committee; and
(iii) to request that officers review standing order 23 and report back to the Board's next meeting on 15 November 2016.

APPOINTMENT OF INTERNAL AUDITORS

6. The Board had before it a report by Alex Stephen (Chief Finance Officer, ACHSCP) which proposed to appoint the shared internal audit service used by both Aberdeen City and Aberdeenshire Councils as the IJB's internal auditors until 31 March 2017.

The report recommended:-
that the Board –
(a) Agree the shared internal audit service used by both Aberdeen City and Aberdeenshire Council would provide internal audit services to the IJB until 31 March 2017;
(b) Instruct a review of the appointment of the Chief Internal Auditor and Internal Auditors before 31 March 2017; and
(c) Note that Audit Scotland would undertake the 2015-16 audit of the IJB accounts and KPMG would take on this role for the 2016-17 accounts.

Alex Stephen informed the Board that the Internal Auditors would report to the Audit and Performance Systems Committee as per Section 8.4 of the Committee's terms of reference.

The Board resolved:-

(i) to agree the shared internal audit service used by both Aberdeen City and Aberdeenshire Council would provide internal audit services to the IJB until 31 March 2017;

(ii) to instruct a review of the appointment of the Chief Internal Auditor and Internal Auditors before 31 March 2017; and

(iii) to note that Audit Scotland would undertake the 2015-16 audit of the IJB accounts and KPMG would take on this role for the 2016-17 accounts.

PERIOD 3 FINANCE REPORT

7. The Board had before it a report by Gillian Parkin (Finance Manager, NHS Grampian) and Jimmie Dickie (Finance Business Partner, ACC) which summarised the current year revenue budget performance for the services within the remit of the IJB as at Period 3 (end of June 2016).

The report recommended:-

That the Board note the report on the month 3 position in relation to the IJB budget and the information on areas of risk and management action that was contained therein.

Alex Stephen spoke to the report and highlighted that the Partnership was forecasting a £1.3million overspend at Year End and this was largely attributable to prescribing. He advised that the Executive Team was reviewing opportunities for efficiencies and reminded members that transformational funding could be utilised to ensure the delivery of a balanced budget.

Thereafter there were questions on the use of transformational funding to cover overspends; the challenges of managing the prescribing budget in a highly volatile market place; and the level of underspend for Learning Disabilities and Mental Health and Addiction budgets. Members also recognised that prescribing was a Grampian-wide issue and Boards had little control over the unit cost of medicines.

The Board resolved:-

(i) to request a workshop session be arranged to highlight issues related to prescribing; and

(ii) otherwise note the report.

EXTERNAL AUDIT REPORT ON ABERDEEN CITY IJB

8. The Board had before it a report by Alex Stephen which provided the Board with an opportunity to discuss the Annual Audit Report to members and the Controller of Audit.

The report recommended:-

that the Board –

(a) Note the content of the Annual Audit Report to members and the controller of Audit;

(b) Agree the action plan appended to the report; and

(c) Request that an External Audit outstanding recommendations report be presented to the APS Committee to provide assurance that the recommendations contained in the action plan were completed in the agreed timeframe.

Anne MacDonald (Audit Scotland) advised that the report set out the audit framework and a code of practice for the IJB. She explained that the financial statements were only audited for a two month period from the Board's establishment on 6 February 2016 to 31 March 2016. She noted that the Board had produced a high quality set of accounts and a sound governance framework had been put in place. Ms MacDonald highlighted that the Board had recognised the need to develop a performance management framework to strengthen their governance arrangements and Alex Stephen advised that a draft framework would be presented to the Executive Team on 31 August 2016 and it was their intention to submit the framework to the Audit and Performance Systems Committee on 25 October 2016 and to the IJB on 31 January 2017.

Thereafter there were questions on the development of the Board's Governance Statement for the 2016-17 Annual Accounts; and how the Board's Integration Scheme and Scheme of Delegation would address issues relating to conflicts of interest, lines of accountability, decision making and ultimate responsibility for quality of care.

The Board resolved:-

(i) to note the content of the Annual Audit Report to members and the controller of Audit;
(ii) to agree the action plan appended to the report;
(iii) to request that an External Audit outstanding recommendations report be presented to the APS Committee to provide assurance that the recommendations contained in the action plan were completed in the agreed timeframe;
(iv) to request that the Chief Officer meet with the Chief Executives of ACC and NHS Grampian to discuss the development of the IJB's Governance Statement to be included in the 2016-17 Annual Accounts; and
(v) to thank Alan Gray and Paul Dixon for their work during the audit of the Board's annual accounts.

ANNUAL AUDITED ACCOUNTS

9. The Board had before it a report by Alex Stephen which provided an overview of the Board's 2015-16 Audited Annual Accounts.

The report recommended:-
That the Board consider and approve the Board's Audited Annual Accounts 2015-16.

Alex Stephen spoke to the report and explained that there was very little detail in the accounts due to the short period of time that the Partnership had been operating but noted that the auditing process had provided them with a robust template for submitting full year annual accounts for 2016-17.

The Board resolved:-
To approve the Board's Audited Annual Accounts 2015-16.

IMPLEMENTATION OF NATIONAL LIVING WAGE TO CARE AT HOME WORKERS

10. The Board had before it a report by Gill Mutch (Finance, ACC) and Alison MacLeod and Jean Stewart-Coxon (Commercial and Procurement Services, ACC) which sought approval from the IJB on the proposal to increase rates paid to external providers of care at home from 1 October 2016 to help implement the Living Wage commitment as part of a positive approach to fair working practices.

The report recommended:-
that the Board –

(a) Agree the proposal of a 6.4% uplift to all rates for purchased services across all client groups and for all hours worked (except those already covered by the National Care Home Contract) from 1 October 2016;
(b) Instruct the Chief Officer to issue a direction to ACC to provide a 6.4% uplift, at a cost of £1.6million as set out in the recommended option to external care providers; and
(c) Instruct the Chief Officer to ensure the implementation of the Living Wage and Fair Working Practices through appropriate contract monitoring processes to provide assurance to the IJB that this had been implemented by the end of the financial year.

Alex Stephen spoke to the report and explained that the Living Wage commitment was made by the Scottish Government and local government as part of the 2016-17 grant settlement to ensure the Living Wage of £8.25 was paid to care workers. He advised that the proposed 6.4% uplift to care providers had been scrutinised through an extensive consultation process and had been agreed by the Audit and Performance Systems Committee on 11 August 2016. Tom Cowan (Head of Operations, ACHSCP) advised that the proposed uplift would make a significant contribution towards stabilising the social care market in terms of recruitment and turnover levels and would provide resources for care providers to invest in their staff through training and development. He added that these investments would help to shape a new paradigm wherein caring would be perceived as an aspirational choice of career with clear routes for progression. Judith Proctor highlighted that the 6.4% uplift was the fairest proposal and aligned with the Partnership's aim to deliver fairer working practices across the sector. She explained that the Board would receive assurance that the uplift was being used to implement the Living Wage or support training and development programmes through the Board's Annual Report and the Partnership's Strategic Commissioning Strategy.

Thereafter there were questions on the process for submitting IJB directions to Aberdeen City Council and NHS Grampian; and the role of third and independent sector partners in the strategic commissioning process. Members also stressed the importance of tracking how the uplift was being utilised by care providers and requested that robust monitoring arrangements be put in place to ensure that the benefits were passed onto staff and not used to award providers who had maintained existing terms and conditions.

The Board resolved:-

(i) to agree the proposal of a 6.4% uplift to all rates for purchased services across all client groups and for all hours worked (except those already covered by the National Care Home Contract) from 1 October 2016;

(ii) to submit a Direction to ACC to provide a 6.4% uplift, at a cost of £1.6million as set out in the recommended option to external care providers;

(iii) to instruct the Chief Officer to ensure the implementation of the Living Wage and Fair Working Practices through appropriate contract monitoring processes to provide assurance to the IJB that this had been implemented by the end of the financial year; and

(iv) to request that the Chief Officer meet with the Chief Executives of ACC and NHS Grampian to discuss the arrangements for submitting IJB directions to its two partner organisations.

ETHICAL CARE CHARTER

11. The Board had before it a report by Claire Wilson (Planning and Development Manager, ACHSCP) which advised the IJB of the principles of UNISON's Ethical Care Charter. It also provided detail in terms of how the adoption of the Charter's principles might support the Partnership in delivering the ambitions set out in its Strategic Plan, in partnership with its third and independent sector partners.

The report recommended:-

that the Board –

(a) Support the principles as set out in the Ethical Care Charter;

(b) Create a working group, including representation from care at home providers to consider the application of principles in the Partnership's strategic commissioning work;

(c) Direct the working group to assess the potential financial impacts of adopting the principles of the Ethical Care Charter; and

(d) Agree to a further update on this to come to a future meeting of the IJB by the end of the financial year.

Tom Cowan spoke to the report and advised that the Charter had been developed in response to a 2011 Unison survey which found that care workers were poorly treated and subject to unfair terms and conditions. He explained that the Charter outlined a set of principles for care providers to phase out existing working practices and highlighted that Unison had indicated their intention to resurvey care providers and review the level of sign-ups to gauge the impact of the principles implementation on the social care sector. Mr Cowan added that the Council's arm's length organisation, Bon Accord Care was a signatory of the Charter.

Members discussed the financial challenges of being a care worker as Mr Cowan explained that a number of workers were paid by the quarter hour and some did not receive travel time pay. He advised that this had a detrimental impact on workers who travelled across the city to provide care in the West End where the proportion of care workers who resided in this area was historically low. Thereafter there were questions on the composition of the working group that would consider the application of the Charter's principles with regards to the Partnership's strategic commissioning work and the timeframe set aside for the group to report its recommendations.

The Board resolved:-

(i) to support the principles as set out in the Ethical Care Charter;
(ii) to create a working group, including representation from care at home providers to consider the application of principles in the Partnership's strategic commissioning work;
(iii) to direct the working group to assess the potential financial impacts of adopting the principles of the Ethical Care Charter; and
(iv) to agree to a further update on this to come to a future meeting of the IJB by the end of the financial year.

NHS GRAMPIAN CLINICAL STRATEGY

13. The Board had before it a report by Dr Nick Fluck (Medical Director, NHS Grampian), Amanda Croft (Director of Nursing, Midwifery and AHPs, NHS Grampian) and Susan Webb (Acting Director of Public Health, NHS Grampian) which provided the IJB an opportunity to consider a consultation draft of the NHS Grampian Clinical Strategy.

The report recommended:-

that the Board –

(a) Endorse the strategic priorities and direction set out in the draft Clinical Strategy; and
(b) Direct the Chief Officer and the Executive Management Team to ensure that the developing Clinical Strategy's aims, objectives and actions align where appropriate with the IJB Strategic Plan and Strategic Commissioning and Transformation Programme in order to ensure effective shared development across the public sector in Aberdeen City.

Dr Nick Fluck spoke to the report and advised that the Clinical Strategy provided the context and direction of travel for the next five years and noted that the strategy had been extensively consulted on. He explained that colleagues from NHS Grampian and the Partnership's Executive Team would meet to ensure that the Strategy's goals aligned with the Partnership's aspirations and objectives. Judith Proctor confirmed that the Strategy largely aligned with the Partnership's ambitions to deliver person centred care and to increase the capacity of individuals and localities to deliver services out with acute settings. She added that the Partnership also endorsed the Strategy's emphasis on maximising the use of technology to underpin these new pathways. Dr Stephen Lynch advised that a Clinical Workshop was scheduled for 31 August 2016 to discuss the Strategy.

Thereafter there were questions on how the Clinical Strategy could be implemented collaboratively; and how the Strategy would be aligned with the IJB's Strategic Plan and the National Mental Health Strategy.

The Board resolved:-

(i) to endorse the strategic priorities and direction set out in the draft Clinical Strategy;
(ii) to direct the Chief Officer and the Executive Management Team to ensure that the developing Clinical Strategy's aims, objectives and actions align where appropriate with the IJB Strategic Plan and Strategic Commissioning and

Transformation Programme in order to ensure effective shared development across the public sector in Aberdeen City; and

(iii) to instruct the Clerk to cascade the omitted Grampian Clinical Strategy Implementation Priorities appendix to members of the Board.

PRESCRIBING PRACTICES

13. The Board had before it a report by Sarah Gibbon (Executive Assistant, ACHSCP) which informed the IJB about an ongoing Grampian wide review into dispensing GP Practices, including the consultation process and to highlight the actions required on the part of the IJB.

The report recommended:-
that the Board –

(a) Note the ongoing work on the review as outlined in the report; and

(b) Agree that the review group recommendations, implementation plan and written responses from principal interested parties would come to the IJB for discussion prior to final approval by the NHS Grampian Board.

David Pfleger (Director of Pharmacy and Medicines Management, NHS Grampian) informed the Board of an ongoing NHS Grampian review of dispensing GP Practices and he explained the existing procedure for dispensing prescriptions and highlighted there were exceptions to these procedures in the general medical regulations if patients had limited access to a community pharmacy. Mr Pfleger explained that the practice at Udny Station was the only practice which provided services to an Aberdeen City practice that would be subject to review and noted that colleagues from NHS Grampian had attended meetings of the local Community Council to raise awareness and receive community feedback on the general practice dispensing review. Thereafter he referred to the key stages and timeframes of the review and noted that the findings of the review and an implementation plan would be presented to the IJB in early 2017 before final approval by the NHS Grampian Board in March 2017.

The Board resolved:-

(i) to note the ongoing work on the review as outlined in the report; and

(ii) to agree that the review group recommendations, implementation plan and written responses from principal interested parties would come to the IJB for discussion prior to final approval by the NHS Grampian Board.

ACHSCP RECOGNISING ACHIEVEMENT SCHEME

14. The Board had before it a report by Gail Woodcock (Integrated Localities Programme Manager, ACHSCP) which proposed to develop a programme of achievement recognition, including an awards ceremony to celebrate and formally recognise the dedication, efforts and achievements of Partnership staff.

The report recommended:-
that the Board –

(a) Endorse the development of a programme of activities to recognise the efforts and achievements of staff working for the ACHSCP; and

(b) Agree to the establishment of an annual awards ceremony to serve as the pinnacle of formal recognition for our workforce.

Gail Woodcock spoke to the report and advised that the proposal would introduce a distinctive award scheme for 1800 Partnership staff and provide a platform to celebrate the delivery of the Partnership's values. She added that the report recommended that an annual awards ceremony be arranged as a way to bring all partners together and formally recognise the efforts of staff and community partners who had made a valuable contribution towards the integration of health and social care in Aberdeen City over the previous twelve months.

Members welcomed the proposal and suggested that the scope of the scheme should be expanded to recognise the contribution of colleagues from the third and independent sectors in supporting the Partnership's objectives and aspirations. Members also discussed the possible award categories that could be included in the award scheme.

The Board resolved:-

(i) to endorse the development of a programme of activities to recognise the efforts and achievements of staff working for the ACHSCP; and

(ii) to agree to the establishment of an annual awards ceremony to serve as the pinnacle of formal recognition for ACHSCP's workforce and as a way to recognise the contribution made by partner organisations to support the integration of health and social care in Aberdeen City.

In accordance with the decision recorded under article 2 of this minute, the following items were considered with the press and public excluded.

EXPANSION OF INTERIM BED POSITION

15. The Board had before a report by Kenneth O'Brien (Service Manager, ACHSCP) which proposed to expand the interim care home bed base to support immediate discharge of patients/clients delayed in hospital. The plan would result in up to thirteen additional beds being brought online to complement the six existing beds already in place. This would be for a twelve month period initially with a review built in.

The report recommended:-

that the Board –

(a) Approve the project to expand the interim bed base;

(b) Request to be updated on the interim bed base project as part of the IJB's periodic updates on the Partnership's delayed discharge position; and

(c) Formally instruct the Chief Officer to issue the Direction to Aberdeen City Council to purchase the thirteen additional beds.

The Board resolved:-

(i) to approve the project to expand the interim bed base;

(ii) to request to be updated on the interim bed base project as part of the IJB's periodic updates on the Partnership's delayed discharge position; and

(iii) to submit a Direction to Aberdeen City Council to purchase the thirteen additional beds.

WORKSHOP SESSION

16. The Board then broke out for a workshop session on mental health presented by Jenny Gibb (Professional Nursing Adviser, NHS Grampian), Dr Alastair Palin (Clinical Director, Mental Health Services and Deputy Medical Director, NHS Grampian) and Claire Wilkie (Service Manager, ACHSCP).

The Board resolved:-
To thank Jenny Gibb, Dr Alastair Palin and Claire Wilkie for the informative presentation.
COUNCILLOR LEN IRONSIDE CBE, Chairperson.

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BUSINESS STATEMENT

15 NOVEMBER 2016

Please note that this statement contains a note of items which have been instructed for submission to, or further consideration by, the Integration Joint Board (IJB). All other actions which have been instructed are not included, as they are deemed to be operational matters after the point of decision. Items which have been actioned are shaded.

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Due
1.	TLG 17.11.14 Article 3	**Delegated Functions and Services** The TLG agreed that the starting position in terms of delegated functions and services would be those set out in set one of the regulations and orders as set out in tables 2 and 3 appended to the report, and within that starting point, agreed that further work on the handling of NHS services delivered across the north east and in relation to hosted services within scope would be carried out by the Strategic Change Management Group and recommendations brought back to the Shadow Board.	The Scheme of Delegation was deferred by the Board at its meeting on 28 June 2016 and will be aligned to the development of Aberdeen City Council's revised Scheme of Delegation. The Board requested a report on future IJB directions for hosted services.	Chief Officer, Aberdeen City Health and Social Care Partnership	28.03.17
2.	sIJB 27.01.15 Article 5	**Delayed Discharges** The Shadow Board agreed in principle to the proposals attached and for officers to develop these further. The Shadow Board also agreed to additional funding support from the Scottish Government and to receive regular updates on progress in developing this work and in relation to Delayed Discharge performance.	An update on delayed discharges was provided to the Board on 28 June 2016 and the Board requested that the next update include information on Code 100 performance. A report on the expansion of interim bed provision was submitted to the Board on 30 August 2016.	Chief Officer, Aberdeen City Health and Social Care Partnership	31.01.17

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Due
3.	sIJB 31.03.15 Article 5	**Winter Planning** The Shadow Board requested a report that would provide an early update on winter planning and the roles of both parent organisations be added to the schedule and for said report to be submitted no later than the August meeting.	A report on winter and contingency planning was presented to the Board on 28 June 2016 and the Board requested that the Chief Officer report to the IJB on recommendations within the approved 2016-17 Grampian Winter Plan. A report on Grampian Winter Planning is on today's agenda under item 9.	Chief Officer, Aberdeen City Health and Social Care Partnership	15.11.16
4.	sIJB 28.04.15 Article 12	**Integrated Care Fund** The Shadow Board requested a report on the proposed planning and delivery expectations for years two and three of the Integrated Care Fund.	The Board received a report on Strategic Commissioning Investments at its meeting on 26 April 2016. The Board requested that a report on progress and milestones be submitted on an annual basis and an update on the principle of ringfencing transformational funding. A Transformation Progress Report is on today's agenda under item 20.	Chief Officer, Aberdeen City Health and Social Care Partnership	15.11.16
5.	sIJB 28.07.15 Article 7	**Draft Strategic Plan Indicative Timetable** The Shadow Board requested an indicative timetable be produced during the development of the Strategic Plan that would focus on service delivery.	A report is on today's agenda under item 8.	Chief Officer, Aberdeen City Health and Social Care Partnership	15.11.16
6.	sIJB 29.09.15 Article 9	**Auditing and Financial Reporting** The Shadow Board requested a report on future reporting arrangements for financial and auditing matters that were within the remit of the sIJB and to explore the option	The Audited Annual Accounts were presented to the Board on 30 August 2016. An External Audit Report on the Aberdeen City IJB was presented to the	Chief Finance Officer, Aberdeen City Health and Social Care Partnership	15.11.16

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Due
		of establishing a Sub Committee to consider these matters.	Board on 30 August 2016. A report on the Audit and Performance System's Terms of Reference is on today's agenda under item 4. The minutes of the Audit and Performance Systems Committee are on today's agenda under items 13 and 14.		
7.	sIJB 27.10.15 Article 6	**Document Management** The Shadow Board requested a report on document management and storage.		Chief Officer, Aberdeen City Health and Social Care Partnership	31.01.17
8.	sIJB 27.10.15 Article 7	**Performance Assurance Framework** The Shadow Board requested a report on the development of a performance assurance framework.	The Board approved the Governance and Improvement Framework as the basis of future IJB reporting on 29 March 2016. A report on Performance Monitoring is on today's agenda under item 7.	Chief Officer, Aberdeen City Health and Social Care Partnership	15.11.16
9.	sIJB 23.02.16 Article 5	**Locality Planning** The Shadow Board requested a timetable which outlined the development of locality planning.	An update on locality planning is on today's agenda under item 8.	Integrated Localities Programme Manager, Aberdeen City Health and Social Care Partnership	15.11.16
10.	sIJB 23.02.16	**Clinical and Care Governance Framework**	The minutes of the Clinical and Care Governance Committee are attached	Chief Officer, Aberdeen City	15.11.16

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Due
	Article 6	The Board resolved to defer decision making on the Clinical and Care Governance Framework on 23 February 2016 to the Board's next meeting on 29 March 2016.	under items 15 and 16 of today's agenda.	Health and Social Care Partnership	
11.	IJB 28.06.16 Article 10	**Good Governance Institute Implementation Plan** The Board instructed the Chief Officer to prepare an action plan on how the recommendations in the Good Governance Institute's final report would be implemented.		Chief Officer, Aberdeen City Health and Social Care Partnership	31.01.17
12.	IJB 30.08.16 Article 5	**Standing Orders** The Board requested that officers review standing order 23 and report back to the Board.		Senior Democratic Services Manager, ACC	15.11.16
13.	IJB 30.08.16 Article 10	**Living Wage Monitoring Arrangements** The Board instructed the Chief Officer to ensure the implementation of the Living Wage and Fair Working Practices through appropriate contract monitoring processes to provide assurance to the IJB that this had been implemented by the end of the financial year.		Chief Finance Officer, Aberdeen City Health and Social Care Partnership	28.03.17
14.	IJB 30.08.16	**Ethical Care Charter**		Chief Officer, Aberdeen City	28.03.17

No.	Minute Reference	IJB Decision	Update	Lead Officer(s)	Due
	Article 12	The Board requested an update on the work of the Ethical Care Charter Working Group and for this report to come to the IJB by the end of the financial year.		Health and Social Care Partnership	

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Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Audit & Performance Systems - Terms of Reference
Lead Officer	Alex Stephen, Chief Finance Officer, ACHSCP
Report Author (Job Title, Organisation)	Alex Stephen, Chief Finance Officer, ACHSCP
Date of Report	31.10.16
Date of Meeting	15.11.16

1: Purpose of the Report

The Audit & Performance Systems Committee's Terms of Reference are required to be reviewed every six months.

2: Summary of Key Information

The terms of reference of the Audit & Performance Systems Committee are attached as appendix 1 of this report. Any decision to change the terms of reference needs to be made by the Integration Joint Board.

One area the Integration Joint Board may wish to consider changing is in relation to approval of the annual accounts. At present point 13 reads 'to consider the annual financial accounts and related matters before submission to and approval by the IJB'.

The Local Authority Accounts (Scotland) Regulations 2014, indicates the following with regard to approval of the accounts:

'the local authority or a committee of that authority whose remit includes audit or governance functions must meet to consider the unaudited Annual Accounts as submitted by the auditor'

'A local authority, or a committee of that authority whose remit includes audit or governance functions, must meet to consider the audited Annual Accounts'

The IJB needs to comply with this legislation and it might be helpful to change point 13 to allow the Audit & Performance Systems Committee 'to consider and approve the annual financial accounts and related matters'. This is the same approach taken by Aberdeen City Council and will allow the accounts to be agreed

at the September 2017 meeting of this committee.

The Audit & Performance Systems Committee considered this change at its meeting on the 25th of October 2016 and recommends the change to the terms of reference as outlined.

3:	Equalities, Financial, Workforce and Other Implications

The delegation of power to the APS Committee to scrutinise and approve the Partnership's annual accounts is reflective of the growing maturity of the Board's governance arrangements. Closely adhering to the current statutory reporting framework and the relevant accounting codes of practice as detailed above negates legal compliance risks.

4:	Management of Risk

Identified risk(s): NA

Link to risk number on strategic or operational risk register: NA

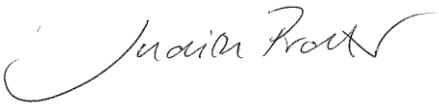
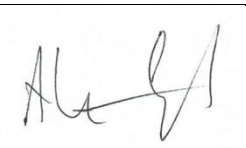
How might the content of this report impact or mitigate the known risks: NA

5:	Recommendations

The Integration Joint Board is asked to:

1. Approve the changes to the Terms of Reference, as recommended by the Audit & Performance Systems Committee and detailed in appendix 1.

Integration Joint Board

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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ABERDEEN CITY INTEGRATION JOINT BOARD
AUDIT & PERFORMANCE SYSTEMS COMMITTEE
TERMS OF REFERENCE

1	**Introduction**
1.1	The Audit & Performance Systems Committee is identified as a Committee of the Integration Joint Board (IJB). The approved Terms of Reference and information on the composition and frequency of the Committee will be considered as an integral part of the Standing Orders.
1.2	The Committee will be known as the Audit & Performance Systems Committee (APS) of the IJB and will be a Standing Committee of the Board,
2	**Constitution**
2.1	The IJB shall appoint the Committee. The Committee will consist of not less than 4 members of the IJB, excluding Professional Advisors. The Committee will include at least two voting members, one from Health and one from the Council.
3	**Chair**
3.1	The Committee will be chaired by a non-office bearing voting member of the IJB and will rotate between NHS and ACC.
4	**Quorum**
4.1	Three Members of the Committee will constitute a quorum.
5	**Attendance at meetings**
5.1	The Board Chair, Chief Officer, Chief Finance Officer Chief Internal Auditor and other Professional Advisors and senior officers as required as a matter of course, external audit or other persons shall attend meetings at the invitation of the Committee.
5.2	The Chief Internal Auditor should normally attend meetings and the external auditor will attend at least one meeting per annum.
5.3	The Committee may co-opt additional advisors as required.
6	**Meeting Frequency**
6.1	The Committee will meet at least 4 times each financial year. There should be at least one meeting a year, or part therefore, where the Committee meets the external and Chief Internal Auditor without other seniors officers present. A further 2 developmental sessions will be planned over the course of the year to support the development of members.
7	**Authority**
7.1	The Committee is authorised to instruct further investigation on any matters which fall

	within its Terms of Reference.
8	**Duties**
8.1	The Committee will review the overall Internal Control arrangements of the Board and make recommendations to the Board regarding signing of the Governance Statement, having received assurance from all relevant Committees.
	Specifically it will be responsible for the following duties:
	1. The preparation and implementation of the strategy for Performance Review and monitoring the performance of the Partnership towards achieving its policy objectives and priorities in relation to all functions of the IJB;
	2. Ensuring that the Chief Officer establishes and implements satisfactory arrangements for reviewing and appraising service performance against the national health and wellbeing outcomes, the associated core suite of indicators and other local objectives and outcomes and for reporting this appropriately to the Committee and Board.. The performance systems scrutiny role of the Committee is underpinned by an Assurance Framework which itself is based on the Board's understanding of the nature of risk to its desired priorities and outcomes and its appetite for risk-taking. This role will be reviewed and revised within the context of the Board and Committee reviewing these Terms of Reference and the Assurance Framework to ensure effective oversight and governance of the partnership's activities..
	3. Acting as a focus for value for money and service quality initiatives;
	4. To review and approve the annual audit plan on behalf of the IJB, receiving reports, overseeing and reviewing actions taken on audit recommendations and reporting to the Board;
	5. Monitoring the annual work programme of Internal Audit, including ensuring IJB oversight of the clinical and care audit function and programme to ensure this is carried out strategically;
	6. To consider matters arising from Internal and External Audit reports;
	7. Review on a regular basis actions planned by management to remedy weaknesses or other criticisms made by Internal or External Audit
	8. To support the IJB in ensuring that the strategic integrated assurance and performance framework is working effectively, and that escalation of notice and action is consistent with the risk tolerance set by the Board.
	9. To support the IJB in delivering and expecting cooperation in seeking assurance that hosted services run by partners are working effectively in order

		to allow Aberdeen City IJB to sign off on its accountabilities for its resident population.
	10.	Review risk management arrangements, receive annual Risk Management updates and reports and annually review with the full Board the IJB's risk appetite document .
	11.	Ensure existence of and compliance with an appropriate Risk Management Strategy.
	12.	Reporting to the IJB on the resources required to carry out Performance Reviews and related processes;
	13.	To consider and approve annual financial accounts and related matters ~~before submission to and approval by the IJB;~~
	14.	Ensuring that the Senior Management Team, including Heads of Service, Professional Leads and Principal Managers maintain effective controls within their services which comply with financial procedures and regulations;
	15.	Reviewing the implementation of the Strategic Plan;
	16.	To be responsible for setting its own work programme which will include the right to undertake reviews following input from the IJB and any other IJB Committees;
	17.	The Committee may at its discretion set up short term working groups for review work. Membership of the working group will be open to anyone whom the Committee considers will assist in the task assigned. The working groups will not be decision making bodies or formal committees but will make recommendations to the Audit Committee;
	18.	Promoting the highest standards of conduct by Board Members; and
	19.	Monitoring and keeping under review the Codes of Conduct maintained by the IJB.
	20.	Will have oversight of Information Governance arrangements and staffing arrangements as part of the Performance and Audit process.
	21.	Ensuring effective IJB oversight of the scrutiny of Serious Incidents in health and social care, including monitoring and reporting systems, timely action, training and improvement activities.
	22.	To be aware of, and act on, Audit Scotland, national and UK audit findings and inspections/regulatory advice, and to confirm that all compliance has been responded to in timely fashion.
9	**Review**	
9.1	The Terms of Reference will be reviewed every six months to ensure their ongoing appropriateness in dealing with the business of the IJB.	
9.2	As a matter of good practice, the Committee should expose itself to periodic review	

	utilising best practice guidelines and external facilitation as required.

Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Finance update at 15th November 2016
Lead Officer	Alex Stephen, Chief Finance Officer, ACHSCP
Report Author	Gillian Parkin (Finance Manager)\Jimmie Dickie (Finance Business Partner)
Date of Report	31.10.16
Date of Meeting	15.11.16

1: Purpose of the Report

i) To summarise the current year revenue budget performance for the services within the remit of the Integration Joint Board as at Period 6 (end of September 2016); and

ii) To advise on any areas of risk and management action relating to the revenue budget performance of the Integration Joint Board (IJB) services.

iii) To request approval of budget virements so that budgets are more closely aligned to anticipated income and expenditure (see Appendix E).

2: Summary of Key Information

Reported position for the period to end September 2016

2.1 A favourable position of £1,199,000 is reported for the six month period to the end of September 2016 as shown in Appendix A. A forecasted year-end position has been prepared based on month 6 results. This has resulted in a projected overspend of £931,000 on mainstream budgets. This can mainly be attributed to the overspend on prescribing which is a highly volatile budget and will be a financial risk for the Integration Joint Board to manage.

2.2 A review has been undertaken of the spend and commitments against the Transformation Funding budget and the forecast has been adjusted accordingly. A report on the transformation fund is included on today's agenda.

2.3 Should it not be possible for the Partnership to manage the overspend position then the funding to cover the overspend will require to be met from Transformational Funding. A contribution of £500,000 from Transformational funds was agreed at the IJB April meeting which leaves a further required

contribution of £431,000.

2.4 An analysis of variances is detailed below:

Community Health Services (Year to date variance - £96,000 overspend)

Within this expenditure category there is a significant underspend on staffing budget £227,000 due to high levels of vacancies within almost all staffing areas and also an underspend on property costs £61,000. This is offset by historical unmet budget reduction targets £439,000 which will be considered during the 2017/18 budget setting process.

Learning Disabilities (Year to date variance - £416,000 underspend)

There is an underspend of £59,000 due to Allied Health Professional vacancies. Also there is an underspend of £357,000 on adult social care services consisting of underspends on needs led care budgets of £309,000 and staffing £103,000; partially offset by under-recovery of client contributions £72,000.

The expenditure on learning disability commissioned services assumes that all of the £768,000 of savings against learning disability budgets will be met. Close monitoring of benefits from savings targets will continue. An exercise will be undertaken during October to check the accuracy of assumptions in the forecast for new packages received from Childrens' with Disabilities services and how much they have been offset by transfers to older people services.

Direct payments year to date expenditure is less than at this point last year. This partly reflects £261,000 of repayments in the year to date figure. Only £37,000 of repayments was received last year.

The under-recovery of client contributions is being investigated. As the financial assessment team checks for completeness this under-recovery might decrease.

Mental Health & Addictions (Year to date variance - £247,000 overspend) -

An overspend of £183,000 on medical locum costs due to the inability to recruit. Mental Health currently have 3 whole time equivalent consultant vacancies and 1 whole time equivalent speciality doctor which are currently all being filled by locums. These vacancies are within adult mental health and substance misuse service.

There is also an overspend of £64,000 on social care spend mainly relating to

under recovery of client contributions. This is consistent with income levels in previous years. A budget virement has been identified to correct this.

Older People & Physical and Sensory Disabilities (Year to date variance - £192,000 underspend) –

This mainly reflects an underspend of £232,000 on needs led commissioned services and £78,000 on staff costs; partially offset by under-recovery of client contributions for in-house services £139,000.

The underspend on staffing is mainly due to a vacant head of service post £66,000. An exercise will be undertaken to ensure that staffing budgets reflect the new management structure in due course.

There have been historical underspends against needs led older people services against a background where providers have difficulties in recruiting staff locally. Exercises are underway to check the reliability of Carefirst data and to improve monitoring of this budget. Outturns may change as a result of this exercise.

There has been a historical under recovery of income against in-house older people services. Budget adjustments have been identified so that budgets are more closely aligned with actual income.

Central Living Wage/Inflation Provision etc (Year to date variance - £1,354,000 underspend) –

The main reason for underspend is that the commissioned services budget for the living wage and commissioned services uplifts have not been allocated yet. The cost of implementing the living wage requirements has been assessed and will be incorporated within the budgets during the year once paid. The position in respect of this budget is likely to change as a result.

Housing (Year to date variance £187,000 underspend) –

The main reason for the underspend is that limited spend has been recorded so far on work against Housing capital aids and adaptations, although the service is confident the full budget will be spent by the end of the financial year. The Housing Revenue Account is a ring fenced budget and therefore any underspend from this element of the budget cannot be vired for non housing services.

Primary Care Prescribing (Year to date variance – £503,000 overspend) –

This position is based on actual information for April to July with an accrual for

August and September report. The budget to September includes uplift from NHSG budget setting process and an efficiency allocation for partnership initiatives and activity. The average unit costs per item prescribed increased from £11.08 in March to £11.30 in June. The volume of items year to date estimated September has increased by 1.45%. This is a slight reduction from the level of increase anticipated in August. Estimates for August and September are based on latest actual information resulting in the overspend position reported. This is a volatile demand led budget.

Primary Care Services (Year to date variance - £57,000 overspend) –

Overspend on Primary Care Services within partnership represents the impact of a number of minor variances including delivery of Enhanced services. These services include diabetic care, extended hours and immunisations.

2.5 The executive team were requested to prepare a recovery plan to bring the overspend back into a balanced position. Since this request was made the level of overspend has reduced to £931,000 from the period 3 projected overspend of £1,261,000. In terms of helping to manage the overspend a request has come forward to implement a Medicines Management Interventions Local Enhanced Service (ES) initiative as outlined below

The aim of the ES is to improve and promote two key areas of activity relating to improving cost effective use of medicines within practices in Grampian. Some patients " over order " mediation – commonly as required analgesics and skin preparation leading to stockpiling of unused medicines . In part one of this enhanced service practice administrative staff will undertake a non-clinical review of patients who order all of their repeat medications as a single order every order (excluding Care Home patients) for the most recent three issues and take appropriate action in line with new NHS Grampian guidance. A computer software package will be provided to practices to support this work.

In part 2 of this enhanced service practices will also be supported to undertake quality improvement and cost effective prescribing switches. Practices will choose at least three switches/initiatives (from a menu of possible switches) following local discussion with their HSCP according to local priorities. Practices are expected to choose at least two initiatives that will generate savings to the practice prescribing budget.

Funding for part 1 of the ES is a £300 engagement fee (to facilitate in house training) and then an activity cost of £0.20 per patient registered. In part 2 of the ES payment is £10 per drug switch to support practices in the work undertaken in patient review.

The total cost of this initiative for Aberdeen City Health & Social Care

Partnership will be funded from the prescribing budget on an invest to save basis i.e. the cost should be offset by prescribing savings. Should the IJB be minded to support this proposal then a direction to the NHS has been prepared and is attached in appendix f of this report.

2.6 The Executive Team will continue to review budgets looking for further opportunities to save money which do not impact on service delivery in order to protect the transformation fund.

3:	Equalities, Financial, Workforce and Other Implications

3.1 Every organisation has to manage the risks inherent in the operation of large and complex budgets. These risks are minimised by the regular review of financial information by budget holders and corporately by the Board. This report is part of that framework and has been produced to provide an overview of the current operating position.

3.2 Key underlying assumptions and risks concerning the forecast outturn figures are set out within Appendix B. Appendix D monitors the savings agreed by Aberdeen City Council.

4:	Management of Risk

Identified risk(s):

Link to risk number on strategic or operational risk register:

A risk of IJB financial failure with demand outstripping available budgets.

How might the content of this report impact or mitigate the known risks:

Good quality financial monitoring will help budget holders manage their budgets. By having timely and reliable budget monitoring any issues are identified quickly, allowing mitigating actions to be implemented where possible.

5:	Recommendations for Action

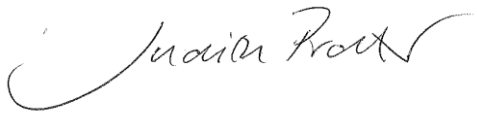
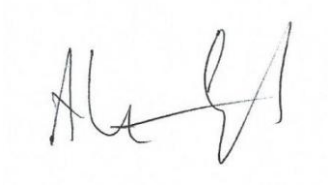
The Integration Joint Board is asked to :-

1) note this report on the month 6 position in relation to the IJB budget and the information on areas of risk and management action that is contained herein,

2) agree to the virements proposed in Appendix E,

3) agree the Local Enhanced Service initiative as detailed in paragraph 2.5 funded from the prescribing budget on an invest to save basis.

4) agree the direction as set out in appendix f.

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

Appendix A

Accounting Period 6	Full Year Revised Budget Budget £'000	end September Budget £'000	Actual Expenditure £'000	Variance Amount £'000	Variance Percent %	Year-End Forecast £'000
Community Health Services	31,851	15,586	15,683	96	0.3%	193
Aberdeen City share of Hosted Services (health)	20,686	10,393	10,438	45	0.2%	90
Learning Disabilities	28,762	14,382	13,966	(416)	(1.4%)	(411)
Mental Health & Addictions	17,681	8,851	9,097	247	1.4%	455
Older People & Physical and Sensory Disabilities	68,968	34,483	34,291	(192)	(0.3%)	(436)
Central Living Wage/inflation provision etc	2,416	1,206	(148)	(1,354)	(56.0%)	124
Criminal Justice	(90)	(38)	(42)	(4)	4.4%	(48)
Housing	1,860	930	743	(187)	(10.1%)	0
Primary Care Prescribing	39,310	19,484	19,987	503	1.3%	818
Primary Care	37,232	18,473	18,531	57	0.2%	135
Out of Area Treatments	1,220	517	522	6	0.5%	11
Sub Total: Mainstream position	**249,896**	**124,267**	**123,068**	**(1,199)**	**(1)**	**931**
Transformational Funding	13,176	3,020	3,020	0	0.0%	(8,954)
TOTAL	**263,072**	**127,287**	**126,088**	**(1,199)**	**(1)**	**(8,023)**

Integration Joint Board

Appendix B: Summary of risks and mitigating action

Service Area	Risks	Mitigating Actions
Community Health Services	Balanced financial position is dependent on vacancy levels continuing at present levels. As more GP vacancies arise within 2C practices there will be an increased level of GP locum expenditure.	Monitor levels of staffing in post compared to full budget establishment.
Hosted Services	Balanced financial position is dependent on vacancy levels continuing at present levels.	Monitor levels of staffing in post compared to full budget establishment.
Learning Disabilities	Procurement savings relating to learning disability services may not be delivered in the current financial year. Workload pressures are being caused by growth in transitional arrangements, an ageing client group and increasing demand for reviews. The service needs to be flexible and robust to deal with instances of market failure too.	Capacity issues will be investigated, workload issues prioritised and a timeline developed for savings and other issues. An exercise is underway to investigate all learning disability payments that have not been invoice matched so that the care transferred from children's services is correctly included in the outturn.

	Not all transitional arrangements from children's services are recorded on carefirst. If additional mental health consultant vacancies arise and inability to recruit will result in high locum expenditure.	
Mental Health And Addictions	A number of City clients with complex and high risk needs are currently awaiting discharge from hospital beds. It will not be easy to find providers with suitable accommodation and a workforce able to cope with a wide range of complexity, including extremely challenging and forensic behaviours. Affordability will be an issue. One client's case has reached the tribunal stage. If the tribunal decides that they should be treated in the community, then the cost could be around £100,000 per annum. More cases may follow. This might affect learning disability too.	A paper outlining background, current problems and potential solutions is to be developed.

Older People Services	Spending patterns of care services may vary from previous years either due to demographic change or the continuing contraction of the care market within the City. Charging policy income may also vary from previous years.	An exercise is under way to tidy up Carefirst which will help to improve budget monitoring. An exercise is being developed with the counter fraud officer to check nursing home placements. Income budgets will be closely monitored. Updates will be requested monthly from the financial assessments team.
Central Living Wage Provision	Providers may not agree to implement the living wage for the hourly rate that is affordable from Scottish Government funding.	An offer 6.4% has been offered from the first of October, to a meeting of representatives of providers. This has now been agreed by the IJB.
Criminal Justice	The funding for the criminal justice team maybe reduced as the grant formula is being reviewed.	Initial indications are the funding levels will be maintained at least in the short term.
Primary Care Prescribing	Primary Care prescribing is impacted by volume and price factors both of which are forecast on basis of available date and evidence at start of each year by the Grampian Medicines Management Group. However, actual data information is provided by Practioner Services Division and is two months in arrears resulting in potentially very late impact on financial position	Monitoring of price and volume variances forecast. Review of prescribing patterns across General Practices and follow up on outliers. Implementation of IT support tools - Scriptswitch and Scottish Therapeutic Utility. Poly pharmacy and repeat prescription reviews to reduce wastage and monitor patient outcomes.

Integration Joint Board

Appendix C: Sources of Transformational funding

	2016/17	2015/16 c/fwd	Total
	£m	£m	£m
Integrated Care Fund	3.750	2.436	6.186
Delayed Discharge Fund	1.125	0.921	2.046
Winter resilience		0.190	0.190
Social Care transformation funding	4.754		4.754
	9.629	**3.547**	**13.176**

Integration Joint Board

Appendix D: Progress in implementation of savings - September 2016

Area	Agreed Target	Delivered - YTD	Action	Responsible Officer
	£m	£m		
Procurement Savings	0.750	0.093	Work is continuing to make further savings from learning disabilities and mental health providers as agreed at Council. This saving needs to be taken forward in a managed manner in order to protect future service provision given the reliance on these providers. Funding has been identified on the central inflation\living wage line to offset any savings not delivered.	Judith Proctor
Bon Accord Care Contract	0.700	0.121	Negotiations are continuing with Bon Accord Care (BAC). At present BAC have identified £430,000 of savings. The main issue to achieving further savings is the additional costs BAC are incurring (in the region of £300,000) due to the increase in National Insurance costs as a result of the ending of contracting out pension arrangements.	Judith Proctor
Efficient Collection of all valid fees and charges	0.300	0.100	Income budgets will be closely monitored. The current list of deregistered properties for both in-house and external providers is being reviewed for completeness by the non-residential financial assessments team to try and close the remaining gap on this saving.	Judith Proctor
Review SDS community	0.168	0	The aim is to rationalise bespoke funding in learning disability services and self directed support into a single	Judith Proctor

engagement strategy in light of the integration Agenda			more cost effective system. Still to be scoped.	
Review of current clients against ordinary residency rules.	0.150	0.150	The aim is to make sure that costs for out of authority service users accommodated within the City are met by their home authority. This remains to be fully scoped, the Strategic Commercial Team are at an early stage in this process, although some work has commenced e.g. Newton Dee, which identified and established the principle that Aberdeenshire and some other Councils had a continuing responsibility for those people placed by them.	Judith Proctor
Review of block funded contracts	0.150	0.050	This saving will be contained within provision for growth and price inflation.	Judith Proctor
Total	2.218	0.514		

Integration Joint Board

Appendix E

Period 6 - Virements

Budget Head	Permanent £'000	Description
Older people	(9)	Reduction in OP direct payments ; offset by increase in mental health direct payments.
Older people	(81)	Reduction in OP spot purchase; offset by reduction in MH client contributions.
Older people	(31)	Reduction in OP direct payments; offset by increase in PD direct payments.
Older people	0	Reduction in client contributions £375k; offset by reductions in needs led spot purchase services £375k
Physical Disability	31	Increase in PD direct payments; offset by decrease in OP direct payments.
Learning Disability	0	Reduction in client contribution budget £201k; offset by reduction in direct payments budgets £201k.
Mental Health & Substance Misuse	0	Mental Health team staffing £36k; offset by mental health premises £36k
Mental Health & Substance Misuse	9	Mental Health direct payments £10k; offset by OP direct payments £9k and MH premises £1k.
Mental Health & Substance Misuse	81	Reduction in client contributions budgets: offset by reduction in OP spot purchase.
Criminal Justice	0	Staffing £83k; offset by reduction in premises £83k.
Hosted Services	(1,021)	Vired to Primary Care City
Primary Care	1,021	Services now run within this budget include GMS Improvement Grants, GMS valuation fees, GMS It expenditure, Dr's retainer scheme, Retainer GP expenses, career start, employers superannuation, needles and syringes, GP appraisers, COPD MCN and Eye Care Network.
Head of Operations	4,750	Adjustment for additional funding Adult Social Care 1617
Total	4,750	

INTEGRATION JOINT BOARD

DIRECTION

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

The **NHS Grampian** is hereby directed to deliver for the Board, the agreed specific direction noted below within the associated budget.

Services:	Primary Medical Services listed in Annex 1, Part 2 of the Aberdeen City Health and Social Care Integration Scheme.
Functions:-	Primary Medical Services listed in Annex 1, Part 2 of the Aberdeen City Health and Social Care Integration Scheme.
IJB Approval	15 November 2016
Specific Direction	Administrative staff will undertake a non-clinical review of patients who order all of their repeat medications as a single order every order (excluding Care Home patients) for the most recent three issues and take appropriate action in line with new NHS Grampian guidance. A computer software package will be provided to practices to support this work. Practices will also be supported to undertake quality improvement and cost effective prescribing switches. Practices will choose at least three switches/initiatives (from a menu of possible switches) following local discussion with their HSCP according to local priorities. Practices are expected to choose at least two initiatives that will generate savings to the practice prescribing budget.
Associated Budget:-	The total cost of this initiative for Aberdeen City Health & Social Care Partnership will be funded from the pharmacy budget on an invest to save basis.

This direction is effective from 15 November 2016 until further notice.

Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Reserves Policy
Lead Officer	Alex Stephen, Chief Finance Officer, ACHSCP
Report Author	Alex Stephen, Chief Finance Officer, ACHSCP
Date of Report	26.09.16
Date of Meeting	15.11.16

1: Purpose of the Report

The proposed reserves policy was considered by the Audit & Performance Systems committee on the 25th of October 2016 and is now presented to the IJB for consideration.

2: Summary of Key Information

The Integration Joint Board (IJB) has the power to carry forward money from one year to the next through its reserves by virtue of the Public Bodies (Joint Working) (Scotland) Act 2014.

It is important that a reserves policy is developed to support the carry forward and use of reserves. A proposed reserves policy is attached in appendix 1 of this report for consideration

The ability to carry funds from one year to the next will help support the transformation agenda which the Health & Social Care Partnership is currently working towards. In particular there will be an underspend on the transformation funds which will require to be carried forward. The underspend of the transformation funds is not unexpected, as it takes time to develop the proposals and programmes to deliver the objectives of the funding.

The IJB will need to decide at the end of the financial year whether it wants to continue to use all this funding for transformation purposes or whether some of it should be held back and placed in a risk fund. Aberdeen City Council (ACC) currently has a risk fund and when considering the adequacy of this fund includes the ACC element of the IJB budget.

The Integration Scheme indicates in section 12.8.5.2 that the Chief Officer and Chief Finance Officer will prepare a reserves policy for the IJB, which requires the approval of the IJB and the Director of Finance of NHS Grampian and the Section 95 Officer of the Council. The reserves policy will be reviewed on a periodic basis.

The Director of Finance of NHS Grampian and the Section 95 Officer of the Council have been consulted and are supportive of the proposed reserves policy.

3:	Equalities, Financial, Workforce and Other Implications

There are no workforce, equalities or other implications directly arising from this report.

The financial implications are contained throughout appendix 1. It is important that the IJB has a reserves policy and this is reviewed on a regular basis.

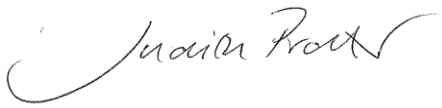
4:	Management of Risk

The creation and approval of a reserves policy will help to mitigate against the risks of IJB failure of demand outstripping available budget and the delivery of priorities and statutory work delivering an overspend.

5:	Recommendations

It is recommended that the Integration Joint Board:

1. Approve the proposed reserves policy.

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

Aberdeen City Integration Joint Board

PROPOSED RESERVES POLICY

Date Created	Date Implemented	Review Date
September 2016	October 2016	April 2017

Developed By Chief Finance Officer	Reviewed By Chief Officer	Approved by

VERSION 1.1

CONTENTS

1. Background

1.1 In July 2014 CIPFA, through the Local Authority Accounting Panel (LAAP), issued guidance in the form of LAAP bulletin 99 - *Local Authority Reserves and Balances* in order to assist local authorities (and similar organisations) in developing a framework for reserves. The purpose of the bulletin is to provide guidance to local authority chief finance officers on the establishment and maintenance of local authority reserves and balances in the context of a framework, purpose and key issues to consider when determining the appropriate level of reserves.

1.2 The Aberdeen City Integration Joint Board Audit Committee (IJB) is subject to the audit and accounts regulations and legislation of a body under Section 106 of the Local Government (Scotland) Act 1973 and is classified as a local government body for accounts purposes by the Office for National Statistics (ONS). The IJB is able to hold reserves which should be accounted for in the financial accounts of the Board.

1.3 The purpose of this Reserves Policy is to:

- outline the legislative and regulatory framework underpinning the creation, use or assessment of the adequacy of reserves;
- identify the principles to be employed by the IJB in assessing the adequacy of the its reserves;
- indicate how frequently the adequacy of the IJB's balances and reserves will be reviewed and;
- set out arrangements relating to the creation, amendment and the use of reserves and balances.

1.4 In common with local authorities, the IJB can hold reserves within a usable category.

2. Statutory / Regulatory Framework for Reserves

Usable Reserves

2.1 Local Government bodies - which includes the IJB for these purposes - may only hold usable reserves for which there is a statutory or regulatory power to do so. In Scotland, the legislative framework includes:

Usable Reserve -	Powers
General Fund -	Local Government (Scotland) Act 1973

2.2 For each reserve there should be a clear protocol setting out:

- the reason / purpose of the reserve;
- how the reserve links to the strategic plan,
- how and when the reserve can be used;
- procedures for the reserves management and control; and
- The timescale for review to ensure continuing relevance and adequacy.

3. Operation of Reserves

3.1 Reserves are generally held to do three things:

- create a working balance to help cushion the impact of uneven cash flows and avoid unnecessary temporary borrowing;

- create a contingency to cushion the impact of unexpected events or emergencies – this also forms part of general reserves; and

- create a means of building up funds, often referred to as earmarked reserves, to meet known or predicted liabilities.

3.2 The balance of the reserves normally comprises of three elements:

- funds that are earmarked or set aside for specific purposes. In Scotland under Local Government rules, the IJB cannot have a separate Earmarked Reserve within the Balance Sheet, but can highlight elements of the General Reserve balance required for specific purposes. The identification of such funds can be highlighted from a number of sources including:

    - future use of funds for a specific purpose, as agreed by the IJB; or

- funds which are not earmarked for specific purposes, but are set aside to deal with unexpected events or emergencies; and

- funds held in excess of the target level of reserves and the identified earmarked sums. Reserves of this nature can be spent or earmarked at the discretion of the IJB.

4. Role of the Chief Finance Officer

4.1 The Chief Finance Officer is responsible for advising on the targeted optimum levels of reserves the IJB would aim to hold (the prudential target). The IJB, based on this advice, should then approve the appropriate reserve strategy as part of the budget process

5. Adequacy of Reserves

5.1 There is no guidance on the minimum level of reserves that should be held. In determining the prudential target, the Chief Finance Officer must take account of the strategic, operational and financial risks facing the IJB over the medium term and the IJB's overall approach to risk management.

5.2 In determining the prudential target, the Chief Finance Officer should consider the IJB's Strategic Plan, the medium term financial outlook and the overall financial environment. Guidance also recommends that the Chief Finance Officer reviews any earmarked reserves as part of the annual budget process and development of the Strategic Plan.

5.3 In light of the size and scale of the IJB's responsibilities, over the medium term it is proposed to hold a prudent level of general reserves. The reserves will be reviewed annually as part of the IJB's Budget and Strategic Plan; and in light of the financial environment at that time. The level of other earmarked funds will be established as part of the annual financial accounting process.

6. Reporting Framework

6.1 The Chief Finance Officer has a fiduciary duty to ensure proper stewardship of public funds.

6.2 The level and utilisation of reserves will be formally approved by the IJB based on the advice of the Chief Finance Officer. To enable the IJB to reach a decision, the Chief Finance Officer should clearly state the factors that influenced this advice.

6.3 As part of the budget report the Chief Finance Officer should state:

- the current value of general reserves, the movement proposed during the year and the estimated year-end balance and the extent that balances are being used to fund recurrent expenditure;

- the adequacy of general reserves in light of the IJB's Strategic Plan, the medium term financial outlook and the overall financial environment;

- an assessment of earmarked reserves and advice on appropriate levels and movements during the year and over the medium term; and

- if the reserves held are under the prudential target, that the IJB should be considering actions to meet the target through their budget process.

7. Accounting and Disclosure

7.1 Expenditure should not be charged direct to any reserve. Any movement within Revenue Reserves is accounted for as an appropriation and is transparent. Entries within a reserve are specifically restricted to ‘contributions to and from the revenue account’ with expenditure charged to the service revenue account.

Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Performance Monitoring
Lead Officer	Judith Proctor, Chief Officer
Report Author (Job Title, Organisation)	Jillian Evans, Head of Health Intelligence NHSG Kevin Toshney, Acting Head of Strategy &Transformation ACHSCP.
Date of Report	26.09.16
Date of Meeting	15.11.16

1: Purpose of the Report

The purpose of this report is to provide the IJB with a progress report on the development of the partnership's performance management framework, to report on the partnership's performance to date against the national outcomes and their suite of national and local indicators and to outline the improvement activity that is being taken forward.

2: Summary of Key Information

1. Introduction.

It is evident that even in the first few months of integration 'go live', the information needs of the partnership are increasing as it operates in a constantly developing environment.

The Integration Joint Board (IJB) and its committees depend on having the right information at the right time to ensure they are focused on the right issues. Doing that to a high standard in and of itself is one of the elements identified by high performing organisations as a key characteristic of success.

1.1 In order for our approach to performance and governance to be wholly effective and support our transformational ambitions it must permeate the partnership across all sectors and services.

The main components of this approach include:

- Managing the 'information challenge' – developing processes to ensure that important intelligence is not missed
- Establishing a systematic cycle of reporting for IJB business– ensuring a balanced approach to the discussion of operational performance and strategic

considerations
- Clarifying delegated accountability – empowering people to take leadership and responsibility at all levels of the organisation
- Enabling constructive challenge – supporting people to interpret data and ask intelligent questions

2. Performance.

In managing services and performance at an operational level, the type of management information that is generally required includes:

- How many/how often/when/where **(facts)**
- How many should we be doing **(targets/trajectories)**
- How likely are we to meet the target given the current position **(forecasting)**
- How does it compare to others **(benchmarking)**

This data is often made accessible for operational teams through the use of dashboards and business intelligence which can be drilled down to different levels i.e. partnership, locality, GP practice etc.

3. Intelligence.

Beyond the performance improvement and governance of operational service delivery, intelligence for the Audit and Performance Committee and Executive Team will be required to help with insights affecting planning decisions, redesign and change. Tailored intelligence will be required for this to help answer the following types of questions:

- What is working well
- What is the evidence about what works well
- What is the impact on strategic aims, objectives and the national outcomes
- Do we meet national standards & targets
- What is the impact if we do not change
- How well do other similar areas perform
- Do we seek feedback from patients and staff, and act on it
- What other things need to be considered in the future

It is recognised, for example, that the IJB might well wish to know what the impact of investment in primary care means for the acute sector and what opportunities to shift the balance of care are likely to arise from this. A framework that outlines our inputs, outputs, throughputs and outcomes will be an invaluable planning tool.

The ongoing development of this reporting format will seek to provide answers and comment in sufficient depth in order that our planning and commissioning discussions and decisions are supported by robust, insightful intelligence.

Integration Joint Board

4. Assurance.

We recognise that the assurance that the IJB and its committees demand is multi-layered and reflects, at any given time, an interrelated set of behaviours, processes and demonstrable outcomes. In managing the complexities of the information challenge it is crucial that our evidence is able to answer the 'so what' question to the satisfaction of those who have governance oversight of the partnership.

In addition to the information provided in this paper, assurance can also be accepted through the business cycles of the IJB, its committees and the Chief Officer's Executive team, the corporate risk register and the board assurance framework.

5. Summary.

The importance of developing a performance management framework that will provide the necessary and desirable assurance about the efficiency and effectiveness of the partnership's operation and performance is crucial to our strategic ambitions and the wider governance arrangements of the Integration Joint Board.

The significant audit risk noted by the external auditor in their 2015/16 annual audit report on the IJB regarding our governance and performance arrangements is taken seriously and steps are being taken to address this.

We acknowledge that there is still work to do to make the framework more reflective of the full extent of our delegated functions and services. In part this reflects the challenge of information sharing and integrated systems, and this is being addressed through information infrastructure groups across all three HSCPs in Grampian. For the past two months we have been engaging with the senior leadership team, the strategic planning group and other partners to identify relevant indicators of performance, assurance and improvement. This feedback is helping to inform more comprehensive performance reporting and to improve ownership of improvement trajectories.

At the mid-year stage of our first 'live' year, our performance reporting and monitoring processes are still being developed. The work presented here is to enable business continuity and management oversight whilst we work with staff and partners to design and refine a performance framework which captures all important intelligence and is relevant for all stakeholders to use.

3:	Equalities, Financial, Workforce and Other Implications

There are no direct equalities, financial and workforce implications arising from this report.

However, failure to develop a robust performance management framework may jeopardise the credibility of the IJB's governance arrangements and perhaps cause the partner organisations to lose confidence in the IJB itself.

4:	Management of Risk

Identified risk(s):

The development of the performance management framework and the need for it to provide robust, relevant assurance and intelligence is critical to the governance and effective functioning of the IJB and its committees and the planning and delivery of our integrated services.

As such, there is a risk that the performance framework is not developed sufficiently enough

- to provide the IJB and its committees with the necessary assurance that the partnership is performing to the highest standards and fulfilling the national outcomes.
- to provide the partnership with the necessary intelligence to ensure that our planning and delivery of service is as safe, innovative and effective as possible.

Link to risk number on strategic or operational risk register:

Having a performance management framework that is not fit for purpose can be viewed as a strategic risk in itself however it will also impact on the following risks identified in the strategic risk register.

1. Failure of the IJB to function, make decisions in a timely manner etc.
2. There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance in through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.
3. There is a risk that the governance arrangements between the IJB and its partner organisations (ACC and NHSG) are not robust enough to provide necessary assurance within the current assessment framework – leading to duplication of effort and poor

relationships

4. There is a risk that the IJB and the services that it directs and has operational oversight of fail to meet performance standards or outcomes as set by regulatory bodies
5. There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care.
6. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system

How might the content of this report impact or mitigate the known risks:

This report seeks to mitigate these risks by:

a) showing the progress that has been made with developing a performance management framework since the shadow Integration Joint Board approved this proposal at its last meeting before 'Go Live' on 29th March 2016.

b) showing how the emerging framework is seeking to find a balance between the information it offers in respect of performance monitoring and the information it offers in respect of planning intelligence.

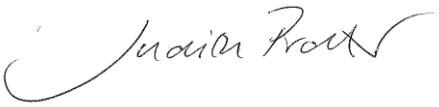
c) showing the partnership's performance to date against the national outcomes and the suite of national and local indicators.

5: Recommendations

The Integration Joint Board is asked to:

1. Note the endorsement of this paper by the Audit and Performance Systems Committee.
2. Note the progress that has been made to date in developing the partnership's performance management framework.
3. Instruct the Chief Officer to make the necessary arrangements for the completed performance management framework to be presented to the IJB at its next meeting.
4. Note the partnership's performance against the national outcomes and the associated suite of national and local indicators.
5. Instruct the Chief Officer to make the necessary arrangements for future performance monitoring reports to be accompanied by an improvement plan.

Integration Joint Board

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

Integration Joint Board

1. Performance Management Framework (Appendix A).

1.1 The statutory guidance requires partnerships to produce an annual report on performance using a 'core suite of indicators' established by Scottish Government and which are grouped against the nine national outcomes. Beyond this, it is for the IJB to decide the breadth, depth and frequency of performance monitoring.

1.2 The Performance Management Work Stream group has overseen the development of the framework, aiming to identify appropriate quantitative and qualitative indicators to enhance the national core suite.

The first set of performance reports have been issued primarily to stimulate discussion and to identify baselines. They are presented in a simple drillable spreadsheet and grouped according to the nine national outcomes. Throughout the year we will be making this data available in a more visual and interactive way, using Tableau software.

1.3 Indicators are grouped according to the nine national outcomes. A simple coding process is applied to compare the performance of the ACHSPC against the Scottish average. This then gives an 'at a glance' benchmark status of red, amber or green for each of the nine outcomes.

	Green	Amber	Red
National Outcomes	1, 4, 7	2, 5, 9	3, 6

In the spirit of exception reporting, further information is provided on those outcomes where ACHSCP performance appears to be lower than the Scottish average are:

Outcome 3: People who use health and social care services have positive experiences and their dignity respected

Ten indicators have been used to capture our progress in respect of this outcome. Of these ten, 7 are from the core suite and 3 are additional local indicators. RAG coding is as follows:

	Green	Amber	Red	Other
core	1	2	3	1
local	0	0	3	

Examining the red indicators further shows that they are all based on the biennial health and care experience survey (2015/16) (http://www.hace15.quality-health.co.uk/index.php/reports/).

The survey was sent to 23,713 people registered with GP practices in the area and 3,361 patients of Aberdeen City Health and Social Care Partnership sent in feedback on their experiences at the practice.

Of the individuals that answered questions about themselves:

- 43% were male and 57% were female;
- 17% were aged 17-34, 17% were aged 35-49, 30% were aged 50-64 and 37% were 65 and over;
- 68% did not have any limiting illness or disability.

Each of the red indicators shows a decrease in its percentage measurement from when the survey was last undertaken in 2013/14. In particular they relate to a drop in respondents having a say in their support for everyday living, and in the co-ordination of their care.

Outcome 6: People who provide unpaid care are supported to look after their health and well-being

Only three indicators have been used to capture our progress in respect of this outcome and of these three only one is a core indicator.

	Green	Amber	Red	Other
core			1	
local	1		1	

As previously, the two red indicators are based on the health and care experience survey and again show a decrease from the equivalent measurement in 2013/14. Support for caring received one of the lowest scores in the survey and this performance report is now highlighting that ACHSCP also compares poorly against the Scotland position.

1.4 A specific commentary on the Health and Care Experience survey was included in a previous paper to the Clinical and Care Governance committee (Appendix D).

1.5 The performance management work stream has discussed the desirability of capturing people's stories and experiences through additional qualitative indicators. The challenge here is to develop a suite of activities and indicators that will reflect the scope and complexity of the delegated functions and services and the diversity of individual experience and opinion therein.

1.6 Sir Harry Burns has been asked by the Scottish Government to chair a review of the national core suite of indicators and it is likely that he will present his recommendations in the period April-June 2017.

2. One Page Summary (Appendix B).

2.1 In its endorsement of the proposed framework, the IJB agreed that the Audit and Performance Committee and the Executive Team will require oversight, mainly through exception reporting of operational delivery issues.

A summary report is provided to show an 'at a glance' picture of performance against a basket of indicators. Although some of these indicators are drawn from the operational/management data, this report typically includes indicators at a higher level to provide a sharper focus for performance and assurance by the Executive Team and Committees. The basket of indicators is liable to change as we refine the framework with staff and partners. The current indicators are aligned with the categories shown below and are based on those used by the Care Quality Commission, although when required, they can be grouped for different audiences and specific purposes.

- **Safe** – how well do our services protect people from abuse and avoidable harm
- **Effective** – how well does the care and treatment we provide and commission achieve good outcomes, help people maintain quality of life and is based on the best available evidence
- **Caring** - how well do staff involve and treat people with compassion, kindness, dignity and respect
- **Responsive** – how well are services organised to meet individual needs
- **Well-led** – how well does leadership, management and governance of the organisation make sure it is providing high quality care, encouraging learning and innovation, and providing an open and fair culture

2.2 Performance against each indicator is colour coded red, amber and green and at this stage it is based on comparisons with Grampian and Scottish average. It highlights whether local performance is stable, improving or worsening. Over the coming months, we expect to set thresholds for triggering remedial action and 'alerting' issues. These will be based on realistic performance discussions with staff and/or with Scottish Government. We will also set improvement trajectories, based on positive and ambitious discussions with staff and partners.

2.3 Those indicators which are showing a worsening position from the last measurement include:

Well led	Views from adults about co-ordination of care
	Views from staff recommending this as a place to work
	Positive views about GP practice
Effective	Premature mortality rate
	Life expectancy
	Smoking cessation
	Alcohol brief interventions
	Emergency admission bed days
Responsive	Adults able to influence care at home
	Carers who feel supported
Caring	People receiving care who are treated with dignity and respect
	People receiving care treated with compassion & understanding
Safe	n/a

2.4 As mentioned in Appendix A, many of these indicators are based on the bi-annual health and care survey

As we refine our systems, more attention will be placed on measures of efficiency (e.g. throughput), as well as intelligent indicators of effective care across the health and social care system.

3. Assurance.

3.1 It is accepted that there are key indicators that the Audit and Performance Systems and the IJB will wish to oversee as a matter of course. These might include:

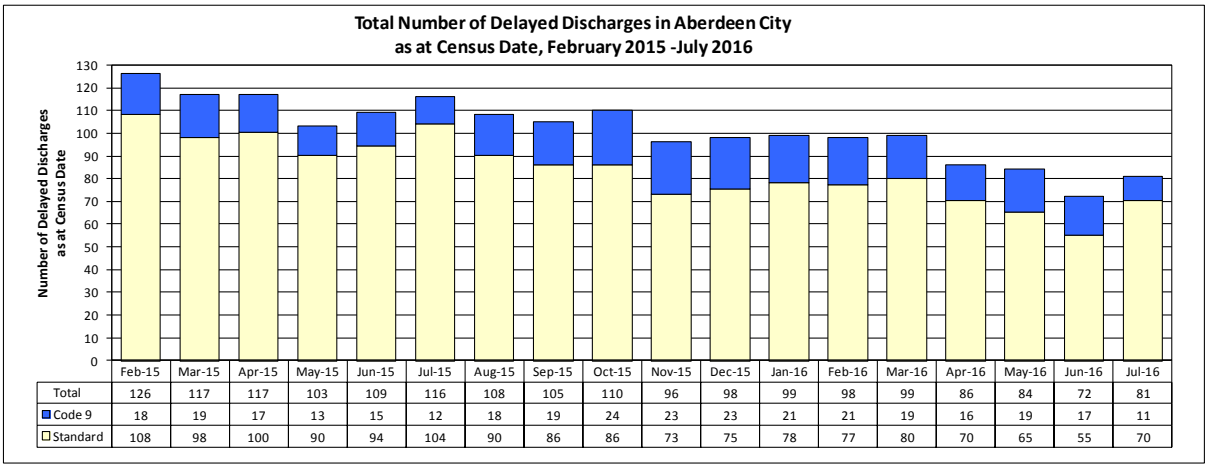
- Delayed discharge
- Emergency admissions
- Unmet social care need

3.2 Delayed Discharges

The number of delayed discharges, in Aberdeen City, fell from 126 in February 2015 to 72 by June 2016. An increase to 81 was recorded at the census in July 2015.

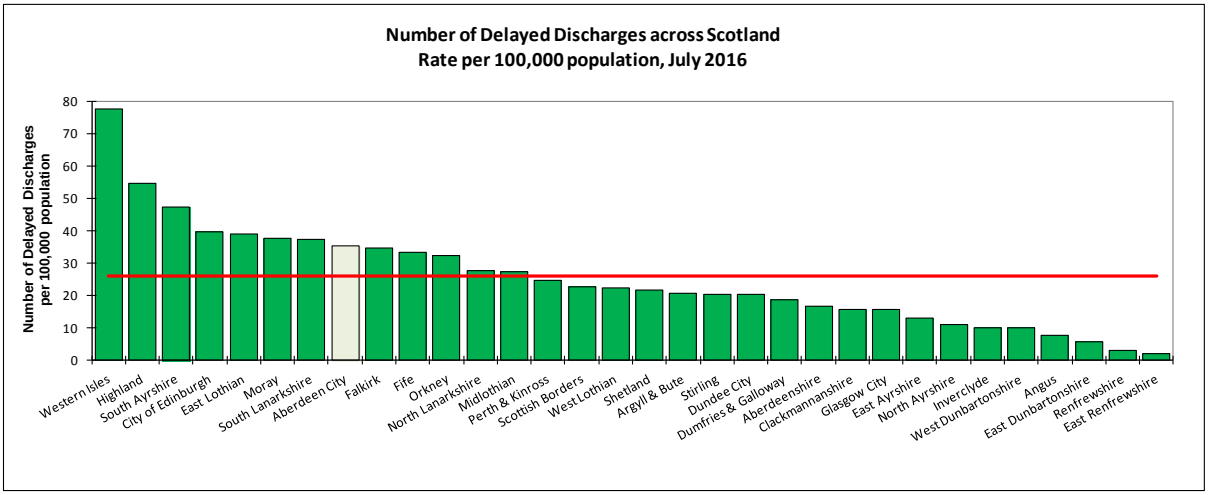
Integration Joint Board

However it should be noted that a change in definitions occurred in July 2016 and the following patients are no longer recorded as delayed discharges: patients delayed for healthcare reasons or in non-hospital locations. Patients discharged within three days of the census date are now included in the number of delays count which have been excluded from census figures since 2006. Hence figures from July 2016 onwards are not directly comparable with previous figures.



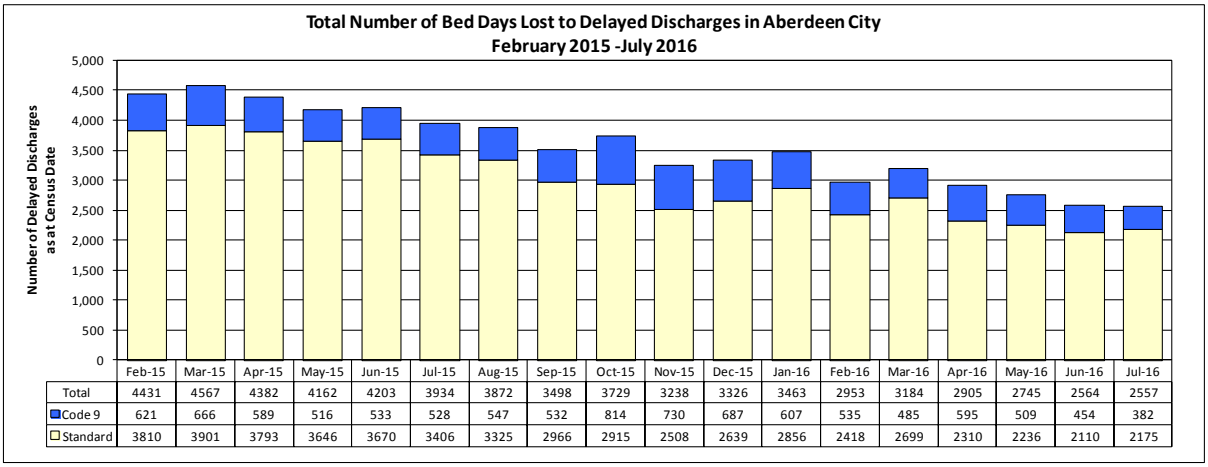
	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Total	126	117	117	103	109	116	108	105	110	96	98	99	98	99	86	84	72	81
Code 9	18	19	17	13	15	12	18	19	24	23	23	21	21	19	16	19	17	11
Standard	108	98	100	90	94	104	90	86	86	73	75	78	77	80	70	65	55	70

The total of 81 delayed discharges in Aberdeen City in July 2016 equated to a rate of 35.2 delayed discharges per 100,000 population. This was above the Scotland wide rate of 26 per 100,000 population and only seven local authorities recorded a higher rate.



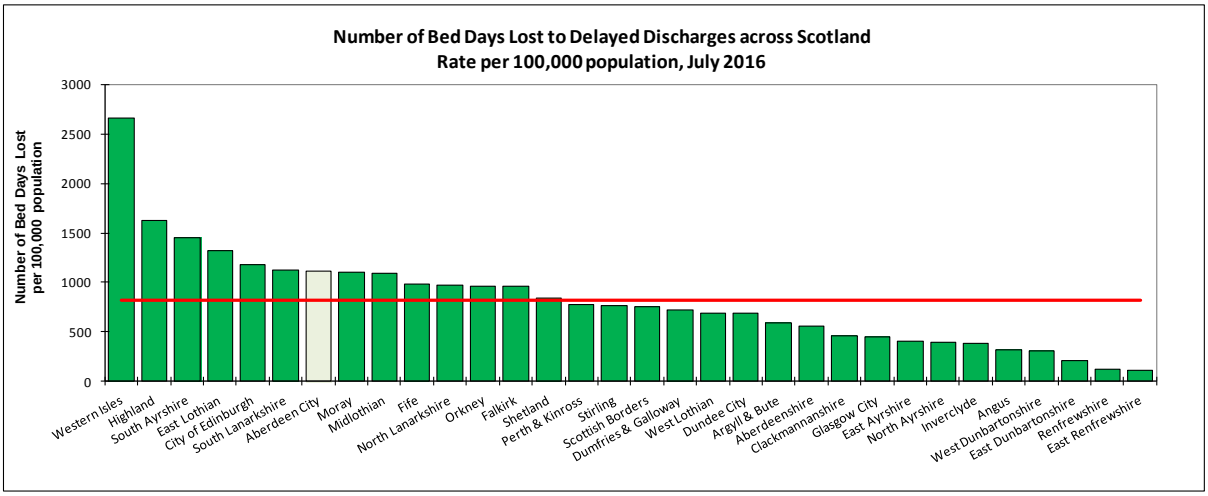
Delayed Discharges Bed Days

The number of bed days lost to delayed discharges in Aberdeen City fell from 4431 in February 2015 to 2557 in July 2016 – a drop of 42%.



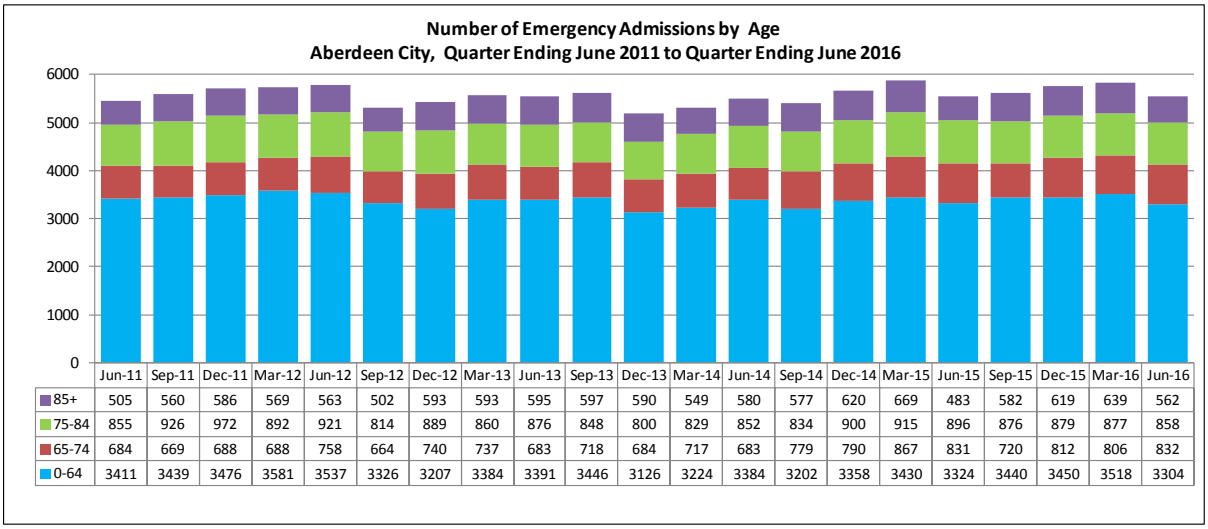
	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Total	4431	4567	4382	4162	4203	3934	3872	3498	3729	3238	3326	3463	2953	3184	2905	2745	2564	2557
Code 9	621	666	589	516	533	528	547	532	814	730	687	607	535	485	595	509	454	382
Standard	3810	3901	3793	3646	3670	3406	3325	2966	2915	2508	2639	2856	2418	2699	2310	2236	2110	2175

Aberdeen City had the sixth highest rate of beds lost to delayed discharges during July 2016 with 1110 per 100,000 population compared to 817 per 100,000 population across Scotland.



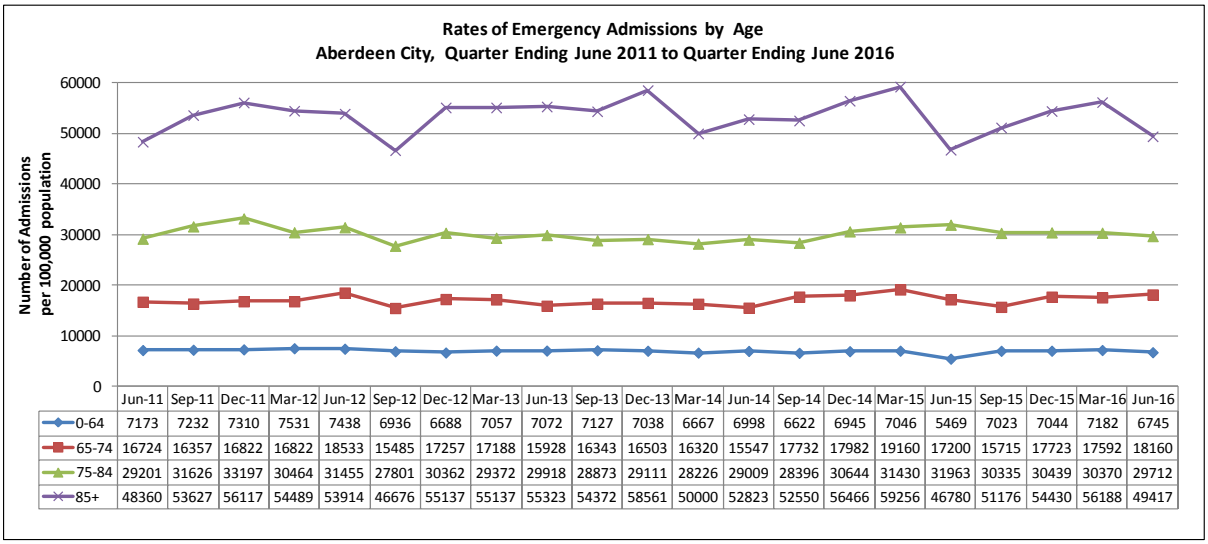
3.3 Emergency Admissions

The overall number of emergency admissions from Aberdeen City has been stable over the last five years. However there has been an increase in admissions amongst the 65-74 year age group and amongst the over 85s age group. By contrast there have been a reduced number of admissions from the 75-84 age group.



	Jun-11	Sep-11	Dec-11	Mar-12	Jun-12	Sep-12	Dec-12	Mar-13	Jun-13	Sep-13	Dec-13	Mar-14	Jun-14	Sep-14	Dec-14	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16	Jun-16
85+	505	560	586	569	563	502	593	593	595	597	590	549	580	577	620	669	483	582	619	639	562
75-84	855	926	972	892	921	814	889	860	876	848	800	829	852	834	900	915	896	876	879	877	858
65-74	684	669	688	688	758	664	740	737	683	718	684	717	683	779	790	867	831	720	812	806	832
0-64	3411	3439	3476	3581	3537	3326	3207	3384	3391	3446	3126	3224	3384	3202	3358	3430	3324	3440	3450	3518	3304

When looking at admission rates it can be seen that no trend is evident, over the past five years, for any of the four groups. Hence the change in number of admissions in each age group has been proportional to the change in population in that age group.

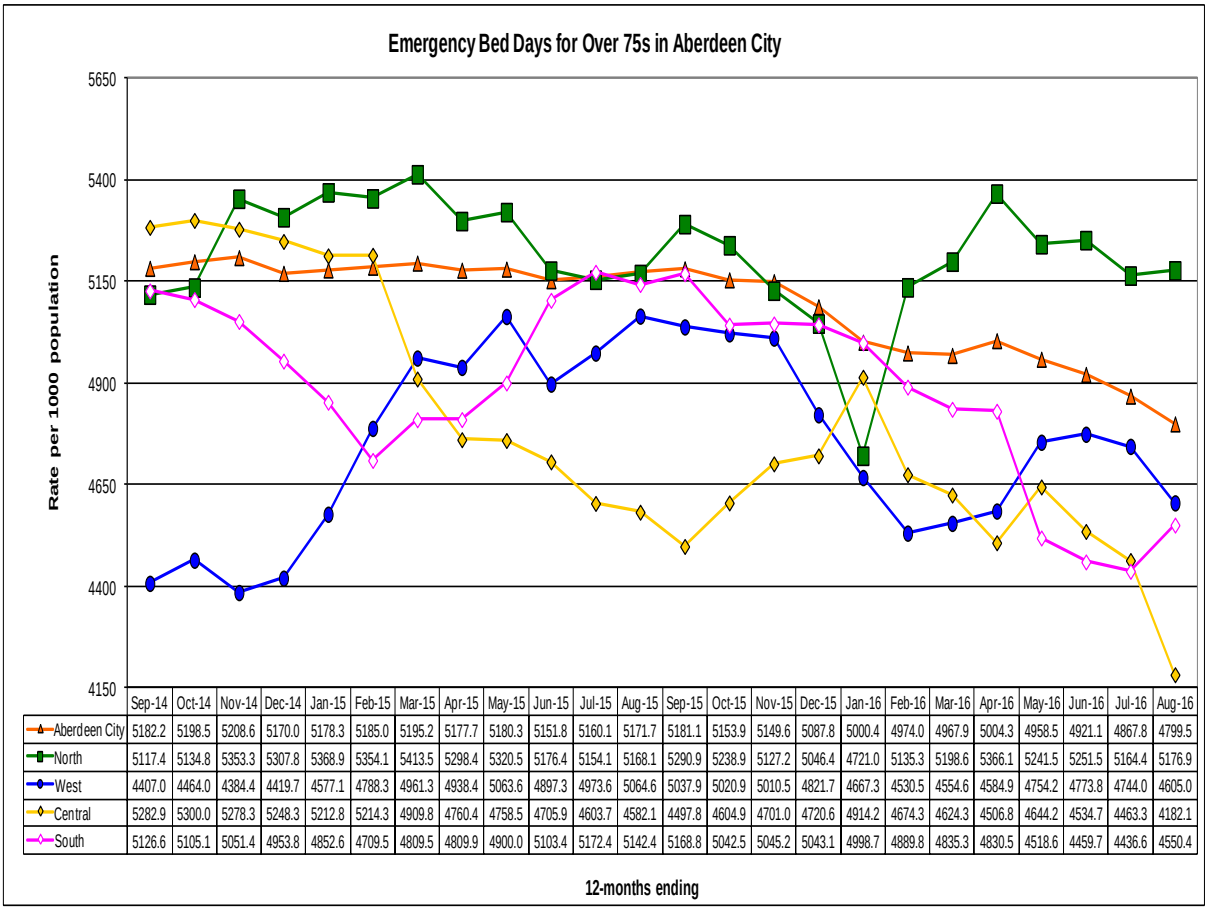


	Jun-11	Sep-11	Dec-11	Mar-12	Jun-12	Sep-12	Dec-12	Mar-13	Jun-13	Sep-13	Dec-13	Mar-14	Jun-14	Sep-14	Dec-14	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16	Jun-16
0-64	7173	7232	7310	7531	7438	6936	6688	7057	7072	7127	7038	6667	6998	6622	6945	7046	5469	7023	7044	7182	6745
65-74	16724	16357	16822	16822	18533	15485	17257	17188	15928	16343	16503	16320	15547	17732	17982	19160	17200	15715	17723	17592	18160
75-84	29201	31626	33197	30464	31455	27801	30362	29372	29918	28873	29111	28226	29009	28396	30644	31430	31963	30335	30439	30370	29712
85+	48360	53627	56117	54489	53914	46676	55137	55137	55323	54372	58561	50000	52823	52550	56466	59256	46780	51176	54430	56188	49417

Emergency Bed Days for Over 75s

The number of beds occupied by emergency patients aged 75 and over dropped from 5182 per 100,000 population in the year ending September 2014 to 4799.5 per 100,000 population in the year ending August 2016. Rates have generally been highest in North locality and lowest in West cluster though rates in South locality have dropped substantially since the end of 2016.

So, although the number of emergency admissions is generally unchanged the number of bed days has reduced implying a reduction in average length of stay.

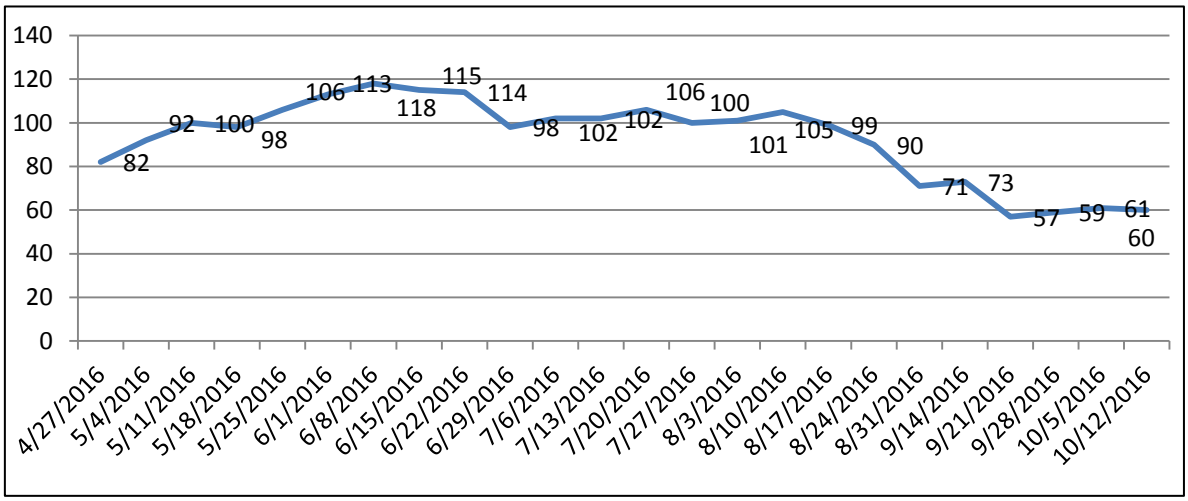


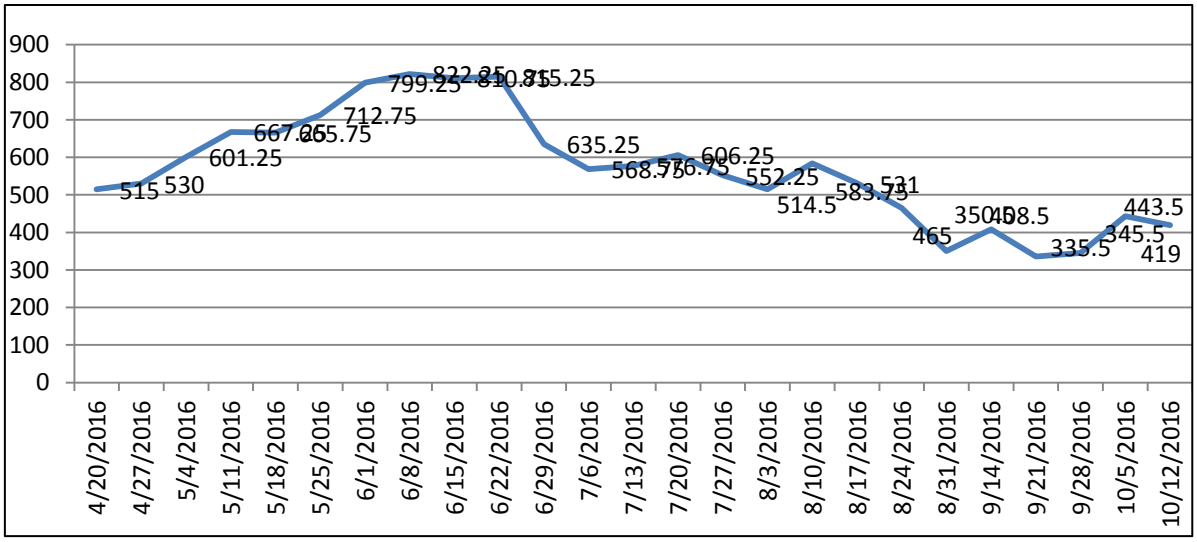
	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Aberdeen City	5182.2	5198.5	5208.6	5170.0	5178.3	5185.0	5195.2	5177.7	5180.3	5151.8	5160.1	5171.7	5181.1	5153.9	5149.6	5087.8	5000.4	4974.0	4967.9	5004.3	4958.5	4921.1	4867.8	4799.5
North	5117.4	5134.8	5353.3	5307.8	5368.9	5354.1	5413.5	5298.4	5320.5	5176.4	5154.1	5168.1	5290.9	5238.9	5127.2	5046.4	4721.0	5135.3	5198.6	5366.1	5241.5	5251.5	5164.4	5176.9
West	4407.0	4464.0	4384.4	4419.7	4577.1	4788.3	4961.3	4938.4	5063.6	4897.3	4973.6	5064.6	5037.9	5020.9	5010.5	4821.7	4667.3	4530.5	4554.6	4584.9	4754.2	4773.8	4744.0	4605.0
Central	5282.9	5300.0	5278.3	5248.3	5212.8	5214.3	4909.8	4760.4	4758.5	4705.9	4603.7	4582.1	4497.8	4604.9	4701.0	4720.6	4914.2	4674.3	4624.3	4506.8	4644.2	4534.7	4463.3	4182.1
South	5126.6	5105.1	5051.4	4953.8	4852.6	4709.5	4809.5	4809.9	4900.0	5103.4	5172.4	5142.4	5168.8	5042.5	5045.2	5043.1	4998.7	4889.8	4835.3	4830.5	4518.6	4459.7	4436.6	4550.4

3.4 Unmet Social Care Need.

The unmet social care need figures (number of clients and number of hours) show a decreasing trajectory in the (financial) year to date..

	No of clients	No of hours
Current	60	419
Lowest to date (April-Oct)	57	335
Highest to date (April- Oct)	118	822





These indicators (and others as thought desirable/necessary) grouped together, help to provide insights into the pressures on the whole system.

4.0 Audit Scotland

Audit Scotland published a report recently on 'Social Work in Scotland' http://www.audit-scotland.gov.uk/uploads/docs/report/2016/nr_160922_social_work.pdf that outlines 4 key messages:

- Current approaches to delivering social work services will not be sustainable in the long term

- Social Work Departments are facing significant challenges because of a combination of financial pressures caused by a real term reduction in overall council spending, demographic change and the cost of implementing new legislation and policies.
- The integration of health and social care has made governance arrangements more complex.
- Councils need to ensure that Chief Social Work Officers (CSWOs) have the status and capacity to enable them to fulfil their statutory responsibilities effectively.

A paper on this report and its implications for the partnership will be submitted to a future meeting of the IJB.

5. Hosted Services.

Hosted services are a unique feature of the integration of health and social care whereby particular health services are hosted by one individual IJB and delivered on behalf of the other IJBs in the health board area.

The performance management framework applies as much to these hosted services as it does to the fully delegated functions and services.

Discussions are ongoing at Chief Officer level as to how the respective IJBs and their committees get assurance about the operation and performance of the different hosted services.

6. Joint Inspection of Services for Older People.

http://www.careinspectorate.com/images/documents/3381/Joint%20inspection%20report%20of%20services%20for%20older%20people%20in%20Aberdeen%20City.pdf

The joint inspection went ahead between November 2015 and February 2016. Its purpose was to assess whether our health and social work services improve outcomes for older people and their unpaid carers by:

- making sure people receive the right care, at the right time, in the right setting;
- delivering high-quality services to older people;
- supporting older people to be independent, safe, as healthy as possible and have a good sense of wellbeing.

The inspection team met more than 100 older people and carers, and around 300 staff from health and social work services, and the third and independent sectors. They also read samples of older people's health and social work service records and studied documents provided by the Partnership about services for older people and their carers in Aberdeen.

The evaluation was as follows:

Quality Indicator	Evaluation
Key performance outcomes	Adequate
Getting Help at the right time	Good
Impact on staff	Good
Impact on the community	Very Good
Delivery of weak processes	Weak
Policy development and plans to support improvement in service	Adequate
Management and Support of Staff	Adequate
Partnership Working/Management of resources	Adequate
Leadership and Direction	Adequate

Excellent – outstanding, sector-leading
Very good – major strengths
Good – important strengths with some areas for improvement
Adequate – strengths just outweigh weaknesses
Weak – important weaknesses
Unsatisfactory – major weaknesses

The recommendations and our draft action plan are set out in appendix C.

7. Financial performance.

The financial performance of the partnership will be reported to the Audit and Performance Systems committee and the IJB on a regular basis by the Chief Finance Officer.

We are endeavouring to strengthen the links between our budget allocations and the national outcomes so that this framework can report more accurately on the impact that our targeted spend is having and in doing so show how efficient and effective the partnership is.

8. Improvement.

As mentioned earlier in this report, establishing specific targets for operational improvement will be done as part of the performance monitoring development process. We will set improvement targets jointly with staff, partners and stakeholders as we extend and refine the scope of our performance framework.

Evaluation of our transformation programme is being conducted systematically using logic modelling and contribution theory to understand the effects of our change programme. We propose these logic models feature in this Committee report when they are developed in order to increase the understanding of the investment we are making and the changes we expect within our transformation and improvement programme.

We recognise that future reports should also include an Improvement Plan showing what activity is being undertaken to improve the quality of our health and social care provision in the light of our performance monitoring.

National Integration Indicators: Aberdeen City

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer	Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected
Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services	Outcome 5. Health and social care services contribute to reducing health inequalities	Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
Outcome 7. People using health and social care services are safe from harm	Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide	Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services

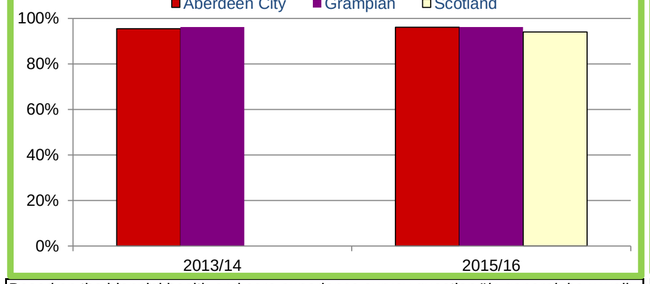
Key

- Performance better than Scotland
- Performance worse than Scotland but improved since last data point
- Performance worse than Scotland - no improvement / no change in performance since last data point
- No comparision to Scotland available (yet) or no comparison to IJB available (yet)
- No data available

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

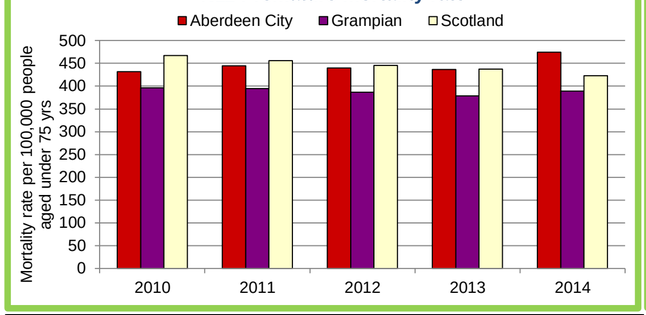
Aberdeen City

N01 Percentage of adults able to look after their health very well or quite well



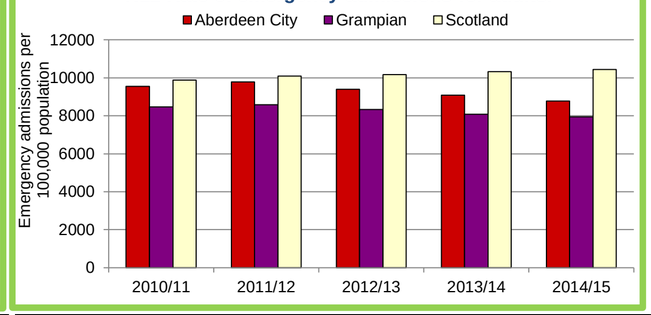
Based on the biennial health and care experience survey question "*in general, how well do you feel that you are able to look after your own health?*"
The number of people answering very well or quite well divided by the total number answering the question.

N11 Premature mortality rate



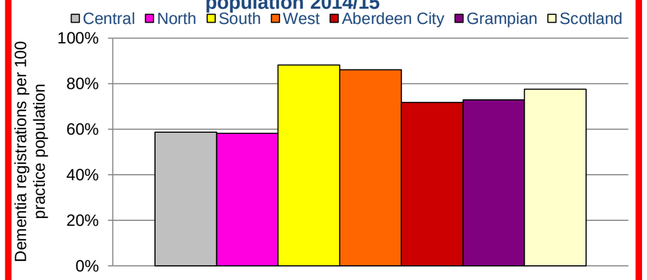
European Age-Standardised mortality rate per 100,000 for people aged under 75 in Scotland.
European Age-standardised mortality rates are calculated by applying the age-specific rates for Scotland to the European Standard Population and expressed per 100,000 persons per year.

N12 Rate of emergency admissions for adults.



Based on SMR01 returns for acute hospitals for all age groups, SMR04 data for psychiatric hospitals is to be included in future.
Note that further work will be done by ISD regarding this data source. - presumably to allow data to be provided for adults only, potentially by locality and to include SMR04 data.

L01 Dementia registrations per 100 practice population 2014/15

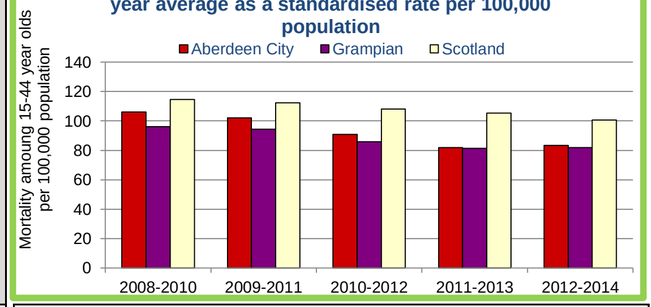


Number of patients on the QOF dementia register per 100 GP practice population.

L02 Number of people who first present with advanced long term conditions symptoms

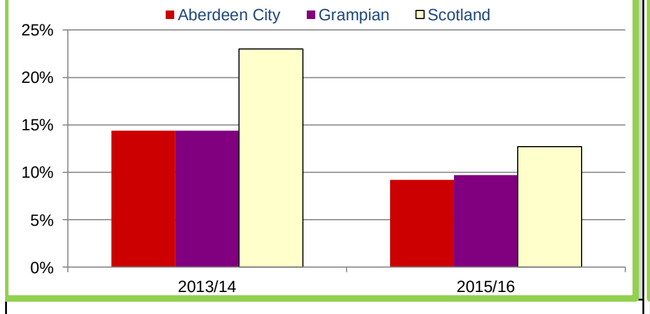
Not sure where to get this data

L03 All-cause mortality among 15-44 year olds. 3 year average as a standardised rate per 100,000 population

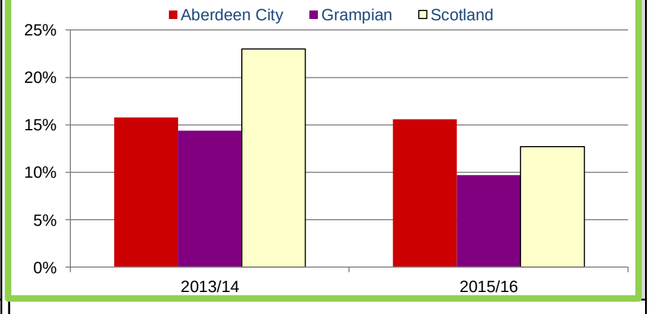


Deaths from all causes 15-44 year olds, 3 year rolling averages, number and as standardised rates oer 100,000 population

L04 - Percentage of males with long term conditions



L04 - Percentage of females with long term conditions

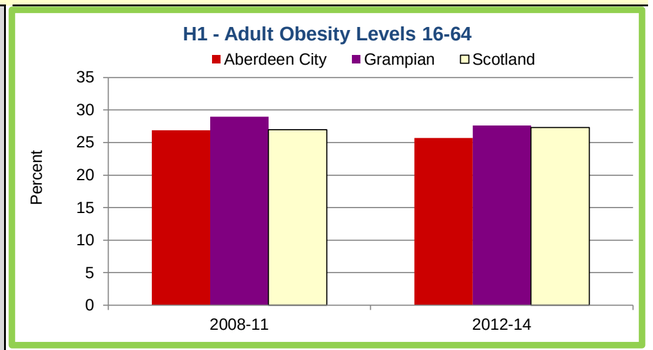


L27 No. of community assets to increase engagement and participation

Not sure where to get this data

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

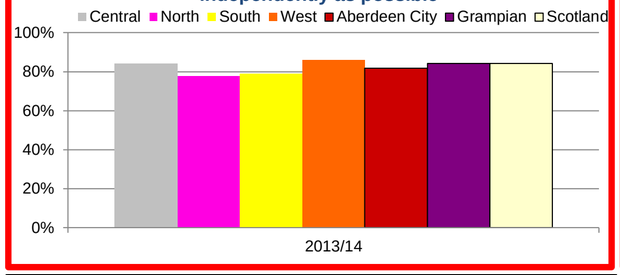
Aberdeen City

L28 Access to online resources / technology Not sure where to get this data	L32 % people who agree with the statement 'I can influence decisions in my local area' Not sure where to get this data	

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

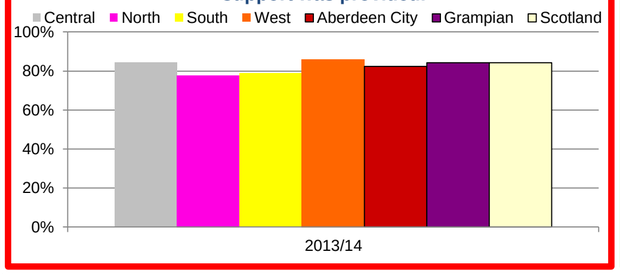
Aberdeen City

N02 Percentage of adults supported at home who agree that they are supported to live as independently as possible



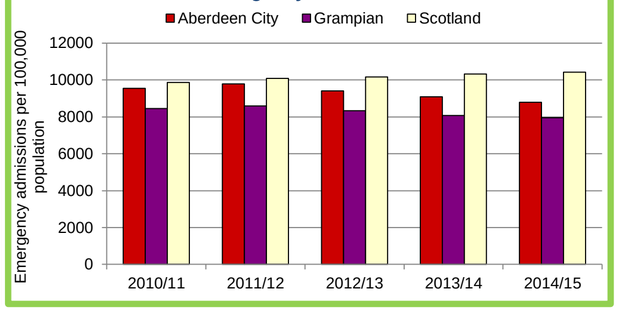
Based on the biennial health and care experience survey question "*I was supported to live as independently as possible* ."
The number of of people who agree or strongly agree divided by the total number answering.

N03 Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.



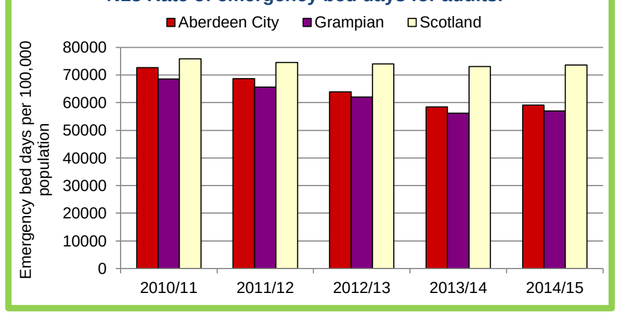
Based on agreement with the statement (Q36b) in the biennial health and care experience survey: "*I had a say on how my help, care or suport was provided* ".
The number of people who agree or strongly agree divided by the total number answering.

N12 Rate of emergency admissions for adults.



Based on SMR01 returns for acute hospitals for all age groups, SMR04 data for psychiatric hospitals is to be included in future.
Note that further work will be done by ISD regarding this data source. - presumably to allow data to be provided for adults only, potentially by locality and to include SMR04 data.

N13 Rate of emergency bed days for adults.



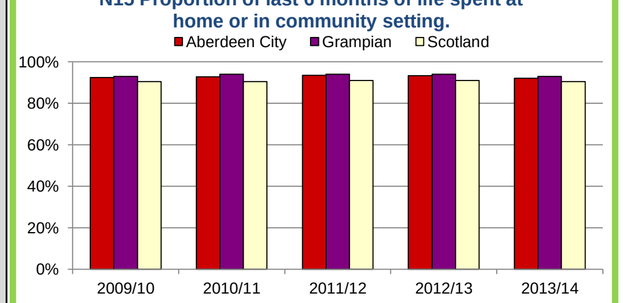
Based on SMR01 returns for acute hospitals for all ages. SMR04 data for psychiatric hospitals is to be included in future.

Note that further work will be done by ISD regarding this data source. - presumably to allow data to be provided for adults only, potentially by locality and to include SMR04 data.

N14 Readmissions to hospital within 28 days of discharge.

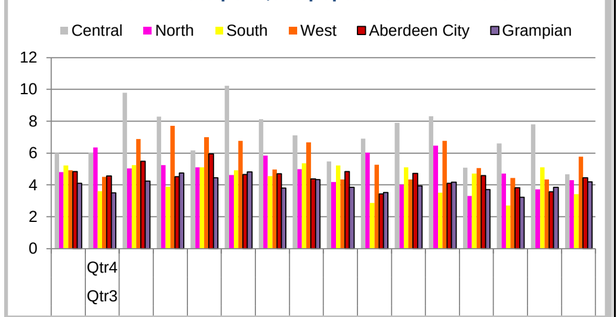
This data is not currently available via ISD publications

N15 Proportion of last 6 months of life spent at home or in community setting.

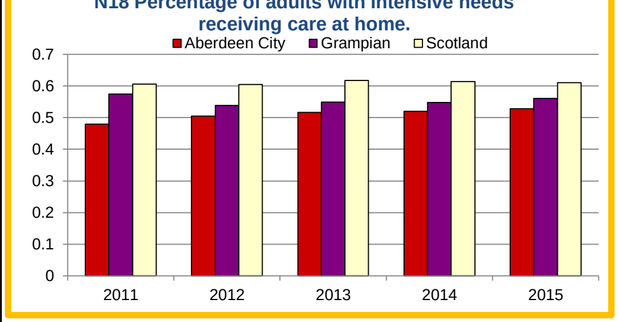


Percentage of last six months of life spent at home or in a community setting.

N16 Falls rate per 1,000 population in over 65s.

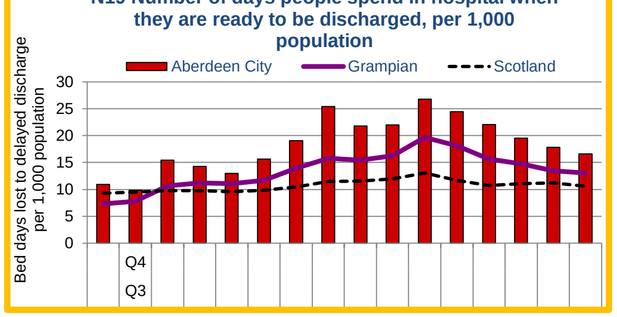


N18 Percentage of adults with intensive needs receiving care at home.



Percentage of people aged 18 and over with long-term care needs who recieved personal care at home.
The number of adults (18+) recieving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care.

N19 Number of days people spend in hospital when they are ready to be discharged, per 1,000 population

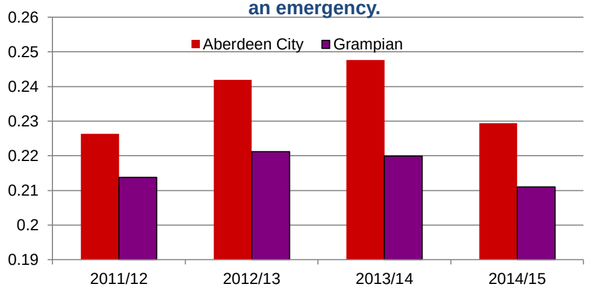


The number of bed days lost due to delayed discharges that have been recorded for people resident within the Local Authority area, per 1,000 population in the area

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

Aberdeen City

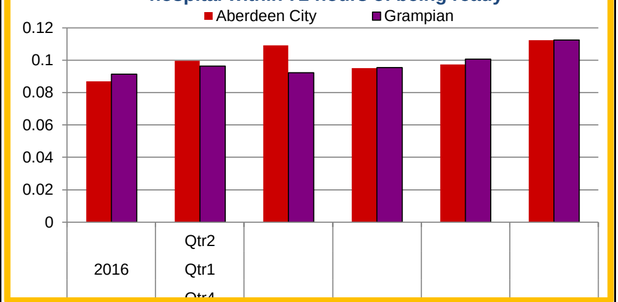
N20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.



N21 Percentage of people admitted from home to hospital during the year, who are discharged to a care home

No data available at present

N22 Percentage of people who are discharged from hospital within 72 hours of being ready



N23 Expenditure on end of life care.

No data available at present

L26 Detect Cancer Early

Not sure where to get this data

L29 % of new dementia diagnosis who receive 1yr diagnostic support

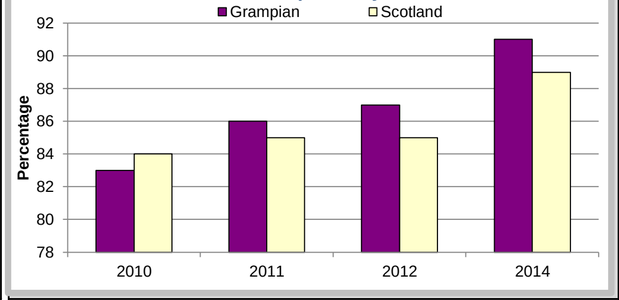
Not sure where to get this data

L30 Volume of Telecare, Telehealth and Community Alarms

No data is available for Telecare prior to 01/04/2016.

These figures do not include people in Sheltered Housing or Very Sheltered Housing who receive Community Alarm as part of their Housing Support package.

H16 - Overall Rating of Care and Treatment During Hospital Stay

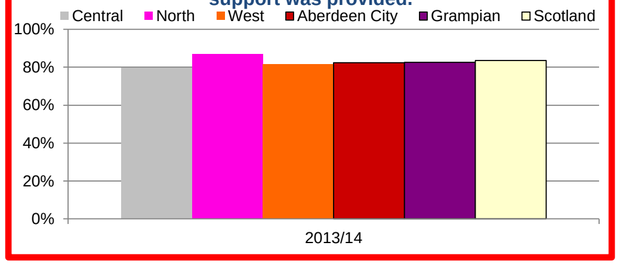


Source: Scottish Inpatient Survey Q2.3

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

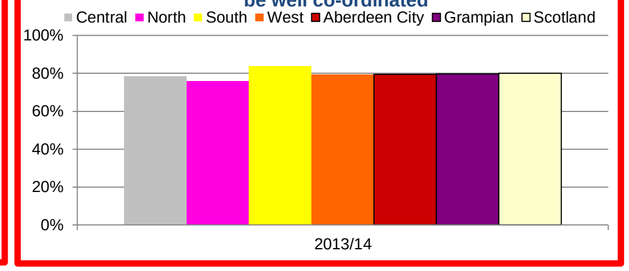
Aberdeen City

N03 Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.



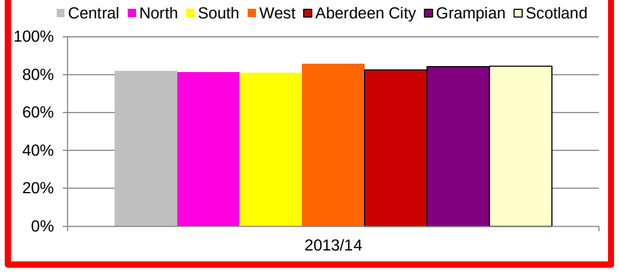
Based on agreement with the statement (Q36b) in the biennial health and care experience survey: "*I had a say on how my help, care or suport was provided*". The number of people who agree or strongly agree divided by the total number answering.

N04 Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated



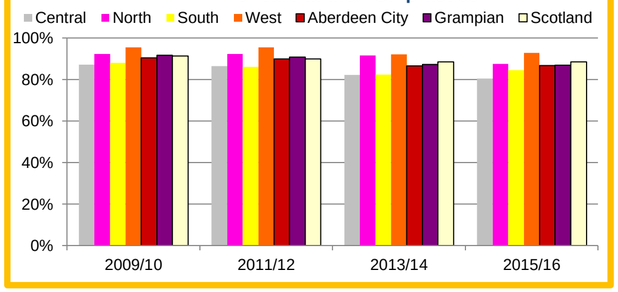
Based on the biennial health and care experience survey question "*My health and care services seemed to be well co-ordinated*"
The number of people answering that they agree or strongly agree diveded by the total number answering.

N05 Percentage of adults receiving any care or support who rate it as excellent or good



Based on the biennial health and care experience survey question "*Overall, how would you rate your help, care, support services?*"
The number of people answering excellent or good, divided by the total number answering the question.

N06 Percentage of people with positive experience of care at their GP practice.

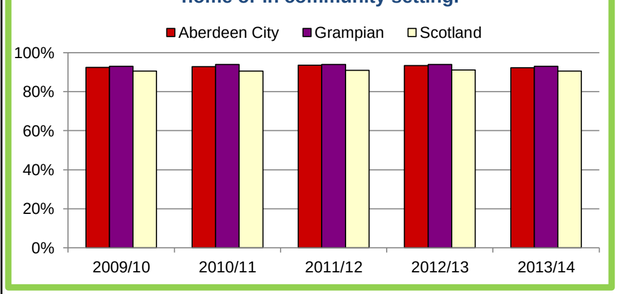


Based on the biennial health and care experience survey question "*Overall, how would you rate the care provided by your GP practice?*"
The number of people answering excellent or good, divided by the total number answering the question.

N14 Readmissions to hospital within 28 days of discharge.

This data is not currently available via ISD publications

N15 Proportion of last 6 months of life spent at home or in community setting.



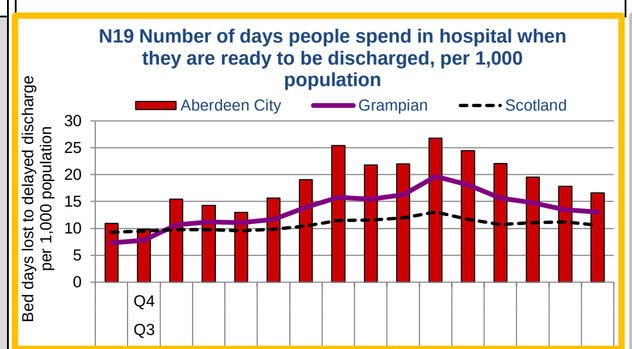
Percentage of last six months of life spent at home or in a community setting.

N17 Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.

2015/16

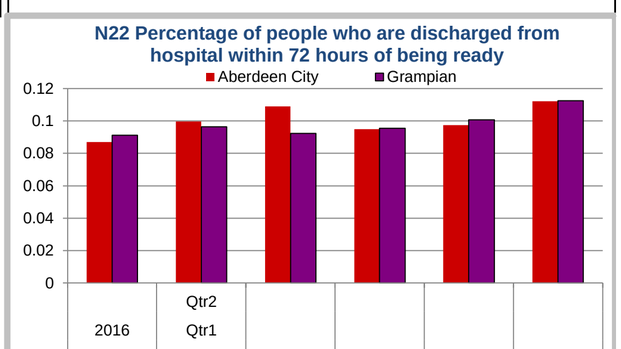
Source: Care Inspectorate Publicatons

N19 Number of days people spend in hospital when they are ready to be discharged, per 1,000 population



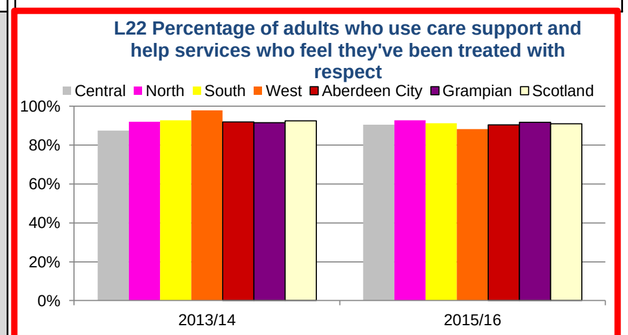
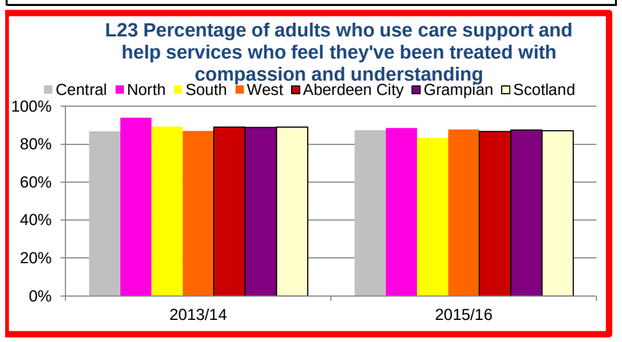
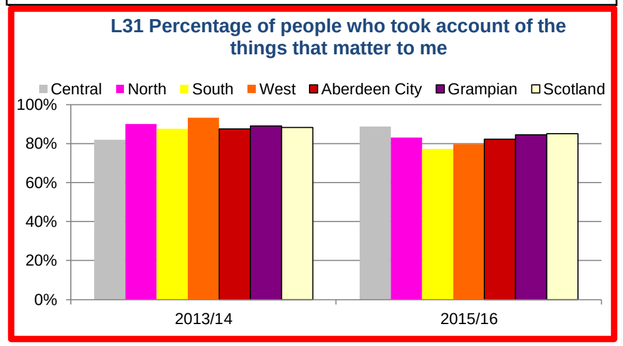
The number of bed days lost due to delayed discharges that have been recorded for people resident within the Local Authority area, per 1,000 population in the area

N22 Percentage of people who are discharged from hospital within 72 hours of being ready



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

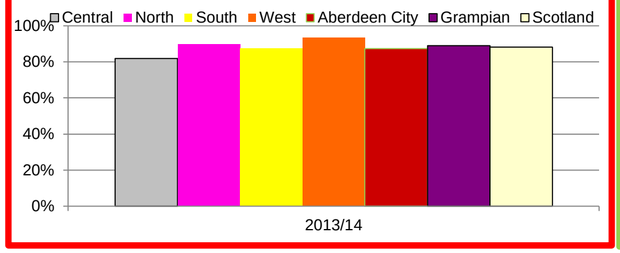
Aberdeen City

N23 Expenditure on end of life care. No data available at present	L06 Percentage of adults satisfied with Self Directed Support outcomes Not sure where to get this data	L07 Variety of complaints Not sure where to get this data
L08 % complaints responded to within 20 working days	L09 Time to resolve complaints Not sure where to get this data	
Based on information collected by Aberdeenshire Council Feedback Team.		Based on the biennial health and care experience survey question "How much do you agree or disagree with the following about your care, support and help services - excluding the care and help you get from friends and family - over the past 12 months? I was treated with respect." The number of people who agree or strongly agree, divided by the total number answering the question.
		L32 % people who agree with the statement 'I can influence decisions in my local area' Not sure where to get this data
Based on the biennial health and care experience survey question "How much do you agree or disagree with the following about your care, support and help services - excluding the care and help you get from friends and family - over the past 12 months? I was treated with compassion and understanding." The number of people who agree or strongly agree, divided by the total number answering the question.	Based on the biennial health and care experience survey question "How much do you agree or disagree with the following about your care, support and help services - excluding the care and help you get from friends and family - over the past 12 months? People took account of the things that matter to me. " The number of people who agree or strongly agree, divided by the total number answering the question.	

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

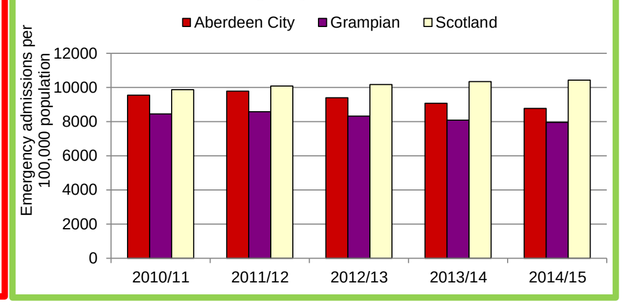
Aberdeen City

N07 Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life



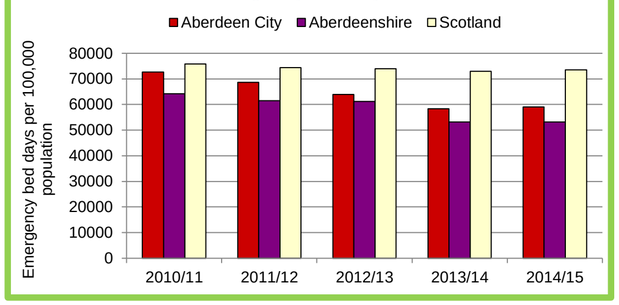
Based on the biennial health and care experience survey question "*The help, care or support improved or maintained my quality of life* "
The number of people who agree or strongly agree, divided by the total number answering the question.

N12 Rate of emergency admissions for adults.



Based on SMR01 returns for acute hospitals for all age groups, SMR04 data for psychiatric hospitals is to be included in future.
Note that further work will be done by ISD regarding this data source. - presumably to allow data to be provided for adults only, potentially by locality and to include SMR04 data.

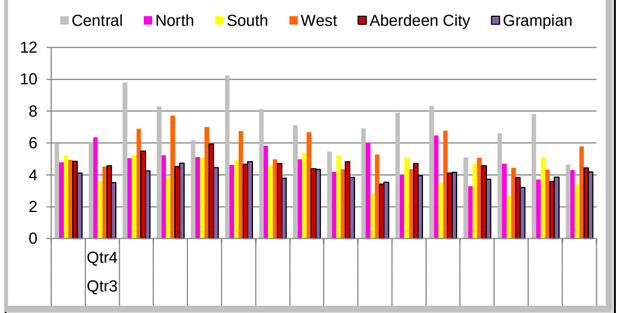
N13 Rate of emergency bed days for adults.



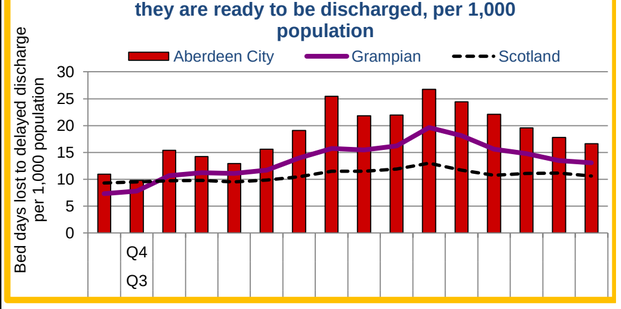
Based on SMR01 returns for acute hospitals for all ages. SMR04 data for psychiatric hospitals is to be included in future.

Note that further work will be done by ISD regarding this data source. - presumably to allow data to be provided for adults only, potentially by locality and to include SMR04 data.

N16 Falls rate per 1,000 population in over 65s.

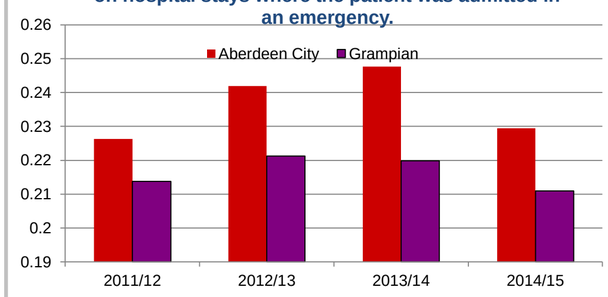


N19 Number of days people spend in hospital when they are ready to be discharged, per 1,000 population



The number of bed days lost due to delayed discharges that have been recorded for people resident within the Local Authority area, per 1,000 population in the area

N20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.



L06 Percentage of adults satisfied with Self Directed Support outcomes

Not sure where to get this data

L29 % of new dementia diagnosis who receive 1yr diagnostic support

Not sure where to get this data

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

Aberdeen City

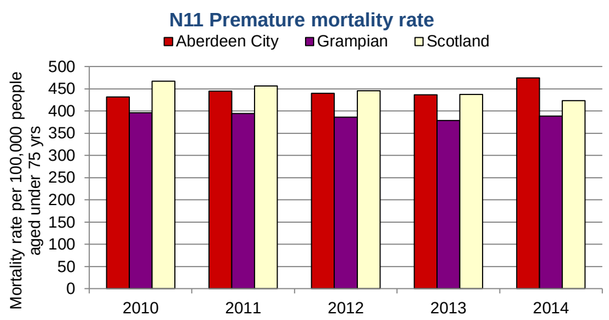
L30 Volume of Telecare, Telehealth and Community Alarms

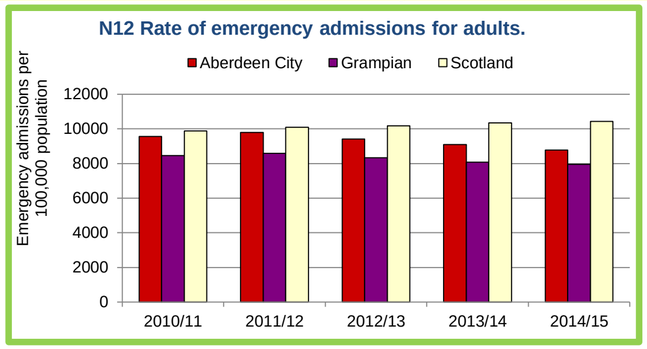
No data is available for Telecare prior to 01/04/2016.

These figures do not include people in Sheltered Housing or Very Sheltered Housing who receive Community Alarm as part of their Housing Support package.

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

Aberdeen City





L32 % people who agree with the statement 'I can influence decisions in my local area'

Not sure where to get this data

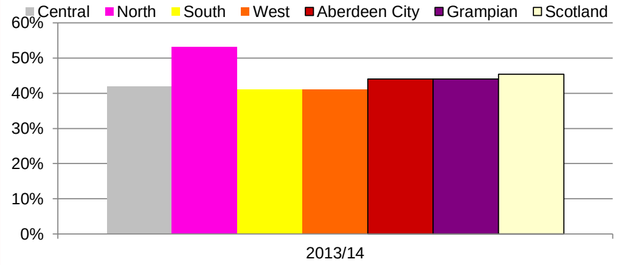
European Age-Standardised mortality rate per 100,000 for people aged under 75 in Scotland.
European Age-standardised mortality rates are calculated by applying the age-specific rates for Scotland to the European Standard Population and expressed per 100,000 persons per year.

Based on SMR01 returns for acute hospitals for all age groups, SMR04 data for psychiatric hospitals is to be included in future.
Note that further work will be done by ISD regarding this data source. - presumably to allow data to be provided for adults only, potentially by locality and to include SMR04 data.

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

Aberdeen City

N08 Percentage of carers who feel supported to continue in their caring role.



Based on the biennial health and care experience survey question "*I feel supported to continue caring*"
The number of people who agree or strongly agree, divided by the total number answering the question.

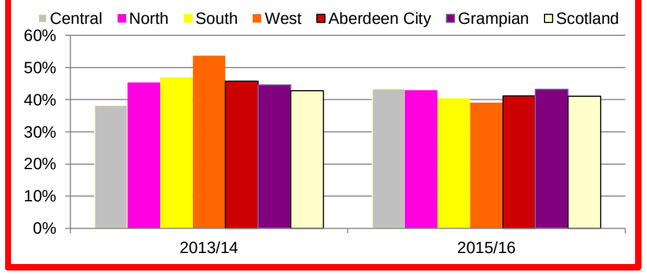
L05 Percentage of unpaid carers who are offered support

Not sure where to get this data

L10 Percentage of carers satisfied with their level of involvement in the design of service user care packages

Not sure where to get this data

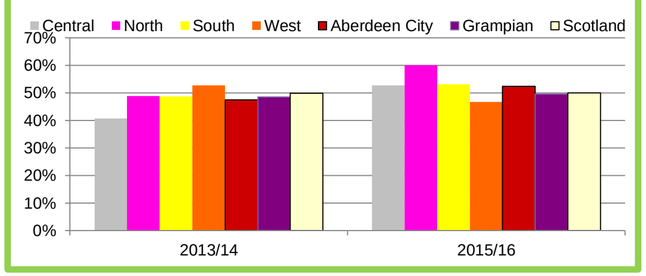
L24 Percentage of carers who feel that caring has a negative impact on my health and wellbeing



Based on the biennial health and care experience survey question "How much do you agree or disagree with the following about how you feel as a carer most of the time? Caring has had a negative impact on my health and wellbeing"

The number of people who agree or strongly agree, divided by the total number answering the question.

L25 Percentage of carers who feel they have a say in the services provided for the person they look after



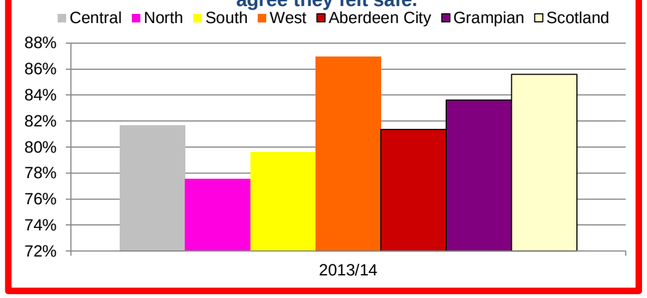
Based on the biennial health and care experience survey question "How much do you agree or disagree with the following about how you feel as a carer most of the time? I have a say in services provided for the person I look after. "

The number of people who agree or strongly agree, divided by the total number answering the question.

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

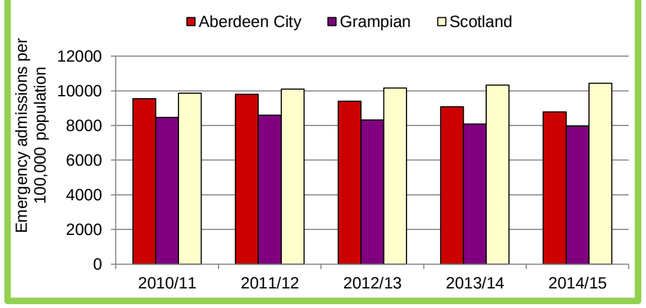
Aberdeen City

N09 Percentage of adults supported at home who agree they felt safe.



Based on the biennial health and care experience survey question "I *felt safe*"
The number of people who agree or strongly agree, divided by the total number answering the question.

N12 Rate of emergency admissions for adults.



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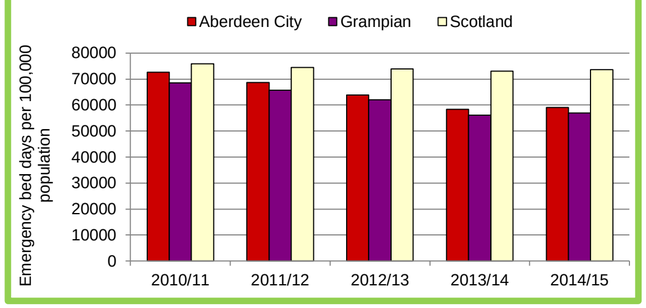


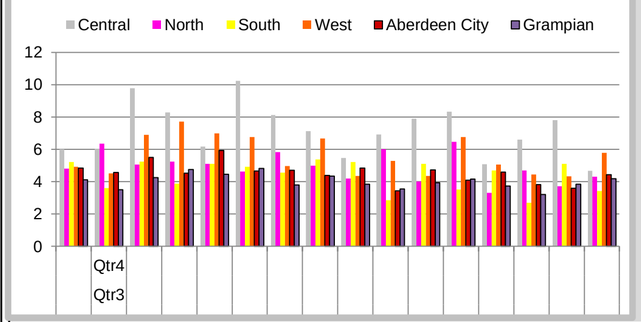
Based on SMR01 returns for acute hospitals for all ages. SMR04 data for psychiatric hospitals is to be included in future.

Note that further work will be done by ISD regarding this data source. - presumably to allow data to be provided for adults only, potentially by locality and to include SMR04 data.

N14 Readmissions to hospital within 28 days of discharge.

This data is not currently available via ISD publications

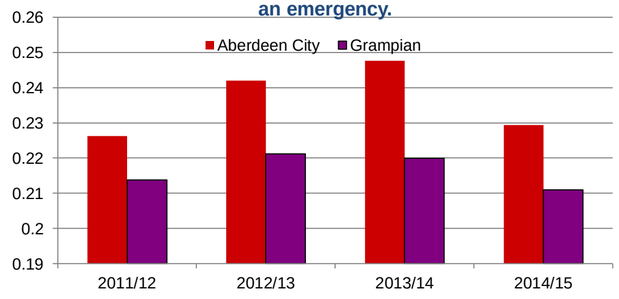
N16 Falls rate per 1,000 population in over 65s.



Falls Group. Data for over 65s who have been admitted as an emergency due to a fall

Source: Care Inspectorate Publications

N20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.



L11 Percentage of adult protection cases screened within 24hrs of notification

Not sure where to get this data

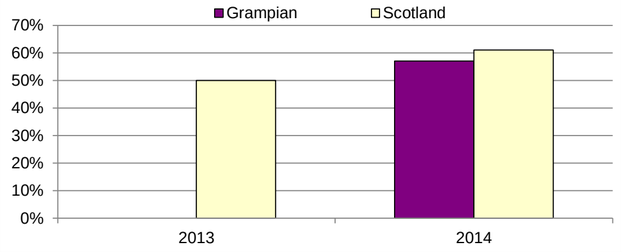
L12 Number of people who have had a falls assessment, individualised management plan agreed

Not sure where to get this data

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

Aberdeen City

N10 Percentage of staff who say they would recommend their workplace as a good place to work.



Based on agreement with the statement "*I would recommend my workplace as a good place to work*" in staff surveys.

L13 Do you understand the direction of the Health and Social Care Partnership, and how you contribute to it

Not sure where to get this data

L14 Percentage of staff that feel tools, training and resources available to them are suffient to undertake their job effectively

Not sure where to get this data

L15 At work, I have the opportunity to do what I do best every day

Not sure where to get this data

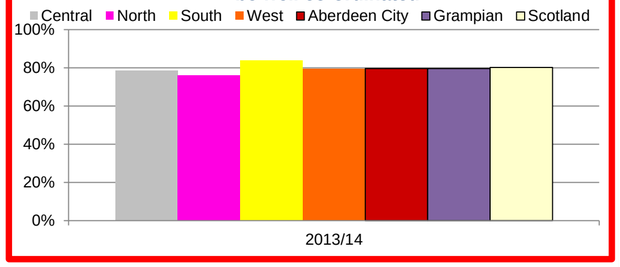
L16 Staff meeting job competencies

Not sure where to get this data

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

Aberdeen City

N04 Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated

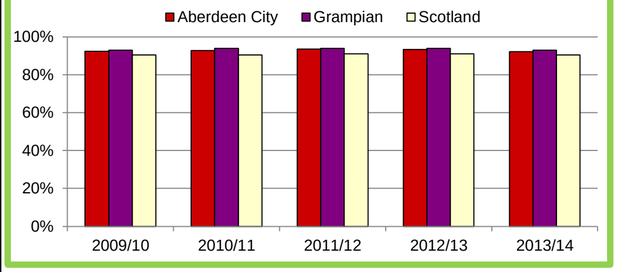


Based on the biennial health and care experience survey question "*My health and care services seemed to be well co-ordinated*"
The number of people answering that they agree or strongly agree diveded by the total number answering.

N14 Readmissions to hospital within 28 days of discharge.

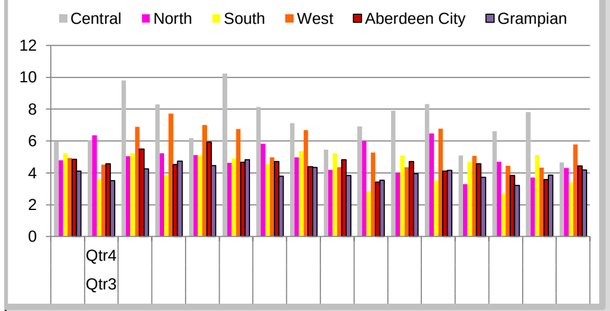
This data is not currently available via ISD publications

N15 Proportion of last 6 months of life spent at home or in community setting.

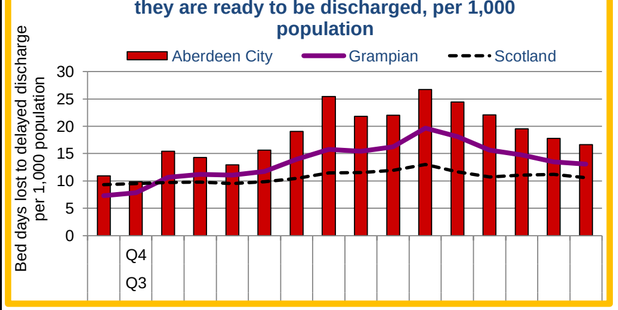


Percentage of last six months of life spent at home or in a community setting.

N16 Falls rate per 1,000 population in over 65s.

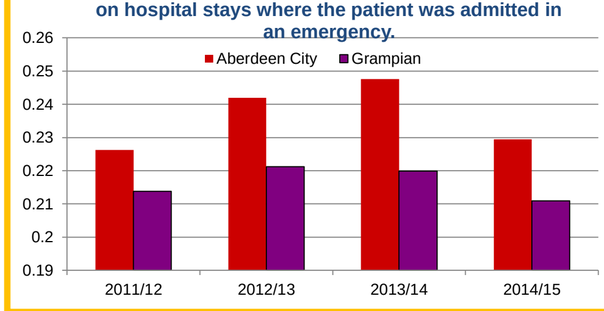


N19 Number of days people spend in hospital when they are ready to be discharged, per 1,000 population

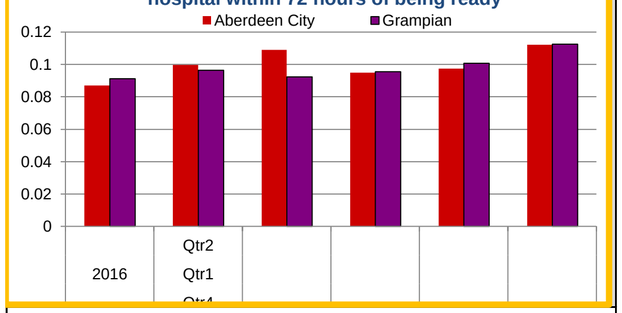


The number of bed days lost due to delayed discharges that have been recorded for people resident within the Local Authority area, per 1,000 population in the area

N20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.



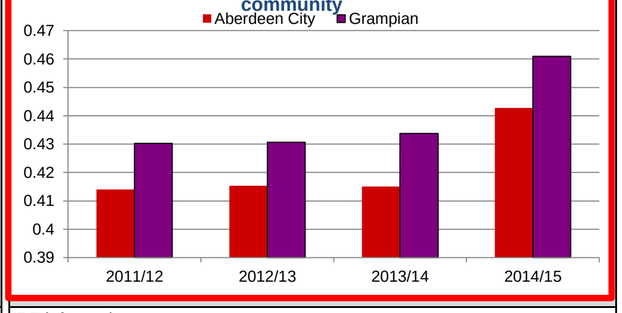
N22 Percentage of people who are discharged from hospital within 72 hours of being ready



N23 Expenditure on end of life care.

No data available at present

L17 Shift of resources from institutional to community



IRF information

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

Aberdeen City

	L19 Use of agency / banked hours Not sure where to get this data	L20 Per capita weighted cost of accumulated bed days lost to delayed discharge Not sure where to get this data
IRF website information - need partnrship level. (44%)	Eunice / John Tait - to be contacted.	Contact Emma Watson
L21 Achieving balanced budgets Not sure where to get this data		

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Category	Indicator	Since Last Time	Benchmark (Grampian)	Benchmark (Scotland)	Alert/Target	Trajectory	Frequency of Update	Current Period
Safe	Adults supported at home who feel safe	I					2013/14	Bi-ann
	Rate of falls							
Well Led	Rating of care & treatment during hospital stay	I					2014	Annual
	Views from adults about co-ordination of care	W					2013/14	Bi-ann
	Views from staff recommending this as a place to work	W					2014	Annual
	Positive views about GP Practice	W					2015/16	Bi-ann
	HSPC Sickness absence	I					Jul-16	Monthly
	HSCP financial performance							
Effective	Premature mortality rate	W					2014	Annual
	Life expectancy	W					2014/15	Annual
	Smoking prevalence	I					2014	Annual
	Smoking cessation	W					Mar-16	Quarterly
	Alcohol Brief Interventions	W					Jun-16	Quarterly
	Adult obesity prevalence	I					2012-14	Annual
	Child obesity prevalence							
	Adults able to look after own health	I					2015/16	Bi-ann
	Quality of life following support at home						2013/4	Bi-ann
	Emergency admission rate	I					Jun-16	Quarterly
	Emergency admission bed days	W					2014/15	Annual
	Resource spent on hospital care	I					2014/15	Annual
Responsive	Adults receiving intensive care at home	I					2015	Annual
	Adults able to influence care at home	W					2013/14	Bi-ann
	Carers who feel supported	W					2013/14	Bi-ann
	Carers who have an influence about care	I					2015/16	Bi-ann
	Bed days spent in hospital after being ready for discharge	I						
	Patients discharged after 72 hours of being ready	I						
	Last six months of life spent at home	S					2013/14	Annual
	Dental registrations children	I						
	Dental registrations adults	I					2014/15	Annual
	Self Directed Support packages							
	A&E attendance rates	I					Auf-16	Monthly
Caring	People receiving care who are treated with dignity & respect	W					2015/16	Bi-ann
	People receiving care treated with compassion & understanding	W					2015/16	Bi-ann
	Staffing levels - vacancies							

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Performance Monitoring Appendix C.

1) The Partnership should increase the pace of its development of sustainable joint approaches that help to support improvement to:

- deliver the Scottish Government's delayed discharge target of no delays over two-week duration;
- ensure fewer older people experience delayed discharge from hospital.

2) **The Partnership should work with carers and those services that support them to ensure that:**

- carers are routinely offered a carer's assessment;
- carers assessments are completed for those carers who request them;
- offering and completing carers assessments is clearly documented;
- revisions to future formats for carers' assessments take into account new carers legislation.

3) **The Partnership should ensure that:**

- pathways for accessing services are clear;
- eligibility criteria are applied consistently across services;
- waiting lists are monitored to manage the allocation of pressurised resources equitably.

4) **The Aberdeen City Adult Protection Committee should support improvement in adult support and protection by:**

- including timescales for all partners for the completion of all stages within the adult protection processes;
- providing oversight of progress against all action plans completed from audits;
- providing oversight and quality assurance of any action plan resulting from the commissioned review of adult support and protection.

5) **The Partnership should take action to ensure that frontline staff are supported to complete initial inquiries, risk assessments and risk managements plans timeously. This action should include:**

- working alongside Police Scotland to develop a joined-up approach for completing inquiries;

- streamlining its risk assessment frameworks
- ensuring that risk assessments and risk management plans are completed and actioned.

6) **As part of the continued development of the new integrated arrangements, partners should develop their strategic approach to joint training and development. This should aim to:**

- offer opportunities beyond mandatory training;
- include the third sector to enhance a shared knowledge of roles and responsibilities,
- achieve a cohesive approach to care delivery for older people.

7) **As part of the continued development of the new integrated arrangements, partners should put a formal plan in place that sets out the future allocation of the integrated care fund and set out clear criteria for how these projects would be evaluated.**

8) **As part of the continued development of the new integrated arrangements partners should set a clear timetable to agree and implement the structure for locality management teams.**

DRAFT – INSPECTION ACTION PLAN

Draft v3 – 26 October 2016

	Recommendation	Areas for Improvement	Update	Lead	Timescale	Reference
1	The partnership should increase the pace of its development of sustainable joint approaches that help to support improvement to: • Deliver the SG delayed discharge target of no delays over two week duration and • Ensure fewer older people experience delayed discharge from hospital	Limitations to the use of legislation relative to the need to gain the consent of all relevant parties.		Delayed Discharge Group		
		Time taken to secure welfare guardianship for individuals.		Sally Wilkins		
		Increasing the availability of care at home.		Sally Wilkins/Tom Cowan		
		Consideration of how reablement will be delivered into the future.		Judith Proctor/Tom Cowan Transformational Programme		
		Future resourcing for fall exercise group.		Falls Steering Group		
		Lack of availability of care home places.		Kenny O'Brien/ Jason Nicol (Bed Base Review)		
		Equitable support for carers.		Sandy Reid (Chairs the Carers Strategy Group)		
		Improve the use and quality of anticipatory care plans.		Lynn Morrison/ Delayed Discharge Group		
2	The partnership should work with carers and those services that support them to ensure that:	Slow progress in delivering self-directed support.		Kate Mackay		
		Easier access to respite care and day services to support carers and the person cared for.		Sally Wilkins		

	Recommendation	Areas for Improvement	Update	Lead	Timescale	Reference
	• Carers are routinely offered a carer's assessment • Carers' assessment are completed for those carers who request them • Offering and completing carers' assessments is clearly documented, and revisions to future formats for carers' assessments take into account new carers' legislation.	Offering and completing a carer's assessment consistent across all teams.		Kate Mackay – Performance Lyndsey Flockhart – Operational		
		Providing timely support.		Kate Mackay – Performance Lyndsey Flockhart – Operational		
		Review of documentation should take account of the new Carers' Bill.		Sandy Reid (Chairs the Carers Strategy Group)		
		Long waits for Multi-compartment Compliance Aids (national issue)		David Pfleger		
		Difficulties in increasing care package – adding to pressure on carers.		Hospital at Home Group Delayed Discharge Group Telecare		
		Lack of staffing capacity, restricting the ability of older people to choose the time or provider for their care package.		Self Directed Support (SDS)		
		NHS Staff knowledge/ training about self-directed support	Develop an awareness sheet for NHSG staff about the process of self-directed support.	Self Directed Support (SDS)		
		Low staff morale in some areas.		Joint Partnership Staff Forum (Staff Partnership Action Plan)		

	Recommendation	Areas for Improvement	Update	Lead	Timescale	Reference
3	The partnership should ensure that: • Pathways for accessing services are clear • Eligibility criteria are applied consistently across services; and • Waiting lists are monitored to manage the allocation of pressurised resources equitably.	Centralised referral processed (health and social work) – services not always provided in an appropriate time frame.		Hospital at Home Group		
		A range of service specific criteria led to multiple pathways into services (e.g. 'some older people who had places at more than one day service, while others had none and were on a waiting list')		Lead TBC – clarity required regarding what is required/ pathways etc.		
		Waiting list for services ('nearly a quarter of older people'). Some delays exceeded 6 months.		Lead TBC – clarity required regarding what is required/ pathways etc.		
		Slow implementation of self-directed support		Transformation Programme Board /Self Directed Support		
		Delays due to: • Increasing level of demand • Lack of care at home staff across the sectors • Variable range of services available to older people depending on their location and lack of equity of allocation of scarce resources		Tom Cowan Delayed Discharge Group		

	Recommendation	Areas for Improvement	Update	Lead	Timescale	Reference
		Unreasonable delay for 7% of older people in being assessed for key services or support		Delayed Discharge Group		
		23% of older people on a waiting list for services with delays of over 6 months for some: care at home; care home; very sheltered housing and day care.		Delayed Discharge Group		
		Collection of data on unmet need to monitor number of older people waiting for services and manage waiting lists and waiting times and inform future commissioning or services.		Delayed Discharge Group Kevin Toshney – Strategy Tom Cowan - Operational		
4	The Partnership should work with the Aberdeen City adult protection committee to support improvement in adult support and protection by: • Including timescales for all partners for the completion of all stages within adult protection processes • Providing oversight of progress of action plans	Initial inquiries and full investigation not undertaken in an appropriate time frame in some cases.		Claire Duncan		
		Delays potentially left older people at significant risk of harm over a protracted period.				
		Delays included police completing their inquiries; health staff completing capacity in adult teams to carry out adult support and protection initial inquiries and investigations timeously; lack of discussion and joint decision making in				

	Recommendation	Areas for Improvement	Update	Lead	Timescale	Reference
	completed from audits; and • Providing oversight and quality assurance of any action plan resulting from the commissioned review of adult support and protection.	some cases creating significant delays for some individuals.				
		Completing more detailed assessment than required at initial inquiry stage.				
		Lack of clear timescales				
		Lack of clarity as to when investigations needed to be progressed to case conference.				
		Improve the use and content of chronologies.				
5	The partnership should take action to ensure that frontline staff are supported to complete initial inquires, risk assessment and risk management plans timeously. This action should include: • Working alongside Police Scotland to develop a joined up approach for completing inquiries. • Streamlining its risk assessment frameworks; and • Ensuring that risk	Review and review the effectiveness of the partnership's governance and oversight systems for adult support and protection.		Adult Support and Protection Short Life Working Group Supported by: • Adult Protection Committee • Clinical and Care Governance Committee • Executive Team		

	Recommendation	Areas for Improvement	Update	Lead	Timescale	Reference
	assessments and risk management plans are completed and actioned.					
6	As part of the continued development of the new integrated arrangements, partners should develop their strategic approach to joint training and development. This should aim to: • Offer opportunities beyond mandatory training • Include third sector to enhance a shared knowledge of roles and responsibilities; and • Achieve a cohesive approach to care delivery for older people.	Staff training delivered, in the main, separately by each organisation.		Alex Stephen/Organisational Development		
		Gaps in specialist dementia training for some staff.				
		Some slippage in adult support and protection refresher training.				
		Challenges in attending training because of workload pressures and shift patterns for some staff.				
7	As part of the continued development of the new integrated arrangements, partners should put a formal plan in place that sets out the future allocation of the integrated care fund and			Kevin Toshney Transformation Programme Board & Worksteams		

	Recommendation	Areas for Improvement	Update	Lead	Timescale	Reference
	set out clear criteria for how these projects would be evaluated.					
8	As part of the continued development of the new integrated arrangements partners should set a clear timetable to agree and implement the structure for the locality management teams.	Gaps in available care provision and the constant struggle to secure services for older people and their carers could be demoralising for staff.		Tom Cowan Kevin Toshney		
		Do more to support a collective responsibility for improving the quality of adult support and protection across all agencies involved in public protection.		Tom Cowan Kevin Toshney		
		The partnership needs a greater impetus to create a more settled structure.		Judith Proctor Tom Cowan		

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Clinical & Care Governance Committee

Report Title	Health and Care Experience Survey Results 2015/16
Lead Officer	Judith Proctor – Chief Officer
Report Author	Jillian Evans, Head of Health Intelligence, NHS Grampian
Date of Report	20th July 2016
Date of Meeting	

1: Purpose of the Report

This report provides information on the Health and Care Experience Survey for 2015/16. The results from this survey provide feedback on people's experiences of GP services and out of hours care. It is a national survey, conducted every two years since 2009/10, allowing a look at change over time, and comparisons to be drawn with other Health and Social Care Partnerships.

Information Services Scotland (ISD) provide results and analysis at Partnership level and for each GP Practice. This Report has been compiled locally to give added insights at Locality level. Its purpose is to help inform local planning and improvements, however care should be taken when interpreting results because of the small numbers involved.

The full report is provided in **Appendix 1**.

2: Summary of Key Information

The survey asks questions about GP care and access, out of hours, social care and carers. It also aligns results with the health and social care outcomes helping to establish a baseline for on-going monitoring for self-care, independent living, experience of care and support for carers.

The following key points for Aberdeen City H&SCP are noted below.

- 96% of respondents say they are able to look after their own health, an increase of 1% over the previous survey

Clinical & Care Governance Committee

- 82% are supported to live as independently as possible, a rise of 3%
- 83% of service users felt safe, an increase of 4% from the previous survey
- 78% of respondents reported having a say in their support for everyday living, a decrease of 7% but consistent with the Grampian average
- 77% of service users felt their care was well coordinated, a reduction of 5% and slightly less than the average for Grampian at 79%
- 80% of respondents reported that the care they received improved their quality of life, a reduction of 2% and lower than the Grampian average of 85%
- 42% of carers felt supported to continue caring, one of the lowest scores in the survey. This was a reduction of 2% but consistent with the Grampian average of 41%.

The attached paper provides more detail, including an 'at a glance' summary of health and social care outcome indicators at locality level. The following key points are drawn from the specific questions in each of the sections of the survey:

Care and Treatment

Comparing over the survey years, the question "*I was involved enough in decisions about my care and treatment"* has seen the greatest decline. All areas were over 80% in 2011-12 and have dropped considerably to below 60% in the latest survey in three out of the four localities.

Access

Arrangements for getting to see a doctor varied across Aberdeen City. The South locality recorded the lowest percentage consistently over the three surveys.

Out of Hours Care

The overall rating for "out of hours care" has reduced in all localities for the most recent survey except for in the West where there has been a slight increase. The

Clinical & Care Governance Committee

North locality has the lowest overall positive response.

Social Care

A new question was added for the latest survey asking if service users were aware of help, care and support options. The positive responses varied across the localities, which was highest in North and lowest in South.

Carers

In all localities except Central, respondents commented more favourably about the negative impact of caring on one's own health in the 2015-16 survey. However Central was the only locality where carers reported an improved balance between caring and other things in their life.

3:	Equalities, Financial, Workforce and Other Implications

Although these results are based on small survey numbers, they have been produced over a number of years and provide some important insights and trends about health and social care.

The vast majority of patients (86%) are positive about the care they receive at GP Practices in Aberdeen City, and patients were very positive about their experiences in consultations with doctors and nurses. Questions relating to the doctor "listening to me" and "having enough time with the nurse" were amongst the highest in the survey (95-96%), consistent with the Scottish average.

However a much lower proportion of patients responded positively about the arrangements to see a doctor (68%). This is a reduction from the 71% who were positive in the previous survey, and is 3% lower than the average for Scotland, a significant difference. Generally there are many downward trends relating to GP access, consistent with the national picture, including "seeing the doctor or nurse in 2 working days" and "can usually see preferred doctor".

This suggests there may be implications for equity of access and workforce and the attached report provides more detail by locality to help pin-point/confirm specific improvements that may be necessary.

The survey is financed nationally through the Scottish Government and there is no

intention to change this arrangement.

4:	Recommendations

The Clinical & Care Governance Committee is asked to:

1. Note the contents of the report and use it to identify areas for improvement and action, potentially in Locality development sessions.

2. Commit to efforts to improve the involvement of users in their care and consider the co-ordination of services, aiming to improve these results for users in time for the next survey.

3. Consider whilst there are difficulties in recruitment, there may be improvements in process that could bring about a better experience for patients.

Clinical & Care Governance Committee

Aberdeen City Health & Social Care Partnership

Health and Care Experience Survey Results 2015/16

Introduction

The 2015-16 Health and Care Experience Survey was sent to 23,713 people registered with a GP Practice in Aberdeen City and a 14% response rate was achieved (3,361 people). Of the patients who answered questions about themselves:

- 43% were male and 57% were female
- 17% were aged 17-34, 17% were 35-49, 30% were 50-64 and 37% were 65 years and over
- 68% did not have any limiting illness or disability

The survey asked respondents to feed back their experiences of their GP Practices and out of hours care. The survey also asked about experiences of social care services and asked specific questions of those with caring responsibilities.

Results for the 2015-16 survey is available by GP Practice, Health and Social Care Partnership, Health Board and at a national level. These and previous results since 2009-10 are available on line at http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey.

These reports have been produced by ISD Scotland and provide a considerable amount of detail and comparative analysis.

We hope that this information will help to inform local planning and improvements, however care should be taken when interpreting these results because of the small numbers involved.

Clinical & Care Governance Committee

SECTION 1: KEY POINTS FOR ABERDEEN CITY

GP Care

86% of patients are positive about the care they receive at GP Practices in Aberdeen City. This is lower than survey undertaken in the previous year (87%) and compares against an unchanged Scottish average of 87%.

Patients were very positive about their experiences in consultations with doctors and nurses. Questions relating to the doctor "listening to me" and "having enough time with the nurse" were amongst the highest in the survey (95-96%), consistent with the Scottish average.

Medication was another area of the survey with positive responses, with the four most positive responses all relating to medicines (96-98%). Respondents were much less knowledgeable about the potential side effects of medicines (82%).

The most negatively answered question in this section related to how perceived mistakes were handled, with only 46% giving a positive response.

GP Access

68% of patients responded positively about the arrangements to see a doctor. This is a reduction from the 71% who were positive in the previous survey, and is 3% lower than the average for Scotland, a significant difference.

There are many downward trends in this section consistent with the national picture, including "seeing the doctor or nurse in 2 working days" and "can usually see preferred doctor".

Out of Hours Care

68% of patients give a positive rating for out of hours care overall. This is a drop of 3% from the previous survey and is 4% lower than the Scottish average.

Significant differences were noted against the Scotland average in "time to wait for out of hours services" and "feel they are getting the right treatment or advice", both 4% lower.

Social Care

46.6% of respondents indicated that help they received did not come from formal services, a higher proportion than the Scottish average of 43%.

82% of people responded positively about overall help, care and support services. This was lower than the previous year (83%) but compared well against the Scottish average.

The biggest negative changes were about “people taking account of the things that matter to service users” down from 90% to 82%, and “service users having a say in how their help, care or support is provided” down from 85% to 78%.

Positive responses about supporting service users to live independently increased from 79% to 82%, and service users feeling safe increased from 79% to 83%.

Satisfaction with the co-ordination of health and care services reduced from 83% to 77% although was 2% higher than the Scottish average.

Carers

The survey indicated that 12.9% of respondents look after or provide regular help or support to others, lower than the Scottish average of 15%.

Carers were least positive about the impact of caring on their health; 42% indicated that caring had a negative impact on their health and well-being.

There was an 8% improvement in relation to involvement in care planning. However, only 54% of respondents reported “having a say in the services provided for the person I look after”, one of the lowest scores in the survey overall.

Just over 40% of people felt that services were well-coordinated and they felt supported to continue caring.

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Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Indicative Strategic Planning Timetable 2017
Lead Officer	Judith Proctor, Chief Officer
Report Author	Kevin Toshney, Acting Head of Strategy &Transformation Gail Woodcock, Integrated Localities Programme Manager.
Date of Report	07.10.16
Date of Meeting	15.11.16

1: Purpose of the Report

The purpose of this report is to provide an overview to the IJB of the strategic planning activities that are being progressed following the publication of the Strategic Plan and to give an indicative timetable in relation to these.

2: Summary of Key Information

2.1 Background

The partnership's Strategic Plan was approved by the shadow Integration Joint Board at its meeting of 29th March and published on integration 'go live' day 1st April.

The vision, values and strategic priorities outlined in the plan are pivotal points of reference for those core activities (locality planning, service transformation and inter-related strategic planning activities) which will be instrumental in achieving our ambitions.

Our strategic planning capacity and capabilities will provide support to our day to day operational delivery and also seek to provide some answers and solutions to the questions and challenges that we need to address in the future.

2.2 Directorate of Strategy and Transformation.

The proposed Strategy and Transformation directorate was referenced in a paper presented to the IJB at its April 2016 meeting by Tom Cowan, Director of

Operations.

This paper emphasized the co-ordinated and flexible approach that would be required to develop three inter-related elements (operations, finance and business and strategic commissioning) of the senior leadership team that would support the Chief Officer and her Executive team in delivering safe and effective services, driving transformation in line with our strategic priorities and ensuring robust governance of our resources and processes.

A related paper presented by the Chief Officer at the same meeting proposed strategic commissioning principles and priorities and the investment required to build capacity and deliver these.

The IJB agreed the proposed organisational design and instructed the Chief Officer to deliver this within the existing resources of the present management structures, along with the additional transformational funding outlined in the Strategic Commissioning report.

The directorate's structure has been revised slightly (Figure 1) to reflect the scope and scale of the partnership's planning and transformation requirements outlined in this paper.

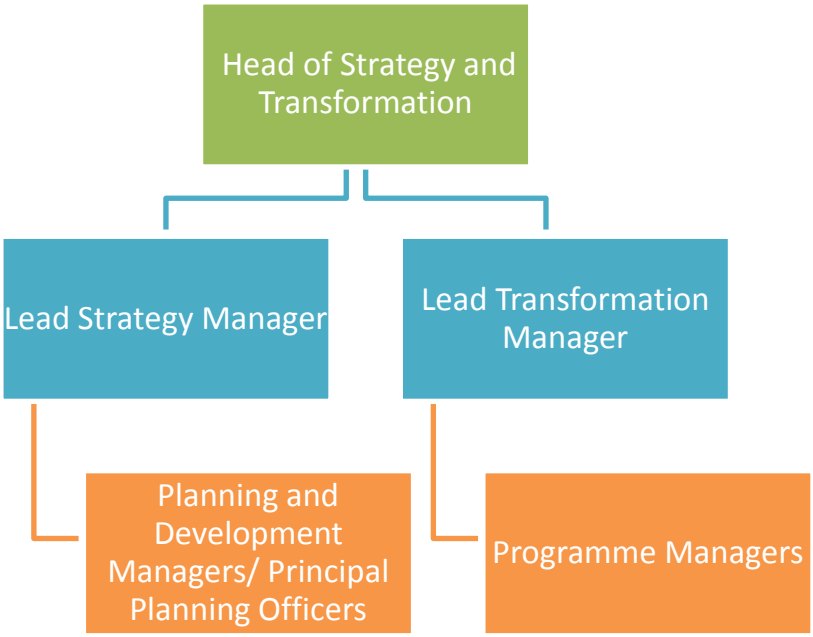

Figure 1: Directorate structure

Integration Joint Board

Core functions of this directorate will include:

- Strategic commissioning
- Market facilitation
- Locality planning
- Policy, strategy and risk
- Community planning
- Integration arrangements and compliance
- Transformation and innovation
- Continuous improvement framework

Those programme managers who will be leading and supporting our transformation work streams will now be wholly aligned to the Lead Transformation Manager and in addition, planning colleagues who have previously been aligned with different social work service managers will align to the Lead Strategy Manager.

A mapping exercise will be undertaken to show the available capacity of the team given their existing responsibilities and/or ascribed activities. A matrix aligning the available resource with the partnership's strategic priorities and planning needs across all of the delegated health and social care functions will then be drawn up in order to identify what additionality is required.

2.3 Strategic Plan Review & Refresh.

It is important that the partnership's Strategic Plan is always seen to be a credible document in the eyes of those individuals who use our health and social care services, their carers and families and the partnership's own constituent sectors (health, social care, third, independent and housing etc).

There is a risk that plans that are allowed to drift towards their published end date can be seen as less meaningful and important although it is very possible that they outline core ambitions and activities that may well continue to be referenced in the subsequent versions. We wish to ensure that our Strategic Plan is always seen to be a credible and meaningful document throughout its lifespan.

The Public Bodies Act (2014) requires the IJB to review its Strategic Plan within

the plan's three year lifespan. This review must reflect the integration principles and national health and wellbeing outcomes and seek the views of the Strategic Planning Group on the effectiveness of the arrangements for carrying out the delegated functions and whether, in the light of this, a new Strategic Plan needs to be prepared.

The integration of health and social care services has been a very significant event but, given that in this first year structures are still being developed and we are only beginning to affect transformational change, it is suggested that a desktop review of our Strategic Plan is undertaken in the first instance to ensure that it continues to be an accurate reflection of the IJB's vision and ambitions.

This review will be led by the Strategic Planning Group and will use as key reference documents 'A Strategic Overview of Strategic Plans' (Appendix A) produced by the Scottish Government and the partnership's first annual report which is due to be published in June next year.

The consultation and engagement that is undertaken on the revised plan will be proportionate to the scale of the review and will most likely be channelled through the respective locality leadership groups and existing strategic networks.

The Integration Joint Board will be presented with the review findings and the revised Strategic Plan.

2.4 Locality Planning.

The significance of localities as the 'engine room' of integration has been highlighted previously and is informing the development of our Locality Leadership Groups.

These groups are integral to our locality planning processes in that they will consider the needs of different population groups in order to help identify locality specific priorities and influence decision making around resource allocation and service delivery activities.

The process undertaken for the initial establishment of each locality group has involved the bringing together of relevant people, including those stipulated within the Locality Planning Guidance, to a "Kick Off" event. This event has provided an opportunity for those present to get to know each other and form relationships; be

informed about integration and the purpose of Locality Leadership Groups; and to start to think about the assets/ strengths of each locality and what activities may be required in order to fulfil the requirements of locality planning (Appendix B shows a draft locality planning outline developed by the South locality Leadership Group).

All four localities in the city have had their 'kick off' event, identified their chairs and are now seeking to develop their leadership groups further.

The Aberdeen City Health and Social Care Partnership and Community Planning Partnership are implementing different locality models because of their different statutory obligations. Colleagues from the two partnerships are collaborating to ensure that those joint opportunities which are in the best interests of our citizens and communities are maximised and obvious differences are mitigated against.

It is envisaged that the partnership will produce its locality plans in late 2017.

2.5 Strategic Planning Framework.

The development of the partnership's current Strategic Plan was undertaken with reference to the Public Bodies (Scotland)(Joint Working) Act 2014, the accompanying statutory guidance and an intuitive 'analyse, plan, do and review' model.

The anticipated benefits from the emerging development of the Strategy and Transformation directorate are increased policy cohesion and activity co-ordination however optimised returns will require more formal supports and tools. Having a 'Plan for how we plan' will be very helpful in explaining what we do, how we do it and why we do it, to a wider stakeholder audience.

A five tiered framework that seeks to align individual elements (governance, strategy, business processes, workforce and outcomes) in a coherent fashion will be produced. It is envisaged that this framework will have a relevance to the partnership's current operational activities, support future planning activities and underpin the development of all of the partnership's strategic policies and plans.

The Strategy and Transformation team and the Strategic Planning Group will jointly progress the development of this framework with a view to it being completed in late 2017.

Integration Joint Board

2.6 Commissioning Plan.

Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.

Effective commissioning requires the development of a comprehensive commissioning strategy. The partnership's Strategic Plan has been well received but it has been acknowledged that it provides a high level narrative of our vision and ambitions but perhaps lacks clarity of detail about our commissioning intentions.

A commissioning plan will be produced that outlines in more detail the models of care that we wish to develop across the city. It will be a statement of intent and as such an invitation to the third, independent and housing sectors to participate in the collaborative development and implementation of these.

We recognise that as was the case in the development of our Strategic Plan, our process needs to be equitable and transparent and open to influence from stakeholders via an ongoing dialogue with individuals, carers and providers.

This plan will be produced in the second quarter of 2017.

2.7 Market Facilitation Plan.

Market facilitation is the process by which there is sufficient, appropriate provision available to meet needs and deliver effective outcomes. There are three broad, inter-related activities that help define market facilitation:

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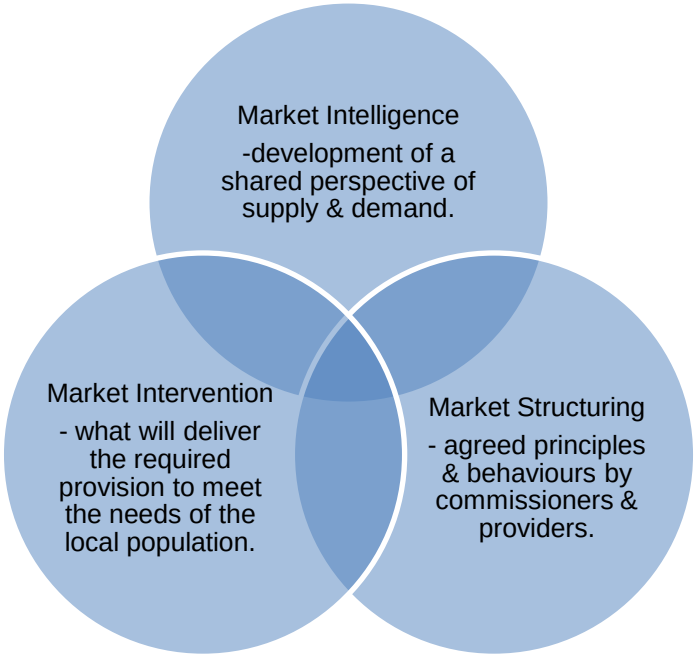


Market facilitation is not a new activity for the partnership. It is an integral element of the commissioning cycle and as such, operational, planning and procurement colleagues have been facilitating ongoing discussions with our partners in the third, independent and housing sectors with respect to many developmental activities including the partnership's Strategic Plan.

We are keen to build on that dialogue and develop a market facilitation plan which will outline the key principles that will underpin commissioner provider relationships and activities that will support the reshaping of existing care models across all of the sectors. Our plan will be an invitation to the third, independent and housing sectors to collaborate in the realisation of our strategic ambitions and priorities.

A market facilitation steering group has been established to oversee the development of this plan. It is envisaged that this plan will be presented to the IJB for approval and publication along with the Commissioning Plan referred to earlier in the second quarter of 2017.

2.8 Client Group Policies and Plans.

Analysis was undertaken earlier this year of national strategies and their alignment with our local strategies and action plans. As part of the development of the

Integration Joint Board

Strategy and Transformation directorate discussions are in progress with appropriate operational, planning and procurement colleagues to prioritise our activities. The existence of a local strategy and/or action plan, its end date and that of the corresponding national strategy along with any impending legislation will all influence those discussions as will the available capacity of the Strategy & Transformation team to progress the production of these policies and plans in the expected manner and to the required quality.

A summary of the analysis is shown below highlighting the need to progress in particular the planning and development of our local policies for carers and individual's with a learning disability.

local strategy	action plan	thematics
yes	yes	• Older People • Mental Health • Autism • Adult Support and Protection • Dementia
no	yes	• Sensory Impairment • Choose Life • Substance Misuse
no	no	• Carers • Learning Disability

A Carer's Strategy steering group, involving the IJB's two carer reps, has been established and has identified November 2017 as being a realistic and appropriate launch date for this strategy. The Carers (Scotland) Act will come into force a few months later on 1st April 2018.

Discussions with appropriate colleagues have commenced with respect to establishing a learning disability strategy steering group to oversee the development of that particular strategy.

The ongoing development of these strategies and plans will be monitored by the Strategic Planning Group which will become a 'place of reference' for all the steering groups to ensure that there is a consistency of approach and policy cohesion in the drafts produced.

Documents that have been consulted upon will be submitted to the IJB for approval and agreed publication.

2.9 Planning of Acute Sector and Hosted services.

Strategic planning of the acute sector services below was delegated to IJBs because of the significant proportion of unplanned admissions that they experience.

- Accident and Emergency services provided in a hospital.
- Inpatient hospital services:
    - General medicine
    - Geriatric medicine
    - Rehabilitation medicine
    - Respiratory medicine
    - Palliative care
    - Mental health
    - Psychiatry of learning disability

In addition, a number of different services are hosted by the three Grampian IJBs on behalf of one another and as outlined in our Integration scheme, the Aberdeen City IJB hosts the Elderly & Rehabilitation and Sexual Health services.

It is has previously been agreed that Aberdeenshire IJB will take the overall lead in hosting the strategic planning of these services on behalf of Aberdeen City and Moray IJBs to ensure that there is a comprehensive and co-ordinated planning process for the relevant acute and hosted services.

A Chief Officers' Acute Sector planning group has been established, chaired by the Aberdeenshire Chief Officer, Adam Coldwells and the most recent meeting (04/10/16) of the North East Partnership Steering Group (NEPSG) discussed a joint presentation by the three Grampian Chief Officers and the Director of Acute services on how best to proceed with these planning requirements given associated urgencies.

The importance of the role of NEPSG in facilitating joint planning and ensuring shared Governance was highlighted and the intention to step up the joint working to ensure strategic and governance processes are refined was also agreed.

A pan Grampian workshop to discuss and agree next steps has been arranged for

December 2016 and further discussions regarding this requirement are scheduled for future meetings of NEPSG.

2.10 Other Strategic Planning Activities.

The Joint Strategic Needs Assessment (JSNA) that underpinned the development of the partnership's Strategic Plan was produced in early 2015. The nature of the information captured by the JSNA is such that it does not need yearly reviews however it would benefit from a review that took a broader asset based approach to the health and wellbeing of the local population.

The Strategic Planning Group will lead this review and it is envisaged that this it will inform and influence the developing locality profiles.

In addition, a bed based review is being undertaken to map out the volume, bed type and usage of the beds utilised across the partnership's delegated functions and services. This information will be fed into different modelling scenarios that reflect varying demographic, financial and market circumstances to produce outcomes and shape recommendations for inclusion in the Commissioning Plan.

Timescales for this bed based review and the Commissioning Plan need to be aligned and prioritised accordingly.

2.11 Community Planning Partnership Local Outcomes Improvement Plan.

Community Planning colleagues are leading on the development of those arrangements required by the Community Empowerment Act 2015 including the establishment of a locality model focussing on prioritised socio-economic areas and the development of a Local Outcomes Improvement Plan.

Partnership colleagues have been actively involved in discussions with their community planning counterparts relating to the commonalities between the respective locality models and the joint working opportunities that could and should be progressed together.

In addition, a specific section of the Local Outcomes Improvement Plan relating to 'Resilient People' is being developed. The timing and sequencing of the respective governance bodies may mean that it is not possible for a draft of that 'Resilient People' section to be presented to the IJB before it is considered by the CPP

however it should be possible for the completed Local Outcomes Improvement Plan to be presented at a subsequent date.

The IJB is now a statutory partner within the Community Planning Partnership and it may be beneficial in terms of increased awareness and understanding for this to be the subject of a future IJB workshop.

2.12 Community Justice Outcomes Improvement Plan.

A national redesign of 'community justice' is taking place underpinned by the Community Justice (Scotland) Act 2016. From 1st April 2017 responsibility for strategic planning and delivery of community justice will be taken forward by partners in each local authority area (Local Authorities, Health Boards, Police Scotland, Scottish Fire and Rescue service, Integration Joint Boards, Scottish Courts and Tribunal service, Skills Development Scotland, Scottish Ministers).

The emphasis of the new model lies in a collaborative approach between partner organisations, communities, and the individuals who are involved with the 'Justice System' and their families. The strategic planning and delivery of services through Community Planning Partnerships are central to the new arrangements.

A Community Justice Outcomes Improvement Plan must be published on 1st April 2017 and must assess the extent to which national Community Justice outcomes are being achieved locally, whether they require to be a priority for action, and what action they intend to take to achieve or maintain them.

The draft Community Justice Outcomes Improvement Plan will be presented to the IJB as part of its consultation prior to its endorsement by the Community Planning Partnership.

2.13 Summary.

A significant amount of planning activity is envisaged for the partnership next year but for this to be undertaken in the desired co-productive manner and to the standard of quality expected will require firstly the means to do so and then agreement of what the partnerships priorities should be. These can be summarised as :

Integration Joint Board

Activity	Priority	Timescale	Comment
strategic plan review	medium	July-September	Priority relates to significance of strategic plan rather than activity given that this would be first review.
locality planning	high	September-December	Statutory requirement but needs to be aligned with development of operational structure esp Heads of Localities.
transformation programme	high	ongoing	Capacity issues will be eased by emerging Strategy and Transformation team.
strategic planning framework	low	September-December	Desirable but not strictly necessary.
commissioning plan	high	January- July	Will provide necessary detail for commissioning intentions/procurement parameters.
market facilitation plan	high	January-July	Supplementary to commissioning plan.
client group strategies & plans	low	January - December	Production of plan(s) needs time/resource.
acute sector planning	high	n/k	Statutory obligation but clarification needed re timeline & resource.
local outcomes improvement plan	high	December 2016	Statutory requirement of CPP; ACHSCP statutory partner & contributor to LOIP.
community justice outcomes improvement plan	high	January – March	Statutory requirement by 1st April; ACHSCP statutory partner in CJA.

A communication and engagement plan will be drawn up to co-ordinate the key messages that will emerge from these different activities.

Integration Joint Board

3:	Equalities, Financial, Workforce and Other Implications

Equalities Implications

No direct implications as such but Equalities Impact Assessments will be an integral element of all of our strategic planning activities and these all these assessments will be published with the plans that they relate to.

The Strategy and Transformation team will lead the discussions with appropriate colleagues from the IJB's partner organisations (ACC, NHSG) about the IJB's own Equalities duties and ensure that it is compliant with the relevant legislation.

Initial discussions have reflected on how colleagues who will be submitting papers to the IJB in the future can be supported with respect to the Equality Impact Assessment that they are required to complete. As part of this process, the assessment template and its accompanying guidance are being reviewed to see what improvements can be made.

Supporting staff to understand why they are completing these assessments and what should be done to ensure that they are thorough will result in a higher standard of assessment with clearer implications for the protected groups.

Financial Implications

The Chief Officer's Strategic Commissioning Paper that was presented to the IJB at its April 2016 meeting outlined an allocation from the Integrated Care Fund to support the commissioning work stream including the recruitment to key roles.

Once the mapping of our existing planning capacity is complete discussions with finance colleagues will be initiated to develop an options appraisal for the next developmental phase of the Strategy and transformation team.

The development of our operational activities across all sectors and client groups and the commissioning of appropriate services arising from our Commissioning Plan, Market Facilitation Plan and client group specific plans will have implications in respect of the integrated budget, transformational funds and ring fenced funding (where applicable).

These financial implications will be more specifically detailed when future papers relating to these plans are presented to the IJB.

Workforce Implications

The development of the Strategy and Transformation team will result in a change of line management arrangements for some staff. Subsequent discussions with them will seek to develop a more cohesive policy approach by co-ordinating the team's planning activities with the partnership's strategic priorities and ambitions.

There are no other direct implications for the partnership's workforce however it is anticipated that greater cohesion and co-ordination across our planning activities will lead to raised awareness levels and increased understanding of the partnership's ambitions and intentions.

Other Implications

There is an increased opportunity to raise awareness of the health inequalities experienced by different population groups living in different parts of the city and for the partnership to get better at showing how, through a health inequalities impact assessment, it hopes to improve health and wellbeing and reduce health inequalities.

4:	Management of Risk

Identified risk(s):

Link to risk number on strategic risk register:

1. There is a risk of significant market failure in Aberdeen City
2. There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance in through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.
3. There is a risk that the IJB and the services that it directs and has operational oversight of fail to meet performance standards or outcomes as set by regulatory bodies
4. There is a risk of reputational damage to the IJB and its partner organisations

resulting from complexity of function, delegation and delivery of services across health and social care.

5. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system

6. There is a risk that the IJB does not maximise the opportunities offered by locality working

How might the content of this report impact or mitigate the known risks:

Strategic planning of its delegated functions and services is a key statutory responsibility for the IJB and there is an opportunity to mitigate the possible risks in a number of ways:

1) Capacity: to undertake the required planning activities and fulfil them in the expected manner and to the required standard will mean an aligned resource being made available.

2) Approach: Having a pragmatic approach that seeks to co-produce the solutions in partnership with the individuals who use our health and care services, their carers, and the third, independent and housing sectors. Engagement is seen as a defining feature of the partnership's activities.

3) Cohesion: Ensuring that all strategies and plans have a policy cohesion with Scottish Government strategies, the Strategic Plan and key strategies of the partner organisations.

4) Co-ordination: Fulfilling the different elements of the strategic commissioning cycle across all the planning activities will require significant co-ordination so that there is no confusion, little duplication of effort and maximised advantages.

5) Transformation: For strategic planning to be effective it must improve the personal experiences and outcomes of the people who use our services and their carers.

Integration Joint Board

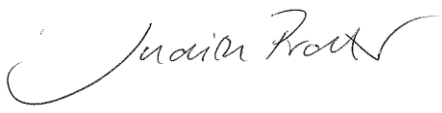
5:	Recommendations for Action

It is recommended that the Integration Joint Board:

1. Notes the emerging development of the Strategy and Transformation team.
2. Agrees the prioritisation of the required planning activities.
3. Directs the Chief Officer to ensure that the completed

    - Locality plans,
    - Commissioning plan
    - Market Facilitation plan
    - Client group specific plans
    - Acute sector plan(s)

    are brought to the Board at the appropriate time for discussion and approval.
4. Agrees that the completed 'Resilient, Supported and Included' section of the Local Outcomes Improvement Plan should be brought to the Board at a future date for noting.
5. Agrees that the completed Local Outcomes Improvement Plan should be brought to the Board at a future date for noting.
6. Agrees that the completed Community Justice Outcomes Improvement Plan should be presented to the Board at a future date for noting.

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

The Scottish Government
Riaghaltas na h-Alba

Health and Social Care Integration

Strategic Commissioning Plans

An overview of strategic commissioning plans produced by Integration Authorities for 2016 - 2019

October 2016

Contents

Key messages

Strategic commissioning is more than the publication of a plan, it is an approach to making sure people have access to the right care at the right time, and in the right place. It involves a range of activities, centred around a continuous cycle of **analyse, plan, do and review** and is iterative and dynamic to support collaborative system change across health and social care. Those Partnerships established in April 2015 have already reviewed and refreshed their plans, through this approach.

Functions of strategic commissioning plans include setting the vision and direction of travel, providing a means of communication, promoting effective and on-going engagement, building consensus, making linkages across a range of plans, services, different parts of the system, sectors and people, and determining strategic priorities.

- All Partnerships completed strategic commissioning plans by 1st April 2016 and these are high level and strategic. Further work is needed in a few plans and in supporting implementation plans to raise the scale of ambition and the pace at which it will be achieved, but most are aiming high.

- All plans include a list of functions that have been delegated by the Local Authority and by the NHS Board. A number of plans use tables and graphics to good effect in order to communicate this information.

- The reach and quality of engagement in the development of strategic commissioning plans is comprehensive and generally of good quality across Scotland. Strong engagement and working on a co-production basis needs to become the norm, not just in agreeing the vision and setting direction. This is emerging in a number of the Partnerships.

- Some plans describe how the Partnership is working with the Community Planning Partnership (CPP). This will ensure a common approach between key public sector agencies and optimise opportunities for joint work on shared priorities.

- Strategic Planning Groups have been established in each Partnership but this is not well covered in many of the strategic commissioning plans and should be given more prominence in subsequent iterations.

- Accessibility of plans and accompanying documents was generally good but there were sometimes difficulties in locating these. Scottish Government is currently working with a small number of Partnerships to identify good practice in engagement strategies, including publishing documents and improving accessibility.

- All Partnerships have undertaken a strategic needs assessment that considers needs, population dynamics and projections, service activity, supply and demand and gaps in provision to inform their strategic commissioning plan. Some are being further developed.

- Some plans include Market Facilitation Plans, and it is essential that these are completed in all Partnerships. Third and independent sector partners and procurement staff should actively participate in the development of these plans.

- Strategic commissioning plans do not deal with procurement arrangements. Effective procurement of care and support services is a crucial aspect of strategic commissioning and Partnerships must plan for how this will developed and improved, using best available evidence and guidance for implementing new approaches.

- There is little evidence that data from the third and independent sectors is included in strategic needs assessments. This is an area for development and work is underway through Source and in some Partnerships to address this.

- A brief analysis of deprivation in the Partnership's population is a particular feature of some plans. Deprivation constitutes a serious issue for many parts of Scotland and its impact should be considered in plans. Tackling health inequality is a strategic priority in almost all plans. This needs further development in some plans in order to move beyond identifying the issues to what action will be taken, often acting in collaboration with others such as community planning partners.

- A number of plans include equality impact assessments and outline the work the Partnership is doing to develop and publish equality outcomes. All Partnerships must publish robust Equality Outcomes and undertake an Equality Impact Assessment to ensure they are meeting their statutory obligations.

- All plans identify strategic priorities and there are a number that are broadly consistent across Partnerships. Where Partnerships have children's services and community justice social work services delegated, specific strategic priorities relating to these services are included

- Plans contain varying levels of financial information. To assist with the production of Annual Financial Statements in future years, the Scottish Government has published an advice note on the scope of these and what they should contain (http://www.gov.scot/Publications/2016/09/1985). We will also work with COSLA to produce a suggested pro-forma that will be issued in late Autumn of 2016.

- The financial impact of re-modelling services is not considered in many plans nor is the method made clear for how decisions will be made about the allocation of resources. This has been challenging for Partnerships to do ahead of finalising budgets and is an area for development across plans. To assist Partnerships with work required on prioritisation, the Scottish Government has published an advice note on the key characteristics that should be incorporated in this process (http://www.gov.scot/Publications/2016/09/9980).

- An area requiring specific attention is the financial planning for the sum set aside for hospital services. The Scottish Government is working with Partnerships, Health Boards and Local Authorities to draft guidance on good practice for budget setting, so that the processes will be better aligned for 2017/18.

- The number of localities in each Partnership ranges from two to nine. The size of localities ranges from a large urban population of 219,422 to a small island population of just 1,264. In all, 128 localities have been established in Partnerships to take forward work on a local basis. Further work is required across Partnerships to fully develop their locality arrangements and maximise the potential of the structured involvement of communities, and local professionals in planning and decision making.

- Some plans contain a high level summary of workforce issues. It is imperative that emergent integrated workforce plans carefully consider and seek to address the panoply of issues for staff in health and social care services, including in the third and independent sectors.

- Many plans emphasise the key role of primary care services in health and social care integration. Some explore the need to develop stronger and more innovative links with primary care, where most patient contact takes place. All plans identify GPs and primary care as a key component of local service delivery and locality planning.

- A number of plans clearly outline the relationship between the Partnership and acute care and identify the Partnerships' statutory role in strategic planning for emergency care services delivered in acute hospitals. In some plans, responsibility for planning for the emergency care pathway is low key and not well covered. Future iterations must pay more attention to this.

- While there may be opportunities for efficiency in some instances through establishing hosting arrangements, it is important that hosting is not used in multi –partnership Health Board areas to maintain existing NHS arrangements where there is scope through the Partnerships for greater local ownership and improvement.

- Housing is recognised in most plans as a key component of effectively shifting the balance of care from institutional care to community based services and supports. Some plans contained information on the local Housing Plan and its fit with health and social care delivery. Just over half of plans contain a housing contribution statement.

- All partnerships have developed a performance framework that includes national and local outcomes and measures. Where appropriate, performance frameworks include children's outcomes and criminal justice outcomes as well as the National Health and Wellbeing Outcomes. Although not a requirement, first iterations of performance reports have been published by Partnerships established last year.

Introduction and background

1. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) put in place the framework for integrating health and social care. The Act places a duty on Integration Authorities (referred to throughout this document as Partnerships) – either Integration Joint Boards or Health Boards and Local Authorities acting as lead agencies – to create a strategic plan for the integrated functions and budgets that they control.

2. Scottish Government published statutory guidance on Strategic Commissioning Plans in December 2014. The strategic plan is the output of what is more commonly referred to as the strategic commissioning process. The statutory guidance provides the following definition of strategic commissioning: *it is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.* The guidance also explains that where we refer to the strategic commissioning plan, we are referring to the strategic plan described in the Act. These are not separate or different plans, they are one and the same.

> ***The importance of effective strategic commissioning for the success of integrated health and social care provision cannot be over-stated. It is the mechanism via which the new integration partnerships will deliver better care for people, and better use of the significant resources we invest in health and social care provision*.**
>
> Strategic Commissioning Plan, Statutory Guidance, December 2014

3. By developing strategic commissioning plans for, as a minimum, all adult care groups, and taking a population approach to planning, Partnerships are focusing on designing, commissioning and delivering services in new and sustainable ways, in collaboration with their partners.

4. All Partnerships completed their strategic commissioning plans by 1st April 2016, as required. Generally, these set out the vision, aims, ambitions and outcomes that each Partnership will seek to deliver, over the life of the plan. Some Partnerships have, or are in the process of, developing further iterations, clearly demonstrating that the plans are dynamic and being actively used. In addition, all Partnerships have developed or are developing detailed, costed implementation or operational plans for the delivery of strategic priorities identified through the strategic commissioning process.

5. This report provides an overview of the content and approach of these first iterations, and identifies common themes and key areas for further development. It is intended to assist local systems to accelerate the transformational potential of their plans, and deliver sustainable new models of care and support that are focused on improving outcomes.

Overall Content and Approach

6. Most Partnerships have produced plans that are easy to read and provide a clear, high-level direction for health and social care services and supports in the coming years. All articulate a clear vision, and many include principles, mission statements and values to support this.

7. The plans are high level and strategic. They do not cover anything in great detail but often provide links or appendices to supplementary material. These do offer more detail, but do not routinely include information about how plans will be delivered, with timescales and costs. A number of plans have a whole range of accompanying documents, which have both informed the plan or been developed as a result of it.

8. Some plans give commitments with timescales for when other plans will be produced and some provide obvious hooks and levers for the development of more detailed plans leading to transformational change. For example, for specific care groups, service redesign or new service delivery, each of which requires to be consistent with the direction established in the strategic commissioning plan, and deliver the intended change on a sustainable basis.

9. All plans draw on relevant extant plans and strategies, and some explain how the strategic commissioning plan relates to these in the immediate and longer-term. Some plans use good graphics to illustrate how various plans and strategies relate to the strategic commissioning plan. However, the strategic commissioning plan is not a summation of other strategies but provides the means for coherence across a range of inter-related plans.

10. All plans include an explanation of why change is necessary, emphasising increasing demand and rising public expectations combined with limited finance. Some make a particularly cogent case by drawing on key data that are specific to their Partnership and which highlight the enormity of what needs to change, and why, in that Partnership area.

11. The scale of ambition expressed varies amongst plans, but most are aiming high. Some plans contain clear statements about their aspirations and ambitions, whilst others describe their ambitions in a more oblique way through the plans they have for delivering new models of care that are sustainable and focused on improving outcomes.

12. Further work is needed in a few plans and in supporting implementation plans to raise the scale of ambition and the pace at which it will be achieved. An increased focus on how transformational and sustainable change will be achieved at pace and scale, using the resources available to the Partnership must be a key aspect of planning and implementation.

13. Innovation and relentless pursuit of established strategic priorities to deliver improved outcomes is vital, as is seizing opportunities, while responding flexibly to the rapidly changing landscape within which Partnerships operate. A small

number of plans highlight the opportunities integration presents and how they plan to use these.

14. The need to do things differently and to support innovation, particularly through more extensive and imaginative use of technology, is a feature of a number of plans. Telehealth is generally not well covered in plans.

15. Working in close partnership with staff, people who use services, carers and the third and independent sectors, as well as local communities, is also recognised throughout plans as a key aspect of working differently and supporting innovation.

Scope of plans

16. The scope of plans is determined by the functions delegated to Partnerships. All plans include a list of functions that have been delegated by the Local Authority and by the NHS Board. A number of plans use tables and graphics to good effect in order to communicate this information.

17. Some plans explicitly cover public protection and all Partnerships, as a minimum, have delegated responsibility for adult protection. Interagency procedures are already in place for child, adult and public protection, however integration offers an opportunity to refresh these and to strengthen public protection.

18. Some plans, where children's services are not within scope refer to the need to build strong and meaningful collaboration with integrated children's services. A list of delegated functions to each partnership beyond the statutory minimum is appended at Annex 1.

19. Plans have been prepared in a variety of formats and styles with length varying between 18 pages to over 250 pages. The lengthier plans tend to include a range of planning material, such as detailed needs assessments and equality impact assessments, as appendices, while shorter plans are usually supported by a suite of associated documents that are separately published.

20. Explanations about what Integration Joint Boards (IJBs) are, who is on them, the number of voting members and other members, including advisors, have helpfully been included in the majority of plans.

21. Some of the clearest and most accessible plans have included light touch information about the Act and other key policy objectives, often by using graphics and charts to good effect. This includes vignettes of what will change for people in new integrated health and social care arrangements and what the overall approach is to delivering change.

Reach and quality of engagement

22. A range of stakeholders including staff, people using services, carers, the third and independent sectors must be fully engaged in the preparation, publication and review of the strategic commissioning plan. This is to establish a meaningful

co-productive approach, to enable Partnerships to deliver the national outcomes for health and wellbeing, and achieve the core aims of integration.

23. The reach and quality of engagement in the development of strategic commissioning plans is comprehensive and generally of good quality across Scotland. All Partnerships have rolled out extensive programmes of meetings with staff, people using services, carers, providers, third and independent sectors, local communities and the wider public to gauge opinion on what's important to them, to inform strategic priorities. A large number of Partnerships also ran formal consultations on their plans and many made significant alterations as a result.

24. Although not all planning will require this level of engagement on such a broad scale, it must be recognised as being a key part of an on-going strategic commissioning process. Strong engagement needs to become the norm, not just in agreeing the vision and setting direction. This co-productive way of working and engaging is emerging in a number of the Partnerships. Locality planning (discussed below) is an additional helpful vehicle for this.

25. Strategic Planning Groups (SPGs) have a formal statutory role in preparing and monitoring strategic commissioning plans. SPGs have been established in each Partnership and form an important cornerstone for effective stakeholder engagement and involvement, with a link directly to the IJB. The role of the SPG is not well covered in many of the strategic commissioning plans and should be given more prominence in subsequent iterations.

26. The model for SPGs varies slightly across Scotland but the majority are meeting regularly, and have developed a programme of work focused on monitoring the implementation of the plans and reviewing and refreshing existing plans. Locality planning leads are now playing into a number of SPGs, providing real opportunities for local community engagement on matters affecting people living and working in localities.

27. Within SPGs and across an extensive range of other stakeholder groups, key relationships and engagement with people using services, carers, professionals and clinicians, along with the third and independent and housing sectors, and with the wider public are being developed and deepened. Many Partnerships have developed engagement strategies and are focusing on developing effective communications with their local stakeholders and beyond.

28. Some plans describe how the Partnership is working with the Community Planning Partnership (CPP) to extend and co-ordinate reach into local communities and neighbourhoods. This link to CPPs ensures that health and social care is not isolated from wider and highly relevant agendas that include transport, leisure and recreation, education, economic development, housing, policing, and fire and rescue services.

29. An array of web platforms have been developed for Partnerships, with the majority being hosted by the Local Authority and/or Health Board. A few Partnerships have developed their own web sites. Many have social media

accounts and are regularly publishing updates and information bulletins, increasing the visibility of their Partnership.

30. One issue we noted, however, was occasional difficulty in locating plans (and more often linked documents) on websites. In response, the Scottish Government is currently working with a small number of Partnerships to identify good practice in engagement strategies, including publishing documents and improving accessibility.

31. With a requirement under the Act to publish strategic commissioning plans and other documents, it is imperative that they are made more readily accessible. This has implications not only for the accessibility of the plans and other information the public may wish to access about Partnerships, but for the general visibility of Partnerships, what they do and what they are setting out to achieve, and requires attention.

Strategic needs assessment

32. All Partnerships have undertaken a strategic needs assessment that considers needs, population dynamics and projections, service activity, supply and demand and gaps in provision to inform their strategic commissioning plan, and shape services and support to deliver better outcomes. A few Partnerships intend to undertake a more in depth analysis to better inform future iterations of their plans.

33. Most plans use information from strategic needs assessment to highlight the challenges faced by the Partnership. This is most effectively described in plans where the challenges are put in simple and fairly stark terms that demonstrate the scale of what needs to be done and provide clear justification for major change across the existing health and social care system.

34. As well as good use of population health and well-being data, many plans provide a range of high level needs assessment information on particular care groups and draw on a range of available data. There are some areas (notably community health services and social care services) where information is historically light, as is not routinely collected nor joined up across data sets.

35. In order to improve the data available to Partnerships, the Scottish Government commissioned NHS National Services Scotland (Information Services Division - ISD) to develop a health and social care dataset, and to develop analytical capacity and skills in Partnerships. This work was known as the Health and Social Care Data Integration and Intelligence Project, now known as Source, and is a development of our longstanding work on the Integrated Resources Framework.

36. The IT platform to support Source has been available since April 2015 and provides a secure data collection, storage, linkage and reporting facility – a “datamart” - for each Partnership. The initial phase of this work has so far focussed on linking a range of existing health datasets with Local Authority social care data. Once Local Authorities have submitted their data, every Partnership will be able to access pseudonymised, individual level longitudinal data for about

70% of the resources used by their populations. Over time, our objective is to capture 100% of partnership resources at this level.

37. In addition, the Local Intelligence Support Team (LIST) has allocated its analytical staff directly to work within each of the 31 partnerships. This resource provides additional capacity and capability in Partnerships for data analysis, to underpin the strategic commissioning process. Feedback on LIST support and the Partnership embedded method of delivering it is very positive across the country.

38. The data now available has been put to effective use by many of the Partnerships in their plans. Improved data availability has encouraged a system-wide focus on how data can help inform future planning by improved understanding of what the current state of play is, and to identify what needs to change to better meet outcomes and build a more sustainable health and social care system.

39. Many plans indicate that the Partnership is adopting an assets-based approach. This is critical in order to fully recognise, develop and make best use of wider assets and resources available in local communities and to facilitate partnership working with local communities.

40. There is little evidence that data from the third and independent sectors is included in strategic needs assessments. This is an area for development as Partnerships develop their data sets, strategic analysis and locality profiling and work is underway through Source and by some Partnerships in this regard. Locality planning and market facilitation work will necessitate a better understanding of the contribution made by the third and independent sectors, sharing and using data across sectors is at an early stage of development in most Partnerships.

41. Some plans include some basic market intelligence and data on service configuration. Some have Market Facilitation Plans as appendices, or available as separate documents. A few plans commit the Partnership to developing a Market Facilitation Plan. It is essential that third and independent sector partners actively participate in the development of such plans (and in any refresh of pre-existing plans), including in the provision of locally collected data about needs, outcomes, service configuration and costs.

42. It is also important that procurement staff are involved in the development of market facilitation plans, drawing on their expertise and knowledge as well as involving them directly in changing relationships with providers. Strategic commissioning plans do not deal with procurement arrangements, implying that this will require to be dealt with elsewhere. Effective procurement of care and support services is a crucial aspect of strategic commissioning and Partnerships must plan for how this will developed and improved, using best available evidence and guidance for implementing new approaches.

43. Data on high resource individuals is used in a few plans to highlight the significant level of resource being directed to the care and treatment of a relatively small number of people. This data is being used to plan improved and

clearer routes for people through the local health and social care system, and potentially for the redirection of resources.

44. A brief analysis of deprivation in the Partnership's population is a particular feature of some plans. Deprivation constitutes a serious issue for many parts of Scotland. Poverty and deprivation can have a devastating effect on health and well-being, none more starkly represented than in death rates in affluent areas compared to those in areas of deprivation, where people can die 15 years earlier due their economic and social circumstances. Deprivation and its impact needs to be part of the work on tackling inequalities, and should be more prominent in plans.

45. A few plans briefly explore equalities issues, describe the diversity of their populations, and highlight some of the difficulties equalities groups may experience in accessing and using health and social care services. A number of plans include equality impact assessments and outline the work the Partnership is doing to develop and publish equality outcomes, which the Partnership considers will enable it to better perform the equality duty set out in the Equality Act 2010 and accompanying regulations.

46. Having published their equality outcomes, Partnerships are required to publish reports on progress on mainstreaming the equality duty. These duties should be considered during the development of the strategic commissioning plan. All Partnerships must also carry out an Equality Impact Assessment when preparing their strategic commissioning plan to ensure they are meeting their statutory obligations.

Strategic priorities

47. All plans identify strategic priorities and many identify commissioning intentions for delivering on these priorities. Where commissioning intentions and action plans are not contained in the plan, local additional work is underway or completed.

48. Many plans map strategic priorities onto national outcomes for health and wellbeing, and indeed a few Partnerships have simply adopted the national outcomes as their strategic priorities and outlined what they intend to do to deliver on these.

49. A number of broadly consistent strategic priorities have been identified by Partnerships, partly as these relate closely to the nine national outcomes. Strengthening and working in partnership with local communities, reducing avoidable admissions to hospital, support for carers, prevention and early intervention, promoting healthy lifestyles, promoting self-management and independence, developing primary care and community responses, delivering integrated care models and single points of entry to services are frequently identified as strategic priorities.

50. Optimising efficiency and effectiveness, and achieving best value are also commonly identified as strategic priorities, as is valuing and developing the

workforce. Delivering personalised care and support alongside giving people more choice and control featured as a priority in a number of plans.

51. Tackling health inequality together with the wider equality agenda and adopting a human rights approach is explored and identified as a strategic priority in almost all plans. This needs further development in some plans in order to move beyond identifying the issues to what action will be taken, often acting in collaboration with others, such as community planning partners.

52. Improving mental health and well-being is identified a strategic priority in a small number of plans, and is recognised as an issue in a number of others.

53. Establishing health and social care systems that keep people safe from harm, usually linked to protecting vulnerable people or wider public protection activity, was a strategic priority in a number of plans. Dignity at end of life and improved palliative care was also prioritised in a few plans.

54. Where Partnerships have children's services and community justice social work services delegated, specific strategic priorities relating to these services are included, such as giving children and young people the best possible start in life and reducing reoffending. Many strategic priorities are applicable to all sections of the population.

Financial planning

55. Robust financial planning to support strategic commissioning plans is essential. Plans contained varying levels of financial information ranging from the overall estimated sum available across the Partnership to details of indicative allocations for each service delegated.

56. Partnerships are required to publish an Annual Financial Statement on resources that it plans to spend in implementing the strategic commissioning plan. This is a summary of the financial plan that underpins the strategic commissioning plan. To assist with the production of Annual Financial Statements in future years, the Scottish Government has drafted an advice note on the scope of these and what they should contain. We will also work with COSLA to produce a suggested pro-forma that will be issued in late Autumn of 2016.

57. We recognise that reporting financial information in the way expected has been a challenge for Partnerships (and Heath Boards and Local Authorities) and that approximations may need to be made during initial planning and reporting cycles, while information systems are developed and bedded in.

58. The allocation of resources to improve outcomes is a key task of Partnerships, particularly in view of the key challenges of increasing demand and constrained resources. How sustainability will be achieved was generally not well detailed in plans although many referred to the need to develop sustainable services and that new, affordable models of care are needed that better meet people's outcomes.

59. The financial impact of re-modelling services is not considered in many plans nor is the method made clear for how decisions will be made about the allocation of resources in terms of investment and disinvestment to achieve identified strategic priorities. Such decisions must be based on the basis of clear criteria, a robust process and application of relevant and focused information, and must take account of the Partnership's duty to achieve best value.

60. This has been challenging for Partnerships to do ahead of finalising budgets and is an area for development across plans. To assist Partnerships with work required on prioritisation, the Scottish Government has published an advice note on the key characteristics that should be incorporated in this process.

61. The process for agreeing the initial allocations from Health Boards and Local Authorities and the associated due diligence was set out in Integration Schemes and supported by statutory guidance. Nevertheless, the process has been difficult and protracted in many partnerships and this has had an impact on financial planning.

62. One area requiring specific attention is the financial planning for the sum set aside for hospital services. It is evident from strategic commissioning plans that many partnerships haven't been provided with sufficient information on their population's use of hospital services to incorporate hospital capacity in their plans. This has been reinforced by the responses to recent surveys of Partnerships, where only thirteen were able to provide a figure for the bed capacity used by their populations.

63. The Scottish Government is working with Health Board and Local Authority Directors of Finance and IJB Chief Finance officers to draft guidance on good practice for budget setting, so that the processes will be better aligned for 2017/18, with the intention to move to a position of providing as much certainty as possible over a three year period.

64. Statutory guidance stipulates that budget setting for year 2 onwards should be a process based on negotiation about the level of funding, performance and associated risks, rather than a roll forward of individual service budgets used for the initial allocations. Together with early engagement between partners in looking forward to 2017/18, we expect that these developments will allow the process for agreeing future budgets to be more straightforward and to provide a framework for improved financial planning.

Outcomes

65. A number of plans refer explicitly to the integration principles set out in the Act and all include detailed references to achieving the national health and well-being outcomes, and to locally determined outcomes. Helpful charts and graphics have been used in some plans to make links between national health and well-being outcomes, strategic priorities and commissioning intentions.

66. The whole purpose of integrating adult health and social care services is to improve health and wellbeing outcomes for people in Scotland. As referred to

above, delivering personalised care and support was identified as a strategic priority of many plans.

67. Self-directed Support (SDS) is identified in some plans as an approach that supports the delivery of joined up, flexible, person-centred care and support with the express intention of providing people with greater choice and more control over how they live their lives. This was occasionally linked to, for example, people being able to choose to die at home, as well as a wider range of options for meeting personal outcomes.

68. Preventative, early intervention and self-management approaches are identified as important to achieving better outcomes in many plans. As is supporting people and communities to take greater responsibility for their own outcomes, reducing the need for services. Well targeted anticipatory care planning is also highlighted as an area for development in a number of plans.

69. In some plans, outcomes are identified at a wholly strategic level with little attention paid to personal outcomes, and how these are linked to and drive service and strategic level outcomes.

Localities

70. As expected, locality arrangements vary significantly across the country and some are at early stages of development. Some locality arrangements are focused on both an organisational unit for operational delivery and for locality planning, while others are entirely focused on one or the other with the intention of developing localities further over time.

"... **effective services must be designed with and for people and communities – not delivered top down for administrative convenience**"

The Christie Commission Report
Commission on the future delivery of public services, June 2011

71. The statutory guidance on localities states that localities provide one route, under integration to ensure strong community, clinical and professional leadership of strategic commissioning of services. Essentially, it is the route whereby local communities and local clinicians and professionals can play an active role in service planning for their local population, in order to improve outcomes. This approach fits well with community empowerment. It ensures that people who live and work in a locality have a forum to inform redesign and improvement in that locality.

72. All plans (except two, where this is detailed separately) include details of the localities proposed or in place in each of the Partnerships. The number of localities in each Partnership ranges from two to nine. The size of localities ranges from a large urban population of 217,422 to a small island population of just 1,264.

73. In all, 128 localities have been established in Partnerships to take forward work on a local basis. A table of localities mapped to Partnerships and Health Boards is appended at Annex 2.

74. Many plans highlight the need to shift to more preventive approaches and to build community capacity. Working closely with local communities and building their on their assets is also widely recognised, especially in locality planning and delivery. In this regard, many Partnerships have used positive learning and evidence from tests of change undertaken at locality levels to inform broader system changes prioritised within their plans.

75. Many localities are based on existing Community Planning Partnership areas to retain or develop a strong connection to community planning. This will ensure a common approach between key public sector agencies and optimise opportunities for joint work on shared priorities.

76. A small number are based on long-standing locality arrangements between health and social care, which have been refreshed and enhanced to meet the requirements of the Act. Most have taken clear account of emerging GP cluster arrangements.

77. Some Partnerships have begun to develop locality plans and a few strategic commissioning plans include initial or outline priorities for localities, in addition to the strategic priorities for the Partnership. Many are developing locality profiles, using partnership wide data and disaggregating this to the locality area. This will be an important aspect of equipping localities to plan for their populations. Similarly, disaggregation of budgets to locality levels will be crucial for place based planning and is not yet complete in most Partnerships.

78. A number of Partnerships have established locality managers' posts, which have the combined responsibility for managing service delivery and locality planning in their patch. Some Partnerships have established locality leads who will work closely with GP locality leads, and others to establish and lead locality planning.

79. Further work is required across Partnerships to fully develop their locality arrangements and maximise the potential of the structured involvement of communities, and local professionals in planning and decision making. Overtime, it is intended that proportionate resources, responsibility and accountability will shift to localities. A level of infrastructure is required to support these arrangements and make them operate effectively, this is at early stages in some Partnerships.

Workforce and multi-disciplinary teams

80. Many Partnerships have either created or are planning the development of multi-disciplinary teams, flowing from priorities identified in strategic commissioning plans. These are intended to bring different professionals across health and social care together to make sure people receive seamless care or support from the right professional. Some of these teams will include input from the third sector.

81. Hubs have been established or are planned in many Partnerships, often focused around GP or primary care practices. These are designed to better meet people's changing and diverse needs, including improved understanding and use of community based supports. The development of multi-disciplinary teams will be a crucial aspect of transforming primary care services in integrated settings, which envisages GPs becoming expert-generalist in complex care and focusing more on quality and leadership.

82. The Scottish Government recently published a National Clinical Strategy for Scotland. It wholly supports the aims and intended outcomes of integration. The strategy sets out the intention to build capacity in primary care, with a broader mix of professionals involved, who will be working collaboratively in clusters and working with social care and the third sector.

83. In secondary care, the strategy is to consider the potential for developing fewer inpatient sites, that will provide more highly specialised services, linked to local hospitals. The Chief Medical Officer's annual report for 2014-15 introduced the adoption of an approach called "realistic medicine" in order to reduce harm and over treatment, and to ensure that treatment is tailored to patient preferences.

"Doctors generally choose less treatment for themselves than they provide for their patients."

Chief Medical Officer's Annual Report 2014-15

84. Some plans contain a high level summary of workforce issues and some indicate wider work is being undertaken on developing an integrated workforce strategy. A few contain outline workforce strategies. It will be imperative that these integrated workforce plans carefully consider and seek to address the panoply of issues for staff in health and social care services, including in the third and independent sectors.

85. Partnerships fully recognise the health and social care workforce as a major asset. Achieving the right skill mix, and having the right staff in the right places is a priority to better meet people's needs and achieve sustainability. Some highlight concern about the age profile of the workforce, while a few note recruitment and retention issues affecting a range of staff form GPs to social care assistants. Growing the social care workforce is jointly on the agenda with some CPPs.

86. Many plans highlight that organisational development resources have been deployed to support and bring different parts of the health and social care workforce together, as well as to support new senior management teams and IJBs. The development of cross sector or intra-professional integrated education and training opportunities is at an early stage in most Partnerships. Leadership development programmes are in place in some Partnerships.

Primary care

87. Many plans emphasise the key role of primary care services in health and social care integration. Some explore the need to develop stronger and more innovative links with primary care, where most patient contact takes place.

88. Some plans identify how the Partnership will support the development of improved primary care services, including improving links with the acute sector, introducing step up and step down beds as alternatives to hospital admission, developing better community links and improving access to a wide range of community services and supports.

89. A few plans also refer to the potential of promoting and enhancing primary care involvement in tackling inequalities.

90. Linking primary care to social care and community services features in a number of plans and as described above many Partnerships are building service hubs around GP or primary care practices. Similarly, improved working and communication between primary and secondary care is also covered in a number of plans.

91. All plans identify GPs and primary care as a key component of local service delivery and locality planning.

Links to acute care and cross partnership working

92. A number of plans clearly outline the relationship between the Partnership and acute care and identify the Partnerships' statutory role in strategic planning for emergency care services delivered in acute hospitals. In some plans, responsibility for planning for the emergency care pathway is low key and not well covered.

93. A number of Partnerships have developed close working relationship with the acute sector, and with neighbouring Partnerships where they share a common boundary within a Health Board. This has assisted with winter planning, which increasingly is described by Partnerships as year round, whole system capacity planning.

94. Many plans outline the arrangements that have been put in place to support services that cannot be easily disaggregated to individual Partnerships, within a Health Board area. To this end, what are variously described as lead partnership or more regularly as hosting arrangements have been established across a number of neighbouring partnerships. This has led to some close working between Chief Officers and their senior teams to address issues of common concern, including linking with acute care senior staff, and the development of new and sustainable models of care.

95. While there may be opportunities for efficiency in some instances through establishing hosting arrangements, it is important that hosting is not used in multi –partnership Health Board areas to maintain existing NHS arrangements where

there is scope through the Partnerships for greater local ownership and improvement.

96. Partnerships are required to have regard to one another's strategic commissioning plans, across neighbouring partnerships. Some plans explicitly mention this and what they have considered in this regard, but most do not.

97. A few plans provide good coverage of the need to improve the interface between communities and hospital, to focus hospital care on those who need it most and can gain most from it. Some plans set out clearly that reductions in bed days lost to delayed discharge and reductions in Accident and Emergency presentations and emergency admissions are needed. What this might imply in terms of disinvestment and reinvestment is not often as well covered.

98. Preventing unnecessary hospital admissions and expediting timely discharge from hospital is a priority of many Partnerships, as outlined above in the strategic priorities section. A decisive move to prevention and early intervention, along with investment in intermediate care are key aspects of the wider approach required to tackling these issues. This was emphasised in many plans but frequently it was not costed.

Housing

99. The housing sector is represented on all SPGs and on some Integration Joint Boards and is or will be involved in locality planning, as this develops.

100. Housing is recognised in most plans as a key component of effectively shifting the balance of care from institutional care to community based services and supports. It also seen as providing and promoting preventive approaches.

101. Some plans contained information on the local Housing Plan and its fit with health and social care delivery. 17 of the 31 plans contain a housing contribution statement. The housing contribution is strongest where the statement is not confined to an appendix in the plan, but where housing and its contribution are also reflected throughout the plan.

102. A lack of affordable housing is noted as a concern in a number of plans as well as the implications this has for local populations and for staff working in health and social care. The need to develop housing options as an alternative to residential care is also mentioned in a few plans. There is an opportunity to deepen and broaden the contribution of housing in future iterations of strategic commissioning plans.

Performance reporting

103. Each Partnership is required to publish an annual performance report setting out progress against the statutory outcomes for health and wellbeing, using the integrated budget. Annual performance reports will report on a core set of indicators as well as additional measures agreed locally.

104. All partnerships have developed a performance framework that includes national and local outcomes and measures. Where appropriate, performance frameworks include children's outcomes and criminal justice outcomes as well as the National Health and Wellbeing Outcomes.

105. Most included the framework in their strategic commissioning plans. Performance reports will be provided on a regular and routine basis to Integration Authorities, as well as to senior management teams, as part of on-going performance management responsibilities, in addition to annual reporting.

106. Although not a requirement, Partnerships that were established prior to April 2016 have begun to publish their performance reports. These outline what has been achieved by the Partnerships and include a mix of national and local measures.

107. Performance reports will provide a means for shared learning across Partnerships, although we fully recognise that what works well in one area may not wholly work in others, due to a number of factors, including how services are configured. That said, there are a number of consistent themes and priorities for Partnerships and there are opportunities for collaboration and learning, which will help inform decisions about transforming services while being mindful of the local circumstances and context of individual Partnerships.

Annex 1

Partnership	Children's Health Services	Children's Social Care Services	Criminal Justice Social Work	All Acute Services
East Ayrshire	Delegated	Delegated	Delegated	Not delegated
North Ayrshire	Delegated	Delegated	Delegated	Not delegated
South Ayrshire	Delegated	Delegated	Delegated	Not delegated
Scottish Borders	Not delegated	Not delegated	Not delegated	Not delegated
Dumfries & Galloway	Delegated	Not delegated	Not delegated	Delegated
Fife	Delegated	Not delegated	Not delegated	Not delegated
Clackmannanshire &Stirling	Not delegated	Not delegated	Not delegated	Not delegated
Falkirk	Not delegated	Not delegated	Not delegated	Not delegated
Aberdeen City	Not delegated	Not delegated	Delegated	Not delegated
Aberdeenshire	Not delegated	Not delegated	Delegated	Not delegated
Moray	Not delegated	Not delegated	Not delegated	Not delegated
West Dunbartonshire	Delegated	Delegated	Delegated	Not delegated
East Dunbartonshire	Delegated	Delegated	Delegated	Not delegated
East Renfrewshire	Delegated	Delegated	Delegated	Not delegated
Glasgow City	Delegated	Delegated	Delegated	Not delegated
Inverclyde	Delegated	Delegated	Delegated	Not delegated
Renfrewshire	Delegated	Not delegated	Not delegated	Not delegated
Argyll & Bute	Delegated	Delegated	Delegated	Delegated
North Lanarkshire	Delegated	Delegated	Delegated	Not delegated
South Lanarkshire	Delegated	Not delegated	Not delegated	Not delegated
East Lothian	Delegated	Not delegated	Delegated	Not delegated
Edinburgh	Not delegated	Not delegated	Not delegated	Not delegated
Midlothian	Delegated	Not delegated	Not delegated	Not delegated
West Lothian	Not delegated	Not delegated	Not delegated	Not delegated
Orkney	Delegated	Delegated	Delegated	Not delegated
Shetland	Delegated	Not delegated	Delegated	Not delegated
Angus	Not delegated	Not delegated	Not delegated	Not delegated
Dundee City	Not delegated	Not delegated	Not delegated	Not delegated
Perth and Kinross	Not delegated	Not delegated	Not delegated	Not delegated
Eilean Siar	Delegated	Not Delegated	Delegated	Not delegated

Lead Agency	Adult Health and Social Care	Children's Health and Social Care
Highland Health and Social Care Partnership	NHS Highland	Highland Council

Annex 2

PARTNERSHIP – NHS BOARD/LOCAL AUTHORITY		**LOCALITIES**
NHS Ayrshire and Arran	East Ayrshire	Kilmarnock
		East Ayrshire - North
		East Ayrshire – South
	North Ayrshire	Arran
		Irvine
		Kilwinning
		Ganock Valley
		North Coast
	South Ayrshire	Troon & Villages
		Prestwick & Villages
		Ayr South and Coylton
		Ayr North and Former Coalfield Communities
		Maybole and North Carrick Villages
		Girvan and South Carrick Villages
NHS Borders	Scottish Borders	Berwickshire
		Cheviot
		Eildon
		Teviot & Liddesdale
		Tweeddale
NHS Dumfries and Galloway	Dumfries and Galloway	Annandale and Eskdal
		Nithsdale
		Stewarty
		Wigtownshire
NHS Fife	Fife	North East Fife
		Glenrothes
		Kirkcaldy
		Levenmouth
		Dunfermline
		South West Fife
		Cowdenbeath
NHS Forth Valley	Clackmannanshire and Stirling	Clackmannanshire
		Stirling City with the eastern villages
		Bridge of Allan and Dunblane; Rural Stirling
	Falkirk	Falkirk
		Grangemouth, Bo'ness and Braes
		Denny, Bonnybridge, Larbert and Stenhousemuir

PARTNERSHIP - NHS BOARD/LOCAL AUTHORITY		LOCALITIES
NHS Grampian	Aberdeenshire	Banff and Buchan
		Buchan
		Formarine
		Garioch
		Marr
		Kincardine and Mearns
	Aberdeen City	Aberdeen North
		Aberdeen Central
		Aberdeen West
		Aberdeen South
	Moray	Moray East - Buckie / Cullen, Keith, Speyside Moray West - Elgin / Lossiemouth, Forres
NHS Highland	Highland	Caithness
		Sutherland
		Easter Ross
		Mid Ross
		Skye, Lochalsh and Wester Ross
		Inverness West
		Inverness East
		Lochaber
		Badenoch & Strathspey, Nairn & Ardersier
	Argyll and Bute	Lorn and the Isles
		Mid Argyll
		Kintyre
		Islay and Jura
		Bute
		Helensburgh and Lomond
NHS Greater Glasgow and Clyde	East Dunbartonshire	West of East Dunbartonshire
		East Dunbartonshire
	East Renfrewshire	Levern Valley
		Eastwood 2
		Eastwood 1
	Glasgow City	North West Glasgow
		North East Glasgow
		South Glasgow
	Inverclyde	East Inverclyde Central
		Inverclyde
		West Inverclyde
	Renfrewshire	Paisley
		West Renfrewshire
	West Dunbartonshire	Clydebank
		Alexandria and Dumbarton

PARTNERSHIP – NHS BOARD/LOCAL AUTHORITY		LOCALITIES
NHS Lanarkshire	North Lanarkshire	Airdrie
		Bellshill
		Coatbridge
		Motherwell
		North (Cumbernauld, Kilsyth and Northern Corridor)
		Wishaw
	South Lanarkshire	Hamilton
		Clydesdale
		East Kilbride
		Rutherglen and Cumbuslang
NHS Lothian	East Lothian	East - Haddington & Lammermuir, North Berwick, Dunbar & East Linton
		West - Musselburgh, Fa'side & Preston, Seton & Gosford
	Edinburgh City	North West North East South West - Pentlands, South West South East / Central
	Midlothian	East Midlothian
		West Midlothian
	West Lothian	East Lothian
		West Lothian
NHS Orkney	Orkney	East Mainland
		West Mainland
		Isles
NHS Tayside	Angus	North West Angus
		North East Angus
		South East Angus
		South West Angus
	Dundee City	Lochee
		Strathmartine
		West End
		Coldside
		Maryfield
		East End
		North East
		The Ferry
	Perth and Kinross	North Perthshire
		South Perthshire & Kinross
		Perth City

PARTNERSHIP NHS BOARD/LOCAL AUTHORITY		LOCALITIES
NHS Shetland	Shetland	North Mainland
		South Mainland
		West Mainland
		Central Mainland
		North Isles
		Whalsay & Skerries
		Lerwick & Bressay
NHS Western Isles	Nan Eilean Siar	Barra & Vatersay
		The Uists and Benbecula
		Harris
		Rural Lewis
		Stornoway & Broadbay

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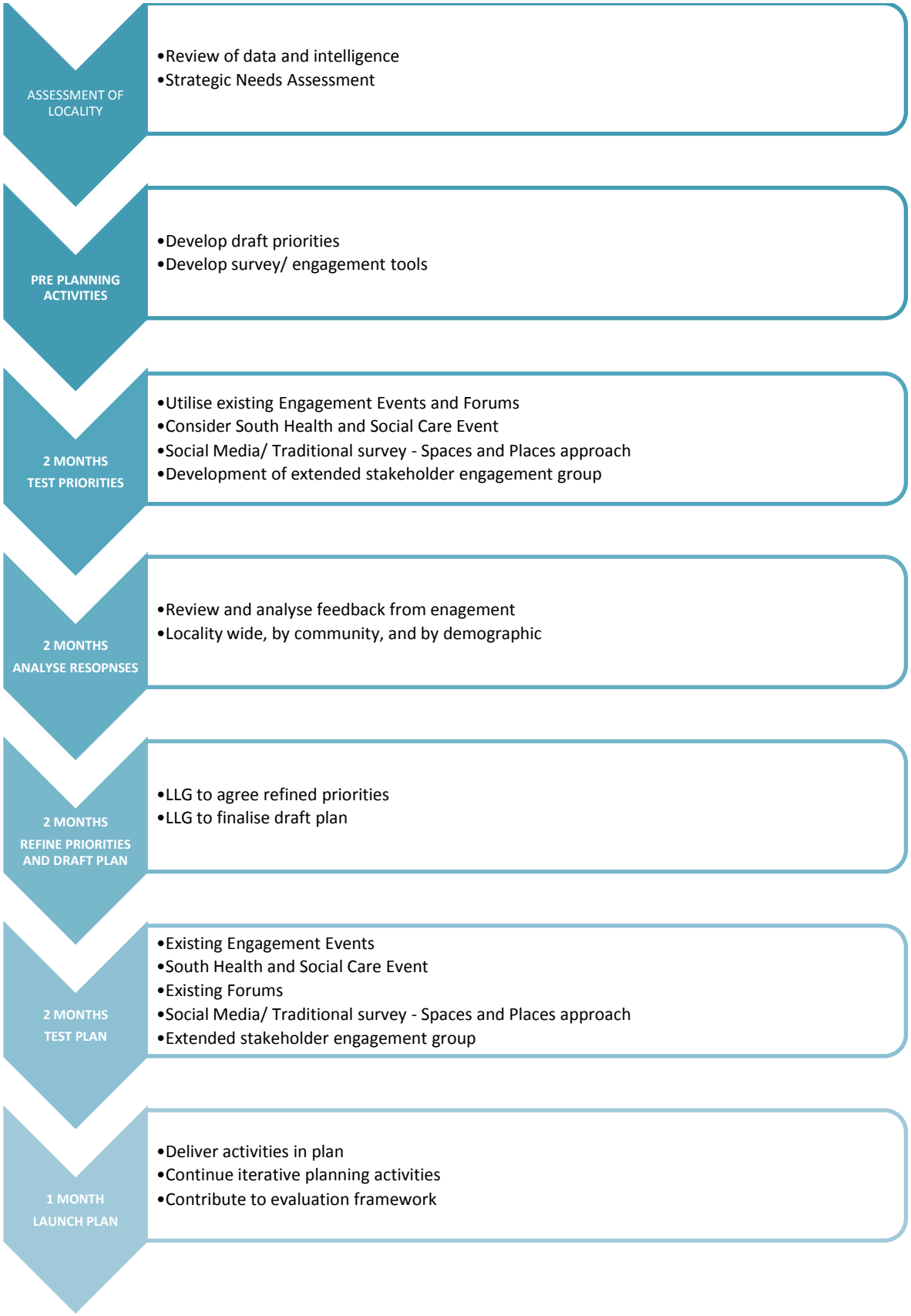
Appendix B: South Locality Leadership Group Planning Process.



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Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Winter (Surge) Planning over Winter 2016-17
Lead Officer	Judith Proctor
Report Author (Job Title, Organisation)	Christina Cameron
Date of Report	03.11.16
Date of Meeting	15.11.16

1: Purpose of the Report

The purpose of this paper is to provide an update on the shared process that has been undertaken for winter (surge) planning for health and social care services in the Grampian area for winter 2016-17. It sets out the steps taken to prepare for winter across community and acute settings and how those efforts have been co-ordinated.

This paper highlights key aspects of the winter planning process and the overall Winter (Surge) Plan that has been prepared for Grampian.

The paper seeks formal noting from the Aberdeen City Integration Joint Board.

2: Summary of Key Information

- Across Grampian, winter planning is a year round planning activity undertaken in partnership. Following the formal end of winter reporting at the end of March, a cross system Winter Debrief was held in May 2016 bringing together key operational stakeholders from partnerships, sectors and other agencies. This provided an opportunity to share experiences and identify lessons that can be learned and incorporated into planning for the coming winter. With similar cross-system involvement, a Winter Planning Workshop was held on 29 June.

- Local draft winter plans were prepared by acute hospitals and the Health and Social Care Partnerships (HSCPs) by July. Following discussion on key winter leadership arrangements with HSCP Chief Officers and the NHS Grampian Chief Executive on 27 September, a draft Grampian Winter (Surge) Plan was

submitted to Scottish Government on 31 August

- A significant learning point from 2015/16 was the degree to which winter planning across Grampian was more robust than in previous years. Senior leadership and engagement by Integrated Joint Boards and the NHS Board resulted in a more thorough planning process, which in turn led to a more confident Plan.

- Planning for surge response has been undertaken on the basis that no dedicated funding for winter will be available to Grampian in 2016/17. Whilst this presents challenges for surge planning, the greater challenge is created by recruitment difficulties and vacancy levels in health and social care teams across Grampian. Local planning has been cognisant of the difficulty this may present and it has been built in to business continuity plans.

- Significant local investment has been made in Grampian over the last two years by the NHS Board and the Health and Social Care Partnerships to improve responsiveness and resilience ahead of winter 2016/17. Progress has also been made in developing partnership approaches too such as the creation of joint posts with Scottish Ambulance Service to streamline transport arrangements and recurring availability of dedicated transport in evenings and at weekends for discharging patients.

- Testing of local plans and of local teams understanding of winter responses has taken place in several settings across Grampian; including a cross sector event that brought together staff form health and social care in each of the three partnerships, staff from the acute sector and colleagues from Scottish Ambulance Service. Aberdeen City has undertaken several test exercises ahead of the winter period.

- Robust and integrated planning, supported by strong and positive working relationships across Grampian has resulted in a position of preparedness for services over the winter period.

3:	**Equalities, Financial, Workforce and Other Implications**

- Planning has been based on optimal use of existing resources, including investment in developments that will support the reduction of delayed discharges in hospitals, keeping people well at home and expediting inpatient experiences. To date, Scottish Government has not announced any dedicated additional funding to Boards as has been made available in

previous years.

- In addition the funding challenges, staffing and vacancy levels across the health and social care sector remains challenging. Key frontline roles such as nurses, carers and others in the community and acute sectors are pressured because of high levels of vacancy and the ongoing difficulties in recruitment.

4:	Management of Risk

Identified risk(s): There is a risk that identified actions do not meet increased demand over the winter period.

Link to risk number on strategic or operational risk register:

1. There is a risk of significant market failure in Aberdeen City
2. There is a risk of financial failure , that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and project an overspend
3. Failure of the IJB to function, make decisions in a timely manner etc
4. There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance in through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.

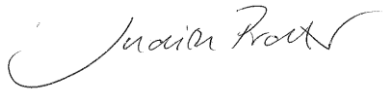
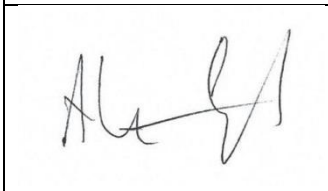
How might the content of this report impact or mitigate the known risks: The plan has been tested as being realistic and robust. Activity and action will be closely monitored across the winter period.

5:	Recommendations

It is recommended that the Integration Joint Board:

1. Note the update on the winter planning process.
2. Note the Approved Grampian Winter (Surge) Plan 2016-17.

Integration Joint Board

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

GRAMPIAN

WINTER (SURGE) PLAN

2016/17

Approved 3 November 2016

Contents

Contact: Christina Cameron, Programme Manager, NHS Grampian – Christina.cameron@nhs.net

Executive Summary

This document is the Grampian Winter (Surge) Plan for 2016/17. It is an overarching document for three Health and Social Care Partnerships in Aberdeen City, Aberdeenshire and Moray and for the Acute Sector of Grampian. It is representative of local Winter Plans of each of these areas and has been coordinated and produced by NHS Grampian.

This Grampian Winter (Surge) Plan sets out the planning and preparations for Winter that are taking place in each of the sectors and settings at a high level and also describes some of the investments and improvements undertaken in Grampian since the previous winter of 2015/16.

Some key aspects of this plan include:

- A significant learning point from 2015/16 was the degree to which winter planning in Grampian was more robust than in previous years. Senior leadership and engagement in all sectors, overseen by the leadership of NHS Grampian's Chief Executive and supported by all Boards resulted in a more thorough planning process, which in turn led to a more confident Plan. As the data shared in this plan demonstrates, there is evidence that this robustness may have directly resulted in an improved experience of winter for the public and staff.

- Health and Social Care partnerships are now fully operational bodies and are experienced in operating in an integrated manner with the Acute Sector and NHS Grampian. The previous year saw IJBs operate in shadow format, providing an opportunity for all sectors to develop shared protocols for communication and integrated planning approaches.

- Safety Briefs are now a daily feature of the two acute hospitals in Grampian and these are focused on achieving a balance of admissions and discharges, providing the safest possible environment for patients and staff. Positive outcomes to date include an improvement in the balance of admissions and discharges, use of criteria-led discharge and agreed step down availability in community hospitals. Partnership working with colleagues in Scottish Ambulance Services provides dedicated ambulatory discharge capacity at weekends and evenings.

- Those areas that are required to respond immediately to periods of acute peaks in demand align staffing rotas accordingly, for example in the Emergency Department and in the Acute Medical Initial Assessment area. All frontline staffing rotas will be complete at the end of October 2016.

- Management of elective inpatient capacity and elective activity will be led by a dedicated Divisional General Manager and a Hospital Manager, supported by approved local policies for managing elective activity.

In addition to the funding allocations made by Scottish Government for unscheduled care and winter resilience, there has been significant local investment made in Grampian by the NHS Board and the Health and Social Care Partnerships to improve responsiveness and resilience ahead of winter 2016/17. Key investments are described in section **J. New Developments & Service Changes Introduced Since Winter 2015/16** on page 15 of this plan.

Introduction

A. Aim of Plan

1. To set out the key partnership actions, timescales and planning processes in effectively managing the potential challenges associated with the winter period for 2016/17 and delivering against the national and local targets and standards for health and care.

2. To ensure that Grampian is as prepared as possible for the coming winter period in order to minimise any potential disruption to services or diminished experience for patients and carers.

B. Rationale and Planning Assumptions

3. This Plan is informed and guided by various formal sources both external and internal as well as planned discussions and workshops to learn from previous experience, assess winter risk and agree shared approaches. Those sources include;

    - 6 Essential Actions National Improvement Programme
    - 6 Essential Actions Grampian Improvement Programme
    - NHSScotland Resilience & Business Mgt Division; Preparing for Winter 2016/17
    - NHSScotland Resilience & Business Mgt Division; Winter Preparedness: Self Assessment
    - Grampian Winter Report 2015/16
    - Winter Planning Process; workshops and debriefs
    - Partners', sectors' and services' winter plans and surge plans

4. Evidence and review of local experience demonstrates that the winter period November to March creates a number of challenges for all partners delivering health and social care services. The main challenges are outlined below and this plan attempts to use learning points and data on activity levels from previous years to support a robust implementation plan to deliver its aim.

5. Winter 2015/16 saw many of the expected challenges associated with the period; an increase in activity for NHS24 and Scottish Ambulance Service, sustained levels of daily emergency admissions ranging from no fewer than 100 up to 199 per day, increased delayed discharges in Woodend and community hospitals and a 3.5% increase in elective admissions.

6. Conversely the winter of 2015/16 also recorded a 16% decrease in delayed discharges in ARI, a reduction in length of stay for emergency patients, an overall reduction in attendance at ED units and a reduction in admissions to the Acute Medical Initial Assessment Unit compared with the previous year.

7. Performance against the 4hr target for patients waiting in ED to be treated, admitted or discharged was significantly improved ; compared with the previous year there were 44% fewer breaches of the target and only one patient waited in ED for longer than 12 hours

rather than 46 patients waiting this long during winter 2014/15. Overall performance by these measures shows ARI improved by nearly 7 percentage points for the highest compliance in 4 years and Dr Grays saw its best performance in 6 years.

8. The improved picture does not in any way reduce the importance of surge and capacity planning; rather it underlines it. Forward- and surge planning is required at team level in order to be sufficiently prepared for the winter period. Space and available equipment should be identified in these plans and there is a requirement for a focus on workforce capacity at a time when Christmas and New Year holidays fall. Workforce rotas that are robust and where possible, eliminate the need for agency staff are required to be in place in advance of winter.

9. Intelligence shows that for some services there are significant surges in activity at particular points during the festive period, particularly when the calendar presents 4 day breaks for public holidays over Christmas and New Year. This can cause a backlog of activity that then presents as a surge when services resume or it can cause demand to shift elsewhere in the system, for example an increase in calls to the out of hours service.

10. Increased risk of severe weather incidents can result in significant, even extreme disruption to the normal delivery of health and social care services. Grampian had the misfortune to experience two separate Major Incidents related to severe flooding during winter 2015/16 with catastrophic results for some in Grampian. This has increased the organisational and service level understanding of the potential of such events to test staff ability to attend for duty; to present a risk to populations for whose care and safety we are responsible and prevent some patients accessing clinical care. Despite evidence of successful partnership working and response; this will be enhanced in local business continuity plans for 2016/17.

11. It is critical that we can continuously deliver high quality, person-centred care in the right place, at the right time and by the most appropriate person/team in an integrated way as possible. Underpinning this is a number of standards (set out in paragraph 31) which supports the quality of care, in addition to the delivery of effective and efficient care. Performance against these standards and targets must be maintained despite the challenges outlined above.

C. Approach

12. In Grampian there is an established process for winter planning which is undertaken as a year-round planning cycle and incorporates an integrated approach with business continuity principles. Partners such as NHS24, SAS and local authorities are key to the process and participate in joint planning and debrief exercises.

13. It is recognised that winter planning is complex and can be challenging, this is addressed by early planning at local and even team level, and by building this into sector, divisional and Board level plans. This ensures local ownership and understanding of responsibilities, actions and responses to surge levels and scenarios.

14. Another important step in the planning cycle for winter is the opportunity to learn from previous experience; much of our predictions and planning assumption come from reviewing the previous years' activity and identifying lessons to be learned. Undertaking this activity allows local teams and services to be clear about what can be improved and how plans can

be refined. Doing so in an integrated way across services, sectors and partners enables a supportive forum for sharing experiences and learning across a whole system. The output from this step in the process is produced in a Winter Report which is shared across the system and with Scottish Government.

15. Services, sectors and partners across the health and social care system in Grampian (Health and Social Care Partnerships, acute sites, G-MED, NHS 24, Scottish Ambulance Service) prepare annually updated business continuity plans relevant to their own respective organisations/services. These can include detailed flu responses, business continuity actions and the prioritisation for core service delivery in times of surge, reduced capacity or critical incident, escalation plans, delayed discharge plans and communication plans as appropriate.

16. In 2015 the national profile and focus was raised for winter planning, in light of a challenging winter for Scotland in 2014-15, and Grampian welcomed this, rising to the challenge of improved winter planning. Grampian benefits from strong and positive working relationships between the chief accountable officers for HSCPs and the acute sector and with NHS Grampian.

17. Following positive feedback from Scottish Government on the Grampian Winter Plan 2015/16 and a request from Scotland's Chief Officers to share the Grampian winter planning process in June 2016, the approach to winter planning for 2016/17 will be broadly similar and build on strengths such as early initiation, integrated workshop and robust governance.

18. As part of learning from the previous winter experience at a senior level, chief accountable officers for HSCPs and the acute sector have already begun to discuss an important aspect of surge planning for winter; how to ensure capacity can match any short term increases in demand. Agreements will be reached in further discussion with NHS Grampian Chief Executive and will feature in the final Grampian Winter (Surge) Plan.

19. Delayed Discharges – rates of delayed discharges are closely monitored by the system and each of the Partnerships is focused on managing the return of people to local communities as early as can be managed. Challenges in Aberdeen City and Shire continue around staffing and recruitment for the homecare workforce, as well as a lack of homecare places. The focus, therefore, is on prioritising those patients who can and should be transferred from acute to community settings as early as possible. This is supported by integrated working across the Discharge Hub in ARI, the daily huddles in Dr Grays and the daily cross system huddle.

20. Health and Social Care Partnerships have developed and are delivering against delayed discharge action plans which aim for local solutions to reduce the rate of delayed discharges. In Moray the focus includes accurate data on bed capacity in community hospitals and use of goal setting to support the transfer from acute to community settings, and use of board rounds in the acute hospital to support positive challenges for the inpatient journey.

21. In Aberdeen City, there are a number of key actions that will deliver improvements; namely the successful recruitment and subsequent introduction of additional social work capacity that is now embedded in both the ARI and Woodend hospital sites. Initial data indicates an

already notable reduction in delays pertaining to social work/care assessment. The 'building up' of interim bed capacity to support the early discharge of patients/clients whilst they await a more permanent care setting of their choice. The partnership's delayed discharge group is presently evaluating the 'first tranche' of interim bed provision and intends to expand this resource further based on early evidence. A 'social care campus' project has now had a feasibility study concluded and proposals approved. A full business case is being developed to move the project to its next phase.

22. Aberdeenshire held a 'KAIZEN' event last year which greatly improved communications between the various sectors and an Action Plan has been completed. Strategic and operational groups continue to meet regularly to review current delayed discharges, both for accuracy of data and to find local solutions which will enable people to move on to more appropriate settings in the community. A number of intermediate care places are located in care homes and have been very successful in rehabilitating patients enabling many of them to go home with no or minimal home care package. Work is underway to commission intermediate care beds across the whole of Aberdeenshire.

23. It is recognised that it can be very difficult to 'flex' certain elements within the system, such as staffing and bed capacity in hospitals and nursing home settings, especially when there is no additional or specific funding to meet the additional and specific challenges. Winter planning in Grampian therefore acknowledges the importance of keeping people healthy, preventing unnecessary hospital admissions, anticipating demand and the reorganisation of capacity and resources to ensure effective patient flow throughout the health and care system.

24. The Scottish Government winter planning guidance and supporting self-assessment checklist informs the development of this Plan.

D. Funding of the Plan

25. In October 2015 the Scottish Government announced £573,524 of funding for NHS Grampian to augment local winter resilience funding. This additional, non-recurring and dedicated funding was almost wholly used to activate the pre-existing contingency plan to provide additional capacity in Aberdeen Royal Infirmary through medical, nursing and AHP support for 16 beds from December 2015 until the end of March 2016.

26. No confirmation of dedicated funding has been received by Grampian and therefore financial planning for winter must be based on zero increase in available resources. As noted earlier in this plan, it must be acknowledged that an increase in capacity is difficult to achieve without a corresponding increase in available resource, presenting operational challenges for responsible managers.

27. In addition to a financial limitation for winter planning, it has highlighted to Boards and Partnerships that any use of agency staffing is not permitted. The implication of this is that should any additional funding be made secured, it is highly unlikely that the contingency plan of additional beds in ARI, which apparently eased flow successfully in 2015, would be possible for 2016. This presents a further challenge for realistically responding to surges in demand.

28. It is imperative therefore that early planning and sufficient testing of plans is complete ahead of winter to enable Grampian to be prepared to meet the challenges of winter within current budget. Tabletop testing proved highly useful and practical for all partners last year and it has been agreed following debriefs and workshops that this will be developed further this year.

29. Aberdeen Royal Infirmary has scheduled tabletop tests of its Winter Plan and a Cross System Tabletop Test ran on 30 August where partners from each HSCP along with colleagues from the acute sector and SAS participated in an exercise designed to test their own plans and how they work collaboratively. Health and Social Care Partnerships have also planned tabletop tests running ahead of the winter and festive period...

30. Timing of these exercises is designed to provide opportunity for all partners and staff to challenge their planning and to refine and amend plans based on any learning points identified by the test. All of the tabletop testing exercises are supported by NHS Grampian colleagues and involve input from NHS Grampian Civil Contingencies, with use of appropriate and national processes for resilience management.

E. Approval of Plan

31. The process and timeline for preparation, review and approval of this plan allows for the following groups to discuss it as demonstrated in the diagram set out in Appendix 2**.**

Date	**Stage**	**Committee / Board**
23 August	First Draft	Senior Leadership Team
30 August	Outline of process	Aberdeen City IJB
30 August	Draft	Scottish Government
31 August	Outline of process	Aberdeenshire IJB
1 September	Draft	Grampian NHS Board
12 September	Draft	Area Medical Committee (AMC)
14 September	Draft	Area Clinical Forum
15 September	Draft	Grampian Area Partnership Forum
27 September	Draft	Senior Leadership Team
29 September	Draft	Moray Development Session (IJB)
11 October	Draft	Grampian Area Nursing and Midwifery Committee
13 October	Draft	Consultants Sub-committee of AMC
24 October	Draft	GP Sub-committee of AMC
3 November	Final Approval	Grampian NHS Board
3 November	Final	Scottish Government
7 November	Final	Area Medical Committee
9 November	Final	Area Clinical Forum
10 November	Final	Moray IJB
10 November	Final	AHP Advisory Committee
15 November	Final	Aberdeen City Integrated Joint Board

32. As in previous years, the final Grampian Winter Plan will be available on the NHS Grampian website following submission to Scottish Government and by 14 November at the latest.

F. Governance Arrangements

33. High level performance management of the Grampian Winter (Surge) Plan for 2016/17 will be through the Senior Leadership Team which is chaired by the Chief Executive and includes the chief accountable officers from each of the Partnerships and the acute sector as well as executive team members from NHS Grampian.

34. Each of the Health and Social Care Partnerships will follow its own local governance arrangements ensuring the local winter plan and the overarching Grampian Winter Plan are included for discussion on agenda at relevant meetings ahead of the final submission to Scottish Government. The calendar for this is outlined in the table above.

35. The Director of Acute Services and the Chief Officers of the three Partnerships have authorised a role of Senior Decision Maker to operate as part of the Cross System Huddle. This role acts as a focus for escalation for flow across the whole system, providing an additional assurance that decisions, actions and risks are being managed in an integrated way and to act as 'command and control' in the event of unmanageable surge or challenge to the system. This does not replace the protocols in existing service level escalation plans; nor is it intended to manage civil contingency scenarios. It will be fulfilled by the Head of Operations for Aberdeen Royal Infirmary, which is the largest acute site.

36. Performance management of underpinning organisational/sector/service winter plans is undertaken as per agreed mechanisms within local teams and areas. In support of the various plans and to ensure effective communication and integrated working over the winter period, the daily cross system huddle, which has been identified as crucial to integrated working, will support business continuity for winter as it would for any surge period.

37. The Unscheduled Care operational service within the acute sector will, on behalf of NHS Grampian, submit the routinely weekly management information to the Scottish Government as per an agreed template. As in previous years it may be required to submit additional and more frequent information such as daily updates on any key pressures or any unusually long waits in the Emergency Department; these will be put in place by the Unscheduled Care Programme Team.

G. Striving To Deliver High Quality, Safe, Person-Centred Care

39. Regardless of the time of the year, we continuously strive to meet local and national standards and performance targets which focus on delivering high quality, safe person-centred care at the right time, in the right place and by the right person/team. A key element of this is delivering national standards and targets on an ongoing basis regardless of the pressures across the system;

- 98% of NHS 24 Priority 1 calls responded to within 60 minutes and 90% of Priority 2 calls responded to within 120 minutes
- 75% of all Scottish Ambulance Category A calls are responded to within 8 minutes
- Reduction in inappropriate attendances at Emergency Departments(ED / Minor Injury Units (MIU's)
- 95% performance against the 4 hour standard for Emergency Departments (ED) and Minor Injury Units (MIUs)
- Elimination of patients waiting over 12 hour for admission or discharge within ED
- Maintain delivery of the 18 week Treatment Time Guarantee (TTG)
- 95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.
- Maximise the number of patients who receive care in the most appropriate setting
- Minimise the number of patients waiting to go to a community hospital
- No delayed discharges beyond 14 days

Since 2014/15, there has been further development and progress of the 6 Essential Actions Improvement Programme, which focuses on key actions to improve unscheduled care in all settings. Grampian is committed to achieving improvement and demonstrating excellence in the 6 Essential Actions Programme locally and significant senior, executive and operational staff are dedicated to and involved in its delivery.

Consequently, this Plan is developed in the context of the 6 Essential Actions and unsurprisingly there are shared priorities, focus and projects as well as partnerships and groups.

Key drivers informed by the 6 Essential Actions Programme are included here:

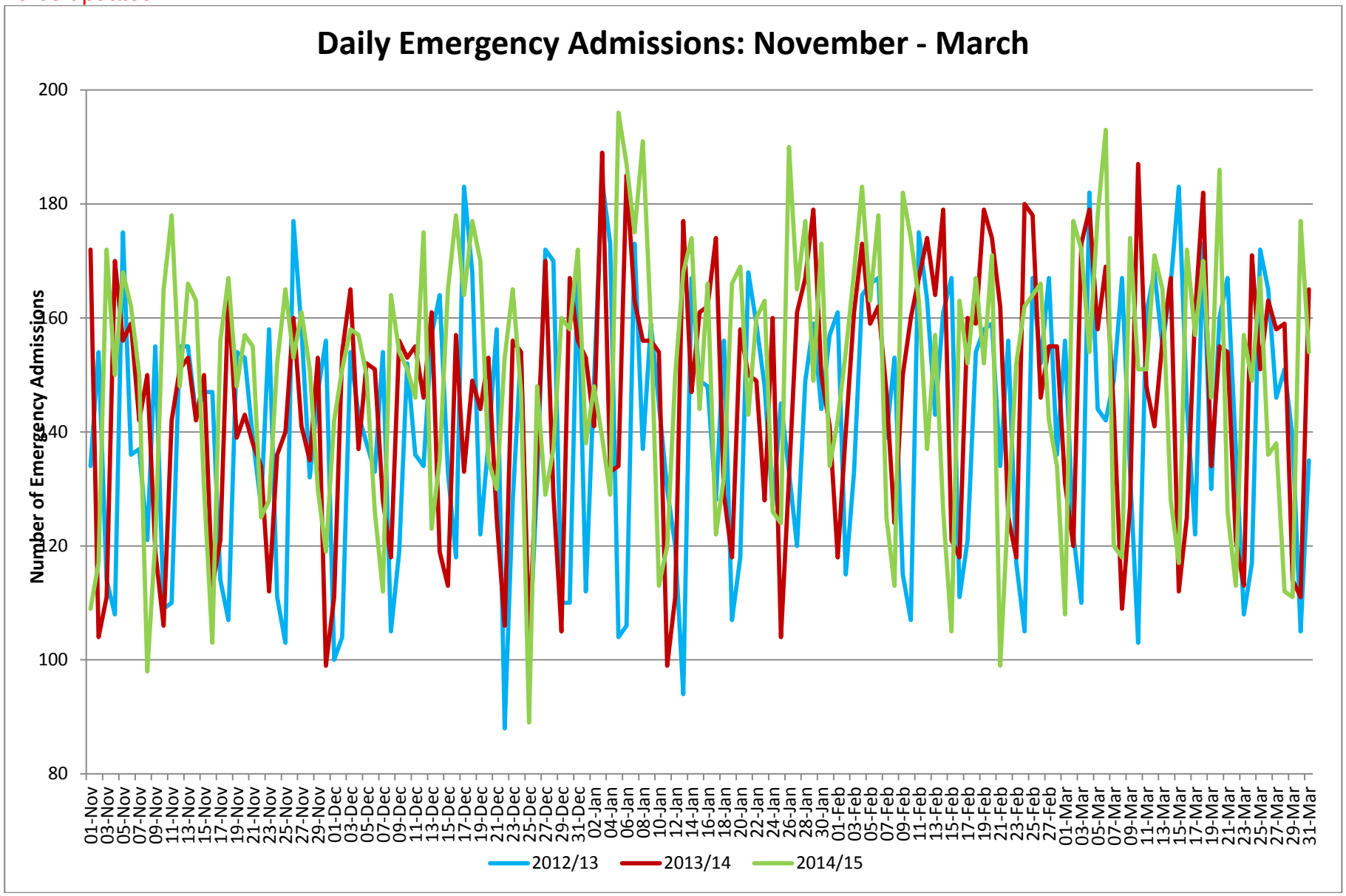

Aim
Improve
By Managing
Do These Well
Safe, person centred, effective care delivered to every patient, every time without unnecessary waits, delays and duplication
Patient and Staff Experience
CLINICALLY FOCUSED AND EMPOWERED MANAGEMENT
Triumvirate Management
Clinical Leadership
Escalation
Safety, Flow Huddles
HOSPITAL CAPACITY AND PATIENT FLOW REALIGNMENT
Basic Building Blocks Analysis
Bed Planning Toolkit
Workforce Capacity Toolkit
Performance Toolkit
PATIENT RATHER THAN BED MANAGEMENT - OPERATIONAL PERFORMANCE
Patient Tracking Through System
Admission/Discharge Prediction
Balance Capacity And Demand
Daily Dynamic Discharge
MEDICAL AND SURGICAL PROCESSES ARRANGED TO PULL PATIENTS FROM ED
Triage to Appropriate Assessment
Flow Through ED
Access To Senior Decision Maker
Access To Assessment/Diagnostics
7 DAY SERVICES
Smooth Variation In Services
Surgical Emergency And Elective Services
Access To Diagnostics/Intervention
GP/OOH Support
ENSURING PATIENTS ARE CARED FOR IN THEIR OWN HOMES
Redirection/Know Who To Turn To
Shift Emergency To Urgent
Short Stay Assessment/Avoid Admission
Discharge When Fit and Ready

H. Trends in Data from Previous Years

40. The NHS Grampian Health Intelligence Department, with partner colleagues, produces trend data for the winter period focussing on the previous three years, to support planning for the resources that will be required and in identifying thresholds for surge planning. For example it can be seen from the graph below that peaks in emergency admissions take place on key dates such as Mondays and particularly following a 4 day closure.

41. The full set of trend data with key highlights is attached at Appendix 4. Activity trends and performance levels have been discussed and shared across sectors and services as part of reflecting on the previous winter in the winter debrief event in May.

To be updated



I. Lessons Learned from 2014/15

42. The following section outlines the key lessons learned from the review of the 2015/16 winter period. The full report is available separately.

- The high value of timely partnership, whole-system and intelligence driven winter planning.
- Recognition that the winter experience of 2015/16 was much improved on the previous year which was particularly challenging.
- Acknowledgement in all areas that a more robust approach to winter planning was partly the reason for the less difficult period, and a willingness to embed this approach.
- Certain features developed in 2015 had a positive impact on sectors' and teams' ability to manage demand and challenges.
- Cross system huddle, safety brief models and the discharge hub were all referenced as beneficial.
- It was recognised that in 2014/15 there was a greater whole-system approach and joined-up working through the development of the plan itself, cross-system huddles, regular reviews and communication.
- Staffing levels due to high numbers of vacancies posed a challenge for several services in terms of managing business continuity as well as surge planning.

43. A number of areas were also highlighted for further improvement which were generally focussed around the following themes:

- Communication/Cross-System Working
    - Improved remote technology could have been better, further enabling virtual communication across sectors and teams
    - Key data such as those patients waiting for community hospitals could be shared widely to aid system level awareness
    - Communication with the public (Know Who To Turn To) re expectations and responsibilities is important.
    - Opportunities for shadowing could be utilised to further understanding of colleagues' roles and responsibilities
    - We should celebrate and communicate success more

- Flow and Discharge Planning
    - Discharge planning could be further improved, building on use of criteria-led discharge.
    - Improve the shared responsibility for beds across the system not just putting pressure on local areas.
    - Practice of ringfenced acute beds in the community could be further improved to support flow
    - SAS should be involved even more in discharge planning and hospitals should focus on reducing same day bookings for transport to smooth the discharge process.

J. New Developments & Service Changes Introduced Since Winter 2014/15

44. Some of the key service and system changes that have occurred (or are due to occur) since last winter and prior to winter 2016/17 are listed below;

System

- The health and social care system is radically different in 2016 with the formalisation and embedding of the Integrated Joint Boards and Health and Social Care Partnerships. Grampian benefits from established and positive working relationships across these partnerships, with evidence of close working across Grampian and with key partners.

- Each of the Chief Officers are well acquainted with the winter planning process and its priority in maintaining safe effective quality services over the winter.

Acute

- The model of safety briefs matured further in Grampian throughout 2015/16 and in the acute hospitals they are now well established as a daily occurrence with capacity and management data shared across ARI and Dr Gray's hospitals. This has provided a better 'grip' on the hospital state and creates a management position that is more ready to respond to barriers to flow on a daily basis.

- Around 60 individuals from all disciplines including SAS, Security and Facilities attend the daily safety huddles which take place early in the morning and throughout the day, enabling an accurate situation report of the hospital status at that time and for the rest of the day. This then supports early decision making and informed management plans for the hospital and for individual patients where required.

- The knowledge and information gained from this daily event can then be shared across teams, escalated across sectors and up to the System Huddle as well as to Scottish Government and NHS Resilience as appropriate and if necessary.

- The Discharge Hub has also advanced in Aberdeen Royal Infirmary and constitutes liaison nursing staff, OPAL team, social work colleagues from each of the three Partnerships, hospital discharge coordinators and is led by a Discharge Hub Team Leader role which will be consolidated for winter 2016.

- Redirection has been a feature of hospital operations for a number of years, however lessons learned from previous winters indicated the value of clinical conversations taking place face to face with patients at the front door. As a result this practice is well established in both acute hospitals.

- As part of positive partnership working with Scottish Ambulance Service, the 6 Essential Actions Programme identified an action to develop a joint role of Hospital Ambulance Liaison Officer for each acute site. This role was identified as greatly advantageous to the smooth operation of transport arrangements which are so crucial to discharge pathways and subsequent flow across the sites and wider system. The roles will be embedded across the acute and SAS systems will be jointly funded by both organisations and will be in place from November.

- The 6 Essential Actions team for ARI noted the success and value of the Discharge Hub since its development in 2015. It recognised that there was now a need for consolidating the leadership role which had been piloted originally and now lacking; so developed an 11 month trial for a Discharge Hub Lead role which will coordinate and provide a central leadership for discharge activities, pathways and improvements, deriving even greater benefit from the Hub approach.

- In Elgin, the acute hospital has chosen to invest in a pilot for an Occupational Therapist to operate as part of the ED team for 11 months. There is considerable evidence that early intervention by AHPs in the ED particularly for patients who have fallen can lead to reductions in avoidable admissions and reduced length of stay. The pilot will be evaluated and the post will be in place from November.

- As part of the continuous improvement work for unscheduled care, a series of networking events has been planned in the format of development sessions for staff working across the unscheduled care pathways in Moray. One event has already been held to date in September which focused on understanding each others roles and contributions to unscheduled care. It was linked closely to the 6 Essential Actions approach and featured the National Improvement Officer as a speaker and facilitator.

- A proportion of last year's funding was used successfully to ensure dedicated and additional transport for discharging patients from the acute hospitals in evenings and at weekends. This proved highly beneficial and acute sites reported that it made a significant difference in supporting flow at key times of the day. This has been prioritised for 2016/17 and will be in place for both Dr Grays and ARI.

Action Plan for Winter 2016/17

45. The Grampian 2016/17 Winter Plan actions are set out in the following themes:

- **Information, Communication and Escalation**
- **Joint Working and Integration**
- **Prevention and Anticipating Demand**
- **Planned Healthcare Capacity and Demand**
- **Unscheduled Care Capacity and Demand**
- **Plans for Pre, During and Post Festive Period**

K. Information, Communication & Escalation

46. Reporting to Scottish Government

Reporting to the Scottish Government will focus on the points below:

- Regular submission of admission data to ISD to inform the national modelling System Watch Project as usual practice.
- NHS Grampian will ensure that information is timeously submitted using the Weekly Winter Monitoring Template.
- Exception/daily reporting such as a daily performance and pressures report will be undertaken as requested by the Scottish Government. This will be ensured by the Unscheduled Care Programme Team and linked to the daily, site based Safety Huddles.
- Immediate notification of significant incidents will occur as per current agreed reporting procedure for each partner organisation. Communication and sharing of such incidents will be highlighted at the daily safety huddles and the daily system huddles.
- In addition, and if required, NHS Grampian will participate in daily/exceptional reporting to NHS Scotland Resilience

47. Staff Communication

- Each partner organisation and service has plans in place for effectively communicating with local staff. Key mechanisms and focus for communicating with staff in partnership are outlined below.

    - The Winter Plan for 2016/17 and any other supporting documents/plans, along with bulletins (weather, transport, flu vaccination, norovirus etc) will be available on the NHS Grampian staff intranet and NHS Grampian website.
    - 'Attendance at Work – Adverse Conditions' is the NHS Grampian policy informally known as the 'Snow Policy' and will be highlighted to appropriate staff ahead of winter.

- Links to the national NHS Scotland winter campaign will be available on the NHS Grampian websites
- Campaigns to encourage all NHS Grampian staff, community healthcare workers, residential care home staff, social care staff, unpaid carers and paid carers to have the flu vaccinations. Targeted communication via displaying posters in key staff areas, electronic bulletins and details posted on the NHS Grampian and local authority intranet sites as well as messages on payslips. Staff roadshows with information will run in December.
- *Know Who To Turn To* (KWTTT) key messages will be displayed as a banner on the NHS Grampian intranet as well as circulated via team brief, newsletter and global email alert for staff. A local article, based on national messages will be prepared for inclusion in existing newsletters (NHS, local authorities and carers) from December 2016.
- Communication of key information on services available over the festive period such as infection control advice, access to social care assessment and care packages, etc will be made available in each nursing and doctors ward station/room across NHS Grampian in response to communication issues highlighted in previous years.

48. Key Messages for Public

Communication activities for 2016/17 will be agreed and implemented between October and January with the aim of:

- promoting winter health and reducing pressure on local services
- encouraging individuals to take responsibility for their own health and seek advice appropriately via the *Know Who To Turn To* (KWTTT) Campaign
- supporting local winter health priorities such as respiratory health via the 'Don't waste a Breath' campaign.
- adding value to existing national campaigns such as flu and pneumococcal immunisation

Key messages to be communicated in partnership to the public via mechanisms outlined below.

- Posters and leaflets specifically associated with flu campaigns will be distributed during late October 2016, linking with and utilising resources available through the national campaign.
- Media releases will be distributed to all local press informing the public on basic self-help messages, stocking of medications, repeat medications, surgery closures and available services over the festive period.
- From December 2016 the KWTTT campaign will communicate the self help messages and highlight the services available to the public and is likely to include
    - A targeted mail drop to 142,000 households across Grampian
    - Re-direction Flyer to be handed out by ED staff when appropriate
    - TV and radio advertising
    - Targeted Social Media messages
    - Maintenance of the KWTTT website

- An Antibiotic Campaign from November through December 2016.
- Healthpoints (NHS Grampian's Health Information Centres) are located in Aberdeen, Fraserburgh, Peterhead and Elgin. Staff working in these units will be fully briefed to provide information on all our key messages to members of the public.
- NHS Inform/Healthline advice lines
- NHS Grampian will use social media, such as Twitter and Facebook, to communicate key messages and alerts
- NHS Grampian's public website reiterates the above key messages, along with useful links to other appropriate websites e.g. NHS 24, national campaigns.
- Specific communication will be in place relating to repeat prescriptions and regarding pharmacy opening times over the Christmas and New Year holidays.

49. Communication Between Key Partners

Since the establishment of new structures and new relationships with the Health and Social Care Partnerships, communications across Grampian are integrated with each of the partners fully represented as drivers of the production of the Winter Plan for Grampian and the actions that will underpin the achievement of its aims.

- This Plan has been developed and agreed as part of the Grampian Unscheduled Care 6 Essential Actions Programme, including communications and participation from partners such as SAS and NHS24.
- The planning process has included participation by the Head of Civil Contingencies.
- Approval of the plan includes all the Integrated Joint Boards.
- Approval of the planning process and timescales as well as the plan itself includes a wide range of committees within the NHSG governance structure as well as the NHS Grampian Board.
- Daily cross system huddle meetings, includes representation from the acute sector, each IJB and the ambulance service Partners participate virtually, joining via teleconference and in this way there is no barrier to participation.
- Escalation and communication in real-time with partners as per agreed protocols.
- Effective communication protocols are in place between key partners in relation to local authority housing, equipment and adaptation services, mental health services and the independent sector.
- To use links with voluntary organisations and related weekly e-bulletins to promote key winter related messages
- Community Pharmacies opening times are communicated to partners
- Review communication mechanisms between NHS Grampian and other NHS Boards

50. Press/Media
- All interview or information requests from the press or media groups will, in the first instance, be managed or if appropriate directed to the relevant organisation's Corporate Communications Department. Opportunities will also be taken to reinforce key winter messages to the public.

51. Escalation

- Each organisation/sector/service has in place agreed business continuity plans that are intelligence based and include responses to winter challenges, staff shortages and escalation procedures. These plans are underpinned by human resources policies which support and guide staff in relation to weather and travel disruption.

- Each sector will test their business continuity plans ahead of the winter and festive period in 2016.

- All business continuity plans have clear escalation procedures if services are affected by weather, staff shortages or any other situations affecting delivery. This includes the provision of situation reports at operational and tactical level within the organisation and onward reporting, as necessary, to NHS Resilience and the Local Resilience Partnership.

- NHS Grampian acute sector has developed escalation policies to a high standard, based on the national publication of guidance on ED and hospital wide escalation. There is interest nationally in following Grampian's example.

Summary of Key Actions for Information, Communication and Escalation

Reporting

- Submission of weekly management information to the Scottish Government.
- Submission of daily performance and pressures reports to the Scottish Government if required.
- Exception reporting and immediate notification of any significant issues to Scottish Government.

Communicating to Public/Staff

- Implementation of key communication activities which includes flu, Know Who To Turn To and antibiotic campaigns.
- Targeted communication to staff on wards regarding key information during the festive period e.g. infection control advice, access to social care assessment/care packages etc,
- Targeted KWTTT campaign in those areas with the highest users of Unscheduled Care and KWTTT used in redirection.

Communication Between Partners / Escalation

- Daily cross system huddles to include all partners and acute sector with Senior Decision Maker to chair.
- All sectors to test winter/business continuity plans ahead of the winter and festive period.

Key Areas of Risk

- People may choose to ignore communication messages
- Ensuring wide-spread dissemination of key messages is challenging due to the wide geographical spread and vast number of staff, partners and public across Grampian.
- Ensuring penetration of messages across partner organisations.

L. Joint Working and Integration

52. Good communication is a key aspect of effective integrated working. This principle is an important aspect of the Grampian approach and is particularly critical when staff and services are under significant pressure. This section covers the various aspects being taken forward in Grampian around ensuring effective joint working over the challenging winter period.

53. In Partnership across NHS Organisations/Sectors/Services

Specific actions to enhance integrated partnership working across Grampian will occur at different levels based on the situation and are summarised below.

- Safety Briefs are now essential features in both acute hospitals and in ARI occur up to 4 times per day. Attendance is generally around 50-60 individuals and include representation from Security, Facilities, SAS and all areas of the acute hospital. The session is delivered via the Site and Capacity Team and information is shared with staff across the hospital twice each day.
- Cross system huddles have been improved and developed even further since they were embedded as part of managing winter in 2015. Feedback from winter debrief discussions has confirmed that this approach can facilitate system-wide resolutions to delivering safe care whilst effectively managing risk.
- Cross system huddles can also support individual partners to anticipate and manage surges in activity at the earliest opportunity e.g. bed/staff capacity, transport, care packages and are a forum for expediting difficult discharges.

54. NHS Grampian, Local Authorities & Third Sector

- The Senior Leadership Team includes each of the three Chief Officers, the Director of Acute Services and members of NHS Grampian's leadership team. The Team meet weekly, alternating with formal meetings and huddles to discuss operational issues and this provides a regular and valuable opportunity to share key pressures and issues. During times of increased pressure this will support the assessment of risk equally across the whole system and the implementation of a system solution.

- The Discharge Hub has developed further since 2014/15 and is a partnership operational team focused on ensuring appropriate supported discharge for prioritised patients by coordinating an integrated plan and actions. Actions include liaison with professionals and families.

- NHSG has a memorandum of understanding with Community Off-Road Transport Action Group (COTAG) to assist with all logistical support during severe weather.

Summary of Key Joint Working and Integration Actions

- Use of the site safety briefs and partnership System Huddle for Winter 2015.
- Regular meetings at all levels to understand, prioritise and resolve system issues
- Discharge Hub to support integrated approach to priority discharges
- Regular forum for the Senior Leadership Team to discuss key issues
- Senior Leadership Team includes HCSP Chief Officers as well as Director of Acute Services and NHSG Chief Executive.

Key areas of Risk

- Ensuring representatives attend the daily huddle meetings and actions are followed though.
- Continuity of attendance at cross sytem huddles
- Level of risk held by each partner may not be equitable

M. Prevention and Anticipating Demand

55. A key purpose of the winter plan is to prevent, anticipate and manage potential demand. This section sets out the key actions for preventing, anticipating and managing demand over the winter period 2016/17.

56. Influenza (Flu) Immunisation Programme

- Annually during October to March there is a predicted surge of flu cases. Organisations and sector/services business continuity plans include both the prevention and the containment of flu and also how services continue core business when flu increases demand on services and creates staff shortages.

- Uptake data for 2015/16 was down from last year's 76% in people aged 65 years and older to 73.2%. Vaccination in people at increased clinical risk aged 64 years or less also fell from 53% to 46.3%. The target uptake for 2015/16 remains 75% for adults aged 65 years and over; 75% for all aged 6 months and over in a clinical risk group; 65% for pre-school children aged 2-5 years old; and 75% for primary school children. The Grampian Flu Immunisation Programme commenced on the 3rd October 2016. This underpins both the national immunisation and the national publicly programme.

  The programme will focus on the following target groups:
  - All those aged 65 and over
  - All those aged 6 months or over in a clinical risk group
  - All pre-school children aged 2 -5 years
  - All primary school aged children
  - All pregnant woman, irrespective of their stage of pregnancy
  - Those living in long-stay residential care homes or other long-stay facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality
  - NHS staff, community health care workers, residential care staff, social care staff, unpaid carers and young carers

- The flu vaccination campaign, commencing 3rd October, aims to encourage all NHS staff, and health and social care staff who deliver hands on care, to take up the opportunity to receive their free flu vaccination. Whilst there is no stipulated target for 2016/17 [SGHD/CMO (2015)], there remains a general expectation that boards should aim for 50% uptake among frontline staff. There is wide access to vaccination for all health and social care workers via a GO Health Services and over 50 participating community pharmacies. See 'Information, Communication and Escalation' regarding communication to staff/partners re flu vaccination.

57. Pandemic Flu

- The NHS Grampian Major Infectious Disease Plan sets out the structures and processes that will be used in the event of an infectious disease incident, such as pandemic influenza, that requires an extraordinary organisational response. On activation of the plan, Local Authorities will be invited to participate to support optimal co-ordination of health and social care activities and resources. An integrated

health and social care response to a major infectious disease incident aims to:

- Detect and assess the impact of the disease;
- Reduce transmission by optimum infection control and public health measures;
- Assess the need for and availability of prophylaxis and treatment medicines and vaccines;
- Prevent infection by using vaccines, if available;
- Provide post exposure prophylaxis, where indicated;
- Provide treatment and care for large numbers of people ill with the infectious disease and its complications, both at home and in hospital;
- Minimise serious illness and death;
- Cope with the increased number of deaths;
- Minimise the impact on health and social services including the consequences for other patients as a result of re-prioritisation of services;
- Provide accurate, consistent, timely, authoritative and up-to-date information to professionals, the public and the media;
- Ensure that essential services are maintained; and
- Minimise the impact on daily life and business and the consequent economic losses.

- There are additional supporting NHSG plans for cross-system services, sector level business continuity and surge capacity, and specific response actions such as anti-viral collection mechanisms and influenza vaccination.

- Planning assumptions for a future influenza pandemic are based on the UK Influenza Pandemic Preparedness Strategy 2011
    - Detection Phase - characterised by normal health service delivery, but with activation of Board operational, tactical and strategic structures and functions, and increased surveillance;
    - Assessment Phase - characterised by increased public health protection, primary care and pharmacy activity, with standing-up of sector and cross-system control rooms;
    - Treatment Phase - which may be low, medium or high impact, with increasing prioritisation of service delivery in relation to scale of illness, and with the escalation phase leading to postponement of elective non-urgent activity across all sectors; and
    - Recovery Phase - characterised by a return to ‘normal’ activities, and preparation for a potential second

- Civil contingency arrangements are in place for a Local Resilience Partnership (LRP) at Grampian level and Regional Resilience Partnership (RRP) at North of Scotland Level. In pandemic influenza, these multi-agency groupings will be convened. It is critical that partner agencies make joint decisions and respond in a unified manner, with efficient and effective use of available resources, to mitigate potential consequences.

58. Norovirus

- The NHS Grampian rate per 100,000 of population of reports of Norovirus continues to decrease in recent years, however remains above the Scottish national average of 24.5.

- There are long standing systems in place for reporting outbreaks in community establishments with vulnerable individuals. Following reporting of an outbreak to the Health Protection Team (HPT), an immediate risk assessment is undertaken and control measures advised. This advice is then followed up in writing to the manager. Regular monitoring of the outbreak is undertaken until the establishment is free of symptomatic residents and staff for 48 hours. Areas that are closed are re-assessed on a daily basis. The Infection Prevention and Control Team is advised of care home closures to help prevent patients being discharged into outbreak settings.

- The Consultant in Public Health Medicine (CPHM) will, if required, activate the NHS Grampian Major Infectious Disease Plan as outlined in section 54.

- The HPT participate in the national health care infection outbreaks reporting system operated by Health Protection Scotland. The Infection Prevention and Control Team produce daily Norovirus SITREPs that are communicated widely throughout NHS Grampian for the duration of the norovirus season (which this year has been over the summer too). Weekly point prevalence data are submitted to Health Protection Scotland to provide snapshot information about ward closures every Monday. Debriefs are held on a situation by situation basis.

- Close communication is maintained between the HPT and community residential establishments affected by an outbreak of gastrointestinal illness to ensure a receiving hospital which admits a symptomatic resident is advised of the potential infection risk. The HPT seeks to reinforce this communication by also advising, wherever possible, the IPCT directly when such a patient is being admitted.

- Information, guidance/policies and support are easily accessible to NHS Grampian staff and other colleagues in relation to preventing and containing incidents of norovirus.

Summary of Key Anticipatory Demand and Prevention Actions

- 75% of those deemed at risk of flu and those over 65 year of age should receive a flu vaccination
- Over 50% of front line staff should receive a flu vaccination
- Campaigns to support uptake of immunisation for both staff and public groups is in place
- All sectors/service plans reflect the NHS Grampian Major Infectious Disease Plan and the phased response set out
- Robust communication mechanisms between HPT and IPCT
- Norovirus rates decreasing but above national average
- Clear process for managing outbreaks is in place

Key areas of Risk

- Flu immunisation target may not be achieved due to personal choice amongst staff
- Flu immunisation target may not be achieved due to personal choice amongst individuals in target groups

N. Planned Healthcare Capacity and Activity

59. Optimising Elective Care and Delivery of the Treatment Time Guarantee

- NHS Grampian is committed to managing its elective and unscheduled capacity successfully and is obligated to meet the Treatment Time Guarantee (TTG) for patients. Due to the pressure of waiting times activity, TTG performance is constantly being reviewed and managed to support achievement of the standard. Due to the natural tension between planned and unscheduled care in terms of bed capacity, activity is reviewed on a daily basis.

- NHS Grampian intelligently flexes the TTG lists in the early weeks of the year to maximise the throughput of lengthy or complex cases. This supports optimal utilisation of theatre capacity with a minimal bed base impact.

- Individual wards view their elective and predicted unscheduled care activity five days in advance in order to optimally manage their demand proactively and minimise the risk of cancelling patients at short notice. To provide further assurance on this issue NHS Grampian has developed an Elective Activity Management Standard Operating Procedure. This procedure sets out a clinically appropriate escalation process that is clear about protecting capacity for clinically urgent and cancer cases and then TTG patients. The Standard Operating Procedure is appended in the Acute Winter Plan.

- Acute Business Continuity planning sets out the essential services to be delivered in the context of planned care should it be necessary to activate plans.

60. Outpatient Clinics

- Acute and community outpatient activity will continue for most of the holiday period with the exception of the public holidays.

61. Admission Capacity & Effective Discharge

- The Acute Sector recognises that to maximise flow and bed efficiency, the number of patients admitted the day before surgery must be minimised. Reducing the number of patients admitted the night before surgery/procedure is a focus in the Acute Sector.

- The Acute Sector has limited ability to open surge beds due to physical restrictions, HAI bed spacing and staff availability. In addition there is no additional financial resource, nor is it permissible to recruit and rota agency staff in 2016/17.

- Adherence to discharge protocols will be monitored via the daily safety huddles at acute sites to ensure optimisation of flow and acute bed capacity. This will be supported by equal focus on policies for escalation, repatriation and boarding.

- Cross system barriers to transfer of patients will be addressed through daily review at the cross system huddle with action tracking and reporting. Barriers to repatriation will be escalated as required.

- Both hospital and community pharmacy plans are in place for provision of services over the winter period and community pharmacy communicates this information to partners. All are open as normal except on the public holidays when provision is made for limited access only.

Summary of Key Planned Healthcare Capacity and Activity Actions

- Use of the predictive data to effectively manage and balance planned and unscheduled activity
- Focused management of elective lists is always in place, and prioritises those patients which are clinically urgent or are cancer patients and those patients subject to TTG.
- A clear Standard Operating Procedure is in place for postponing elective activity.
- Escalation, repatriation and boarding policies are also available and utilised to support the balance of demand and capacity.
- Use of and adherence to protocols for safe, effective discharge will be promoted through the Discharge Hubs and monitored and reviewed through the safety briefs and cross system huddles.

Key areas of Risk

- TTG targets can be challenging in certain areas and winter pressures may present further challenge
- Lack of surge beds may mean an inability to relieve pressure on the system

P. Unscheduled Care Capacity and Demand

62. Across the unscheduled system the overall activity seen over the winter period is slightly higher with wider peaks and troughs of activity evident during the three weeks covering the festive period. It is also evident that the flow through the system is more challenging.

63. SAS

- The average number of emergency incidents per day during the period November to March has increased year on year from 2010/11 through to 2015/16. While this increase is levelling off in recent years, SAS report that this is countered by increasing complexity and frailty in the population, staffing and recruitment challenges and longer turnaround times Key actions include:
    - To provide adequate emergency resources for care and transport of emergency patients by e.g. re-deploying vehicles
    - Increased collaboration with acute sites including regular involvement in cross system huddles
    - Increased collaborative planning for improvement at strategic level
    - Planned co-hosted, co-funded post in Hospital Liaison Ambulance Officers in each site
    - Planned approach to supporting additional discharge at weekends and evenings through collaborative improvement project
    - Provide additional Ambulance cover at local festive events.
    - The introduction of specialist paramedics in Aberdeen and Elgin

64. NHS 24

- In previous winters, NHS 24 has received an average 5% more calls with a monthly average of 9,154 compared to 8,314. Peak winter activity is experienced during December and January, each of which average over 10,000 calls. Last year March saw an increase of 4.8% in call handling.
- NHS 24 detailed Winter Plan is being developed and it is anticipated that it will incorporate:
    - Prediction of activity with associated planning, to align workforce to times of peak demand Internal and External Communication strategies
    - Consideration of previous performance and lessons learned incorporating elements identified within the detailed planning to minimise potential risk going forward
    - Maximising use of call handlers, call operators and pharmacists
    - Maximising National Clinical and Call Handler support lines.
    - Contingency planning and escalation process.
    - Engagement with GP surgeries to ensure that patient special notes and electronic palliative care summaries are fully updated with relevant medical information prior to the public holidays.
    - Agreement with NHS Grampian Unscheduled Care Team to secure slots to send pre-prioritised calls during key dates.

- Telephony screening messages can be applied to the telephony system in a timely manner to inform the Public of a changing situation. Through constant reappraisal of the Service Delivery Model NHS 24 have ensured that real time deployment of resource and effective utilisation of multiple skill sets aids the delivery of an efficient service.
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65. G-MED Out of Hours Services

- GMED calls followed same pattern as NHS24 calls with an increased number in 2015/16 for the second successive year. GMED experiences on average around 2,000 calls per week, excluding Christmas and New Year. Calls per day can average around 550 over the Christmas period and average around 290 per day for the rest of the year.

The G-Med Out-of-Hours Service Winter Plan has been updated. The plan takes full account of:

- the need for a robust plan covering the full winter period, paying particular attention to the festive period
- the possibility of an outbreak of flu or other seasonal illness
- the above normal level of demand for primary care at that time of year particularly on Saturdays and public holidays throughout the festive period.
- the need to provide the service over the festive period, specifically addressing the periods of festive breaks.
- the need to demonstrate support for NHS 24 in terms of capacity to cope with unpredicted and predicted demand of triaged and untriaged calls.
- the need to maximise primary care capacity on the Monday and Tuesday (3rd/4th day of closing) of the 2 festive weeks.

It must be noted that increased staffing levels are already factored in to the GMED service over this period; however, further measures must be put in place in light of the possible issues encountered if faced with an increase of viral illness, of up to 10%. In anticipation of increased demand over the festive period additional on-duty GP slots have been incorporated into the rota, i.e. compared to a regular Saturday or Sunday rota.

The Plan also discusses in detail the management of demand and capacity, what the escalation triggers are and the actions to be taken at each change of state and by whom. Contingency plans in case of a breakdown of IT and/or telephone/fax systems are described as is the escalation process and how to communicate this to the media.

66. Emergency Department & Minor Injury Units

- Key actions to effectively manage the demand are outlined below.
  - Use of triage as part of initial assessment.
  - Implementing use of redirection protocol as part of triage at front door
  - Workforce will be deployed to cover the predictable peaks in demand.
  - In Dr Gray's, the Surgical Assessment Unit will reduce the numbers going through

A&E and therefore alleviate pressure.

- Ongoing use of the Clinical Decision Support Service to provide support and advice to professionals to ensure patients receive the right care, at the right time, in the right place and by the right person/team.
- Communication with public actions e.g. KWTTT, national campaigns to minimise inappropriate demand.
- Ensuring the flow across the hospital and the community is effectively maintained so patients are able to receive the right care, at the right time and in the right place.

67. Acute Sector

- Policies are operational with regard to escalation, boarding and discharge which ensure clarity and consistency of practice and provides a clear understanding of patient placement and bed allocation within ARI. The decision where to place a patient in terms of speciality of care is made by medical staff only: however, bed allocation can only be undertaken by the Site and Capacity Management Team or those working on their behalf.

- Supported by the Head of Operations and in discussion with clinicians Operational Support Managers will give priority status to appropriate patients in both the elective and non-elective scenarios. They will work closely with the Nurse on for the hospital and the Duty Manager who will advise the Site Manager as to the current bed state and all actions taken to improve the situation. Decisions to transfer, board or discharge patients will be supported through daily and regular opportunity to highlight, discuss and escalate any barriers to flow in the sector. This will be overseen by the Head of Operations and implemented by the supporting framework for site management.

- Business Continuity Plans are in place for all Grampian hospitals.

68. Primary/Community/Social Care

- Community Pharmaceutical Services will support service delivery over the winter and specifically festive period through the:
    - Community Pharmacy Urinary Tract Infection (UTI) Service
    - Community pharmacy provision of emergency hormonal contraception
    - Community pharmacy will continue to provide advice and treatment via the Minor Ailments Service
    - Community Pharmacy Unscheduled Care Patient Group Directive (repeat medication)
    - Both hospital and community pharmacy plans are in place for provision of services over the winter period. All are open as normal except on the public holidays when provision is made for limited access only. Exceptions to normal opening times will be notified.
    - Community Pharmacy opening on public holidays will be notified to partners (G-MED, NHS 24, Substance misuse service etc) via the Primary Care Contracts Team and corporate communications. There will be some pharmacy coverage in all communities every day.

- Within the acute sector, pharmacy distribution and dispensary opening information and service levels will be provided directly to wards and clinics in the lead up to the festive period. It is essential that pharmacy staff are included in plans for patient discharge at the earliest time to ensure required medication is available in a timely manner.

69. Key actions in Primary/Community Social Care are:

- Ensuring high risk individuals are identified within practices and up to date Anticipatory Care Plans are in place.
- Accessing real-time decision support via local networks to ensure patients receive the right care in the right place at the right time. This approach will also reduce inappropriate admissions.
- Utilising the capacity within Community Hospitals to predict and effectively manage demand for admissions and transfers. Contributing to the intelligence regarding bed capacity across Grampian.
- Community healthcare provision continues throughout winter period and business continuity plans are in place
- The main action for surge activity is to ensure all beds are open and areas staffed appropriately. This will remain a challenge with the various workforce and winter pressures.
- No additional primary care capacity has been identified; however the management of surge activity or workforce capacity issues will be managed on the basis of service prioritisation for that day.
- Increased social care provision can be commissioned during peaks throughout the winter period. Collaborative communication will make staff aware that social care provision (and on call) is available 365 days per year through.
- During times of increased pressure social care resources are allocated according to priority and, wherever possible, Partnerships will ensure that priority is given to hospital discharge or prevention of admission.

70. Cross System Challenges

- NHS Grampian, and the three Health and Social Care Partnerships all see the crucial role that delayed discharges play in the delivery of a successful winter plan as well as an optimal experience for public and staff. Partnerships are focused on reducing the number of people who are delayed within hospitals.

- Key aspects of each of the Partnerships' winter plans coincide with the delayed discharge plans and the use of the resource envelope across the whole system.

Summary of Key Unscheduled Care Capacity and Demand Actions

- Local Winter Plans which meet predicted challenges are agreed and tested ahead of the winter and festive period.
- Implementing use of redirection protocol in ED
- Site Capacity and Management Approach in acute hospitals
- Minimising delayed discharges by prioritising the most urgent via collaborative working in the Discharge Hub
- Collaboration on winter planning across partner agencies and services such as SAS, NHS24, GMED.

Key areas of Risk

- Pattern of increasing demand for SAS and GMED services in the face of recruitment difficulties.
- People may choose not to use self care and may present at ED inappropriately
- People may wait until closed services reopen and the volume of demand at that time may be overwhelming.

R. Specific Plans for During and Post the Festive Period

71. All organisations and services within Grampian have/will have in place the following:

- Agreed rotas for the festive period in place by October 2016 which aims to match the forecasted demand.
- Business continuity plans which cover the delivery of resilient services over the festive period.
- Regular communication regarding local actions in their surge or winter plans via established channels e.g. safety briefs, cross system huddles, Senior Leadership Team huddles.

72. SAS

- As set out in the SAS Winter Plan, arrangements are in place to respond to and manage the predicted peaks in demand, including early preparation of staffing rotas during the festive period.

73. NHS 24

- The NHS 24 Winter Plan for 2016/17 will set out how the predicted peak in service activity will be appropriately managed through adequate workforce capacity maximising the use of Call Handlers, Call Operators and Pharmacist and maximising National Clinical and Call Handler support lines. Contingency plans and escalation processes will be in place.

74. G-MED

- G-MED Winter Plan outlines the key actions for ensuring appropriate delivery of quality services which meet the demand over the winter and festive period, including the early arrangement of festive rotas, which take into account the pattern of increased demand for services over the festive period. The Plan also sets out escalation procedures should the service's ability to respond within agreed times be compromised.

75. In-Hours General Practice/Community

- GP practices will be open on the days between the public holidays. On these days some practices will embargo more appointments for same day booking than usual. They have also noted that general practice is not, when fully staffed, under increased pressure at the period over Christmas and New Year but with a surge usually occurring in the first week of January and are prepared for this.

- The three Partnerships will have community nursing cover arrangements in place for 25th and 26th December and for 1st and 2nd of January. The Out-of-Hours nurses based in G-MED will continue as normal.

76. Social Care

Key actions to effectively manage demand over the festive period are:

- Reduce number of patients with a delayed discharge prior to the festive period.
- Delivery of prompt assessment and implementation of social care packages over the festive period.
- Work with cross system huddle and discharge hub in acute sector to ensure staff are aware that social care packages are available over the festive period.
- During times of increased pressure resources are allocated according to priority and wherever possible, priority is given to hospital discharge or prevention of admission

77. Pharmacists

Community Pharmacy

- A pharmacy plan for the festive season is in place. Community pharmacists offering public holiday cover will be encouraged to stagger the hours they open to give the widest possible cover to the public. During October – early December practices usually provide public information regarding repeat prescriptions to remind people to order their repeat prescriptions in plenty of time and when the GP and pharmacy will be closed around public holidays.. Community Pharmacy opening on public holidays will be notified to partners (G-MED, NHS 24, Substance misuse service etc) via the Primary Care Contracts Team and corporate communications. There will be some pharmacy coverage over all Health and Social Care Partnership areas every day.

Hospital Pharmacy

- A plan is in place for the hospital service over the festive season. In the acute sector there will be an emergency service only on Sundays 25 December and 1 January. There will be weekend service on Saturdays 24 December and 31 January and there will be a reduced level of service on Monday/ Tuesday 26-27 December and 2-3 January. In DGH and RCH there will be an emergency service only on Sunday/ Monday 25 -26 December and 1- 2 January with normal Saturday arrangements in place for Saturdays 24 and 31 December. There will be a reduced service at DGH and RCH on Tuesdays 27 December and 3 January. All other days during the festive period will operate as normal. Ordering pharmacy supplies for emergency out-of-hours centres and community hospitals will be planned well in advance taking account of transport arrangements and ensuring adequate medicine stock. Pharmacy opening information will be provided directly to wards and clinics. It is essential that the pharmacy staff is included in plans for patient discharge at the earliest time to ensure required medication is available in a timely manner.

- The above arrangements will be widely publicised to the public and NHS staff

78. Dental Services

- From Wednesday 21st December 2016 through to Wednesday 4th January 2017 (inclusive) the following arrangements will be in place:

Excluding public holidays, Public Dental Services and independent dental practices will be expected to provide access to dental advice and treatment during normal working hours Monday to Friday. During **in-hours 08.00 – 18.00hrs**, unregistered patients and visitors to the region can access dental advice and treatment if required, by contacting the **Dental Information and Advice Line (DIAL)**

- **Out of hours** will be available as below:-

Aberdeen GDENS emergency dental clinics will operate 18.15 - 21.15hrs on normal working weekdays, and 09.00 – 12.30hrs normal weekend days Elgin GDENS clinic will operate 9.00-12.30hrs Sundays

- **Public Holiday** cover will be available as below:-

Sat 24th Dec	Aberdeen clinic 9.00 – 12.30hrs
Sun 25th Dec	Aberdeen clinic 9.00 -12.30hrs
Mon 26th Dec	Aberdeen clinic 09.00 – 12.30hrs
	Elgin clinic 09.00 – 12.30hrs
Tue 27th Dec	Aberdeen clinic 09.00 – 16.30 hrs
	Elgin clinic 09.00 – 13.00hrs
Sat 31st Dec	Aberdeen clinic 9.00 – 12.30hrs
Sun 1st Jan	Aberdeen clinic 9.00 -12.30hrs
Mon 2nd Jan	Aberdeen clinic 09.00 – 12.30hrs
	Elgin clinic 09.00 – 12.30hrs
Tue 3rd Jan	Aberdeen clinic 09.00 – 16.30 hrs
	Elgin clinic 09.00 – 13.00hrs

- For unregistered dental patients and patients of practices participating in the SEDS national service, Out of hours and public holiday services are accessed via **NHS 24 on 111** between 18.00 – 08.00hrs weekdays and throughout the weekend and public holidays. Patients will be triaged according to national Emergency dental Service standards and directed to appropriate care as required.

- Registered dental patients should contact their practice directly in the first instance.

79. Diagnostics

- Elective activity will be managed in accordance with unscheduled care need and available capacity. Detailed planning of activity levels for ultrasound, CT and MRI are in place and will help to ensure that no elective activity will be unnecessarily postponed as a result of pressures on the diagnostics service.
- CT, Ultrasound and MRI in Radiology have a clear process for prioritising patients from the 21 Dec and over the festive period; these are appended in the Acute Winter Plan.

80. ED/MIUs

- Intelligence shows us that the week prior to Christmas and the first two weeks in January ED and MIU departments tend to be significantly busier than usual. Key actions to manage this are in place with specific emphasis in ensuring workforce capacity is in place to manage predicted demand.

81. Mental Health Services

- Intelligence demonstrates that there are surges in demand on mental health services prior to and post the festive period. The unscheduled care team work 365 days per year and will absorb this as part of their work pattern.

On call consultants are available to attend the hospital if activity increases.

82. Modelling and Testing

- Surge planning is closely linked to the degree of preparedness that will be in place for likely challenges over winter. Preparation for and integral to surge planning is an understanding of what capacity the current system has, what levels or thresholds will challenge that capacity beyond manageable levels and what ability and resources can be put in place to step up to a 'surge' response.

- From experience of participating in tabletop tests last year, all stakeholders recognised the value in exercising winter plans ahead of finalisation and implementation Based on this value, sectors have scheduled and delivered events for tabletop exercises which afford the opportunity to identify barriers and flaws to implementing the plans and a chance to refine them, also sufficient time to address any issues that will prevent successful activation.

- Local teams are being encouraged to test their own plans by senior leadership figures and all events are supported by the Grampian Unscheduled Care 6 Essential Actions Programme and the NHS Grampian Civil Contingencies Unit. A joint Winter Tabletop Test for all stakeholders and partners was also arranged to test winter planning and collaborative working.

Themes explored and tested are:

- The potential activation of four winter plans and the initial response to a disruptive event that has a direct impact on patient care.
- The joint approach that is in place across all the organisations and how the plans dovetail together; how risk is assessed across the board and how Command and Control functions across the joint approach.
- How the sectors and others will continue to deliver services and maintain performance against key measures and standards during a period of significant challenge.

In each case, the exercise process follows national resilience protocol and utilise standardised documentation, enabling a consistent method for review and feedback, as well as ensuring quality control.

Summary of Key Festive Period Actions

- All organisations and services will have in place the following:
  - Agreed rotas for the festive period
  - Locally tested business continuity plans
  - Clear communication channels for discussing pressures and key actions
- There is a partnership approach to festive period planning, acknowledging interdependencies of services
- Focus is business continuity and minimising impact of closures
- Testing has contributed to the efficacy of continuity planning

Key areas of Risk

- Availability of staff over the festive period may not be optimal, compounded by vacancy levels
- Higher than anticipated levels of unscheduled care activity

References

Scottish Government : 6 Essential Actions Improvement Programme

Scottish Government Resilience and Business Management Division:

- Preparing for Winter 2016/17
- Winter Preparedness : Self Assessment

Grampian Winter Report 2015/16

Grampian Winter Intelligence Report 2015/16

The NHS Grampian Major Infectious Disease Plan version 5.3. Approved October 2013

Sector/Organisation Winter Plans which underpin the Grampian Winter Plan 2015/16

Acute Sector Winter Plan (ARI and Dr Grays) for 2016/17

Aberdeenshire Winter Plan for 2016/17

Aberdeen City Winter Plan for 2016/17

Moray Winter Plan for 2016/17

GMED Winter Plan 2016/17

Scottish Ambulance Service Winter Plan for 2015/16

NHS24 Winter Plan for 2015/16

Appendix 1

Summary of Winter Plan Actions & Finance Status for 2016/17

The table below sets out the key actions within this plan along with the nominated lead, timescales for delivery and financial status.

Ref.	Action	Timescales	Lead/s	Financial Cost/Status
1.	*Reporting* Reporting to the Scottish Government in a timely manner by: i. Submitting weekly management information commencing October 2016 ii. Producing daily performance and pressures reports as and when required iii. Providing exception reports and immediate notification of any significant issues.	 Oct 2016 As required As required	 V. Fox C. Cameron G. Mortimer	 Via existing resources. Via existing resources. Via existing resources.
2.	*Communication Between Partners & Escalation* i. Partnerships, Acute sector and other Departments along with Partners to test winter/business continuity plans. ii. Daily Cross System Huddles Chaired by Senior Decision Maker and include all partners to be held iii. Real-time reporting of critical incidents to partners as per agreed protocols iv. All partners contribute to/inform the submission of exception reports to the Scottish Government	 During August/September/October 2016 Ongoing Ongoing Ongoing	 Chief Officers and Lead Managers Gary Mortimer, Judith Proctor, Pam Gowans & Adam Coldwells Gary Mortimer, Judith Proctor, Pam Gowans & Adam Coldwells Gary Mortimer, Judith Proctor, Pam Gowans & Adam Coldwells	 Via existing resources.

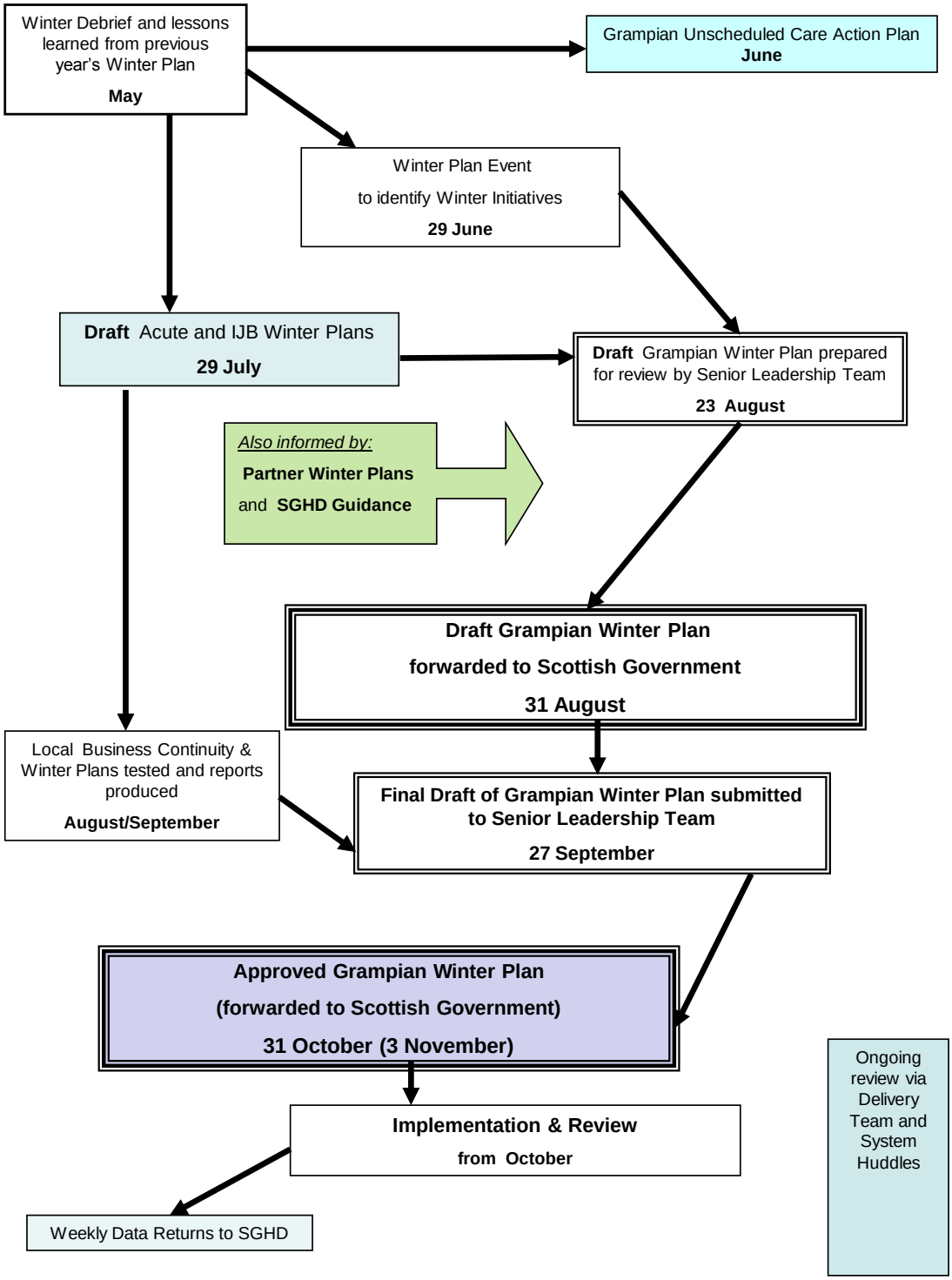
Ref.	Action	Timescales	Lead/s	Financial Cost/Status
3.	*Communicating to Public/Staff*			
	i. Implementation and regular review of the Winter Health Communication Plan which includes flu, 'Be Ready for Winter', KWTTT and antibiotic campaigns.	From October 2016	C Cameron	Via existing resources
	ii. Targeted communication to staff on wards regarding key information during the festive period e.g. infection control advice, access to social care assessment/care packages and KWTTT	From November 2016	A Hardy	Via existing resources
	iii. Targeted KWTTT public campaign	From Nov 2016	C Cameron	6 Essential Actions Funding
4.	*Joint Working and Integration*			
	i. Regular meetings involving Partnerships, Acute Sector and NHS Grampian to prioritise system issues	Weekly	Senior Leadership Team	Via existing resources
	ii. Discharge Hub to support integrated approach to priority discharge	Daily	A. Hardy	Via existing resources
	iii. Safety Brief models to ensure 'system grip' on a daily basis	In place / ongoing	A.Hardy	Via existing resources
5.	*Anticipatory Demand and Prevention*			
	i. Encouraging and promoting flu vaccination for all individuals over 65 years, all patients in at risk groups under 65 years in a clinical risk group, to achieve a 75% uptake rate	From October 2016	S. Webb	Via existing resources
	ii. Promoting flu vaccination for all staff and aim to achieve a 50% uptake of front line staff	From October 2016	Gary Mortimer, Judith Proctor, Pam Gowans & Adam Coldwells	Via existing resources
	iii. All sector/service plans reflect details within the NHS Grampian Major Infectious Disease Plan	October 2016	Sector Plan Leads	Via existing resources
	iv. Robust communication mechanisms between Health Protection Team and Infection Prevention and Control Team	Ongoing	IPCT Head and Head of Health Protection	Via existing resources

6.	*Planned Healthcare Capacity and Activity* i. Use of predictive data to effectively manage and balance planned and unscheduled activity ii. Capacity and Demand management is in place in all sites, as are clear escalation plans iii. Use of and adherence to protocols for safe, effective discharge will be promoted through the Discharge Hubs and monitored and reviewed through the safety briefs and cross system huddles	 ongoing ongoing ongoing	 G. Mortimer Gary Mortimer, Judith Proctor, Pam Gowans & Adam Coldwells A Hardy	 Via existing resources Via existing resources Via existing resources
Ref.	**Action**	**Timescales**	**Lead/s**	**Financial Cost/Status**
7.	*Unscheduled Care Capacity and Demand* i. Robust Winter Plans, which reflect predicted demand, are agreed and tested ii. Implementing use of redirection protocol in ED iii. Site Capacity and Management Approach in acute hospitals iv. Minimising delayed discharges by prioritising the most urgent via collaborative working in the Discharge Hub v. Collaboration on winter planning across partner agencies and services such as SAS, NHS24, GMED.	 October 2016 Ongoing ongoing Ongoing October 2016	 Gary Mortimer, Judith Proctor, Pam Gowans , Adam Coldwells & Directorate Leads G. Mortimer G. Mortimer A.Hardy, S. Coady, T. Cowans, I. Ramsay C.Cameron	 Via existing resources Via existing resources Via existing resources Via existing resources Via existing resources
Ref.	**Action**	**Timescales**	**Lead/s**	**Financial Cost/Status**

8.	*Specific Plans for During and Post the Festive Period*			
	i. All organisations and services will have in place the following:			
	a. Agreed rotas for the festive period	October 2016	Sector and Service Leads	Via existing resources
	b. Locally tested business continuity plans	November 2016	Sector and Service Leads	Via existing resources
	c. Clear communication channels for discussing pressures and key actions	ongoing	Gary Mortimer, Judith Proctor, Pam Gowans & Adam Coldwell and Sector and Service Leads	Via existing resources
	ii. There is a partnership approach to festive period planning, acknowledging interdependencies of services	October 2016	C. Cameron	Via existing resources
	iii. Testing has contributed to the efficacy of continuity planning	November 2016	Sector and Service Leads, C. Cameron	Via existing resources
Ref.	**Action**	**Timescales**	**Lead/s**	**Financial Cost/Status**

Appendix 2

Process & Timescales for Development and Review of the Grampian Winter Plan 2016/17



Appendix 3

Critical Areas, Outcomes and Indicators

The critical areas identified below have been identified by Scottish Government Winter Planning Guidance as key to effective winter planning. The local indicators, which underpin each critical area, are required to be included in relevant local management processes to achieve the outcomes described. Where appropriate the local evidence is described including the data measure, the geography and the frequency of collection and /or use.

1. Business continuity plans tested with partners.
Outcome required: • The board has fully tested business continuity management arrangements / plans in place to manage and mitigate key disruptive risks including the impact of severe weather.
Local indicator(s): • progress against any actions from the testing of business continuity plans.
Local evidence: • sectors have completed test exercises as at October 2016 • some sectors have undertaken testing of multiple scenarios • the acute sector has scheduled events into November and December to ensure multiple staff groups can participate • reports have been prepared on outcomes and learning from events • events have been supported by Civil Contingency Team • Cross system event held in August 2016 • Plans refined based on learning

2. Escalation plans tested with partners.
Outcome required: • 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.
Local evidence: • ED capacity reports are produced on daily basis and shared with key services for review. • ED escalation policy and site based escalation policy written in tandem and reflect the national guidance of 2016. • Includes agreed key indicators of pressure

3. Safe & effective admission / discharge continues in the lead-up to and over the festive period and also in to January.

Outcomes required:

- 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.

Local evidence:

- balance of admissions/discharges is monitored and discussed at daily safety briefs in both acute sites
- boarded patients are discussed and prioritised via daily safety briefs
- delayed discharges are reviewed daily and prioritised via the Discharge Hub
- community hospital occupancy is discussed daily via the Cross System Huddle
- identification of need for priority social work assessments is addressed via partnership review in Discharge Hub

4. Strategies for additional surge capacity across Health & Social Care Services

Outcome required:

- 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, 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
- planned number of extra next day GP and hospital appointments

Local evidence:

- *Additional capacity may be made available in the acute sites.*
- *In ARI this is likely to be up to 9 beds Monday to Friday.*
- *In Aberdeen City and in Moray, the HSCP may spot purchase additional packages of care*
- *Boarding levels in acute hospitals will be monitored with boarding decisions made in accordance with agreed policy and the Standard Operating Procedure.*

5. Whole system activity plans for winter: post-festive surge / respiratory pathway.

Outcome required:

- 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.

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.

Local evidence:

- The level of elective procedures during the post-festive period has been discussed planned by the acute sector since August 2016
- As per the policy and the Standard Operating Procedure, these are based on the principles of prioritising the clinically urgent, cancer patients, those at risk of failing TTG.
- Non-essential activity outwith the above criteria has been postponed for the first two weeks after the post-festive return.

6. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

Outcome required:

- 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.

Local evidence:

- Data on performance and activity is collected via usual routes and mechanisms. e.g. daily circulation of ED activity and performance levels
- Additional winter monitoring is in place with reporting of any exceptional events
- Winter planning cycle includes opportunity for festive hot debrief in January and full winter debrief in May
- Winter Planning Cycle includes production of a Winter Intelligence report that allows for year-to-year comparison of activity and performance levels for NHS and partners services.

7. Workforce capacity plans & rotas for winter / festive period agreed by October.

Outcomes required:

- 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 admission and discharge of emergency and elective patients. This should encompass all relevant health and social care services.
- Maintain discharges at normal levels 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

Local evidence:

- workforce rotas are in place by October 2016
- including additional shifts in priority areas, i.e. GMED
- Discharges continue to be prioritised as safety briefs are delivered over festive holiday periods

8. Discharges at weekends & bank holidays

Outcome required:

Patients are discharged at weekends and bank holidays to avoid unnecessary stays in hospital and to improve flow through the hospital. Medical and Nurse Directors provide monthly report on weekend (pre-noon) discharge rate progress and performance.

Local indicator(s):

- % of discharges that are criteria led on weekend and bank holidays;
- daily number of elective and emergency admissions and discharges.

Local evidence:

- use of predictive data is in place at ward level and discussed at daily safety briefs
- additional transport dedicated to supporting discharges at weekends and evenings is in place for both acute sites.

9. The risk of patients being delayed on their pathway is minimised.

Outcome required:

- Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty 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.

Local evidence:

- daily capacity (demand and capacity)report produced in ED and shared
- breaches for first assessment monitored and actioned
- discharge activity and performance led on via Discharge Hub and daily meetings
- boarding levels discussed daily in safety briefs

10. Communication plans

Outcome required:

- The public and patients are kept informed of winter pressures, their impact on services and the actions being taken.

Local indicator(s) :

- daily record of communications activity;
- early and wide promotion of winter plan

Local evidence:

- winter plan is made available via the local intranet and internet site, promoted to staff
- national and local social marketing activity is undertaken as outlined in **Section K. Information, Communication & Escalation** on page 17 of this Plan.

11. Preparing effectively for norovirus.
Outcome required: 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.
Local evidence: • Norovirus Preparedness Plan in place from August 2016 • Daily attendance at Safety Briefs by Infection Prevention and Control Team • Regular communication on local norovirus activity • IPCT Communication Strategy in place and implemented, including escalation process

12. Delivering seasonal flu vaccination to public and staff.
Outcome required: • 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.
Local evidence: • The flu immunisation campaign in Grampian commenced 3rd October 2016 • Uptake levels for the public and for staff will be recorded and monitored, and reported following the winter period.

Appendix 4

Grampian Winter Intelligence Report 2015/16

The NHS Grampian Health Intelligence Department with partner colleagues is developing a Winter Plan Intelligence Report looking at the last five winters (2011/12 to 2015/16). Key points from the evolving report are outlined below.

NHS 24

- 10% more calls on average during the winter period with a monthly average of 9,214 compared to 8,429 between April and October.
- Peak activity during December and January. Each of which average around 10,000 calls. By contrast November is the least busy month averaging fewer than 8,000 calls.
- 5.3% fewer calls in 2015/16 than in 2014/15. 6083 calls in November 2015 compared to 9061 in November 2014.
- Incomplete data for first third of November due to unsuccessful implementation of new IT System so true volume of calls over this period is unknown.
- Excluding November there were 1.0% more calls in 2015/16 than in 2014/15. March was responsible for most of this increase: up 4.8% compared to 2015.
- The table below illustrates the activity trends over the last five years for both average number of calls per day and average number of calls per week:

Time Period	Average Calls per Day	Average Calls per Week
Nov - Mar 2011/12	296.7	2076.7
Nov - Mar 2012/13	312.2	2185.8
Nov – Mar 2013/14	290.9	2036.3
Nov – Mar 2014/15	319.3	2234.9
Nov – Mar 2015/16	302.4	2116.8

Scottish Ambulance Service (SAS)

- Number of incidents was increasing by average of 5% each year but has levelled off over the past three winter periods.
- Trend data shows a predictable peak in activity during the first week in January.
- The table below illustrates the activity trends over the last five years for both average incidents per day and average incidents a week:

Time Period	Average Incidents per Day	Average Incidents per Week
Nov - Mar 2011/12	117.2	815.9
Nov - Mar 2012/13	122.0	851.7
Nov – Mar 2013/14	129.7	907.9
Nov – Mar 2014/15	128.2	897.4
Nov – Mar 2015/16	129.8	908.6

GMED

- GMED calls follow same pattern as NHS24 calls with an increased number in 2015/16 for the second year in succession. There were 2.4% more calls than in 2014/15.
- The number of calls is much higher around Christmas/New Year but fairly consistent at other times. Calls per day average around 550 over the Christmas period and average around 290 per day for the rest of the year.
- In each year around 10% of calls resulted in no action.
- The table below illustrates the activity trends over the last five years for both average number of calls per day and average number of calls per week:

Time Period	Average Calls per Day	Average Calls per Week
Nov - Mar 2011/12	305.6	2139.5
Nov - Mar 2012/13	326.6	2286.3
Nov – Mar 2013/14	319.4	2235.7
Nov – Mar 2014/15	327.2	2290.4
Nov – Mar 2015/16	335.1	2345.7

Grampian A&E (All Sites)

- Peak attendances occur during spring, early summer and early autumn.
- In each year up to 2014/15 Christmas Day had the fewest number of attendances: 196 in 2011, 182 in 2012, 192 in 2013 and 165 in 2014. In 2015/16 Christmas Eve had the fewest number of attendances with 160.
- Periods of peak attendances vary. March had noticeably higher attendance numbers in 2012 but not in other years. Days with the highest number of attendances in each winter were:25/3/12 with 380, 1/11/12 with 352, 2/2/14 with 372, 22/2/15 with 344 and 28/3/16 (Easter Monday) with 364 attendances.
- Peak number of waits over 4 hours and over 12 hours occurs just after New Year.
- The number of 4-hour breaches almost doubled between 2010/11 and 2014/15 but returned to 2011/12 levels in 2015/16.
- 2015-16 was the first winter period with no 12 hour breaches.
- The table below summarises activity trends and breach data over the last five years:

Time Period	Average Attendances per Day	Average Number of Breaches Per Day		
		4-Hour	8-Hour	12-Hour
Nov - Mar 2011/12	288.3	12.5	1.3	0.2
Nov - Mar 2012/13	283.9	18.3	1.7	0.2
Nov – Mar 2013/14	278.8	18.1	1.1	0.1
Nov – Mar 2014/15	267.8	22.2	2.3	0.3
Nov – Mar 2015/16	261.9	12.4	0.3	0.0

Grampian Admissions (All Sites)

- There are on average 2239 admissions per week over the winter period: 1203 elective and 1036 emergency.
- There are generally between 1,000 and 1,500 elective admissions each week except for the weeks beginning 20th December and 27th December when activity is much reduced. This reduction in activity is also evident for week beginning 3rd January when New Years Day falls on a Saturday or Sunday.
- The number of emergency admissions is more consistent from week to week with no marked drop off over Christmas though an increase can be seen following New Year.
- 2015/16 saw a 3.5% increase in elective and 0.5% decrease in average number of emergency admissions per day compared to 2014/15.
- The table below illustrates admission trends over the last five years for both average number of admissions per day and per week:

Time Period	Average Admissions per Day		Average Admissions per Week	
	Elective	Emergency	Elective	Emergency
Nov – Mar 2011/12	172.6	153.5	1208.5	1074.5
Nov – Mar 2012/13	172.1	141.3	1204.6	988.8
Nov – Mar 2013/14	163.7	145.7	1145.6	1020.1
Nov – Mar 2014/15	172.4	150.0	1206.5	1050.0
Nov – Mar 2015/16	178.4	149.2	1248.8	1044.4

Length of Stay (All Sites)

- There was little change in Elective LOS between 2014/15 and 2015/16.
- Emergency LOS dropped by 7% in 2015/16 and was 2nd lowest of the five years.
- The table below illustrates average length of stay over the last five years for both elective and emergency admissions:

Time Period	Average Elective Length of Stay (days)	Average Emergency Length of Stay (days)
Nov - Mar 2011/12	1.17	8.23
Nov - Mar 2012/13	1.11	7.61
Nov - Mar 2013/14	1.37	8.10
Nov – Mar 2014/15	1.07	8.42
Nov – Mar 2015/16	1.11	7.85

Delayed Discharges

- A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient's discharge, and who continues to occupy the bed beyond the ready for discharge date.

- Number of delayed discharges showed little change in 2015/16 compared to 2014/15 (853 v 846).
- 2015/16 saw a 16% drop at ARI which contrasted with a 60% increase at Woodend.

Number of Non-Complex Cases	ARI	Dr Gray's	Woodend	Cornhill	Community	Total
Nov – Mar 2011/12	42	0	73	20	144	279
Nov - Mar 2012/13	275	7	110	18	196	606
Nov – Mar 2013/14	275	41	67	14	242	639
Nov – Mar 2014/15	404	39	101	38	264	846
Nov – Mar 2015/16	337	37	162	36	281	853

- The number of complex case (code 9s) delayed discharges are illustrated in the table below. In 2015/16 there were nearly twice the number of complex cases compared to 2014/15, but numbers had been unusually low. There was a big increase at Cornhill: 14 compared to fewer than 5 in three preceding winters.

Number of Complex Cases	ARI	Dr Gray's	Woodend	Cornhill	Community	Total
Nov - Mar 2011/12	5	0	5	13	18	41
Nov - Mar 2012/13	7	0	9	4	24	44
Nov – Mar 2013/14	5	1	5	0	38	49
Nov – Mar 2014/15	3	4	4	4	12	27
Nov – Mar 2015/16	4	3	6	14	24	51

Norovirus

- The NHS Grampian rate per 100,000 population of reports of Norovirus reduced from 26.1 in 2014 to 22.8 in 2015. This was lower than the Scottish rate of 26.0.

Flu Immunisation

- Uptake for the seasonal flu vaccination dropped in 2015/16.
- 73.2% of over 65s were immunised compared to around 76% in each of the preceding four winters.
- Amongst under 65s, at increased clinical risk, there was an even greater decrease in the uptake rate with 46.3% compared to between 53 and 56% in previous winters.
- Uptake for the past five winters is illustrated in the table below:

Year	Aged 65 and older	Aged 64 or less and at increased clinical
2011/12	76.4%	55.6%
2012/13	76.1%	53.8%
2013/14	76.0%	55.2%
2014/15	75.7%	53.0%
2015/16	73.2%	46.3%

Appendix 5

Hospital Safety & Flow Brief

HOSPITAL HUDDLE AIM 'Making every day a safe day for patients and staff''
1. Positive Story (e.g. Quality, Safety or Patient Care) ***Weekly on a Monday & Friday only***
Local Action: At own huddle today consider positive patient story / practise experience to share wider.
2. H@N Status (e.g. Patients concerned about, requiring urgent review, Cardiac Arrests Overnight)
Local Action: Complete Resuscitation Audit form and review case at MDT for any potential learning
3. Managing Deteriorating Patients: Who are the other patients we are concerned about this morning?
Ward: **Ward:** **Ward:** **Ward:**
Local Action: Every patient of concern must have an early review this morning by a senior Doctor.
4. Critical Care Safety Issues
ITU - **CITU -** **MHDU -** **CCU -** **SURGICAL HDU's (15) -** **217 HDU -** **THEATRES**
Local Action - Are there downstream beds available for transfer out of these areas to accommodate predictions and/or anticipated theatre activity in the next 24hours, if not consider reviewing theatre activity scheduled for safety reasons.
5. Significant Incidents: e.g. injury, absconding, medication, fire call-out, equipment & systems issues.
Local Action: All Datix reports to be completed. Any unusual circumstances to be reported immediately to the Nurse Manager or UOM. Consider early communication with patient and family
6. Infection Control

Local Action: Senior Charge Nurse and the Infection Prevention Control Team to ensure an infection control management plan is in place.

7. Boarding Patients (Do these patients have management plans, deterioration plans, sealing of treatment or anticipated length of stay in place?)

Ward:

Ward:

Ward:

Ward:

Ward:

Ward:

Local Action: Every patient must have a senior clinical review by the 'parent ward' medical team. Any concern or Delay in review should be escalated to the Patients consultant.

8. Repatriation Patients: Both in and out of the Acute Sector from Moray (e.g. Cardiology) and other Health Boards

Local Action : If unable to secure placement for repatriation, has this been escalated through UOM?

9. Key Staffing Issues (Are you safe to start? If not what is your plan, have you escalated?)

Ward:

Ward:

Ward:

Ward:

Ward:

Ward:

Local Action: Can anyone help support hot spot areas identified during the briefing?

10. Additional Services Issues

Pharmacy
AHP's
Outpatient Service
Domestic Services
Estates
Portering
Security
Chaplaincy

Health & Safety
Any Other Issues

11. HOT SPOT AREAS

1
2
3
4
5
6

12. MANAGING PATIENT FLOW

Operational Support to Deliver Overnight / Current Status:

Unscheduled presentations:		Performance 4HR Standard
Emergency Admissions:		
Elective Admissions:		
Current Bed Status on Trek:		
Discharges Predicted:		

ED & AMIA CURRENT STATUS

Emergency Department		**AMIA**	
Total No in Dept:		**Total No in Dept:**	
Longest wait:		**Longest wait:**	
Patients> 3 hrs:		**Patients> 3 hrs:**	
Queue for beds:		**Queue for beds:**	
Breaches last 24hrs:		**Breaches last 24hrs**	

Resus / HDU Cases:		**Resus / HDU Cases:**	

SURGICAL RECEIVING		
Current Beds:	**Predictions:**	**End of Day Position:**

ORTHOPAEDIC TRAUMA RECEIVING		
Current Beds:	**Predictions:**	**End of Day Position:**

13. Discharge Hub Report and discharge priorities based upon predicted activity and capacity during the next 24 hours.

Local Action: Ensure Delayed Discharges are Documented on EDISON or removed as appropriate.

Daily Safety Brief Actions Plan **Duty Manager :**	**Status**
1.Safety Issues: **ACTION:**	
2.Staffing Issues: **ACTION:**	
3.Capacity Issues: **ACTION:**	
4.Enviroment: **ACTION:**	

5.Repatriation: **ACTION:**	
6. On Call Duty: **Duty Manger: Senior Nurse: Site Manager: Medical Director:**	
7	
8	

Appendix 6

Grampian Winter Plan 2016-17
Primary Care Risk Register

Risk Description	Risk Impact	Mitigating Actions	Risk Owner
Workforce			
Shortage of primary care workforce roles, including GPs, Practice nurses, admin staff, Advanced Nurse Practitioners across Grampian in primary care workforce	Failure to have sufficient staff to deliver services and primary care sector unable to meet the needs of the population.	• Continue to advertise posts • Consider locum use where possible • Well planned rotas • Early stages of shared discussion with neighbouring practices	• Grampian level responsibility for Primary Care sits with Moray HCSP • Corporate responsibility for ensuring appropriate workforce sits with NHSG • Individual responsibility for practices sits with HCSPs and practices
Shortage of social care workforce roles, including carers and care managers across Grampian	Failure to have sufficient care staff to deliver services and social care sector unable to meet care needs of the population. Linked negative impact on health services as a result.	Continue to advertise posts and to recruit, working in partnership across localities.	Grampian level responsibility for social care sits with each HCSP
Sickness absence levels reach higher than manageable levels	Failure to have sufficient staff to deliver services. Unable to meet the needs of the population for primary care	• Flu immunisation programmes for staff and priority groups in the population • Access to locum staff • Infection control protocols communicated to staff groups	• HCSP responsible for ensuring compliance with corporate policies • Practices responsible for staff line management
Reduced availability of community pharmacy, optometry, dental services during festive periods	Increased need for people to access providers further afield than their usual or local provider	Contractual requirements with providers are upheld where appropriate. Local providers prioritise essential services.	Grampian level responsibility for contractors sits with each partnership

Risk Description	Risk Impact	Mitigating Actions	Risk Owner
Premises/ Equipment			
Older buildings with high backlog maintenance needs may not be wind and water tight over winter	Buildings may become unusable, preventing services from being delivered or preventing staff from being able to access them, including records, documents	Backlog maintenance programme is being progressed on a prioritised basis	• NHSG Estates department deliver the backlog maintenance programme • HCSPs responsibility to report building risks and failures
Buildings are less secure during long periods of vacancy because of holidays	Buildings may not be inhabited to report failures such as flood or electrical issues or break ins	On call system provides 24/7 cover to address any external report of increased risk or building failure.	Each partnership operates on call system
Access to and delivery of equipment and consumables may be reduced due to bad weather	Services may be negatively affected due to lack of access to required specialist equipment or consumables such as dressings, medications	• Good stock control • Use of local networks and partners	Each partnership operates on call system
IT / Telecommunications			
Vital access to IT may be affected , linked to premises failure.	Staff not able to access patient information for the purpose of delivering services	Staff operate information governance protocols to ensure responsible management and security of information.	• NHSG responsibility for providing appropriate systems and network access. • Each partnership is responsible for ensuring staff operate information governance protocols.
OOH Services			
Shortage of filled shifts in GMED rota	Failure to have sufficient staff to deliver ooh services. Unable to maintain an OOH service	• Continue to promote and recruit to shifts for GMED • Continuing with redirection protocol • Use of remote advice practice where telephone advice is provided by a GP direct to the patient, similar to an in-hours duty doctor model	Grampian level responsibility for GMED sits with Moray HCSP

Risk Description	Risk Impact	Mitigating Actions	Risk Owner
Weather			
Severe weather may affect service delivery	Contractors such as GPs and pharmacists may not be able to open as normal, in the event of flooding.	Local winter plans for all services have included lessons learned form 2016 floods and have business continuity plans in place.	Local providers and HCSPs and NHSG
Severe weather may affect transport	SAS may not be able to provided expected level of service for emergency and planned transport services.	Local winter plans for all services have included lessons learned form 2016 floods and have business continuity plans in place.	SAS
Public Awareness			
Public are unaware of reduced availability of services due to winter pressures	Level of demand continues to rise in the face of reduced ability to deliver, further impacting the service	• Public information campaigns run over winter, e.g. KWTTT, antibiotics campaign, closure dates of practices, pharmacists, opticians, dentists, as well as reminders to ensure stock of household medicines and prescriptions. • Option to circulate ad-hoc messages about increased pressure on services if required.	NHSG

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Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Civil Contingencies
Lead Officer	Judith Proctor
Report Author (Job Title, Organisation)	Lorraine McKenna, Business Manager
Date of Report	03/10/2016
Date of Meeting	15/11/2016

1: Purpose of the Report

To report progress on the Civil Contingencies response capability of the Health & Social Care Partnership to an emergency situation.

To present a three year Civil Contingencies plan which outlines the pathway to an integrated Health & Social Care response to an emergency situation.

To inform the IJB of the requirements of the Scottish Government with relation to their recently released Standards for Organisational Resilience.

2: Summary of Key Information

A paper was presented to the June IJB meeting outlining the existing arrangements for Civil Contingencies within the Health & Social Care Partnership. Contained in that report were the recommendations of the joint short life working group. Of the ten recommendations, progress or plans have been made to achieve them all.

A workshop to progress having a single duty senior manager on call for Health & Social Care is planned for 28/10/2016. (Recommendation No.1) The workshop will explore which posts should be included on the rota, what changes to the existing resources are required to ensure responses to social care issues are handled appropriately and what training is required. (Recommendations 4 & 6) The single duty senior manager on call system will lead to a joint emergency/major incident response team for the Partnership. (Recommendation No. 2)

Integration Joint Board

The Chief Officer has confirmed that her role in an emergency situation will be to link with the senior manager on call for the Partnership and subsequently the Chair of the Command & Control team. She will also advise, as appropriate, the executive manager on call for NHS Grampian and the Emergency Response team at Aberdeen City Council that an incident has occurred and will provide updates via the Command & Control team. (Recommendation No. 5)

A training needs analysis forms part of the three year Civil Contingencies Plan presented to the IJB as an appendix to this report. (Recommendation No. 7)

In June, separate business continuity plans were available for Health & Social Care with the recommendation from the Short Life Working Group that this continue for the foreseeable future. The overarching business continuity plan for Health has been updated along with the business impact analyses for each of the critical services in Health the Partnership is responsible for i.e. in-patient services at Woodend Hospital, community services, general practice and Social Care. It should be noted that Independent GP Practices are responsible for producing their own business continuity plans and the Partnership cannot enforce this, which could present a risk. As recommended by the short life working group, Social Care has a separate business continuity plan. (recommendation No. 8)

The overarching business continuity plan for Health was tested during Exercise Skyfall on 14/09/16 and a number of actions resulted. The business continuity plan has been updated and the action plan is being worked through. Social Care colleagues were in attendance at the exercise as the scenario used for the exercise impacted on both health and social care services.

One of the actions agreed at Exercise Skyfall was to conduct an options appraisal to ascertain the best location for a single Health & Social Care control room. This will be completed by the end of this year. (Recommendation No. 3)

The Business Manager continues to attend the NHS Grampian Civil Contingencies Group and a sector report is submitted monthly. Reports such as this one to the IJB also form part of the governance arrangements suggested by the short life working group. (Recommendation No. 9)

The short life working group recommended that a joint resilience group for the Partnership should be formed from the existing Health Civil Contingencies group.

To date, the terms of reference, agenda and membership of this group have been amended to reflect the inclusion and attendance of social work representatives. (Recommendation No. 10)

In addition, the Scottish Government has issued a set of Standards for Organisational Resilience of which there are 41. Health Boards are required to submit a self-assessment against the standards and while some of the standards are specifically for the acute sector, the Partnership has also been requested to complete the self-assessment. This has been done and passed on to NHS Grampian who will submit a return to the Government in the form of a summary statement based on the sector assessments.

3:	Equalities, Financial, Workforce and Other Implications

There would appear to be no direct impact on the IJB's equalities duties as such but the ongoing health and wellbeing of the protected groups underpins our wish to have comprehensive effective plans in place

Activation of the business continuity plan will have financial implications if services have to be relocated and if staff work additional hours. If the Options Appraisal indicates that a new location for the control room should be found, funding will be required to identify and equip the new centre. If the control room at Summerfield House is to remain, video conferencing facilities will need to be installed.

The wellbeing of staff needs to be considered during an emergency situation, especially a situation that lasts more than 12 hours.

4:	Management of Risk

Identified risk(s):

There is a risk of catastrophic environmental issues, failure of external support systems, pandemic episodes and/or other emergency situations resulting in the inability to deliver services and/or keep staff and citizens safe from harm.

Link to risk number on strategic or operational risk register:

The risk is linked to the Environmental Factors section on the Partnership's

Integration Joint Board

Operational Risk Register. **How might the content of this report impact or mitigate the known risks:** The content of this report forms the controls and assurances sections on the risk register, which mitigate the risk.

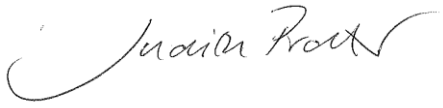
5:	**Recommendations**

It is recommended that the Integration Joint Board:

1. Note the improved response capabilities of the Health & Social Care Partnership to emergency situations

2. Continue to support the ongoing development of an integrated system for responding to emergency situations

3. Endorse the three year Civil Contingencies plan as presented

6:	**Signatures**
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

Aberdeen City Health and Social Care Partnership
Civil Contingencies
3 year plan 2016 – 2019

Aberdeen City Health & Social Care Partnership
A caring partnership

	Action	Lead	Frequency	Completion Date	Comments
1	**Planning**				
1.1	Complete Business Impact Analyses for each relevant service of the HSCP 1.1.1 Draft SOP's for activating staff in an emergency which also outlines the roles and responsibilities staff are expected to undertake as part of a major incident response	Service Leads	Annually	June 2017 June 2018 June 2019	
1.2	Complete overarching Business Continuity Plan for HSCP 1.2.1 Include a section about communication during an emergency and include lessons from previous emergencies and exercises	Business Manager	Annually	August 2017 August 2018 August 2019	
1.3	Review Major Infectious Disease and Prophylaxis Plans	Information Coordinator	Annually	March 2017 March 2018 March 2019	
1.4	Review Winter Plan	Service Manager	Annually	August 2017 August 2018 August 2019	
1.5	Complete a Major Incident protocol for the HSCP	Information Coordinator		January 2017	
1.6	Prepare a Lockdown protocol for buildings the HSCP deliver services from	Buildings & Administration Support Manager		March 2017	
1.7	Devise a process for horizon scanning to future-proof resilience plans, organisational preparedness and overall capacity	Business Manager		March 2017	
2	**Exercise Plans** BCP, Major Infectious Disease and Prophylaxis Plans, Winter Plan, Control Room Protocol				
	The plans should be tested by regular exercises, which should include:				
2.1	- Communications exercise (call out cascade, control room activation and testing links between NHSG and external agencies)	Business Manager	Bi-annually	February 17	
2.2	- Tabletop exercises to test BCP, MID and Prophylaxis Plans, in	Business Manager	Bi-annually	Sep 16 & Mar 17	Exercise Skyfall held 14/09/16.

	rotation.			Sep 17 & Mar 18 Sep 18 & Mar 19	Tested overarching BCP
2.3	- Debriefs will be held following each exercise: hot (right after) and full debriefs (4 weeks after)	Business Manager	Bi-annually	Oct 16 & Apr 17 Oct 17 & Apr 18 Oct 18 & Apr 19	
2.4	- One unplanned exercise table top/live within the three-year period.	Business Manager	Every 3 years	Sept 17	
2.5	- Winter Plan – table top exercise	Service Manager	Annually	September 2017	
3	**Training needs analysis**	Information Co-ordinator	Every 2 years	January 2017	
4	**Training to ensure staff have the relevant competencies**				
4.1	Create Senior Manager on Call (SMoC) induction programme.	Business Manager	One-off	January 2017	
4.2	SMOC initial half-day awareness raising and training session.	Business Manager	Annually	January 2017 January 2018 January 2019	
4.3	Train Control Room Managers (NHSG & LA staff) in both locations (SFH and Woodend Hospital).	Business Manager		When available	One control room manager trained to date.
4.4	Train a cohort of staff drawn from NHS and LA backgrounds to staff the control room.	Business Manager		June 2017	4 staff attended Control Room Operations training.
4.5	WRAP (prevention of radicalisation) training for front line staff	Business Manager		January 2017	
4.6	Remaining staff to complete on line training in the prevention of radicalisation (ePREVENT)	Information Coordinator		January 2017	
4.7	Loggist training – staff should be able (willing) to work out of hours in case of an incident. Band 5 and above.	Information Coordinator		Ongoing	6 members of staff identified and trained
4.8	Business Manager to attend • Major Incident training and exercises arranged by NHS Grampian and/or Aberdeen City Council • Crisis Management training organised by the Scottish Resilience Development Service (ScoRDS)	Business Manager		When available When available	
4.9	Draft a staff awareness programme which includes • Informing staff that we have resilience plans and that we are exercising them. Include a system for documenting for audit purposes • Advising staff how to prepare for and cope with various	Business Manager/ Information Coordinator		January 2017	

	situations e.g. adverse weather, security threats • A system that will enable staff to input into the organisations resilience and preparedness				
5.0	Ensure that General Practitioners/Primary Care services are aware of their role in the plans of the Partnership and what is expected of them in an emergency situation	Primary Care Development Managers		January 2017	
5.1	Remind GP practices of what they need to do in a clinical contamination incident and make them aware of prophylaxis	Primary Care Development Managers		January 2017	
5.2	Relevant staff to attend Lockdown training	Business Manager and B&A Manager		When available	
6	**Control Room**				
6.1	Protocols for maintenance: to include updating staff contact lists and a copy of the SMoC rota.	Information Coordinator	Annually	May 2017	
6.2	Information sheets describing location, access and equipment available.	Information Coordinator	Annually	May 2017	
6.3	Procedure for activating the control room.	Information Coordinator	Annually	June 2017	
6.4	Action cards for Control Room Staff	Information Coordinator	Annually	November 2017	
65	Refresher Training for Control Room Staff.	Information Coordinator	Bi-annually	Mar & Sep 2017 Mar & Sep 2018 Mar & Sep 2019	
6.6	Undertake an Options Appraisal to decide where the integrated control room should be located	Business Manager		January 2017	Should the options appraisal conclude the control room should be relocated then the one at Summerfield House would be closed.
7	**Senior Manager on Call (SMoC)**				
7.1	Protocols for updating SMoC folders and SMoC bag.	Information Coordinator	Annually	April 2017	
7.2	Recall and check SMoC folders to ensure the most complete and up to date information is being used.	Information Coordinator	Bi-annually	Jan & July 2017 Jan & July 2018 Jan & July 2019	

7.3	More formal training for both Health & Social Care staff in out of hours arrangements. GEPU and CC from NHSG	Business Manager		February 2017	
8	**Joint Resilience Group**				
8.1	Civil Contingencies Group of the former CHP to take on this role for the HSCP.	Business Manager		June 2017	Work towards a Joint Resilience Group has commenced with representatives from Social Care sitting on the existing group and Social Care being a standard item on the agenda.
8.2	A common terms of reference (ToR) for a HSCP Resilience Group to be developed by the SLWG and adopted by each HSCP.	Business Manager		May 2016	The terms of reference for the City HSCP has been adjusted to reflect Social Care participation
8.3	To continue reporting to the NHSG Civil Contingencies Group.	Business Manager	Quarterly	November 2016	
8.4	Chief Officer to develop governance arrangements to ensure appropriate risk management and assurance reporting regarding HSCP Resilience to IJBs, NHS CEO and Local Authority CEO.	Chief Officer		June 2017	Current governance includes Business Manager reporting to IJB in June and November on response readiness. Reports can be used to assure NHS CEO and Local Authority CEO
9	**Integration with Aberdeen City Council**				
9.1	HSCP to put in place a single, integrated, SMoC rota comprised of NHS and Local Authority senior HSCP staff.	Business Manager		March 2017	Workshop planned for 28/10/16 to discuss and plan
9.2	SMOC rota for initial period 01/04/16 to 31/03/17 to include only experienced NHS SMOCs.	Business Manager			
9.3	Identify LA staff who will be part of the SMOC.	Chief Officer/Head of Operations		November 2016	Will be discussed at workshop on 28/10/16
9.4	Formalise the shared contact information covering both NHS and LA senior management and operational contacts	Business Manager Information Coordinator		November 2016	Will be discussed at workshop on 28/10/16
9,.5	Participate in the information standardisation process to establish a core set of information and resources to support incident management and tracking of incident information.	Business Manager NHSG LA		November 2016	Will be discussed at workshop on 28/10/16
9.6	Chief Officer to clarify their position with regard to emergency response and incident management arrangements.	Chief Officer		October 2016	
9.7	Business Continuity leads from NHS and Local Authorities, to assess	Business Continuity		June 2017	

	existing plans against the HSCP service delivery model and identify any planning gaps or areas of inconsistency.	Leads from NHS & Local Authority			
9.8	Complete an integrated Business Continuity Plan for the City HSCP	Business Manager		August 2019	The joint short life working group recommended that separate Business Continuity Plans are used in the short to medium term whilst working on an integrated plan
10	**IT**				
10.1	Map critical infrastructure assets and update regularly	Information Coordinator		June 2017	
10.2	Look at a possible electronic solution to providing a list of vulnerable patients cared for by Health. CareFirst can already provide a list of vulnerable clients	Information Coordinator		June 2017	

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Aberdeen City Health & Social Care Partnership
A caring partnership

Integration Joint Board

Report Title	Engagement, Empowerment & Participation Strategy
Lead Officer	Judith Proctor, Chief Officer
Report Author	Gail Woodcock, Integrated Localities Programme Manager (ACHSCP)
Date of Report	07.10.16
Date of Meeting	15.11.16

1: Purpose of the Report

This report brings to the attention of the IJB the Engagement, Empowerment and Participation Strategy that has been developed by Community Planning Aberdeen partners, and seeks agreement that this strategy would be adopted by the Aberdeen City Health and Social Care Partnership.

2: Summary of Key Information

2.1 Background

The Health and Social Care Integration Scheme for Aberdeen City sets out that the IJB will develop a Participation and Engagement Strategy. The purpose of the Participation and Engagement Strategy being to ensure “significant engagement with, and participation by, members of the public, representative groups and other organisations in relation to decisions about the carrying out of integration functions.” The Integration Scheme goes on to state that the IJB will be encouraged to “access existing forums that the Parties (ACC and NHSG) have established, such as Public Partnership Forums, Community Councils, groups and other networks and stakeholder groups with an interest in health and social care.”

It was intended that this strategy was developed alongside the Strategic Plan development. However while the strategy was not in place at that time, the key principles around engagement and involvement were adopted to underpin the comprehensive consultation process associated with the iterative development of the Strategic Plan.

Integration Joint Board

2.2 Empowerment, Engagement and Participation Strategy

Along with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, other legislation, namely the Community Empowerment (Scotland) Act 2015 has provided an impetus to create an increased focus on how organisations and communities experience engagement, participation and empowerment. This has provided an opportunity for the Aberdeen City Health and Social Care Partnership to work in a co-production manner with other Community Planning partners to develop a city-wide "Empowerment, Engagement and Participation Strategy."

This strategy (attached at Appendix A) has been developed via an iterative process which aligns with the aspirations of the strategy.

The strategy utilises the metaphor of a ladder to represent different types of interactions between public organisations and people, from one-way provision of information (informing), through involvement and collaboration, to self-determination, where people implement what they decide.

The strategy was developed by a working group including representatives from: Aberdeen City Council, Aberdeen Civic Forum, Aberdeen City Health and Social Care Partnership, Aberdeen Community Council Forum, Aberdeen Council or Voluntary Organisations, Castlehill & Pittodrie Community Council, Community Renewal, NHS Grampian, Police Scotland and Scottish Fire and Rescue. Its development has incorporated iterative additional input from a range of partnerships, networks and third sector organisations.

The strategy has yet to receive final approval by the Community Planning Board, and is in a final draft form. Given the highly participative manner of development, it is understood that any final changes may be minor in nature.

2.3 Strategic Objectives

The strategic objectives of the strategy are as follows:

- Communities' inherent strengths and assets – their people, their energy, their connections, sense of purpose and resources, and their abilities to self-organise and exercise autonomy, will be valued as a fundamental building block of a healthy society
- Every community will be equally heard and listened to
- Participation will be the norm rather than the exception
- Staff will be empowered to work in collaborative and empowering ways
- People will be able to see the difference that involvement has made

Integration Joint Board

There is a clear alignment between these objectives and the Integration Principles, our vision and values, and our strategic priorities.

"We are a caring partnership working together with our communities to enable people to achieve fulfilling, healthier lives and wellbeing" – our vision

3:	Equalities, Financial, Workforce and Other Implications

Financial Implications

None.

Equalities Implications

The strategy seeks to be proactive in ensuring participation from those who may be at risk of being seldom heard. A full list of people at risk of being marginalised is included in Appendix 3 of the strategy. In the final version of the document the list will also include veterans.

Workforce Implications

One of the strategic objectives is: "Staff will be empowered to work in collaborative and empowering ways". It is recognised that this may challenge the culture within some of our existing systems. The support required to enable delivery of this objective is covered within our Transformational Programme within the Organisational and Cultural Change priority and the associated developing work stream of activity.

Other Implications

Having a single, shared Empowerment, Engagement and Participation Strategy across all Aberdeen Community Planning Partners, many of whom are considered as part of our extended Health and Social Care Partnership system, and are critical to ensuring the delivery of our strategic plan, will help to ensure consistency and alignment in the way that we collectively support engagement and participation within and across services and the wider community.

Integration Joint Board

4:	Management of Risk

Identified risk(s):

Strategic Risk Register (3) There is a risk that the IJB fails to function properly within its Integration Scheme, Strategic Plan and Schemes of delegation in particular reference to being able to make appropriate decisions in a timely manner and meet its required functions: The Health and Social Care Integration Scheme for Aberdeen City sets out that the IJB will develop a Participation and Engagement Strategy, this report recommends the adoption of a strategy which will fulfil this requirement.

Strategic Risk Register (8) There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care: Effective engagement and participation across all stakeholder groups will help to mitigate against this risk.

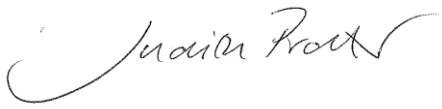
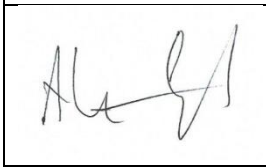
Strategic Risk Register (10) There is a risk that the IJB does not maximise the opportunities offered by locality working: a key opportunity offered through locality working is the opportunity to work in a co-productive manner with a range of stakeholders. Adopting the principles within the Empowerment, Engagement and Participation Strategy will help to maximise such opportunities.

5:	Recommendations

It is recommended that the Integration Joint Board:

1. Adopt the Community Planning Aberdeen Engagement, Empowerment and Participation Strategy as the partnership's Engagement and Participation Strategy as identified within the Integration Scheme.

Integration Joint Board

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

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Engagement, Participation and Empowerment Strategy

Community Planning Aberdeen

Foreword

This strategy is of relevance to everyone in Aberdeen. It is about the way in which individuals and families, the communities they belong to, community groups, community councils, charitable and voluntary organisations, and people working in the private sector and the public sector, collectively create and contribute to life in the city.

The Community Empowerment (Scotland) Act 2015 provides an impetus to create a step-change in how organisations and communities experience engagement, participation and empowerment. Until now the standard approach has been to provide information and consult on plans that have already been developed. Our ambition is to move significantly beyond this.

While the Act sets out legal rights and responsibilities around participation, we seek to go beyond these legal requirements. The strategy sets out a vision of collaboration and empowerment as the new standard approach. Examples of existing practice are used to bring the different levels of engagement and empowerment to life, helping everyone to imagine what the vision would look like in real life.

This will be of vital interest to every person and every community in Aberdeen, as it offers a new way to work with organisations towards the common good.

This will be of vital interest to every statutory community planning partner in Aberdeen, as it will underpin all their activities with people and communities. Equally it will underpin the methods used to develop and deliver the Community Planning Aberdeen local outcome improvement plan and locality plans.

Contents

Community Planning Aberdeen

Executive Summary

New legislation provides communities with the right to make participation requests of public organisations and places a duty on the latter to meet these. A consistent approach by community planning partners will help staff and public develop a shared understanding of participation as the legislation comes into force. This strategy has been developed by a multi-partner working group who have sought wider participation throughout its development.

The strategy is intended to inform (a) the development of consistent participation policies by each community planning partner and (b) subsequent actions to help communities understand their rights under the Community Empowerment (Scotland) Act 2015.

The metaphor of a ladder is used to represent the interactions between public organisations and people. The bottom rung represents the one-way provision of information, usually from public organisations to the public. The top rung represents self-determination, all the activities and decisions that are made independently by people in their communities. The rungs in between represent increasing two-way communication and decision-making between public organisations and communities.

Participation requests can be located on the ladder between "collaboration" and "empowerment". While the rungs below remain very important – keeping people informed, consulting on decision-making, and hearing people's concerns – the direction of travel will require public organisations to go beyond these. Fortunately there is already experience of doing so that can be drawn upon, and examples from practice are used to illustrate how collaborative participation and empowerment can become a routine way of working.

Evolution to this future will be a journey rather than an event. The strategy does not set out a detailed implementation plan, as this cannot be imposed, but must be developed with the participation of those expected to deliver it.

The implementation plan will need to detail actions, evaluation methods and content for communication.

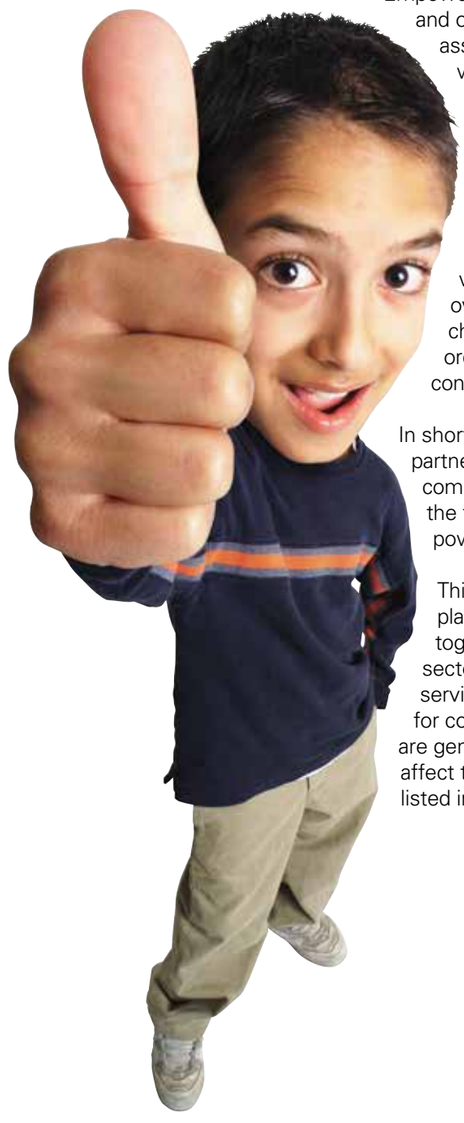
Community planning Aberdeen will have a vital role to play in facilitating and coordinating this work.

Empowerment	**Self-determination** People implement what they decide
	Empowerment Organisations implement what people decide
Engagement methods (increasing participation)	**Collaboration (coproduction)** Organisations seek people's involvement in identifying issues, outlining options and making decisions
	Involvement People's concerns inform organisations' proposed decisions
	Consultation People's views are listened to in respect of organisations' proposed decisions
	Informing Organisations keep people informed of proposed decisions

Introduction

Community engagement is increasingly at the forefront of public policy (see appendix one). Engagement methods range from the provision of information to supporting people's participation in decision-making processes. Engagement is a means of developing better services, better use of resources and encouraging more productive and positive relationships between communities and public bodies. 'Communities' are defined as groups of people that may or may not live in the same area, and who share common interests, concerns or identities.

Community engagement is a way to build and support community empowerment. This is the name given to the process through which people have more of a say and have more control over the decisions that shape their lives and factors that contribute to their quality of life. Empowerment recognises that communities are independently able and often wish to organise themselves and use their inherent assets and resources to improve the lives of those who live within them. While empowerment cannot be 'given to' people, it is something that communities and individuals can be supported to achieve. Empowerment requires people to take more power for themselves over their local resources and decision-making.



Community empowerment is therefore more than the involvement, participation or engagement of communities with public sector organisations. It also describes community ownership and action with a view toward social and political change. It is a process of re-negotiating the balance of power in order for communities to have a greater say and to have more control over the decisions that affect them.

In short, community engagement is the pursuit of collaborative partnership working between public sector organisations and the communities they serve, while community empowerment reflects the fact that communities' own autonomy and freedom can be a powerful asset in creating a strong and resilient society.

This strategy reflects these positions in light of community planning arrangements in Aberdeen. Community planning brings together partners and agencies such as public organisations, third sector and communities to work together to plan and deliver better services to make a real difference to people's lives. A key principle for community planning is to ensure that people and communities are genuinely involved in the decisions made by public services which affect them. (Current community planning partners in Aberdeen are listed in appendix two.)

Strategic objectives

The local outcome improvement plan 2016 – 2026 and underpinning locality plans articulate the vision of Aberdeen City as a place where all people can prosper. This strategy will help ensure that all communities have an opportunity to shape what this means for them, and how they can get involved in making this happen

Our objectives:

- communities' inherent strengths and assets – their people, their energy, their connections, sense of purpose and resources, and their abilities to self-organise and exercise autonomy – will be valued as a fundamental building block of a healthy society
- every community will be equally heard and listened to
- participation will be the norm rather than the exception
- staff will be empowered to work in collaborative and empowering ways
- people will be able to see the difference that involvement has made

Where we are just now

Before considering the future we need to take stock of where we are just now. This section sets out a way to think about the issues at hand using the metaphor of a ladder. Informing is the lowest rung of the ladder with each rung above that representing greater involvement and participation, through to self-determination at the top. The ladder is represented in the picture. Examples of current practice allow the ladder to be brought to life, and can serve as a solid foundation to build upon, alongside the newly developed national standards for community engagement (available at www.voicescotland.org.uk).



The ladder of engagement, participation and empowerment

	RUNG (goal)	TECHNIQUES
Empowerment	**Self-determination** People implement what they decide	• Public sector stays out of the way or makes available support when requested
Empowerment	**Empowerment** Organisations implement what people decide	• Community capacity building • Community Development Trusts
Engagement methods	**Collaboration (coproduction)** Organisations seek people's involvement in identifying issues, outlining options and making decisions	• Participatory decision-making • Citizen advisory panels • Open space events
Engagement methods	**Involvement** People's concerns inform organisations' proposed decisions	An ongoing process of engagement • Workshops • Deliberative Polling
Engagement methods	**Consultation** People's views are listened to in respect of organisations' proposed decisions	One-off opportunities for engagement • Focus groups • Surveys • Public meetings
Engagement methods	**Informing** Organisations keep people informed of proposed decisions	Providing information • Newsletters • Websites • Exhibitions

With reference to the 'ladder', there are significant efforts to inform and consult with the public, through a broad range of public forums and civic groups, making use of a range of both traditional and digital methods.

Informing

Consulting

There are also excellent examples in Aberdeen of effective involvement, collaboration and empowerment. The examples are colour-coded to align with the ladder of engagement, participation and empowerment.

Participatory Budgeting

Participatory Budgeting is a democratic approach which supports communities (of locality or interest) to plan and decide how resources are allocated.

There are a number of examples locally where such an approach has been used. There is an opportunity for partners to develop participatory budgeting further in order to establish this as a core methodology for decision making on public resources.

Participatory budgeting is particularly effective in encouraging all varieties of community groups to come forward to debate and discuss their priorities together.

COLLABORATION

Community Health Partners

Community partners have been exploring ways to build a wider 'community of health' with two primary care practices in Aberdeen. By strengthening the links between the practices and local charitable and voluntary organisations, health professionals have been better able to link people to helpful activities and support. This supports people to improve their health by linking them with wider supports and resources in their community. One general practitioner particularly values having healthy activity workers in the practice as people can be directly introduced to someone able to provide this wider support.

Jenny's story:
Jenny was seeing her GP for depression and described her feelings of isolation. The GP introduced her to the healthy activity worker in the practice, thinking that some light exercise might help both with physical fitness and getting out and meeting new people. After some discussion it became clear that she was scared to go out due to anti-social behaviour in the neighbourhood. As well as being provided with information about activities, she was also put in touch with the anti-social behaviour team. Jenny felt that she was listened to and understood, and also realised that her depression was not just because of medical reasons. Jenny felt she had taken some control back and helped her to work out what she could do to make things better for herself. The GP described often seeing people facing complex social situations, and wants to continue to work with both healthy activity organisations and community support providers to support people in finding solutions to these.

EMPOWERMENT

Bumping Spaces – ABCD Conversation

As a result of awareness raising about the possibilities of Asset Based Community Development (ABCD), local, self-appointed ABCD champions, have supported ABCD Conversations to tease out:

- "What are the 'networks' in your community?"
- "What are the areas where people naturally 'bump into' each other in your community?";
- "What are you really passionate about that you would like to share with others in your community?"
- "What would you like to learn from others in your community?"

EMPOWERMENT

Community of interest: women involved in the Justice System

A range of activities take place in the Connections Women's Centre for and with women involved in the Justice System, aimed at supporting women to more positive outcomes. A 'Women's Forum' comprising users of the Centre meets to discuss possible future events, and plays a key role in the development of the Centre.

The Centre provides a much needed meeting space for women who have been harmed by domestic abuse along with a range of other services.

The Women's Forum discusses future plans and activities that are relevant to the women. Forum participants have been full of enthusiasm and have identified various activities they would like to pursue and get involved in such as fund raising activities and days out. They have discussed various craft making projects to make items to sell (for charity), and would like to explore options to sell items made via summer/ Christmas fayres.

EMPOWERMENT

Northfield Total Place

Northfield Total Place is a place based approach that seeks to improve outcomes for the local community in the Northfield, Middlefield, Cummings Park, Heathryfold and Mastrick neighbourhoods of Aberdeen. The approach involves community planning partners, community organisations and local citizens working together to identify priorities and put in place solutions, using the best available resources, to meet the unique needs of the local people within the area.

The approach has been successful in connecting people locally. Local people are more empowered to determine and deliver the best for their community, and Northfield Academy has increased learning experiences for young people through partnership working.

EMPOWERMENT

Community Driven Engagement – Tillydrone Network

Tillydrone Network was established by Aberdeen City Council around 15 years ago. The Network has continued to grow and flourish, and is run and managed by its community members, with public sector support from the community support fund. The Network is a driving force in terms of identifying community issues and priorities and helping to raise the profile of these priorities to be addressed.

SELF DETERMINATION

Our vision for the future

The Community Empowerment (Scotland) Act 2015 sets out the legal rights and responsibilities around community participation in public sector organisations. However, our vision is for this level of participation to be the expected standard. Communities should not have to call on the legal procedures the Act requires in order to participate, rather it should be woven into the everyday operation of partner organisations.

The case studies show that it is possible to work with high engagement and to support and respect empowerment. While informing and consulting will remain an important foundation for transparency and openness, the strategic ambition is for collaboration and empowerment to become the norm in all communities throughout the city.

This requires a universal commitment to using processes that allow everyone to be heard. It is fully recognised that some communities vary in their preparedness and confidence to become empowered and will 'need to be empowered to be empowered'. This will require deliberate time and effort to be devoted towards supporting people in the least heard communities to become empowered (appendix three identifies the wide range of organisations who are involved in actively reaching out to individuals and groups at risk of discrimination and disadvantage).

Evolving towards an increasingly collaborative and empowerment culture will take time. People vary in their willingness to embrace change and new ways of living and working. The legislation raises many questions for many people, and many of the answers will require to be negotiated by those involved at a local level. Some people in some communities and some people in some organisations may perceive these changes as a risk rather than an opportunity. Public authorities will continue to have statutory responsibilities that they have to fulfil. The evolution of collaboration and empowerment will therefore be a journey rather than an event.

How we will know things are working

A strategy that is focused on engagement, participation and empowerment must be implemented in a manner that is consistent with its own values – it cannot be delivered through diktat or coercion!

Therefore the first indication of progress will be the successful development of an agreed implementation plan, created using collaborative and empowering methods by those who will be required to implement it. The implementation plan will require content relating to communication, actions and evaluation.

The implementation plan will need to be built around the strategic objectives, giving consideration to methods to:

- engage people and obtain their participation
- ensure seldom heard voices are equally sought and heard
- measure improvement resulting from collaboration and empowerment
- empower staff to work in a collaborative and empowering way
- help people see the difference their involvement has made

The second indication will be the collation and sharing of every public authority's point of contact for participation requests to facilitate coordination across organisations in Aberdeen (appendix four).

Community Planning Aberdeen has a vital role to play in the facilitation and coordination of the strategy's implementation.

For more information about this work

Community Planning Aberdeen is a formal partnership by which organisations in Aberdeen City work together and with the community to plan and deliver better services which make a real difference to people's lives.

http://communityplanningaberdeen.org.uk
Email: communityplanning@aberdeencity.gov.uk

Strategy Development Group

This strategy was developed by a working group of representatives from:

Aberdeen City Council
Aberdeen Civic Forum
Aberdeen City Health & Social Care Partnership
Aberdeen Community Council Forum
Aberdeen Council of Voluntary Organisations
Castlehill & Pittodrie Community Council
Community Renewal
NHS Grampian
Police Scotland
Scottish Fire & Rescue

with the participation of colleagues from across these organisations and additional input from:

Advocacy Service Aberdeen
Community Food Initiative North East
Grampian Regional Equality Council
Inspire
Northfield Total Place Strategic Board
South Locality Leadership Group
Station House Media Unit
University of Aberdeen
VSA

Appendix One

Policy and legislative context

In November 2010, the Scottish Government established the 'Commission on the Future Delivery of Public Services', also known as 'the Christie Commission' to develop recommendations for the future delivery of public services in Scotland.

A key finding of the Christie Commission was that public services should be built around people and communities, their needs, aspirations, capacities and skills, and that work should be done to help build up their autonomy and resilience.

The Commission recommended that a proposed 'Community Empowerment' bill should make sure that community participation is embedded in the design and delivery of services throughout Scotland.

The Community Empowerment (Scotland) Act received Royal Assent in July 2015 and it provides a legislative framework to promote and encourage community participation and empowerment, including:

- Placing 'Community Planning Partnerships' on a statutory level and requiring specific duties from them in the planning and delivery of local outcomes, and the involvement of community bodies at all stages of community planning.

- Providing ways for communities to have a more proactive role in having their views heard and play a greater role in shaping how public services are planned, designed and delivered.

- Enabling Scottish Ministers to require Scottish public authorities to promote and facilitate the participation of members of the public in the decisions and activities of the authority, including in the allocation of its resources.

- Extending the community 'Right to Buy' to all of Scotland, including urban and rural areas and improving related procedures. This includes introducing a new provision for community bodies to purchase land which is abandoned, neglected or causing harm to the environmental wellbeing of the community, where the owner is not willing to sell that land (as long as the purchase is in the public interest and compatible with the achievement of sustainable development of the land).

- Providing community bodies with a right to request to purchase, lease, manage or use land and buildings belonging to Local Authorities, Scottish public bodies or Scottish Ministers. This includes a 'presumption of agreement' to requests, unless there are reasonable grounds for refusal would then have to be explained.

In the Community Empowerment (Scotland) Act, participation rights are given to community controlled bodies such as community councils, incorporated bodies, formal groups with a written constitution or loosely associated groups without. In each case such bodies are expected to have similar characteristics in common:

- They will relate to a defined community.
- The majority of members of the body will be members of that community.
- The body will be open to and controlled by
- They will be able to state the body's aims and purposes, including the promotion of a benefit for that community.
- The funds and assets of the body are to be used for the benefit of that community.

The Act also gives community bodies the right to work with all public sector organisations to help improve outcomes. Outcomes are defined as the changes, benefits, learning or other effects that result from what the organisation makes, offers or provides. For example, community bodies might discuss with service providers how they could better meet the needs of users, to offer volunteers to support a service or even propose to take over the delivery of the service themselves.

There are other pieces of legislation that also require public bodies to engage with and involve members of communities in particular public services and functions (For example the Public Bodies (Joint Working) Scotland Act). The intention of this strategy is to provide a consistent model/ framework for such engagement, which can be used as appropriate and relevant to the situation.

Appendix Two

Community Planning Aberdeen partners

At the date of writing this strategy the community planning partners in Aberdeen City are:

- Aberdeen City Council
- ACVO
- Aberdeen Civic Forum
- North East Scotland College
- Police Scotland
- NHS Grampian
- Aberdeen City Integration Joint Board (Health & Social Care Partnership)
- University of Aberdeen
- The Robert Gordon University
- Scottish Enterprise
- Scottish Fire and Rescue Service
- Skills Development Scotland
- North-East of Scotland Transport Partnership

Appendix Three

People at risk of being seldom heard

- **People at risk of being marginalised**

People with lived experience of being in care

People with lived experience of the criminal justice system includes
Apex
Families Outside
Integrate Aberdeen
Sacro

People with lived experience of housing challenge
Aberdeen Foyer
Cyrenians
Shelter Aberdeen

People with lived experience of literacy challenge
Aberdeen Dyslexia Learning Centre
Adult Learning Team ACC
ESOL (people for whom English is not their first language)

People with lived experience of mental health challenge includes
3rd Sector Mental Health Providers Forum
Cairns Counselling
Healthy Minds
MHA (ACIS & ACIS Youth)
Momentum
Pathways
SAMH
SHMU

People with lived experience of poverty
Aberdeen City Food Bank Partnership
Aberdeen Cyrenians
AHEAD Partnership (CFINE)
Bethany Christian Trust
CAB
Cash in Your Pocket Partnership
Employability
Fairshare
Grampian Credit Union
Grampian Housing
Instant Neighbour
Langstaine Housing
Lighthouse Support Centre
NESCU
Pathways
SCARF (Fuel Poverty)
St Machar Parent Support
Tenants First
The Trussell Trust
Training Providers Forum

People with lived experience of problems associated with alcohol or drugs

People with lived experience of refugee status
ACVO TSI
Community Planning Partners

People with lived experience of unpaid care
Alzheimer's Scotland
Care and Support Providers (CASPA) Forum
VSA
VSA Young Carers Group

- **The Nine Protected Characteristics**

1. Age
Aberdeen City Youth Council
Aberdeen Foyer
Aberdeen over 60's social club
Aberdeen University Students association
Befriend a Child
Care and Repair Aberdeen
Castlehill Housing Association
Citizens Advice Bureau (CAB)
City Youth Groups
Cyrenians
EncourAGE Dyce
Footprints Connect
Grampian Regional Equality Council (GREC)
Grampian Senior Citizens Forum
i-connect
Intergenerational Network
NESCO: Aberdeen College Students Association
North East Scotland Equality Network (NESEN)
Older Peoples Monitoring Group, Froghall
Pupil Voice
Respected and Included Group (0-25 yrs) ACVO
RGU Students Association
Silver City Surfers
Scottish Youth Parliament
Sunrise Partnership

2. Religion and Belief
Aberdeen for a Fairer World
Aberdeen Interfaith Group
Aberdeen Moslem and Islamic Centre (AMIC)
Aberdeen Presbytery
GREC
Individual faith Organisations (120+ in the city)
NESEN
New Multi-faith Forum
Thai Buddharam Temple

3. Disability
Aberdeen Action on Disability
Aberdeen Adult Asperger's and Autism Support Group
Aberdeen and District Cerebral Palsy Association
Aberdeen and District Disabled Multi-sports Coaching Team
Archway
Blackwood Housing Association
Bon Accord Access Panel
Citizens Advice Bureau (CAB)
Cornerstone, Turning Point,
Disability Positive
Future Choices
GREC
Individual Disability organisations:
Inspire, C-Change, North East Sensory Service (NESS)
Learning Disability Group of Aberdeen
MeToo
PAMIS
NESEN
New Disability Cross Sector Forum
Shop mobility

4. Race
Aberdeen Hindu Association
Aberdeen International Centre
Aberdeen Learning ESOL (English for speakers of other languages)
Aberdeen Multicultural Centre
Aberdeen Sikh Sangat Charity
Aberlour Play Rangers: Gypsy Traveller Children
BEMIS: Gathered Together Project
Chinese School
Ethnic Minority Forum
Grampian Gypsy/Traveller Interagency Group
GREC
Integrate Grampian
Nepalese Himalayan Association
NESEN
NHS Ethic Minority Users Forum
Polish Association Aberdeen
Polish Sunny School
Pool of registered Interpreters/Translators from ACC/GREC

5. Marriage and Civil Partnership
CAB
Grampian Women's Aid
GREC
Relate
Stonewall

6. Pregnancy and Maternity
Baby Centre Community Aberdeen
CAB
Choices Aberdeen
GREC
Homestart

7. Gender Reassignment
GREC
NESEN
North East LGBT Development Group
T-Folk

8. Sex Equality
Aberdeen Women's Alliance (AWA)
CAB
Grampians Women's Aid
GREC
NESEN
RASANE: Rape & Abuse Support

9. Sexual Orientation
CAB
Gay Men's Health
GREC
LGBT Staff networks and student associations
LGBT Zone Youth Group: Ellie Hepburn ACC
NESEN
North East LGBT Development Group
Stonewall

- **Other support to be aware of:**
  - Also everyone has access to EHRCS – Equality and Human Rights Commission Scotland and their helplines
  - Advocacy Service Aberdeen (ASA)

Advocacy Service Aberdeen is a local third sector organisation supporting people to express their views and participate in decision making. ASA has projects specialising in working with the following groups of people:

Carers
Children with additional support needs
Older people
People with learning disabilities
People with mental health issues
Victims of Domestic Abuse

Independent advocacy is about speaking up for an individual or group.

Independent Advocacy is a way to help people have a stronger voice and to have as much control as possible over their own lives. Independent Advocacy organisations are separate from organisations that provide other types of services. An independent advocate will not make decisions on behalf of the person/group they are supporting. The independent advocate helps the person/group to get the information they need to make real choices about their circumstances and supports the person/group to put their choices across to others. An independent advocate may speak on behalf of people who are unable to do so for themselves. (Scottish Independent Advocacy Alliance SIAA)

Contact details

Advocacy Service Aberdeen
Aberdeen Business Centre, Willowbank Road,
ABERDEEN AB11 6YG
Tel 01224 332314

Advocacy Service Aberdeen
Royal Cornhill Hospital, Cornhill Road,
ABERDEEN AB25 2ZH
Tel 01224 557912

www.advocacy.org.uk
asa@advocacy.org.uk

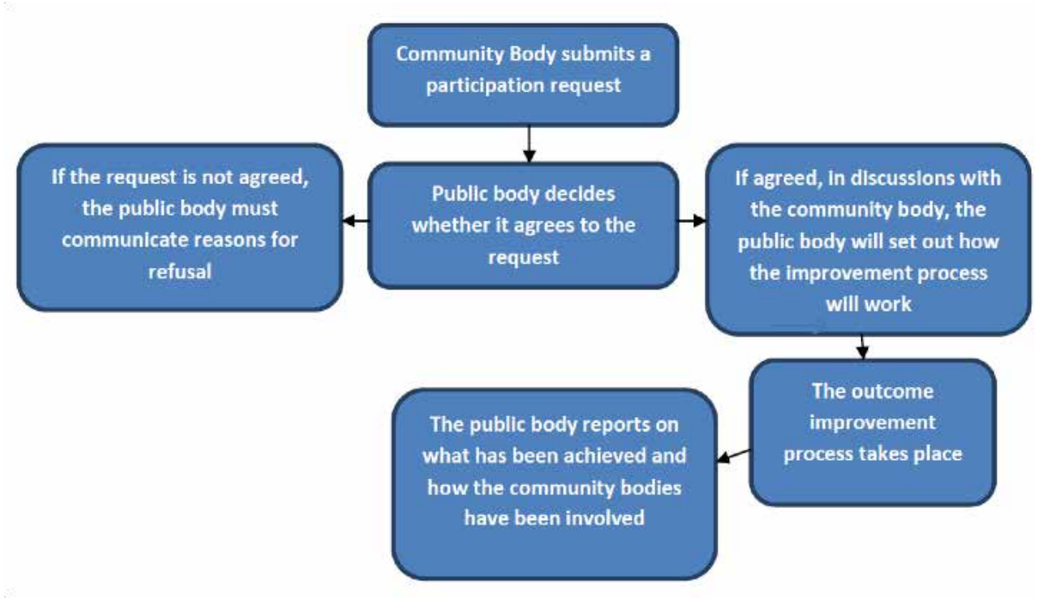
Appendix Four

Participation requests

The Community Empowerment (Scotland) Act 2015 requires every public sector organisation to have a process for receiving and responding to participation requests.

Community Planning Aberdeen provides an opportunity for partner organisations to create and encouraging a consistent way of working across all community planning organisations and services.

The regulations and guidance for participation requests is currently out for consultation. The expected process is shown here:



Every community planning partner organisation will need to develop and communicate:

- The point of contact for community bodies making a participation request
- The point of contact for other public sector authorities where a multi-agency approach in required
- A range of accessible ways to make contact
- A variety of access points offering different levels of support
- The policy and set of processes in place that identify the appropriate decision-making person or group(s) within the organisation who will co-produce an outcome improvement process with the community body and/or liaise with other public sector organisations if a multi-agency approach is required

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Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Report Title	Social Work in Scotland – Audit Scotland Report
Lead Officer	Judith Proctor
Report Author (Job Title, Organisation)	Sarah Gibbon, Executive Assistant, ACHSCP
Date of Report	27.09.16
Date of Meeting	15.11.16

1: Purpose of the Report

To consider the recent 'Social Work in Scotland Report' written by Audit Scotland and to highlight key areas and recommendations relevant for the Aberdeen City Integration Joint Board (IJB).

2: Summary of Key Information

The 'Social Work in Scotland' report (appendix A) features 3 main sections:

1. challenges facing social work services, particularly in light of financial and demographic pressures;
2. how councils are addressing the challenges; and
3. governance and scrutiny arrangements.

Recommendations are made by Audit Scotland to both councils and IJBs. The Aberdeen City IJB responses are set out in the table provided in Appendix B.

Key issues with particular relevance to the IJB are:

- Workforce;
- Social Work strategy and service planning; and
- Governance arrangements in integrated health & social care (including the role of the Chief Social Work Officer (CSWO)).
- Service efficiency and effectiveness

Workforce.

The report discusses the ongoing recruitment difficulties in both social work and social care services. These difficulties are particularly relevant given the longstanding public sector recruitment and retention challenges in the city, relating

to the high-cost of living in Aberdeen City. These issues continue despite the recent economic downturn.

At its meeting on the 30th of August 2016, the IJB agreed to the implementation of the Living Wage across care at home providers in Aberdeen City. Additionally, at the same meeting, the IJB endorsed the principles of the Ethical Care Charter and agreed to establish a short-life working group to progress implementation. This may contribute to counteracting some of the concerns raised in the report (relating to low pay and difficult working conditions)and support the development of a highly motivated and stable workforce.

The report also recommends they work to ensure providers who use zero hours contracts allow staff to accept or turn down work without being penalised. The Ethical Care Charter, whose principles the IJB support, seeks to eliminate zero hours contracts and will guide work towards this recommendation.

The report recommends that 'councils' work with representatives and the private/third sectors in order to develop a coordinated approach to workforce issues. Within the Aberdeen City IJB the Chief Finance Officer is leading work, with Organisational Development (OD) leads across both NHS Grampian and Aberdeen City Council to implement an OD Strategy for the partnership. This includes a focus of support to our 3rd and independent sectors as well as in terms of partnership staff.

Social Work strategy and service planning.

The report recognises an increased volume of legislation related to social work, alongside a number of policy developments moving towards personalised services, an increased focus on prevention and an increased focus on joint-working. This links well with the IJB's strategic plan which clearly demonstrates a commitment to personalisation, prevention and community involvement.

The report recommendations emphasise the importance of instigating a broad debate with communities and joint-working across all stakeholders to develop long-term strategies for the future provision of social work services and future funding arrangements.

The report states that councils are finding it hard to fund a strategic approach to prevention. The integration of health and social care offers several opportunities for IJBs to focus on a strategic approach to prevention, including the provision of the integrated care fund. Given this, the IJB should be careful to ensure that transformational monies are spent in a way that helps to fund this strategic approach to prevention.

The IJBs strategic commissioning approach highlights six areas for investment priority, which includes a focus on prevention and how this will be funded. The strategic commissioning approach considers that focussing on a smaller number of significant transformation projects will have the biggest effect on the whole system, and support a shift in delivery towards a more person-centred and community focussed health and care economy.

Additionally, the IJB has clear working groups established for major legislative changes, for example the Carers' Strategy Steering Group, who will help implement and monitor the impact of new legislation.

Governance arrangements in integrated health & social care.

The integration of health & social care has resulted in complex governance arrangements, which differ between integration authorities. The Aberdeen City IJB, as with all IJBs, is still in a relatively early stage of its development, merely 6 months from 'go-live'. However, good progress towards sound governance and scrutiny arrangements is being made with the involvement of the Good Governance Institute. On-going development work is set to be undertaken with the Committees and Executive Group.

The report recommends that IJB governance and scrutiny arrangements efficiently cover the whole of social work services and review these regularly. The IJB should develop its committee business cycle in order to ensure that the governance and scrutiny arrangements are subject to sufficient review. The next phase of work on Governance Structures within the IJB will focus on ensuring that these are robust, efficient and effective.

The report also highlights the need to improve accountability by having processes in place to measure the outcomes, effectiveness and efficient of services. This should be kept in mind as officers further develop and implement the performance management framework.

It is also recognised that the role of the Chief Social Work Officer (CSWO) has changed significantly in recent years and there may be a risk that CSWOs become overstretched. The IJB is intending to host a workshop with the CSWO in order to further understand this role which is a positive step towards mitigating this risk.

Service Efficiency and Effectiveness

The report also recommends that IJBs ensure that initiatives are planned with evaluation criteria which can allow the extension or conclusion of the initiative depending on its success. The IJB has a performance group which is working

towards developing a comprehensive performance framework. This group should consider evaluation criteria for initiatives to be included within the framework.

3:	Equalities, Financial, Workforce and Other Implications

Equalities

Any action arising from this report and its recommendations will support us in achieving our equalities duties, especially as these relate to older people and carers.

Financial

Whilst the report highlights current financial pressures, which the IJB is aware of, there are no direct financial implications arising from this report.

Workforce

The report provides several recommendations for improving the stability of the workforce within social care, which the IJB is aware of and already working towards.

Other

NA

4:	Management of Risk

Identified risk(s):

The report presented does not present any risks in itself, the recommendations contained within it have relevance to several risks represented on the IJB's strategic risk register.

Link to risk number on strategic risk register:

2. There is a risk of financial failure , that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and project an overspend
3. Failure of the IJB to function, make decisions in a timely manner etc
4. There is a risk that the outcomes expected from hosted services are not

delivered and that the IJB does not identify non-performance in through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.

5. There is a risk that the governance arrangements between the IJB and its partner organisations (ACC and NHSG) are not robust enough to provide necessary assurance within the current assessment framework – leading to duplication of effort and poor relationships
6. There is a risk that services provided by ACC and NHS corporate services on behalf of the IJB do not have the capacity, are not able to work at the pace of the IJB's ambitions, or do not perform their function as required by the IJB to enable it to fulfil its functions
7. There is a risk that the IJB and the services that it directs and has operational oversight of fail to meet performance standards or outcomes as set by regulatory bodies

How might the content of this report impact or mitigate the known risks:

The content of this report provides recommendations that will help the IJB to mitigate risk as they relate to workforce; social work strategy and service planning; service efficiency and effectiveness; and governance arrangements.

5:	Recommendations

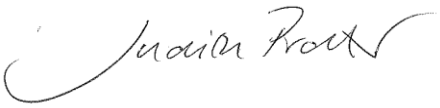
It is recommended that the Integration Joint Board:

1. Note the content of the Audit Scotland 'Social Work in Scotland' report and the ongoing work within the IJB relevant to the recommendations raised.

2. Note the Health & Social Care Partnership response to the recommendations in the report.

3. Agree to a development workshop on the role of the Chief Social Work Officer in relation to the Integration Joint Board.

INTEGRATION JOINT BOARD

6:	Signatures
	Judith Proctor (Chief Officer)
	Alex Stephen (Chief Finance Officer)

INTEGRATION JOINT BOARD

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Health and social care series

Social work in Scotland

ACCOUNTS COMMISSION

Prepared by Audit Scotland
September 2016

The Accounts Commission

The Accounts Commission is the public spending watchdog for local government. We hold councils in Scotland to account and help them improve. We operate impartially and independently of councils and of the Scottish Government, and we meet and report in public.

We expect councils to achieve the highest standards of governance and financial stewardship, and value for money in how they use their resources and provide their services.

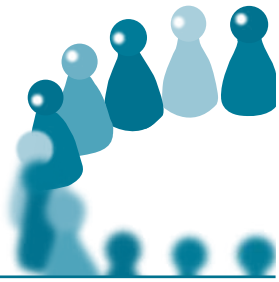
Our work includes:

- securing and acting upon the external audit of Scotland's councils and various joint boards and committees
- assessing the performance of councils in relation to Best Value and community planning
- carrying out national performance audits to help councils improve their services
- requiring councils to publish information to help the public assess their performance.

You can find out more about the work of the Accounts Commission on our website: www.audit-scotland.gov.uk/about/ac

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

Contents



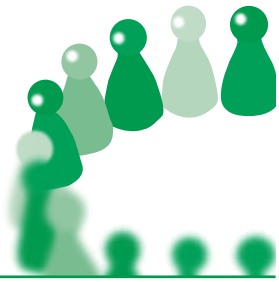
These quote mark icons appear throughout this report and represent quotes from interested parties.

Links

PDF download

Web link

Key facts



Estimated annual value of the contribution of 788,000 unpaid carers

£10.8 billion

17,400 children are looked after or are on the child protection register

Councils spend £3.1 billion on social work services a year

£3.1 billion

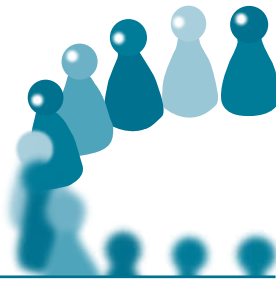
36,000 adults are in care homes and 61,500 people receive homecare

Councils spend £1.6 billion a year on social work services purchased from the third and private sectors

£1.6 billion

200,000 people are employed in social work/care, including 10,000 professional social workers

Summary



Key messages

1 Current approaches to delivering social work services will not be sustainable in the long term. There are risks that reducing costs further could affect the quality of services. Councils and Integration Joint Boards (IJBs) need to work with the Scottish Government, which sets the overall strategy for social work across Scotland, to make fundamental decisions about how they provide services in the future. They need to work more closely with service providers, people who use social work services and carers to commission services in a way that makes best use of the resources and expertise available locally. They also need to build communities' capacity to better support vulnerable local people to live independently in their own homes and communities.

2 Councils' social work departments are facing significant challenges because of a combination of financial pressures caused by a real-terms reduction in overall council spending, demographic change, and the cost of implementing new legislation and policies. If councils and IJBs continue to provide services in the same way, we have estimated that these changes require councils' social work spending to increase by between £510 and £667 million by 2020 (16–21 per cent increase).

3 The integration of health and social care has made governance arrangements more complex, but regardless of integration, councils retain statutory responsibilities in relation to social work services. Elected members have important leadership and scrutiny roles in councils. It is essential that elected members assure themselves that service quality is maintained and that risks are managed effectively. Elected members have a key role to play in a wider conversation with the public about service priorities and managing people's expectations of social work and social care services that councils can afford to provide in the future. The Scottish Government also has an important role to play in setting the overall context of the debate.

4 With integration and other changes over recent years, the key role of the chief social work officer (CSWO) has become more complex and challenging. Councils need to ensure that CSWOs have the status and capacity to enable them to fulfil their statutory responsibilities effectively.

current approaches to delivering social work services will not be sustainable in the long term

Key recommendations

Social work strategy and service planning

Councils and IJBs should:

- instigate a frank and wide-ranging debate with their communities about the long-term future for social work and social care in their area to meet statutory responsibilities, given the funding available and the future challenges (paragraph 111)
- work with the Scottish Government, their representative organisation (COSLA or the Scottish Local Government Partnership (SLGP)), Social Work Scotland and other stakeholders to review how to provide social work services for the future and future funding arrangements (paragraphs 35–41)
- develop long-term strategies for the services funded by social work by:
  - carrying out a detailed analysis of demographic change and the contribution preventative approaches can make to reduce demand for services (paragraph 52)
  - developing long-term financial and workforce plans (paragraph 81)
  - working with people who use services, carers and service providers to design and provide services around the needs of individuals (paragraphs 69–72)
  - working more closely with local communities to build their capacity so they can better support local people who may be at risk of needing to use services (paragraph 112)
  - considering examples of innovative practice from across Scotland and beyond (paragraphs 54, 67–68)
  - working with the NHS and Scottish Government to review how to better synchronise partners' budget-setting arrangements to support these strategies (paragraph 36).

Governance and scrutiny arrangements

Councils and IJBs should:

- ensure that the governance and scrutiny of social work services are appropriate and comprehensive across the whole of social work services, and review these arrangements regularly as partnerships develop and services change (paragraphs 87– 93)
- improve accountability by having processes in place to:
  - measure the outcomes of services, for example in criminal justice services, and their success rates in supporting individuals' efforts to desist from offending through their social inclusion
  - monitor the efficiency and effectiveness of services

  - allow elected members to assure themselves that the quality of social work services is being maintained and that councils are managing risks effectively
  - measure people's satisfaction with those services
  - report the findings to elected members and the IJB (paragraph 90, 108–109).

Councils should:

- demonstrate clear access for, and reporting to, the council by the CSWO, in line with guidance (paragraphs 104–106)
- ensure the CSWO has sufficient time and authority to enable them to fulfil the role effectively (paragraphs 102–107)
- ensure that CSWO annual reports provide an annual summary of the performance of the social work service, highlighting achievements and weaker areas of service delivery, setting out the council's response and plans to improve weaker areas and that these are actively scrutinised by elected members (paragraphs 108–110).

Workforce

Councils should:

- work with their representative organisation (COSLA or the SLGP), the Scottish Government and private and third sector employers to put in place a coordinated approach to resolve workforce issues in social care (paragraphs 21–23)
- as part of their contract monitoring arrangements, ensure that providers who use zero hours contracts allow staff to accept or turn down work without being penalised (paragraph 24).

Service efficiency and effectiveness

Councils and IJBs should:

- when planning an initiative, include evaluation criteria and extend or halt initiatives depending on the success of new approaches in improving outcomes and value for money (paragraphs 53–53)
- work with COSLA to review the eligibility framework to ensure that it is still fit for purpose in the light of recent policy and legislative changes (paragraphs 46–47)

Councils should:

- benchmark their services against those provided by other councils and providers within the UK and overseas to encourage innovation and improve services (paragraphs 54, 67–68).

Introduction

1. Scottish councils' social work departments provide and fund essential support to some of the most vulnerable people in society. They supported and protected over 300,000 people in 2014/15, around 70 per cent of whom were aged 65 and over.[1] Social work departments also provide and fund social care, for example care at home for older people who require help with dressing and taking medication. People supported by social work and social care in Scotland in 2014/15 included:

- 15,404 looked-after children (LAC), that is children in the care of their local authority
- 2,751 children on the child protection register, a list of children who may be at risk of harm[2]
- 61,500 people who received homecare services[3]
- 36,000 adults in care homes.[4]

2. In 2014/15, councils' net expenditure on social work was £3.1 billion.[5] Net spending is total spending less income, for example from charges for services. Just over 200,000 people work in social work and social care, around one in 13 people in employment in Scotland.[6] Many are employed in the private and third sectors that councils commission to provide services.[7] In addition, the Scottish Government estimates that there are 759,000 unpaid carers aged 16 and over in Scotland, 17 per cent of the adult population, and 29,000 young carers under 16.[8]

3. Social work services have recently been reorganised. The Public Bodies (Joint Working) (Scotland) Act 2014 requires councils and NHS boards to create an integration authority to be responsible for the strategic planning of adult social care services, some health services and other functions delegated to it. It is also responsible for ensuring the delivery of those functions. The Integration Joint Board (IJB) also has an operational role as described in the locally agreed operational arrangements set out within their integration scheme. The Act also allows councils to integrate children's and families' services and criminal justice social work.

4. Councils delegate their responsibility for strategic planning of adult social services, and any other services they have decided to include, to the integration authority. All council areas, apart from Highland, have created an IJB to plan and commission integrated health and social care services in their areas. The voting membership of IJBs comprise equal numbers of council elected members and NHS board non-executive directors. Our recent report *Health and social care integration* includes a description of the integration arrangements in each council area.[9]

5. The Scottish Government sets the legislative basis and the overall strategic framework for the delivery of social work. Its overall vision is 'a socially just Scotland with excellent social services delivered by a skilled and valued workforce which works with others to empower, support and protect people, with a focus on prevention, early intervention and enablement'.[10] The Scottish Government also sets the key outcomes that councils' social work services are expected to contribute to achieving, for example 'Our people are able to maintain their independence as they get older and are able to access appropriate support

when they need it.' This report focuses on councils' social work services, but recognises the role of the Scottish Government in setting the overall context in which councils operate.[11]

About the audit

6. The overall aim of the audit was to examine how effectively councils are planning to address the financial and demographic pressures facing social work. The objectives were to assess:

- the scale of the financial and demand pressures facing social work
- the strategies councils are adopting to meet these challenges
- the effectiveness of governance arrangements, including how elected members lead and oversee social work services
- the impact of financial and demand pressures on people who use services and on carers, and how councils involve them in planning how services are provided.

7. Social work comprises a wide range of services, and we have not covered all of them in this report. We also did not examine health and social care integration arrangements, which will be the subject of separate audit work, but we did consider their impact on councils' financial, operational and governance arrangements. Our methodology included:

- fieldwork interviews with elected members, senior managers and social workers in six council areas, Midlothian, East Renfrewshire, Comhairle nan Eilean Siar, Glasgow City, Perth and Kinross and West Lothian
- meetings and focus groups with stakeholders, including:
  - 33 focus groups and 12 interviews with service users and carers (165 participants)
  - four focus groups with service providers (over 40 participants)
  - attending the Coalition of Carers in Scotland Annual General Meeting
- desk research, including analysing both the impact of legislation and policy, and financial and demographic data.

8. Our audit took into account the findings of previous audits including:

- *Commissioning social care* (March 2012)
- *Reshaping care for older people* (February 2014)
- *Self-directed support* (June 2014)
- *Health and social care integration* (December 2015)
- *Changing models of health and social care* (March 2016)

In addition, we are planning further audit work on health and social care integration and following up our report on self-directed support.

9. We have produced four supplements to accompany this report:

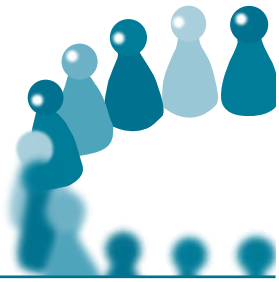
- Supplement 1 presents the findings of our survey of service users and carers.
- Supplement 2 lists advisory group members, who gave advice and feedback at important stages of the audit. It also describes the detailed audit methodology, the roles and responsibilities of the key social work organisations and social work legislation.
- Supplement 3 describes the governance and scrutiny arrangements in each of our fieldwork councils, providing an illustration of the variety and complexity of arrangements across Scotland.
- Supplement 4 is a self-assessment checklist for elected members.

10. This report has three parts:

- Part 1 Challenges facing social work services.
- Part 2 Strategies to address the challenges.
- Part 3 Social work governance and scrutiny arrangements.

Part 1

Challenges facing social work services



Key messages

1 Councils' social work departments provide important services to some of the most vulnerable people across Scotland. But they are facing significant challenges. These include financial pressures caused by a real-terms reduction in overall council spending, demographic changes, and the cost of implementing new legislation and policies. We have estimated that these changes require councils' social work spending to increase by between £510 and £667 million by 2020 (16–21 per cent increase), if councils and IJBs continue to provide services in the same way. Additional funding provided to IJBs via the NHS may partially relieve the financial pressures.

2 Councils are implementing a wide range of legislation and policy changes aimed at improving services, better supporting carers, improving outcomes for people and increasing the wages paid to adult care workers. This has significant financial implications. Councils are also under pressure due to increasing demand associated with demographic changes, particularly people living longer with health and care needs.

3 Since 2010/11, councils' total revenue funding has reduced by 11 per cent in real terms. Social work spending increased by three per cent in real terms over the same period, and now accounts for a third of overall council spending. Further reductions in councils' budgets are an additional pressure on social work services, particularly as their financial commitments continue to increase.

4 Social care providers have difficulty recruiting and retaining suitably qualified staff, particularly homecare staff and nursing staff. However, the number of social workers has increased over recent years.

councils' social work departments provide important services to some of the most vulnerable people across Scotland

Social work is a complex group of services

11. Social work departments provide and fund a wide range of specialist services for children, adults and families, and other specific groups. These services aim to improve the quality of their lives and help people to live more independently (Exhibit 1, page 12). Each of these client groups will include people requiring care, support or protection. For example, through care at home, child protection or helping people overcome addiction. Social workers deal with people with complex problems and with vulnerable people who need support at different

times or sometimes throughout their lives. They often specialise in particular service areas, for example criminal justice, children and families or mental health.

Social work services are implementing a considerable volume of legislation and policy change

12. Since the Scottish Parliament was established, there has been an increase in the volume of legislation related to social work. Councils are currently implementing several important pieces of legislation (Exhibit 2, page 13). This legislation is designed to improve services and the outcomes for people who use them, for example by bringing about increasingly personalised services to meet individuals' needs. However, implementing legislation can increase financial pressures and staff workload in the medium term.

Exhibit 1

Social work and social care services

Social work provides a variety of services to protect and support people in three client groups.

Children's services	Adult services	Criminal Justice services
Support for families	Residential care	Offender services
Child protection	Care at home	Providing social enquiry reports
Adoption services	Day care	Supervision of community payback and unpaid work
Kinship care	Hospital discharge coordination	Supporting families of prisoners
Fostering	Adult support and protection	Supervision of offenders on licence
Child care agencies	Mental health and addiction services	
Looked-after young people	Dementia and Alzheimer's services	
Day care	Supporting people with disabilities	
Residential care	Services to support carers	
Child and adolescent mental health	Provision of Aids and adaptations	
Supporting child refugees	Re-ablement services	
Supporting trafficked children	Supported living	
Support for young people involved in offending behaviour	Supporting refugee families	
Support for children with disabilities and their families	Supporting victims of people trafficking	
	Intermediate care	

Source: Audit Scotland

Exhibit 2

Social work and social care services

Councils are implementing a great deal of legislation, some with significant cost implications.

Legislation	Key features of legislation	Associated costs (from the financial memorandum to the Bills)
Social Care (Self-Directed Support) (Scotland) Act 2013	The Act aims to ensure that adults and children (including carers and young carers) have more choice and control over how their social care needs are met. It stipulates the forms of self directed support (SDS) that councils must offer to those assessed as requiring community care services.	• All local authorities are at different stages in the self-directed support agenda, meaning costs will vary widely.
The Children and Young People (Scotland) Act 2014	The Act makes provisions over a wide range of children's services policy, including 'Getting it Right for Every Child'. It includes: • local authorities and NHS boards having to develop joint children's services plans in cooperation with a range of other service providers • a 'named person' for every child • extending free early learning and childcare from 475 to 600 hours a year for all three and four-year-olds and two-year-olds who have been 'looked after' or have a kinship care residence order • a statutory definition of 'corporate parenting' • increasing the upper age limit for aftercare support from 21 to 26.	Additional annual costs estimated to be: • £78.8 million in 2014/15 • £121.8 million in 2016/17 • £98.0 million in 2019/20 • Cumulative total from 2014-15 to 2019-20 is £595 million.
The Public Bodies (Joint Working) (Scotland) Act 2014	The aim of the Act is to achieve greater integration between health and social care services to improve outcomes for individuals. It also aims to improve efficiency by 'shifting the balance of care' from the expensive acute sector, such as large hospitals, to less expensive community settings. The Scottish Government estimates partnerships should achieve potential efficiencies of £138-£157 million a year by providing support to keep people out of hospital and enabling them to return home as soon as they are well enough.	Costs to health boards and local authorities: • 2014/15: £5.35 million • 2015/16: £5.6 million • 2016/17: £5.6 million.

Cont.

Legislation	Key features of legislation	Associated costs (from the financial memorandum to the Bills)
The Carers (Scotland) Act 2016	The Act aims to improve support to carers by: • changing the definition of a carer so that it covers more people • placing a duty on local authorities to prepare an adult care and support plan or young carer statement for anyone it identifies as a carer, or for any carer who requests one • introducing a duty for local authorities to provide support to carers who are entitled under local criteria • requiring local authorities and NHS boards to involve carers in carers' services • introducing a duty for local authorities to prepare a carers strategy • requiring local authorities to establish and maintain advice and information services for carers.	Estimated additional costs for local authorities are: • £11.3-£12.5 million in 2017/18, rising to £71.8-£83.5 million by 2021/22. • The total estimated impact on councils between 2017/18 and 2022/23 is £245-£289 million.
The Community Justice (Scotland) Act 2016	The Community Justice (Scotland) Bill seeks to establish new arrangements for providing and overseeing community justice. Currently eight community justice authorities (CJAs) bring together a range of agencies to coordinate local services for offenders and their families. They will be abolished and replaced by a model involving national leadership, oversight and support for community justice services by a new body called Community Justice Scotland, funded by, and responsible to, Scottish ministers.	The provisions will have few if any financial implications for local authorities other than during the transitional period.
The UN Convention on the Rights of Persons with Disabilities (UNCRPD) (Scottish framework and delivery plan)	The delivery plan provides a framework to allow people with disabilities to have the same equality and human rights as non-disabled people. It includes legislation, such as Self-Directed Support and the Children and Young People (Scotland) Act 2014. The draft delivery plan groups the UNCRPD articles into four outcomes covering equal and inclusive communication and access to: • the physical and cultural environment, transport and suitable affordable housing • healthcare and support for independent living, with control over the use of funding • education, paid employment and an appropriate income and support whether in or out of work • the justice system.	It is difficult to predict the overall impact in terms of cost, but it may have a significant impact on the way councils deliver services.

Note: Cost information is taken from the financial memorandum that accompanies each Bill.

Source: Audit Scotland

13. In addition to changes in legislation, there have been a number of significant policy developments, some backed by legislation, that require considerable change to the way that social work services are provided. These include:

- Increased personalisation of services – Personalisation of services, for example through self-directed support (SDS), is a major change to the way councils support people with social care needs. The human rights principles of fairness, respect, equality, dignity and autonomy for all form the basis of SDS. Social work professionals need to see people as equal partners in determining their care needs and controlling how they meet their needs. This means they are not limited to choosing from existing services. Social work services may need to move spending away from existing services towards giving people their own budget to spend. This can lead to a reduction in use of some services. However, it can be difficult for councils to withdraw existing underused services because of public and political pressures.

- An increased focus on prevention – The report from the Commission on the Future Delivery of Public Services (the Christie Commission) highlighted the need to transform the way public services are planned and delivered.[12] The report identified prevention, early intervention and providing better outcomes for people and communities as key to this transformation.

- An increased focus on joint working – A series of initiatives over recent years has aimed to encourage a more joined-up approach to health and social care. These include the creation of Local Health Care Cooperatives (LHCCs) in 1999, and their replacement by Community Health Partnerships (CHPs) in 2004. LHCCs and CHPs lacked the authority to redesign services fundamentally.[13] The Public Bodies (Joint Working) (Scotland) Act 2014 aimed to achieve greater integration between health and social care services to improve outcomes for individuals and improve efficiency by 'shifting the balance of care' from the acute sector to community settings.

14. New legislation often has financial consequences and, to allow MSPs to consider the full impact of legislation, a financial memorandum to each Bill sets out the estimated cost of implementation. These are the best available estimates at the time, but have sometimes proved inaccurate. The Scottish Government may fund or partially fund these costs but councils sometimes dispute these estimates and the level of funding required.

15. New legislation can also affect how councils deliver services by creating entitlements to services based on specific criteria. Councils need to respond to these and manage the expectations of people who use services and carers. These entitlements can be based on needs assessments, or on the expected outcomes, or they can create rights to services for particular groups. Transitions are important as entitlements change depending on age. For example:

- Children have the right to specific support that adults may not have. As a result, councils have to be careful in managing the expectations of parents as children reach adulthood.

- People aged over 65 may be entitled to free personal care, but 64-year-olds with similar needs may have to make a financial contribution to their care.

I receive 37 hours of support and seven sleepovers. I get personal care, support with the running of my flat, to shop and support to be involved in the community. They also enable me to attend university.

Service user, physical disabilities

When [grandchild] turned 16 I was told that this Saturday service was going to stop because he would now be under adult services. I had no forewarning, no-one from adult services contacted me; I contacted them and they couldn't offer any support. It's a funding issue.

Carer

Social work services face significant demographic challenges

16. The impact of demographic change on health and social care spending has already been well reported.[14] Between 2012 and 2037, Scotland's population is projected to increase by nine per cent. All parts of the population are projected to increase, but by different amounts:

- the number of children by five per cent
- the working age population by four per cent
- the number of people of pensionable age by 27 per cent.[15]

17. Overall demand for health and social care will depend significantly on the number of older people and the percentage who require care. Although life expectancy continues to increase, healthy life expectancy (HLE), that is the number of years people can expect to live in good health, has not changed significantly since 2008 (Exhibit 3). This means that a larger number of older people may require support for longer, unless HLE increases. Councils and the Scottish Government have taken steps to try to increase HLE. This includes measures to reduce smoking, alcohol consumption and environmental pollution and providing information to the public about the benefits of a healthy lifestyle.

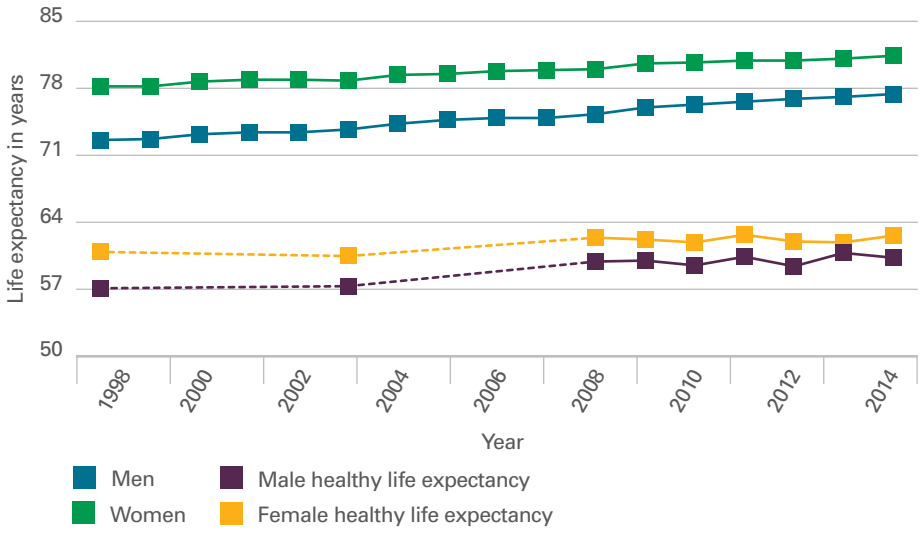
Supporting looked-after children and child protection has increased demand on social work services

18. Looked-after children (LAC) are children in the care of their local authority. They may live in their own home, with foster or kinship carers or in a residential

Exhibit 3

Changes in life expectancy and healthy life expectancy

Life expectancy is increasing faster than healthy life expectancy, potentially increasing service pressures.



Note: Data on healthy life expectancy was not collected annually until 2008.

Source: Scottish Health Survey, Scottish Household Survey, National Records of Scotland births, deaths and populations data

home. Most become looked after for care and protection reasons. The term also includes unaccompanied children seeking asylum and young people who have been illegally trafficked. As at July 2015, 17,357 children in Scotland, around 1.8 per cent of the total, were looked after or on the child protection register.[16,17] Of these 15,404 were looked after, 2,751 were on the child protection register and 798 were both looked after and on the register. While there has been a recent reduction, possibly due to improvements in prevention, the number of LAC has increased by 36 per cent since 2000, although the numbers and trends vary among councils. The number of children on the child protection register increased by 34 per cent between 2000 and 2015, with three in every 1,000 children under 16 now on the register. In smaller councils, the number of children on the register (and resultant workload) can fluctuate significantly, particularly when sibling groups in large families are registered.

19. The reasons for these increases are likely to be complex. Many of the councils we visited think that increases in drug and alcohol use by parents are important factors. Others have seen an increase in reporting of domestic abuse and alcohol-related incidents in more affluent areas that might have gone unreported in the past. In addition, early intervention policies are likely to have led to an increase in the number of looked after children, but a decrease in the time that councils look after them. Early intervention means identifying people at risk and intervening to prevent the risk. Between 2007 and 2014, the number of children removed from the register who had been on it for less than a year increased from 2,421 (79 per cent of the total) to 3,930 (87 per cent). Over the same period, the number of children who had been on the register for more than a year fell from 663 to 569.

Councils and service providers face difficulties in recruiting staff

20. Just over 200,000 people work in social work and social care services, representing around one in 13 people in employment in Scotland.[18] Almost half work part time and 85 per cent are women. The private sector is the biggest employer (42 per cent of staff), followed by the public sector (31 per cent) and the third sector (28 per cent). This distribution varies considerably among councils, and the public sector is the biggest provider in the three island authorities.

21. Many third and private sector providers raised staff recruitment as a significant issue for them. Councils have fewer recruitment problems, the exception being in remote rural areas, where it can be difficult to recruit specialised staff. Third and private sector providers reported that the apparent causes for these difficulties included:

- Low pay – providers in both the private and third sectors felt that the rates councils pay under their contracts only allowed them to pay staff at, or near, the minimum wage. In addition, travel time between clients is sometimes unpaid.
- Antisocial hours – providing homecare often requires carers to assist people to get out of bed in the morning and into bed at night. This can mean weekend working, split shifts and antisocial hours, with no additional pay. The increased personalisation of care has contributed to this as carers increasingly provide care to suit individuals, rather than fitting individuals into the care system.

Driving down costs to the extent that staff are recognised as being in a 'low wage sector' increases the problem of recruitment.

Service provider

- **Difficult working conditions** – staff have to take care of people with a variety of care needs that some find difficult, for example, assisting people with bathing and personal hygiene, or who have dementia or incontinence.

22. The cycle of continually recruiting and training staff is costly and could potentially have an impact on the quality of services provided. Service provider focus groups highlighted a need to provide staff with a sustainable career path to improve recruitment and retention. Overall, the public sector has the most stable workforce and the private sector the least, although this does not appear to be the case for all categories of staff (Exhibit 4).[19]

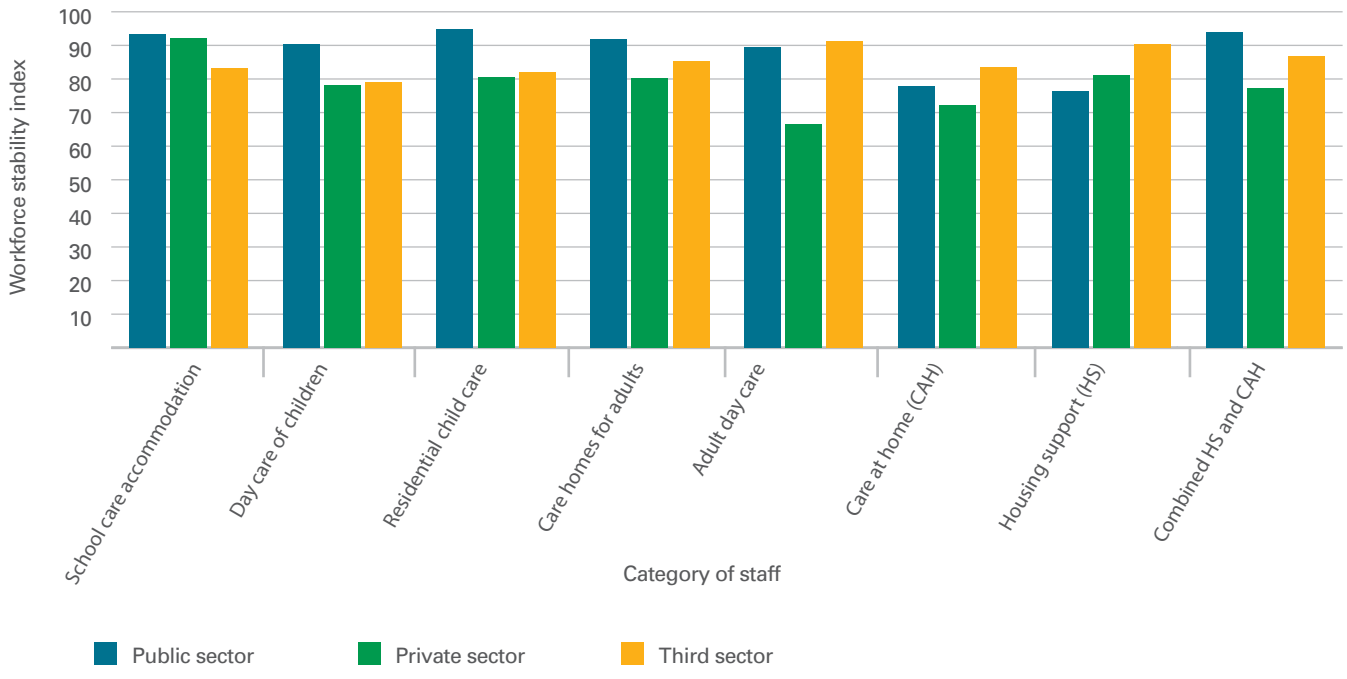
23. Some care providers expressed concerns that leaving the EU and the potential introduction of a points-based immigration system could create problems for staff recruitment. A 2008 workforce survey indicated that 6.1 per cent of the social care workforce in Scottish care homes for older people were EU – non-UK workers, and a further 7.3 per cent were employed under work permits. Most of those employed from within the EU came from Poland and the Czech Republic and those from outside the EU were from the Philippines, India and China.[20]

24. Four per cent of the workforce have a no guaranteed hours (NGH) contract.[21] When combined with the other contract types that may be considered a zero hours contract (bank and casual or relief), they comprise roughly ten per cent of the contracts in the workforce. Providers believe zero hours contracts are

Exhibit 4

Social work workforce stability 2013/14

The public sector workforce is generally the most stable.



Note: Because of data limitations, the SSSC cannot provide an accurate estimate for turnover. However, they are able to calculate a 'stability index' of staff who are still in post after a year. If the index is 90 per cent it means that 10 per cent of staff present at the start of the period are no longer present. It is important to note that this does not mean that turnover is 10 per cent as the measure excludes staff who joined and left within the period under consideration.

Source: Scottish Social Services Council (SSSC)

essential to provide a flexible and personalised service to people, while also providing flexibility for staff. These contracts are suitable as long as they are not exclusive and staff are free to accept or turn down work without being penalised. As part of good contract management, councils should ensure that providers use zero hours contracts properly.

25. There are skills and staffing shortages in several areas of social work and social care, including:

- Homecare staff – 69,690 people work in housing support or care at home.[22] Both third sector and private sector providers find it difficult to recruit staff. Rapid staff turnover is a significant threat to maintaining service standards, particularly in adult day care.

- Nursing staff – 6,620 registered nurses work in the care sector, 4,930 of them in adult care homes. Ninety-one per cent of registered nurses are in the private sector. Care providers in both the private and third sectors are having trouble recruiting qualified nursing staff for care homes. As a result, providers were trying to recruit staff from outside the UK. Although data is not collected on vacancy rates for nursing staff in the care sector, there were 2,207 whole-time equivalent (WTE) vacant nursing and midwifery posts in the NHS in Scotland at 31 March 2016.[23]

- Mental health officers (MHOs) – are specialist social workers with a statutory role in the detention and treatment of people with mental illness. They look into the circumstances of individuals where people have concerns about their mental health. They can apply for a court order that would allow an individual to be taken to a 'place of safety' for up to seven days.[24] In December 2014, the number of registered MHOs was at its lowest level since 2005. However, in 2015 there was a small increase (two per cent) to create a total of 670 practising MHOs. In 2015 there were 15 unfilled posts for MHOs in Scotland and 17 further post holders who were unavailable, for example through career breaks or secondments, about five per cent of the total.[25]

The professional social work role is changing

26. The workforce includes 11,127 professional social workers registered in Scotland. Almost three-quarters, 8,242, work in councils and 2,040 (18 per cent) are employed by other providers. Most of the rest are self-employed, unemployed or recently retired. Not all qualified social workers work in roles where they are required by law to hold a social work qualification (statutory roles), for example they may work in management roles. The number of WTE social workers employed by councils in statutory roles increased significantly between 2001 and 2015, from 3,873 to an estimated 5,630. Of these, 31 per cent work with adults, 49 per cent with children, 15 per cent in criminal justice; five per cent work generically.[26]

27. The majority of social workers in our focus groups were optimistic about their role and their ability to make a positive difference to people's lives. Changes in structural and partnership arrangements in health and social care have introduced more working in multidisciplinary teams, for example with health visitors or occupational therapists. Social workers sharing offices with other disciplines can be both rewarding and effective. We found that social workers who had worked in multidisciplinary teams for some time were convinced that improved

communication with community NHS staff had improved services. However, some were concerned about erosion of their professional identity. Moreover, adapting to working with colleagues from a different culture, for example in approaches to risk, could be challenging.

Unpaid carers provide the majority of social care in Scotland

28. The Scottish Government estimates that there are 759,000 unpaid carers aged 16 and over in Scotland, around 17 per cent of the adult population. Of these, 171,000 (23 per cent) provide care for 35 hours or more a week. In addition, there are an estimated 29,000 young carers under 16, around four per cent of the under 16 population.[27] There are many more unpaid carers providing support to people than those in the paid social services workforce.

29. In 2010, the Scottish Government reported that unpaid carers saved health and social services an estimated £7.68 billion a year.[28] More recently, Carers UK estimated the value of unpaid care in Scotland to be £10.8 billion, more than three times current social work net spending.[29]

30. The Carers (Scotland) Act 2016 became law in March 2016. It provides for the planning and provision of support, information and advice for unpaid carers and encourages councils to become involved in carers' services. It also means councils are required to prepare a carer support plan for carers, including young carers, who want one. A carer support plan sets out information about the carer's circumstances, the amount of care they are able and willing to provide, the carer's needs for support and the support available. The Act also requires each council to establish and maintain an information and advice service for carers who live or care for people in its area.

> **(Unpaid) Carers do everything! Link everything! Anchor everything!**
>
> Carer

> **24/7 carers are there, understanding the person's needs.**
>
> Carer

Social work services are facing considerable financial pressures

31. In 2014/15, councils' net spending on social work services was £3.1 billion (Exhibit 5, page 21). Services for older people made up around 44 per cent of this spending, and services for children and families around 28 per cent. A range of other services make up the remainder.

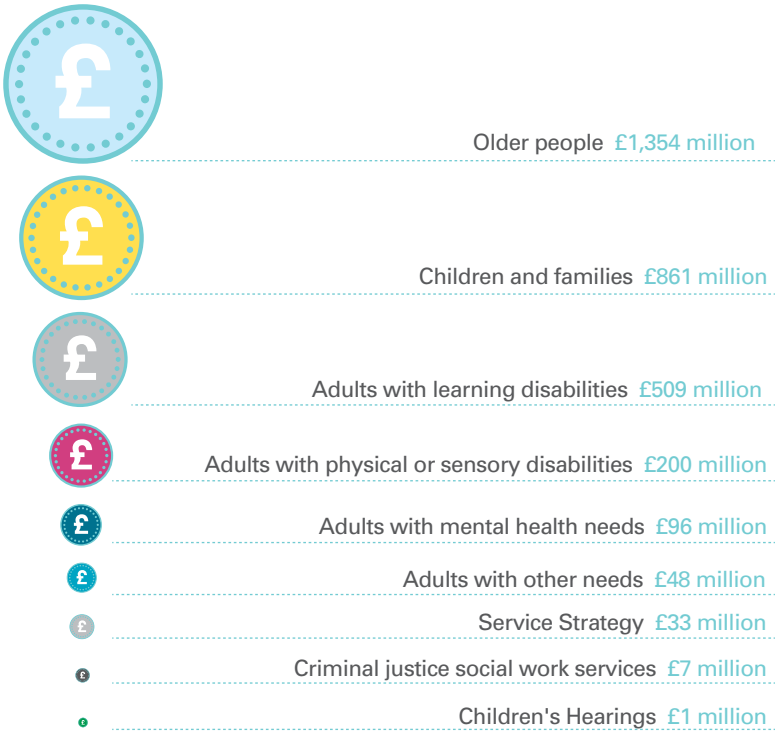
32. In 2016/17, councils' total revenue funding, that is the funding used for day-to-day spending, will be five per cent lower than in 2015/16. This is a reduction of 11 per cent in real terms since 2010/11.[30] This is a significant pressure on all council services, including social work. The 2016/17 figure does not include £250 million that the Scottish Government allocated to health and social care integration authorities to support social care, because the Scottish Government routed it through the NHS boards' budgets rather than council budgets.

33. Against the trend of falling council spending, councils' total social work net spending increased in real terms from £3.2 billion to £3.3 billion between 2010/11 and 2014/15, an average increase of 0.8 per cent a year.[31] As a result, spending on social work increased from 28.9 per cent to 32 per cent of council spending.[32] An analysis of council accounts found that two-thirds of councils reported social work budget overspends totalling £40 million in 2014/15. Most councils identified homecare services for adults and older people as the service under most pressure.

Exhibit 5

Social work spending, 2014/15

Around 44 per cent of the £3.1 billion net social work spending is on services for older people and this percentage is likely to increase with demographic change.



Source: Local Government Financial Statistics 2014-15 (Annex A), February 2016

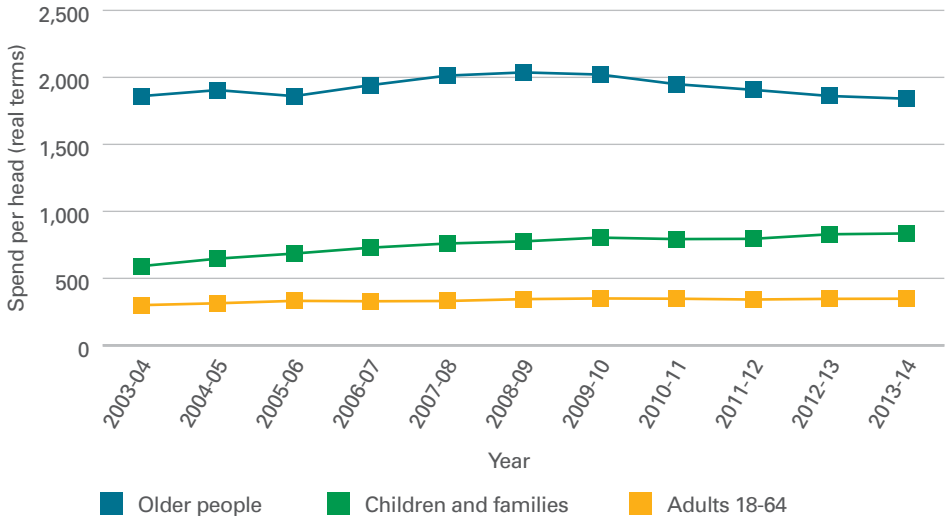
34. There have been significant long-term changes in spending per head among different age groups (Exhibit 6, page 22). The reduction in spending on older people is a combination of a lower percentage of older people receiving services (paragraph 46) and a reduction in the real-terms cost of care homes (paragraph 62) and homecare (paragraph 59). The increase in spending on children and families may be related to an increase in the number of looked after children, an increase in the complexity of children and families' cases and an increased focus on early intervention.

Few councils and IJBs have long-term spending plans for social work

35. We examined council budgets and spending plans for 2015/16, 2016/17 and beyond to assess whether the trends identified above are likely to continue in the medium term. Budget information is more difficult to collect and interpret than historic expenditure information because councils do not present this information consistently. In addition, most IJBs had not finalised their budgets at the time we were conducting our analyses. Budgets for 2016/17 were very similar to 2015/16 in cash terms. We also analysed councils' savings plans. Councils plan to save £54 million from social work budgets in 2016/17, mainly through changing how they provide services, reducing services and making efficiency savings.

Exhibit 6

Real-terms spending on social work services per head, 2003/4 to 2013/14



Source: Expenditure on Adult Social Care Services, Scotland, 2003/4 to 2013/14, Scottish Government

36. Councils and NHS boards work on different financial planning cycles and agree budgets at different times of the year. A survey of IJBs by the Scottish Parliament's Health and Sport Committee found that over half of IJBs were unable to set a budget for 2016/17 before June 2016, and over a quarter before August 2016.[33] A number of responses mentioned delays in receiving the health allocation for the partnership as a cause of difficulty in setting budgets. If councils and NHS boards continue with different budget cycles, it will make it more difficult for IJBs to agree budgets for services in a timely way.

37. In February 2016, as part of the local government settlement, the Scottish Government announced funding of £250 million to support social care for the three years to 2018/19. Some of this funding was to help pay the Living Wage (£8.25 an hour) to all care workers in adult social care, regardless of age from 1 October 2016.

38. The Living Wage Foundation sets the Living Wage. It is up-rated annually and they will announce a new rate in November. The local government settlement does not require councils to increase wages to the new Living Wage rate when the Living Wage Foundation announces it in November.

39. The Scottish Government has estimated that over the period 2012-32, spending on social care for older people will need to increase by between 1.5 per cent and 3.3 per cent a year, depending on changes to healthy life expectancy (HLE).[34] We have calculated lower and upper limits of the cost of demographic change based on Scottish Government projections. Added to this are cost pressures arising from legislation, based on their financial memorandums, and the cost implications of the commitment to the Living Wage for care workers (Exhibit 7).[35]

Exhibit 7

Potential financial pressures facing Scottish councils by 2019/20

Councils face significant cost pressures.

Reason for cost increase	Lower limit (£ million)	Upper limit (£ million)
Demographic change (older people only)	£141	£287
The Children and Young People (Scotland) Act 2014	£98	£98
The Carers (Scotland) Act 2016	£72	£83
The Living Wage	£199	£199
Potential cost increase by 2019/20	**£510**	**£667**

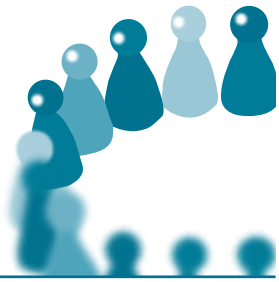
Source: Audit Scotland analysis of financial memorandums and information provided by the Scottish Government

40. Together they imply increases in social work spending of between £510 and £667 million (a 16–21 per cent increase) by 2019/20. Additional Scottish Government funding to implement legislation and to IJBs (via the NHS) may partially relieve some of these pressures, as could potential savings from health and social care integration and by providing services differently.

41. Councils and IJBs need to develop longer-term financial strategies and plans for social work services, taking into consideration the above financial pressures. For example, they need to assess the affordability of options for changing the way they deliver services, so that elected members can consult the public and make informed decisions. Some of the councils we visited had already done this. For example, West Lothian Council had detailed projections of cost pressures for the client groups in social work and had considered the options available to meet those pressures depending on the level of funding available.

Part 2

How councils are addressing the challenges



Key messages

1 Councils have adopted a number of strategies to achieve savings. They have tightened eligibility criteria so that fewer people receive services and targeted funding to people in greatest need. They have also achieved significant savings in the cost of homecare and care homes through competitive tendering and the national care home contract.

2 Current approaches will not be sustainable given the scale of the challenge, and there are risks that reducing costs further could affect the quality of services. Fundamental decisions are required on long-term funding and social work service models for the future.

3 There has been a limited shift to more prevention and different models of care. Many councils have taken an opportunistic or piecemeal approach to changing how they deliver services, often to meet financial challenges or as the result of initiative funding by the Scottish Government.

4 Opportunities for people who use social work services and carers to be involved in planning services are limited. There is scope for councils and IJBs to do more to work with them to design, commission, deliver and evaluate services to achieve better outcomes. Service providers also have an important role to play in commissioning services, and councils are not doing enough to work with them to design services based around user needs.

5 People who use services and their carers value the support they get from social work and social care services. Our focus groups had a number of concerns about homecare, such as shorter visits and people using services seeing a number of different carers.

6 The Scottish Government's Living Wage commitment provides an opportunity to improve recruitment and retention of social care staff, and to create a more stable skilled workforce. But it adds to the financial pressures on councils and providers.

fundamental decisions are required on long-term funding and social work service models for the future

Councils, COSLA and the Scottish Government have agreed approaches intended to address major long-term pressures

42. Social work services operate within a number of national strategies, developed by the Scottish Government and councils that are intended to

respond to the major challenges set out in Part 1, such as demographic change, personalisation and prevention. These include:

- **Social Services in Scotland: a shared vision and strategy for 2015-2020** – this builds on the *21st Century Social Work Review* published in 2005. It covers the whole of social work and its aims include:
  - encouraging a skilled and valued workforce
  - working with providers, people who use services and carers to empower, support and protect people
  - a focus on prevention, early intervention and enablement.[36]
- **The 2020 Vision for Health and Social Care in Scotland** envisages that by 2020 people will live longer healthier lives at home, or in a homely setting and that Scotland will have an integrated health and social care system with a focus on prevention and supported self-management.[37]
- **Reshaping Care for Older People** (RCOP) – a ten-year change programme focused on giving people support to live independently in their own homes and in good health for as long as possible. In 2011/12, the Scottish Government introduced the Change Fund, totalling £300 million to 2014/15, specifically to develop this area of policy.[38]

43. Our report, *Reshaping care for older people* commented on slow progress of RCOP and the need to monitor its impact. It also reported that initiatives are not always evidence-based or monitored and that it was not clear how councils would sustain and expand successful projects.[39] Our report *Changing models of health and social care* concluded that the shift to new models of care is not happening fast enough to meet the growing need, and the new models of care that are in place are generally small-scale and not widespread.[40]

Councils have changed eligibility criteria to reduce the number of people who qualify to receive services to balance their budgets

44. Councils have a statutory duty to assess people's social care needs. If they assess a person as needing support and eligible to receive services, they must provide or pay for services to meet these needs.[41] If people are eligible for support, the Social Care (Self-Directed Support) (Scotland) Act 2013 also requires councils to offer people a choice of four options in how their social care is provided:

- a direct payment – this allows people to choose how their support is provided, and gives them as much control as they want over their individual budget
- direct the available support – the person asks others to arrange support and manage the budget
- the council arranges support – the councils choose, arrange and budget for services
- a mix of all the above options.

45. To balance their budgets, councils prioritise funding and staff to those people most in need by setting eligibility criteria and assessing each person's needs against these criteria. Councils have discretion on the thresholds for care they use locally. The level set in each council will depend on the resources available and

> **I have a say about who is on my team. I got to meet them and do interviews. I did the questions in advance.**
>
> Service user, young person with physical disabilities

on the council's policies and priorities. Councils assess people's needs using a common framework of four eligibility levels:

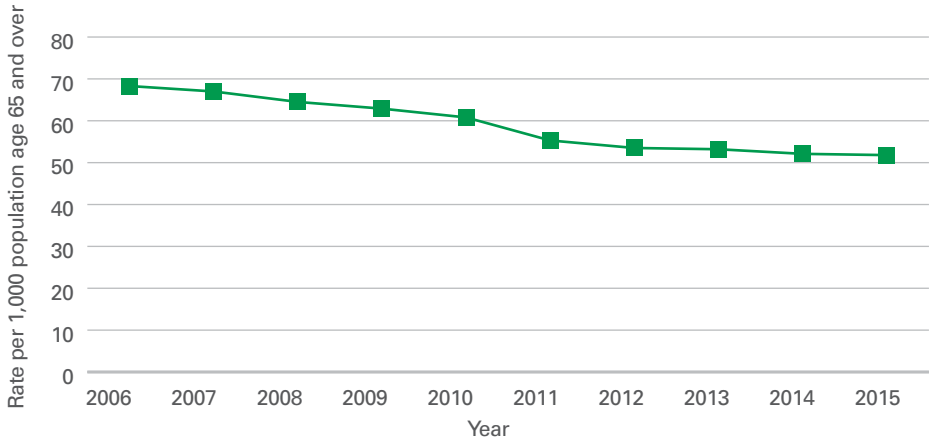
- **Critical Risk (high priority)** – Indicates major risks to an individual's independent living or health and wellbeing likely to require social care services 'immediately' or 'imminently'.
- **Substantial Risk (high priority)** – Indicates significant risks to an individual's independence or health and wellbeing likely to require immediate or imminent social care services.
- **Moderate Risk** – Indicates some risks to an individual's independence or health and wellbeing. These may require some social care services that care providers manage and prioritise on an ongoing basis, or they may simply be manageable over the foreseeable future with ongoing review but without providing services.
- **Low Risk** – Indicates that there may be some quality of life issues, but low risks to an individual's independence or health and wellbeing with very limited, if any, requirement for social care services. There may be some need for alternative support or advice and appropriate arrangements for review over the foreseeable future or longer term.[42]

46. Because of funding pressures, most councils now only provide services to people assessed as being at critical and substantial risk. Focusing services on people with higher levels of need resulted in a reduction in the percentage of older people receiving homecare between 2006 and 2015, from just under 70 per 1,000 population to 50 per 1,000 (Exhibit 8). Of the councils we visited, only West Lothian still provides services to people assessed as at moderate risk.

Exhibit 8

Proportion of people aged 65+ receiving homecare, 2006 to 2015

The proportion of people aged 65 and over receiving homecare has fallen from just under 70 per 1,000 to just over 50 per 1,000.



Source: Expenditure on Adult Social Care Services, Scotland, 2003-04 to 2013-14, Scottish Government

47. Because most councils no longer provide services to people in the two lower risk eligibility criteria, and because of the considerable financial and legislative changes in social work since the current framework was developed, it may be an opportune time for COSLA and councils to review the framework to ensure that it is still fit for purpose.

48. Some councils have also limited the level of service they provide in some areas. Examples from our fieldwork include reducing the length of carer worker visits, providing ready meals and frozen meals, with one hot meal per day (leaving snacks for other meals) and restricting showers to once or twice a week for some people.

Councils are finding it hard to fund a strategic approach to prevention

49. Developing a strategic approach to prevention is essential for councils to sustain provision of social services. In 2011, the Christie Commission concluded that Scotland needed to 'devise a model of public services that is both financially sustainable and is capable of meeting the significant longer-term challenges'. It also proposed that a radical shift towards preventative public spending was essential. In September 2011, the Scottish Government set out an ambitious vision to enable everyone to live longer, healthier lives at home or in a homely setting by 2020.[43] Central to the vision is a focus on prevention, anticipation and supported self-management. The Scottish Government also set up change funds to stimulate prevention work, specifically in the areas of early years, re-offending and re-shaping care for older people.

50. Councils, IJBs and other stakeholders all believe that prevention is the key to meeting the growing demands for social work services within finite resources. However, the councils we visited varied in how well they are developing and implementing preventative strategies. Some, including West Lothian and East Renfrewshire, have a strong focus on prevention, for example they maintain prevention budgets and build prevention into how they plan and provide services. Councils cited various challenges to shifting service models towards prevention:

- a lack of funding because resources are locked into current service models to meet existing demands and savings may not materialise for several years after implementation
- a lack of social worker time – a concern that social work has become crisis based
- managing relatives' expectations – for example, some relatives prefer the council to provide a full care package of residential care rather than have their relation go through a re-ablement programme to allow them to live more independently at home
- community resistance – for example, opposition to closing a local hospital or care facility to free up funding for more accessible community-based care
- cultural differences between councils and the NHS – a common perception among a number of social workers in our focus groups is that the NHS is more risk averse and less used to giving staff responsibility to take the initiative on the care of individuals.

> **I had an OT (occupational therapy) assessment, and social work and they gave me 15 minutes of care. It's really not enough time. It's the choice between getting washed or getting dressed**
>
> Service user, physical disabilities

51. Councils have commonly adopted some prevention initiatives, most of which are effective in the short term, but examples of long-term initiatives are more limited. Common prevention activities included:

- Re-ablement – involves encouraging people using services (often people leaving hospital) to develop the confidence and ability to live more independently and be less reliant on social care. This is usually a six-week programme of intensive help; it commonly results in people requiring less or even no ongoing support. Glasgow City Council found that 30 per cent of clients had no further need of a service following a period of re-ablement. The change fund initially funded this project but the council now funds it as the savings justify the investment.

- Using technology to enable people to continue living in their own homes for longer and to give reassurance to their carers and families. All councils provide a community alarm service. More advanced telecare systems use movement sensors and smoke detectors to alert the service to potential problems or prompt people to take medication. For example, West Lothian Council uses technology to help people with dementia, their families and carers manage issues that may arise in and around the home. Examples include:
  - a GPS device to help relatives or carers to find a vulnerable person if they get lost
  - extreme temperature and flood sensors fitted in kitchens
  - sensors to alert a carer when the person gets out of bed
  - removable sensors, called 'just checking', placed at doorways to monitor movement and assess lifestyle patterns.

- Early intervention for children and families is another widely implemented approach. Social work services work with relevant partners to support children and families at risk of needing support that is more intensive in future, or with older children at risk of becoming an offender. Midlothian Council attributed a significant drop in the number of their children on the child protection register from 158 in 2011 to 29 in 2015, at least partially, to early intervention and prevention work.[44]

- Restricting out of area service for looked-after children – out of area placements tend to involve young people with troubled histories and challenging behaviour and children with significant learning disabilities. Some out of area placements will be the most suitable for a child, such as where the child has complex treatment needs that the council cannot meet or to ensure they can be effectively safeguarded. However, such placements are very expensive (weekly fees to independent providers range from £800 to £5,500) and can have negative consequences. For example, children may try to run away, putting themselves at risk, and children away for long periods will lose contact with their peers and find it difficult to re-integrate into the local community when they leave care.[45] Our fieldwork councils reported that keeping children local to their communities, for example in supported foster placements, could achieve better outcomes for children and achieve considerable financial savings for the council.

I have a feature that picks up if I get out of bed for too long, in case I've fallen in the night. I like to get up and wander about if I can't sleep, and then there is this booming voice asking if I am OK! It's a first class service.

Service user, older person

Councils need to measure the impact of prevention initiatives more systematically

52. Measuring and evaluating the success of prevention work is difficult. By its very nature, it is not easy to quantify what has not happened because of

prevention. It is also hard to attribute outcomes to specific courses of action in an environment where many factors are involved. Even so, councils do not always systematically evaluate initiatives, and there is a risk that opportunities for improvement, making savings or stopping ineffective activity are lost. Councils and IJBs should bring together information on the evaluation of successful prevention initiatives. They can use this to make long-term strategic investment decisions towards prevention as a key part of their long-term budget planning, rather than relying on short-term initiative funding as at present. Prevention needs to be seen as an integral part of councils' and IJBs' overall long-term strategies for services they can continue providing over the long term, rather than an add-on financed by short-term funding.

53. In our fieldwork, we found examples of successful evaluation. An evaluation of Glasgow's Recreate service to support ex-offenders found that in 2014/15 it generated a Social Return on Investment of between £6.14 and £9.54 per £1 invested (Case study 1).[46]

Case study 1

Glasgow Recreate

This service gives ex-offenders the chance to volunteer for up to six months in meaningful roles where they gain new skills and experiences to help them to move forward in their life. Volunteers can access various opportunities, including landscaping and gardening, painting and decorating, retail and warehousing, and woodwork.

With the support of skilled tradespeople, they work on projects for organisations such as community groups, charities, housing associations, and Glasgow Land and Environmental Services. Each volunteer has a dedicated mentor who helps them to access additional volunteering opportunities, housing support, employability services, and money advice and make positive changes in their personal life. They also help volunteers to complete CVs, identify training and development needs, and set goals to help them become more work-ready to help them break the cycle of re-offending.

Volunteers benefit from rail, bus and subway travel, lunch, gym membership, training and development, information about other organisations, and employment support. During 2015/16, there were 58 volunteers in the scheme (up from 34 in 2013/2014), 57 per cent of whom moved into employment. Ninety-six per cent of participants did not re-offend and of those who did, the frequency and severity of the offending was reduced.

Source: Glasgow City Council

Recreate is a good mix of volunteering, learning and mentoring. I worked hard and it paid off.

Recreate volunteer

54. Some councils are learning from experience elsewhere to tackle particular issues. For example, East Renfrewshire Council visited Shropshire County Council to explore how it developed a community-led social work service. It has agreed to be one of three organisations that will pilot the programme in Scotland. There is scope for councils to do more to look at what others are doing, nationally and internationally, and share experience and learning.

Councils have achieved savings through competitive tendering

Councils purchased around £1.6 billion of services in 2014/15

55. Currently, councils spend around £1.6 billion a year on outsourced social care services, roughly two-thirds to the private sector and a third to the third sector (Exhibit 9). Spending on private sector services is mainly to provide homecare, residential care and nursing homecare for older people (£800 million). Most third sector spending is to provide services for children with disabilities (£244 million). Larger providers provide services across a large number of councils and are in a good position to identify good practice.

56. In procuring services, councils need to take into account the long-term financial viability of care providers. Providers could be put at risk by a combination of several factors, including:

- a fall in the number of care home residents
- increased paybill costs because of knock-on impacts of Living Wage
- increased uncertainty following Brexit may make it difficult for private sector providers to finance capital investment, such as building or refurbishing care homes.

Exhibit 9

Breakdown of contracted out social care spending by sector, 2014/15

Most private sector services are for adults while the third mostly sector provides services for children.

		Third sector £'000	Private sector £'000	Total £'000
Social care adult	Day care	43	1,113	1,156
	Homecare	18,290	261,403	279,693
	Mental health services	14,297	12,974	27,272
	Nursing homes	19,273	318,376	337,649
	Residential care	1,883	219,962	221,845
Social care children	Adoption	23,208	35,871	59,079
	Childcare services	49,481	30,217	79,698
	Domestic violence	3,229	41,511	44,740
	Children with disabilities	243,878	17,831	261,708
Social care other		195,945	112,363	308,308
Total		**569,527**	**1,051,621**	**1,621,148**

Note: 'Other' includes advice and counselling services, advocacy service providers, alcohol and drug rehabilitation, community centres, community projects, disability and special needs service providers.

Source: Spikes Cavell database

57. Councils and Scotland Excel need to monitor the financial health of providers as part of their contract monitoring activity. The failure of a provider could have significant consequences for care services as well as people who use care services because Section 12 of the Social Work (Scotland) Act 1968 places a duty on Scottish local authorities to provide or arrange care for any individual in their area who requires assistance in an emergency.

Competitive tendering has reduced the cost of homecare

58. Councils have achieved significant financial savings through outsourcing services such as homecare to the private and third sectors through competitive tendering and re-tendering contracts. The percentage of homecare provided directly by council staff has fallen steadily, both in terms of the number of clients served and the number of hours provided (Exhibit 10, page 32).

59. Between 2010/11 and 2014/15, the average cost of providing homecare to people aged over 65 fell by 7.2 per cent in real terms, to £20.01 per hour.[47] An unintended consequence of driving down spending is increased staff turnover, as private and third sector providers employ staff on poorer terms and conditions than some other large employers or councils.

Too many (paid) carers – regular new carers needing shown ropes again! Gah!!

Unpaid carer

60. Third sector and private sector providers in our focus groups described some councils' procurement processes as inefficient and wasteful. They highlighted inconsistencies in how councils used framework agreements. These are agreements with suppliers to establish the terms that will govern contracts that councils may award during the life of the agreement.[48] Some private sector providers were concerned that they had invested time and money in signing up to frameworks, only to find that councils did not use their services.

Councils have made savings in the cost of care home services

61. The National Care Home Contract sets out the cost to councils of care home placements into private or third sector care homes. COSLA negotiates the fee structure annually with the representative bodies for private and third-sector providers in Scotland.[49] These bodies are Scottish Care and the Coalition of Care and Support Providers in Scotland. The contract includes an additional payment for care homes doing well in Care Inspectorate assessments, with penalties for poorly performing homes.

62. Between 2006 and 2015, the number of residents in older people's care homes decreased by two per cent (from 33,313 to 32,771).[50] The net cost of residential care (gross expenditure on care homes minus income) to councils has been falling. Between 2010/11 and 2014/15, the weekly residential costs to councils for each resident aged 65 or over fell by ten per cent in real terms to £372.[51]

63. The pattern of service provision has changed, with an increase in private sector provision and a fall in other sectors. Between 2006 and 2015, the change in the number of older people in residential care in each sector was:

- private sector – increased by five per cent (24,568 to 25,700)
- local authority/NHS – decreased by 23 per cent (4,876 to 3,747)
- third sector – decreased by 14 per cent (3,869 to 3,324).[52]

64. The percentage of adults in care homes who mainly pay for their own care is increasing; the percentage increased from 22 per cent of residents in 2006 to 27 per cent in 2015.[53] In 2015, the average gross weekly charge for people who paid for their own care was £708, compared with the average weekly fee for publicly funded residents of £508.[54]

Service providers want to be more involved in commissioning services

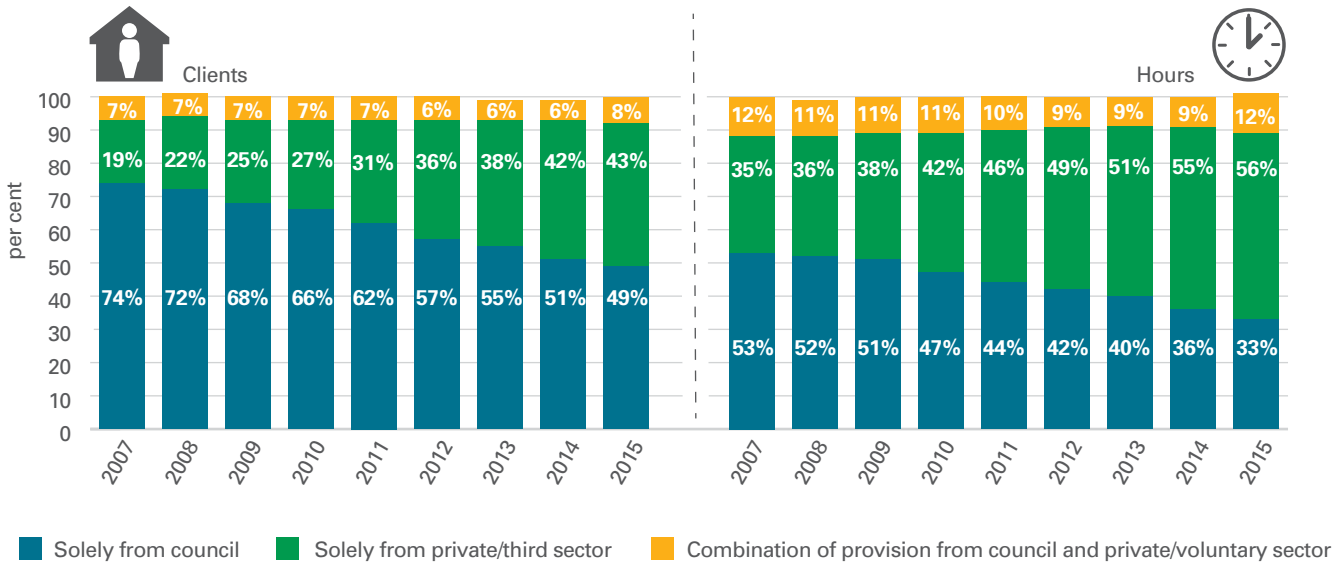
65. Commissioning social care is about how councils, NHS boards and others work together to plan and deliver services that will meet future demands and use resources, such as money, skills and equipment effectively. Jointly planned investment in home or community-based social care can save spending on unnecessary, and relatively expensive, hospital or residential care, and encourage innovation. The Christie Commission concluded that it is particularly important to:

- work closely with individuals and communities to understand their needs, maximise talents, resources, and support self-reliance, and build resilience
- recognise that effective services must be designed with and for people and communities – not delivered 'top-down' for administrative convenience
- maximise scarce resources by using all available resources from the public, private and third sectors, individuals, groups and communities.

Exhibit 10

The share of homecare provided by councils and the private/third sector, 2007 to 2015 (all ages)

Homecare provided directly by councils has fallen steadily over the past ten years.



Note: Of data limitations, the SSSC cannot provide an accurate estimate for turnover. However, they are able to calculate a 'stability index' of staff who are still in post after a year. If the index is 90 per cent it means that 10 per cent of staff present at the start of the period are no longer present. It is important to note that this does not mean that turnover is 10 per cent as the measure excludes staff who joined and left within the period under consideration.

Source: Social care services, Scotland, 2015, Scottish Government, December 2015

66. Councils have a challenging task to manage the market for providing services in their local area. There are potential tensions around making savings while ensuring high-quality services at a fair cost in an environment of increasing demand and financial pressures. There are risks to the quality of services if councils continue to drive down costs at the rate they have in the past without changing how they provide services.

67. Service providers from our focus groups who work across more than one council area found that different councils have different processes, procedures and attitudes to partnership working. They identified commissioning and procurement as common areas for improvement. In particular they felt that councils should:

- ensure they have staff with the appropriate skills for commissioning, such as financial planning and managing contracts, and be open in commissioning and contract decision-making processes. Some participants complained about unnecessary bureaucracy, noting gaps in expertise and risk appraisal and a lack of awareness of the challenges facing providers, for example the cost of employing qualified and experienced staff

- collect evidence about the effectiveness of all services (both in-house and external) and use this evidence in planning and decision-making. Councils face difficult choices, but providers felt councils sometimes protected their in-house services and workforce while cutting externally provided services, without comparing cost-effectiveness

- improve partnership working and relationships with providers. Although there were pockets of good practice, providers suggested that councils needed to work more collaboratively to provide stability to both those who provide and those who use services

- involve providers more in assessing and designing services, taking advantage of the experience and knowledge of good practice that larger providers have gained from working with councils across the UK.

68. One innovative example we identified was the Public Social Partnerships (PSP) approach used at East Renfrewshire Council (Case study 2, page 34). PSPs are strategic partnering arrangements, based on a co-planning approach. In this instance, the council worked with third-sector organisations and people who use services to share responsibility for designing services based around the needs of those who use them. Once designed, the council can then commission the service for the longer term. Several service providers in our focus groups mentioned the inclusive approach taken by East Renfrewshire Council as an example of good practice in commissioning services. It is important that councils have effective means of sharing good commissioning practice and working with practitioner groups within national organisations, such as COSLA and Social Work Scotland.

Some councils think 'out of the box', others are in a box with a very large padlock!

Service provider

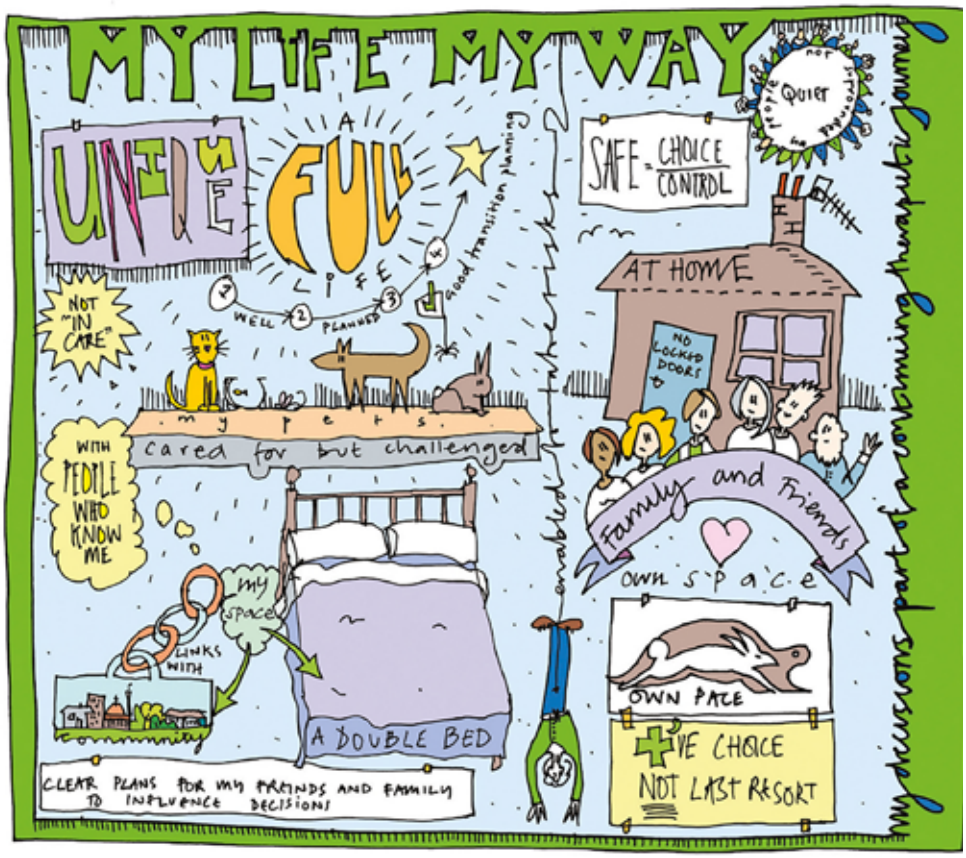
We are left out of planning discussions while having to deal with the consequences of decisions made by councils.

Provider focus group

Case study 2

East Renfrewshire Council: innovation in commissioning services

The Public Social Partnerships approach is a two-year funded programme, supported by the Scottish Government and designed to develop creative ideas for meeting the needs of people in, or about to enter, residential care. The partnership is across sectors and between people who use services. It is designed to develop thinking and support innovation. Participation in the project also helps to build resilience in people and communities by focusing on what people want rather than the services they currently receive. The illustration below describes one of the outputs from the process showing a visualisation of residential care from the point of view of someone who uses services.



Source: East Renfrewshire Council

People who use services, and carers, would value being more involved in planning how services are provided

69. The Christie Commission recognised the importance of people being involved in designing services to meet their needs. This approach is now supported by legislation such as the Community Empowerment (Scotland) Act 2015 and the Carers (Scotland) Act 2016.

70. People in our focus groups, both carers and people using services, valued the support they receive from social work services. Several said that without support they would not be able to cope or maintain employment. Feedback from our survey of 165 people indicated that the type of service provided determined whether service users felt able to influence their service delivery. For example, where service users had one-to-one support or had close relationships with staff in sheltered accommodation, they felt confident about influencing the service.

71. However, a significant number of service users felt that they had little influence over their social care provision. Some had concerns about speaking up in case the care they received was reduced or changed. Others, particularly older people, didn't want to hurt the feelings of the people providing care. While some had experience of raising issues with care providers and services being adapted accordingly, others found that no steps were taken to rectify issues. Some service users then felt care providers did not listen to them. Carers were more likely than people who use services to speak up if they were concerned about any aspects of the service delivery, but carers felt that care professionals did not treat them as partners.[55]

72. People who use social work services, and their carers, are very diverse, with differing needs. Although it is not easy to do, it is important that councils seek views and provide opportunities for involving as wide a range of people as possible in planning services or changing how they are provided. However, we found limited opportunities for people to be involved. Most of the six fieldwork councils involve representatives of both people who use services and carers in planning groups. For example, Perth and Kinross Council includes carer representatives on its multidisciplinary Carers Strategic Group. However, we found less evidence of people who use services and carers being involved more extensively in designing services.

73. Midlothian Council is one example where people who use services and carers are represented on joint planning groups, such as the Joint Older People's Planning Group that developed the Midlothian Joint Older People's Strategy 2011-15. A recent tender exercise for Care at Home in Midlothian included volunteer carers assessing all submissions, interviewing and final scoring. However, carers and people who use services generally have little involvement in commissioning or tendering, and there is scope to do more.

74. All of our fieldwork councils have a carers' strategy. All provide information for carers on their websites, including how and where to get help, which is usually through a carer assessment in the first instance. They also have partnerships with, or links to, other organisations and carers' centres in their area that provide information and support to carers. About half of the carers' centres are network partners of the national organisation Carers' Trust Scotland. Councils use various methods to collect the views of people using services, and of carers, including annual satisfaction surveys, carers' conferences and carer representatives on panels.

75. IJBs' membership must include a representative from people using services and a carer representative.[56] This is intended to ensure that carers have a role in planning and delivering of services delegated to IJBs. However, this alone is not enough to involve and consult the diverse range of people who use services and carers. Glasgow City Council has a carers' champion to represent the views of carers within the council (Case study 3, page 36).

I feel very lucky to live in [local authority]. The services for disabled people are the best in Scotland compared to other areas. [Local authority] listened to what people wanted, like supported living and individually tailored support plans.

Carer

Mental health services don't always recognise the carer input until they need them!

Carer

Everything is subject to funding therefore there is no consistency. Carers' centres need to be funded so that their services are ongoing.

Carer centre staff saved my life.

Carers

Case study 3

Glasgow City Council's Carers' Champion

Glasgow City Council's Carers' Champion represents the collective views of the city's unpaid carers within the council and speaks independently on carer issues. His role includes raising the profile of unpaid carers across the council and its wider network of agencies while also helping to develop strategies and policies that will support carers.

Glasgow has also introduced a privilege card for adult carers living in Glasgow who provide care for a Glasgow resident. It entitles them to various savings including:

- savings as part of Glasgow Life's concessionary discount scheme
- 20 per cent discount at a range of cafes in venues, such as art galleries and museums
- 20 per cent off City Parking multi-storey car parks
- discounts at certain cinemas and other commercial outlets.

In July 2015, Glasgow evaluated its Glasgow Carers Partnership, which includes Glasgow City Council, NHS Greater Glasgow and Clyde and voluntary sector organisations supporting carers within Glasgow. The council will use the resulting report and recommendations in planning and investment in carer services.

Source: Glasgow City Council

I had a procedure in hospital and I was in and out the same day, but the carer came to take me to hospital and came back at midnight to take me home. It was above and beyond.

Service user, physical disabilities

Some people we surveyed who use a homecare service were unhappy with the quality of their service

76. Between 2010/11 and 2014/15, the percentage of adults satisfied with social care or social work has fallen from 62 per cent to 51 per cent.[57] Our survey of 165 people who use services and of carers found that views on homecare dominated their discussions about the quality of care. Generally, participants with positive experiences of their current service provision highlighted some of the following factors:

- the importance of respectful and flexible carer workers
- good relationships with carer workers
- the ability to influence service delivery through self-directed support
- good timekeeping.

77. However, there were many examples of people not happy with their service experience. Common issues identified across all five local authority areas covered included:

- **Length of time a care worker spends with the person** – Most said that the care worker would be in their home for 15–20 minutes at a time. Many reported that this was not enough time to provide good quality care.

I did have [care company], and I got 15 minutes, so I had a choice between having breakfast and them running a bath for me to have on my own once they'd gone, or a shower with no breakfast.

Service user, physical disabilities

- **Timekeeping** – People who receive homecare discussed their experiences of homecare staff arriving earlier or later than expected. People we spoke to were frustrated at the homecare staff's timekeeping and poor communication.

- **Flexibility of role (undertaking tasks)** – Most people felt that the quality of care they received was affected by the limited flexibility of homecare staff in undertaking other household tasks.

- **Meals** – A large number of people receiving homecare and carers were not satisfied with the quality of the meals.

- **Trained homecare staff** – Others questioned the skills of some homecare staff. Their experience was that the homecare staff did not know how to handle them, or use equipment safely.

> **Sometimes they're late and sometimes they don't come at all.**
>
> Service user, learning disabilities

Paying care staff the Living Wage could help to reduce problems recruiting care staff, but may create other risks for providers

78. The Scottish Government's Living Wage commitment provides clear benefits for low-paid workers. However, increases in employee costs and contract costs will put pressure on councils' and service providers' finances. There are a number of risks with the current approach:

- The Scottish Government has no powers to enforce the Living Wage commitment; the UK Government reserves the power to set and enforce the legal minimum wage. The legal minimum wage across the UK is £7.20 for people aged 25 and over. The Living Wage is £8.25.

- There is a risk that providers operating across the UK may choose not to pay the Living Wage in Scotland.

- There is a risk that this could lead to unsustainable paybill increases. As well as increasing wages, National Insurance contributions and pension contributions will also rise, and service providers will need to maintain wage differentials. A recent survey of independent providers found that almost all will struggle to fund increases to £8.25 an hour. Future rises in the Living Wage may increase this pressure.

- Where councils have awarded contracts based on price before the adoption of the Living Wage, there is a risk that contractors who lost contracts, but who already pay wages at or above the living wage (and offering higher quality services) may ask councils to re-tender contracts.

> **Many people felt it was very important to have some continuity of care worker in terms of safety and building a rapport, but this was lacking. Just depressed at so many different (paid) carers coming in at all different times.**
>
> Carer

79. Applying the Living Wage also provides significant opportunities to better manage the staffing issues we describe in Part 1. Reduced staff turnover could potentially offset increased costs and provide an opportunity to improve staff skills. It could also make it easier to create a career structure for care workers and an opportunity to specialise, for example in providing services for younger people with particular disabilities, or for older people suffering from dementia.

80. Comhairle nan Eilean Siar and Perth and Kinross council felt there were particular challenges in recruiting suitably qualified staff to deliver services in isolated rural areas. In Eilean Siar, the council has set up college courses to encourage young people to view care as a worthwhile career option (Case study 4, page 38).

> **She gave me a fish pie and it was cold in the middle. She said she didn't have time to do it again, so I had to ask her to make me an omelette."**
>
> Service user, older person

Case study 4

Comhairle nan Eilean Siar: developing a stable workforce

Comhairle nan Eilean Siar faces major demographic change over the next 20 years including a projected 19 per cent decline in the working age population and a 19 per cent increase in the over 75 population. There are also a high number of single person households with no family carers available. To help arrest the decline in working age population through migration, the council has developed a project to make being a care worker a viable and attractive career for young people leaving school, as well as adults looking at career options. There are four programmes:

- Pre-Nursing Scholarship: developed to encourage people to take up a nursing career locally and part of a national initiative to increase the nursing workforce. A critical aspect of this programme is the facility to provide equitable access to learning across the Western Isles in rural and remote locations.
- Prepare to Care: This course aims to qualify and prepare students for employment, further training, or both of these, within health and social care by developing the knowledge, skills and understanding required to work in the care sector.
- Senior Phase SVQ2 Pilot: Provides flexibility in terms of work-based assessment across health and social care and equips young people to work in the community. The newly revised Social Care and Health SVQ2 is being piloted with young people in Uist and Barra by Cothrom in partnership with the council and NHS Western Isles.
- Foundation apprenticeship: Skills Development Scotland selected the council's Education and Children Services department as a pathfinder authority for the senior phase vocational pathway development in Health and Social Care.

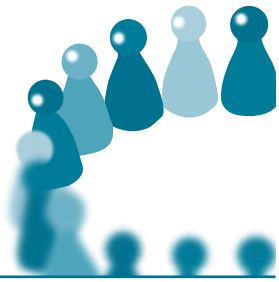
Source: Comhairle nan Eilean Siar

81. As explained in Part 1, the recruitment and retention of suitable staff is a significant problem across the care sector. Councils and providers need to work together and with the Scottish Government on long-term planning to ensure there is an effective, well-trained sustainable workforce to meet future demand. The Scottish Government has commissioned work to identify the recruitment and retention challenges facing the sector and assess whether there is a case for a national workforce-planning tool. In addition, the Scottish Social Services Council (SSSC) is working with partners to develop career pathways within social care. The first is to develop foundation apprenticeships, a vocational pathway to enable young people to experience work in the care sector and encourage care as a positive career choice.

> **The girls that came in didn't know how to use a stand aid, and they couldn't do manual lifting.**
>
> Service user, physical disabilities

Part 3

Governance and scrutiny arrangements



Key messages

1 The integration of health and social care has resulted in complex and varied governance arrangements for social work services. Elected members have important leadership and scrutiny roles, but there are risks that increased complexity could lead to members not having an overall view of social work. At a time of great change, it is essential that elected members assure themselves that the quality of social work services is being maintained and that councils are managing risks effectively. It is important that elected members receive training and guidance on the operation of the new governance arrangements and that elected members not involved in the IJB are fully informed about its operation.

2 The key role of the chief social work officer (CSWO) has changed significantly in recent years and there are risks that CSWOs may have too many roles and have insufficient status to enable them to fulfil their statutory responsibilities effectively.

3 There is scope for councils and their community planning partners to do more to promote and empower communities. This includes working with them to design, commission, deliver and evaluate services to achieve better outcomes, and to build capacity to allow communities to do more to support themselves. Elected members need to play a key role engaging with communities in a wider dialogue about council priorities.

elected members need to play a key role engaging with communities in a wider dialogue about council priorities

Social work governance and scrutiny arrangements are more complex because of health and social care integration

82. Councils' responsibilities in relation to social work are set out in the Social Work (Scotland) 1968 Act. The Act's provisions include promoting social welfare, caring for and protecting children, supervising and caring for people put on probation or released from prison and the children's hearings system.

83. Under the Public Bodies (Joint Working) (Scotland) Act 2014, councils and NHS boards are required to create integration authorities. These are responsible for the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. Governance describes the structures, systems, processes, controls and behaviours by which an organisation manages its activities and performance. The Act also allows councils and NHS boards to integrate other areas of activity, such as children's health and social care services and criminal justice social work.

84. This means that councils delegate to the integration authority (IA) their responsibility for strategic planning for adult social services and for any other services they decide to include. Councils still carry the ultimate responsibility for the delivery of social work services in their area and elected members need to assure themselves that the council is meeting its statutory responsibilities.

85. IAs are responsible for planning and commissioning functions delegated from the local council and NHS board. IAs can adopt one of two main structures. All areas except the Highland Council area are following the body corporate model. Under this, they have created an Integration Joint Board (IJB) to plan and commission integrated health and social care services in their areas. Highland is following the lead agency model, NHS Highland is the lead for adult health and care services, with Highland Council the lead for children's community health and social care services. IJBs are local government bodies, as defined by Section 106 of the Local Government (Scotland) Act 1973. Councils and NHS boards delegate budgets to the IJB. The IJB decides how to use these resources to achieve the objectives of its strategic plan. The IJB then directs the council and NHS board to deliver services in line with this plan.

86. Councils have adopted various arrangements for integration. Nine councils integrated children's social work services within the IJB and 16 councils integrated social work criminal justice services.[58] The following arrangements were adopted by our fieldwork councils:

- Midlothian Council and Comhairle nan Eilean Siar include criminal justice but not children's social work services.
- East Renfrewshire Council and Glasgow City Council include both children's social work and criminal justice social work services.
- West Lothian Council and Perth and Kinross Council only include adult services.

87. The governance and scrutiny arrangements in four of our fieldwork councils (Comhairle nan Eilean Siar, Glasgow, Perth and Kinross and West Lothian) are included in Supplement 3. These illustrate the variety and complexity of arrangements now in place within councils.

88. At the time of our fieldwork, governance arrangements were still under discussion. Council chief executives were clear that accountability lies with the council for services delegated to the IJB because, under legislation, the council retains statutory responsibility for delivering social work services. But we have previously highlighted the risk that ultimate responsibility might lie with IJBs, which plan and direct councils and NHS boards in how services are to be delivered.[59] All parties need to recognise this risk and set out clearly an agreed understanding of each other's roles and responsibilities. It is essential that the chief officer of the IJB is clear about how this joint accountability will work in practice.

89. Accountability arrangements for the IJB chief officer are complex. The chief officer has a dual role. They are accountable to the IJB for the responsibilities placed on the IJB under the Act and the integration scheme. They are accountable to the council and NHS board for any operational responsibility for integrated services, as set out in the integration scheme.

90. Governance and scrutiny arrangements for IJB and non-IJB services within our fieldwork councils varied, even where the same services are included within

the IJB's remit. For example, in East Renfrewshire, scrutiny of performance happens within the IJB Audit and Performance Committee and an annual report is presented to the Council. While Comhairle nan Eilean Siar concluded that appropriate scrutiny could be provided within its existing council committee structure and that a separate mechanism for IJB functions was not required. Supplement 3 shows the variation in integration arrangements in four of our fieldwork councils. Whatever model councils choose, elected members need to assure themselves that the scrutiny arrangements are working effectively.

91. As governance and scrutiny arrangements for social work were still in transition at the time of our fieldwork visits (some changes were implemented in March 2016), it is too early to make judgements as to whether there are duplications or gaps in scrutiny. Councils indicated that they would review arrangements if they did not appear to be working effectively. Our fieldwork highlighted a number of potential risks. These include:

- the potential for an overall view of governance being lost when social work services (and budgets) are split, for example between education and children's services and the IJB
- a focus on health and adult services could restrict discussion of children's services and, in particular, criminal justice services on IJB scrutiny committees.

92. Council representation on the IJB is generally four or five senior elected members (around ten per cent of elected members), usually including the leader of the council and a senior opposition member. This means that a small subset of elected members of the council and members of the NHS board will be responsible for social work governance and scrutiny within the IJB and its committees. There is a risk that the majority of elected members could feel excluded from social work decision-making and scrutiny. There is also a risk that this arrangement leaves responsibility for governance and scrutiny with a small number of very busy elected members. Councils have set up a variety of mechanisms to ensure they keep all elected members informed. For example, Comhairle nan Eilean Siar and the IJB will hold at least two meetings a year with the wider membership of the council and NHS Western Isles.

93. It is important that elected members receive training and guidance on the operation of the new governance arrangements. The Scottish Government has produced guidance on the roles, responsibilities and membership of the Integration Joint Board.[60] COSLA is working with the Improvement Service and the Scottish Government to support elected members who do not sit on IJB boards to help them fulfil their role, including councils' ongoing statutory duties. COSLA intends to produce an elected member briefing note focusing on councils' role and interests to ensure they are kept informed of the changes. It is also hosting workshops for elected members to share their experiences. We have included an elected member's checklist as Supplement 4. Elected members may wish to use the checklist to help them consider the effectiveness of the arrangements in their council.

Health and social care integration may make strategic planning of services more difficult

94. Each IJB is required to produce a strategic plan that includes strategies for all the services delegated to it. We examined strategies for social work services in our fieldwork councils. Strategies are set out in various ways depending on the health and social care arrangements in each council. While the plans for integrated services were well developed, they are new and untested.

95. Where councils have chosen not to include services for children within their IJB, they usually continue to follow existing arrangements. For example, some align children's social work services with education, in education and children's services. In others, these services are part of an existing Health and Social Care Partnership Directorate. Strategies for services that are not within the IJB are set out in council plans such as the education and children's services plan.

96. Where criminal justice services are included within the IJB, strategies were not always as clearly set out. IJB plans generally included few references to criminal justice and some services did not have a specific criminal justice plan. Whether as part of the IJB or not, councils have, until now, worked in partnership with their Community Justice Authority (CJA) and contributed to its area and action plans. However, under The Community Justice (Scotland) Act 2016, CJAs will be abolished from 2017. Responsibility for community justice will transfer to community planning partnerships. It is important that under the new approach, strategies for criminal justice services are clearly set out as part of the IJB or community planning arrangements.

97. All the social work plans we examined demonstrate links to community planning. As members of the community planning partnerships, both IJBs and councils have signed up to local single outcome agreements (SOA) with the Scottish Government, and share the vision and priorities within these.

98. It is important that there are clear linkages between the planning of those services that are integrated and those that are not, for example the transition from children's services to adult services or between children's services and criminal justice. Planning for these transitions needs to be well coordinated to ensure a seamless service without overlaps or gaps in services, particularly where responsibility is split between the IJB and the council.

99. It is important that the scrutiny arrangements reflect the risks associated with managing transitions. Councils and elected members will need to ensure they have a strategic overview of the whole of social work service and ensure that strategy, budget arrangements, commissioning, procurement and workforce planning are coordinated at a council-wide level.

I'm happy with the services for my daughter but it was a hard fight over many years. As she moves to adult services, am I going to have to start fighting again? It worries me.

Carer

There is a risk that chief social work officers may become over-stretched

100. The Social Work (Scotland) Act 1968 requires local authorities to appoint a single chief social work officer (CSWO) who must be a qualified social worker and registered with the Scottish Social Services Council. The CSWO should demonstrate professional leadership. They have a responsibility to highlight where a council policy may endanger lives or welfare and ensure that they provide councillors and officers with professional advice in relation to social work and social care services. The CSWO should have access to the chief executive and other senior managers, councillors and social work officers. The CSWO is one of five statutory officers in councils: that is, officers that each council is required to appoint by law.[61]

101. Scottish ministers issued revised guidance on the role of the CSWO in July 2016 to reflect the introduction of health and social care integration. This summarises the minimum scope of the CSWO role, recognising the diversity of the structures and partnerships that deliver social work services. The CSWO's responsibilities apply to social work functions whether delivered by the council or

by other bodies under integration or partnership arrangements.[62] The guidance states that management and reporting structures are a matter for councils. But if the CSWO is not a full member of the corporate management team, elected members must be satisfied that the officer has appropriate access, influence and support at the most senior level. We found consensus among elected members and chief executives that it is important that the CSWOs are senior enough to carry out their responsibilities effectively. However, the CSWO's position in the hierarchy, and the arrangements to allow them to contribute to decision-making, varied between councils.

102. When the CSWO role was combined with that of Director of Social Work, the ability to influence was clear. But councils have developed executive team structures and most no longer have a Director of Social Work. At present six CSWOs are at director level and 24 are heads of service, the tier below this, with one tier-three manager in a temporary acting up role. In addition, a large proportion of CSWOs are new to the role. A survey by Glasgow Caledonian University, in November 2015, found that over half had been in post less than three years, and nine for less than a year.

103. CSWOs have strategic and professional responsibility for social work, including monitoring service quality and professional standards. Good practice indicates this should be across the full range of a council's social work functions. Scottish ministers' guidance says the CSWO must have the power and authority to provide professional advice and contribute to decision-making in the council and health and social care partnership arrangements. However, the structure of social work provision has changed over time and CSWOs do not always have operational responsibility across all functions. For example, in Midlothian, the CSWO has operational responsibility for adult services but not for services for children or older people.

104. Integration does not change the CSWO's responsibility to provide professional leadership. However, some CSWOs expressed concerns that, where children's services and/or criminal justice sit within the IJB, health issues and adult care will dominate the IJB both in terms of the agenda and in terms of personnel. They were concerned that representation of these services on the agenda would be small in comparison to adult services.

105. Reporting lines for CSWOs always lie within the council and the establishment of IJBs does not change this. However, CSWOs now have an additional statutory, non-voting place as adviser to the IJB (or the Integration Joint Monitoring Committee in Highland's lead agency model). CSWOs need to establish good, effective working relationships with their IJB chief officer. CSWOs' roles vary across all thirty-one IJBs in terms of what they are accountable for. Integration means that those CSWOs who were previously responsible for adult social care services will lose direct responsibility for their management and budget.

106. Scottish ministers' guidance indicates that the CSWO must be visible and available to any social services worker, and ensure well-grounded professional advice and guidance on practice is available. Social workers in our focus groups generally felt that their CSWO was both visible and accessible, and felt confident about consulting them.

107. The ability of CSWOs to carry out their role effectively and not become too 'stretched' across multiple functions is a potential concern. CSWOs may have

to report to one or more council committees, sit on the IJB, and attend the council corporate management team or senior management team and the IJB management team, as well as undertake day-to-day service management roles. It is important for CSWOs to achieve the trust and confidence of councils' NHS partners in order to have an influence in decision-making. CSWOs had mixed views on whether their role within the IJB would have a negative impact on their visibility or accessibility to elected members and social workers. It is too early to see how effective new arrangements will be.

108. The statutory guidance requires all CSWOs to report annually to the council and IJB on all of the statutory, governance and leadership functions of the role and delivery of the council's social work functions. This applies however they are organised or delivered. A review of CSWO annual reports in 2013 found a lack of consistency in the content and format. After consultation with relevant individuals and groups, the chief social work adviser published guidance on the content and a template for the report. The CSWO annual report gives an opportunity for the CSWO to draw together all the important strands of their work and report on them to elected members. It should provide an opportunity for the CSWO to raise their profile with elected members and, more importantly, draw their attention to any potential concerns about social work or governance issues.

109. The CSWO reports we examined from our fieldwork sites generally followed the template, but varied in the amount and level of information included. For example, Glasgow's report for 2014/15 is more concise (nine pages long with links to relevant reports and strategies), with less detail included compared with Perth and Kinross (71 pages), which contains a lot of activity information and good practice examples. CSWO reports may be considered at various meetings including full council, relevant council committees or panels or the IJB. Social work performance is regularly scrutinised through council or IJB monitoring systems and scrutiny happens through monthly, quarterly or six-monthly performance reports at appropriate committees. CSWO reports are also important in providing a high-level summary of the performance of social work functions during a particular year. It is essential that they are subject to effective scrutiny by elected members. However, we did not find evidence of detailed scrutiny of the report or challenge at these meetings.

110. The Scottish Social Services Council (SSSC) working with universities and others, has recently developed a qualification for CSWOs. The postgraduate diploma is aimed specifically at those currently in the CSWO role or who aspire to the role. There is also an option to proceed to a Masters qualification. CSWOs and social worker managers who we interviewed who are studying for this qualification all found it helpful and useful in practice, as well as helping the council in succession planning.

Elected members are key decision-makers for local social work services

111. During the era of steadily increasing council spending that ended in 2010, people's expectations were raised as to the level of service that social work services could provide. Councils are now in an era of reducing spending. Councils need to play a leading role in a wider conversation with the public about the level of social work services they can realistically provide and how they can best provide it. Current arrangements for providing care are not sustainable in the long term, given the demographic and financial pressures. As we reported in *Changing models of health and social care*: 'Services cannot continue as they are and a significant cultural shift

in the behaviour of the public is required about how they access, use and receive services'.[63] Elected members need to play a key role in this change, engaging with communities in a wider dialogue about council priorities.

112. The Christie Commission suggested that councils should work closely with individuals and communities to understand their needs, maximise talents and resources, support self-reliance, and build resilience. Communities have a significant role to play, and councils and their community planning partners should do more to encourage and help them to assume more responsibility for supporting themselves. North Lanarkshire's *Making Life Easier* service is a website that helps people to identify problems and develop their own solutions through information, professional advice and direct access to services and support (Case study 5).

Case study 5

Making Life Easier

North Lanarkshire Council worked with ADL Smartcare to develop a website to help those who wish to live independently at home. Making Life Easier provides professional advice and guidance on health issues and on managing daily living tasks. It includes hints and tips and signposts to organisations such as social and support groups, lunch clubs and drop-in cafes.

People and their carers can do an online self-assessment to identify safe and suitable equipment and minor adaptation choices that will help them manage their lives. People can choose to get the equipment and minor adaptations they need without charge through a link to the council's integrated equipment and adaptation service, or there is information on how to buy it for themselves.

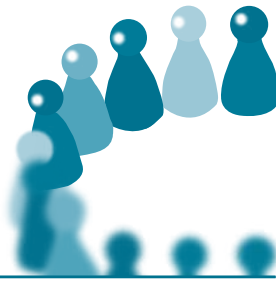
East Lothian Council is developing a similar service, which they will call HILDA – Health and Independent Living with Daily Activities.

Source: North Lanarkshire Council

113. Although health and social care integration will change the way social work services are commissioned and funded, councils remain responsible for promoting social welfare.[64] This includes improving outcomes for people who use services. Councils and IJBs need to ensure they are scrutinising budgets, plans and outcomes, including the effectiveness of services and the impact on individuals.

114. Elected members may find that their role changes, but they remain the key decision-makers for social work services on behalf of their constituents and they ensure effective scrutiny, governance and strategic oversight of the new arrangements. It is essential that elected members assure themselves of the quality of social work services and ensure councils manage risks effectively at a time of great change. With increasing financial pressures, councillors may face a difficult challenge in managing people's expectations, but they have a crucial role in doing so and providing leadership for their communities.

Endnotes



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4 Social Work and Social Care Statistics for Scotland: A Summary, Scottish Government, January 2016.

5 Scottish Local Government Financial Statistics, Scottish Government, February 2016.

6 Scottish Social Service Sector: Report on 2015 Workforce Data, August 2016.

7 We use the term 'third sector organisation' to describe organisations that are neither public sector nor private sector, including voluntary and community organisations (both registered charities and other organisations such as community groups), social enterprises, mutuals and co-operatives.

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13 *Health and social care integration*, Audit Scotland, December 2015.

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15 *Scotland's Population, The Registrar General's Annual Review of Demographic Trends 2014*, published August 2015.

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29 *Valuing Carers; The rising value of carers' support*, Carers UK, 2015.

30 *An overview of local government in Scotland 2016*, Audit Scotland, March 2016.

31 The net expenditure breakdown in Exhibit 5 is taken from Scottish Local Government Financial Statistics 20014-15. The total net expenditure figure of £3.3 billion is from the audited accounts and includes pension costs and capital accounting costs that the £3.1 billion in the local financial returns (LFRs), on a funding basis, will exclude.

32 *An overview of local government in Scotland 2016*, Audit Scotland, March 2016.

33 Scottish Parliament, Health and Sport Committee, Integrated Joint Board survey responses, August 2016.

34 Information supplied by Scottish Government.

35 Scottish Government unpublished analysis, March 2016.

36 *Social Services in Scotland: a shared vision and strategy 2015-2020*, Scottish Government, March 2015.

37 *Route Map to the 2020 Vision for Health and Social Care*, Scottish Government, May 2013.

38 *Reshaping Care for Older People – A Programme for Change 2011–21*, Scottish Government, COSLA and NHS Scotland, 2010.

39 *Reshaping care for older people*, Audit Scotland, February 2014.

40 *Changing models of health and social care*, Audit Scotland, March 2016.

41 The NHS and Community Care Act 1990 provides a statutory framework for community care, which forms the cornerstone of community care law. It places a duty on local authorities to assess an individual's need for 'community care services'.

42 Scottish Government and COSLA guidance on a national framework for eligibility criteria, 2009.

43 *Route Map to the 2020 Vision for Health and Social Care*, Scottish Government, May 2013.

44 Data from Children's Social Work Statistics Scotland, 2011/12, Scottish Government, March 2013 and Children's Social Work Statistics Scotland, 2014-15, Scottish Government, June 2016.

45 *Getting it right for children in residential care,* Audit Scotland, September 2010.

46 Recreate Volunteer Programme: A social return on investment (SROI) analysis, Margaret Smith and Vikki Binnie, 2014. An SROI considers the length of time changes last to assess future value. Because this user group is often associated with a chaotic lifestyle, the study shows a range in value to reflect a conservative estimate and an estimate reflecting the sustained changes possible.

47 Local Government Benchmarking Framework, Improvement Service (website).

48 A framework agreement does not have to be a contract. However, where it is a contract it is treated like any other contract, and the EU procurement rules apply.

49 The 2016/17 fees paid to providers for local authority placements are set at £624.54 a week for nursing care and £537.79 for residential care until 30 September. After that, fees will increase to £648.92 a week for nursing care, and £558.77 for residential care until April 2017 (the £372 figure in paragraph 62 has income from contributions deducted). Fees for self-funders tend to be substantially higher.

50 Scottish Statistics on Adults Resident in Care Homes, 2006-2015, ISD Scotland, October 2015.

51 Local Government Benchmarking Framework, Improvement Service (website).

52 The Care Home Census: Scottish Statistics on Adults Resident in Care Homes 2006-2015. The census includes data on adults living in care homes in Scotland that are registered with the Care Inspectorate.

53 NHS National Services Scotland, Public Health and Intelligence, 2016.

54 These figures are for residents who do not require nursing care. The equivalent figures for residents who do require nursing care are £775 and £590.

55 The Scottish Government is holding a 'national conversation' on health and social care services. Some of the carer's quotes are taken from the Coalition of Carers in Scotland event to support carers to contribute their views, held on 25 November 2015.

56 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

57 Local Government Benchmarking Framework, the improvement service.

58 A full list of the arrangements in all councils is included in Exhibit 8, page 22 of *Health and social care integration*, Audit Scotland, December 2015.

59 *Health and social care integration*, Audit Scotland, December 2015.

60 Roles, Responsibilities and Membership of the Integration Joint Board, Scottish Government, September 2015.

61 The others are: The Head of Paid Service (chief executive) responsible to councillors for the staffing and ensuring the work of the council is co-ordinated; the Monitoring Officer prepares governance documents and advises councillors about legal issues; the Chief Financial Officer; the Chief Education Officer.

62 The Role of Chief Social Work Officer, Guidance Issued by Scottish ministers, pursuant to Section 5(1) of the Social Work (Scotland) Act 1968, Revised Version, July 2016.

63 *Changing models of health and social care*, Audit Scotland, March 2016.

64 Social Work (Scotland) 1968 Act.

Social work in Scotland

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SOCIAL WORK STRATEGY AND SERVICE PLANNING	
Recommendation	**Response**
Community involvement about the long-term future for social work and care to meet statutory responsibilities.	• This will form part of the work we will do in relation to community engagement and participation in strategic and locality planning • Our workforce planning approach will take cognisance of this
Recommendation	**Response**
Work with Scottish Government, Social Work Scotland and other stakeholders to review how to provide social work services for future and future funding arrangements	• We will continue to engage with relevant Scottish Government and SWS work streams. • There are twice yearly meetings with Scottish Government Officials, the Chief Officer and Chief Executives. • Senior Managers and CSWO are members of SWS and engage in relevant standing committees of that organisation.
Recommendation	**Response**
Develop long term strategies for the services funded by social work by: 1. Carrying out a detailed analysis of demographic change and the contribution. preventative approaches can make to reduce demand for services. 2. Developing long-term financial and workforce plans.	• Demographic analysis is a key element of the strategic planning process and a focus on prevention and sustainability underpins the structure of the Strategic Transformation Programme as well as our Strategic Commissioning aims • Financial Strategy and workforce planning both

3. Working with service users, carers and service providers to design and provide services around the needs of individuals. 4. Working more closely with local communities to build community capacity to support people. 5. Consider examples of innovative practice. 6. Working with NHS and SG to review how to better synchronise partners' budgeting-setting arrangement to support these strategies.	underway and will be presented to the IJB. • This is key to our locality team development as well as our approach to Self-Directed Support. • Our locality approach sets out to lead this capacity building and we are recruiting via the 3rd sector community builders to enhance this approach. • We believe our transformation programme to be innovative and also participate in national discussion and forums where best practice is shared and consider if new models can be adapted for the Aberdeen City context. • Aberdeen City Council and NHS Grampian have already synchronised budget setting arrangements in support of the Integration Joint Board.
GOVERNANCE AND SCRUTINY ARRANGEMENTS	
Recommendation	**Response**
Ensure that governance and scrutiny of social work services are appropriate and comprehensive across the whole of social work services and review these arrangements regularly as partnerships develop and services change	• The CSWO is an advisory member of the IJB • CSWO is a member of the Clinical and Care Governance Committee and has an open invitation to attend the Clinical and Care Governance Group • The Clinical and Care Governance Structure sits within a wider Board Assurance Framework and is developing its governance and scrutiny processes – for social work purposes using the information routinely and regularly reported previously to the Service Committee • Clinical and Care Governance processes are in place for ACC and NHS Grampian to get assurance from the

	processes being in place and for social work and statutory purposes the CSWO and Chief Exec of ACC also report to Full Council – the CSWO in her report and the CE in relation to 'matters of interest to the Council in regard to the IJB • The Good Governance Institute have been commissioned to review the governance processes of the IJB and its Committees over the course of its first 'live' year and this will be reported to the IJB
Recommendation	**Response**
Improve accountability by having processes in place to: • Measure the outcomes of services and their success rates • Monitor the efficiency and effectiveness of services • Allow elected members to assure themselves that the quality of social work services is being maintained and that councils are managing risks effectively • Measure people's satisfaction with services Report the findings to elected members and the IJB.	• Clinical and Care Governance framework includes measurement of outcomes • Performance framework in development for the IJB measures against the 9 national outcome measures and includes a suite of local and national measure of service quality and user experience • We are also developing and refining approaches to measure outcomes across services commissioned for adult social care by the ACC as directed by the IJB • We will seek to strengthen our approaches to people's satisfaction with services • Regular performance reports are presented and the IJB is responsible for delivering an annual report to the Council and NHS also

WORKFORCE (councils should)	
Recommendation	**Response**
Work with representative organisation, Scottish Government and third/private sector employers to put in place a coordinated approach to resolve workforce issues in social care.	• A market facilitation plan is being developed in conjunction with our partners in the third and independent sectors showing the agreed principles and interventions that will provide individual support to providers and stabilise the local market. • The UNISON ethical care charter is in the process of being adopted by the Council and IJB. • Regular meetings are held with the third and private sector employers. • Resolving the workforce issues in social care will cost more money at a time when budgets are already stretched due to the increasing complexity of client needs and demographics.
Recommendation	**Response**
As part of contract monitoring arrangements, ensure that providers who use zero hours contracts allow staff to accept or turn down work without being penalised.	• There are currently no monitoring arrangements in respect of the relationship between employees on zero hours contracts and their employer. • However the IJB supports the principles of the Ethical Care Charter and has directed that a working group be established to consider the implementation of the Charter and to provide the IJB with an update before the end of the financial year.

SERVICE EFFECIENCY AND EFFECTIVENESS	
Recommendation	**Response**
When planning an initiative, include evaluation criteria and extend or halt initiatives depending on the success of new approaches in improving outcomes and value for money.	• The Programme Office Approach to the Transformation Programme sets out a clear, proportionate approach to evaluation.
Recommendation	**Response**
Work with COSLA to review the eligibility framework to ensure that it is still fit for purpose in the light of recent policy and legislative changes.	• ACC are members of the Scottish Local Government Partnership and not CoSLA however currently apply the agreed national eligibility criteria guidance in respect of Social Work assessments.

Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

Minute of Meeting

11 August 2016
Town House, Aberdeen

Present: Professor Mike Greaves (NHS Grampian) Chairperson and Councillors Ironside CBE and Young.

Also in attendance: Judith Proctor (Chief Officer, Aberdeen City Health and Social Care Partnership (ACH&SCP)), Kevin Toshney (Planning and Development Manager, ACH&SCP), Jimmie Dickie (Accountant, Aberdeen City Council (ACC)), Gill Mutch (Senior Accountant, ACC), David Hughes (Internal Audit), Deirdre Sim (Audit Scotland), Steven Inglis (Team Leader, Legal Services, ACC) and Iain Robertson (Clerk, ACC).

Apologies: Alex Stephen (Chief Finance Officer, ACH&SCP) and Tom Cowan (Head of Operations, ACH&SCP).

OPENING REMARKS

1. The Chair opened the meeting and advised that a paper would be presented to the IJB at its next meeting on 30 August 2016 recommending that Ms Rhona Atkinson be appointed to the Audit and Performance Systems Committee as a voting member. Thereafter members introduced themselves and apologies were noted.

The Board resolved:-
To note that a report would be presented to the IJB on 30 August 2016 recommending that Ms Rhona Atkinson be appointed to the Audit and Performance Systems Committee as a voting member.

MINUTE OF PREVIOUS MEETING – 31 MAY 2016

2. The Committee had before it the minute of the previous meeting of 31 May 2016.

The Committee resolved:-
(i) to approve the minute as a correct record;

(ii) to note that the suggested changes to section 8.2 of the Terms of Reference had been actioned; and
(iii) to note that an example of a worked SIPOC analysis had been received from the Good Governance Institute.

CORPORATE RISK REGISTER

3. The Committee had before it the updated Corporate Risk Register for members' consideration.

Judith Proctor (Chief Officer, ACH&SCP) advised that the Corporate Risk Register was being reviewed and revised on a regular basis by the Executive Team and they were in the process of adding a column which would highlight if performance had improved, deteriorated or remained unchanged at a glance. Mrs Proctor added that the Executive Team had identified market failure as a key risk and they had looked at conducting a market analysis through the use of Scotland Excel to further inform the assignment of risk and the adoption of appropriate controls and mechanisms to manage and mitigate this risk.

The Committee resolved:-
To note the revisions made to the Corporate Risk Register.

PERIOD 3 FINANCE REPORT

4. The Committee had before it a report by Gillian Parkin (Finance Manager, NHSG) and Jimmie Dickie (Finance Business Partner, ACC) which summarised the current year revenue budget performance for the services within the remit of the Integration Joint Board (IJB) as at Period 3 (end of June 2016). The report also advised on areas of risk and management action relating to revenue budget performance of IJB services.

The report recommended:-
that the Committee -
(a) Note the report on the period 3 position in relation to the IJB budget and the information on areas of risk and management action that was contained therein; and
(b) Note that the Executive Team would be required to agree a plan to reduce the level of anticipated overspend to a break even position for financial year end.

Jimmie Dickie spoke to the report and advised that the Partnership was in a favourable financial position but highlighted that there was a Prescribing overspend of £1.3m and informed the Committee that meetings had been scheduled with lead officers to manage this position and to identify areas where efficiencies could be made. Councillor Young asked how this overspend would be managed between the Council and NHS Grampian and Judith Proctor explained that for the Board's first financial year overspend costs would remain the responsibility of the relevant partner based on existing service and funding commitments but noted that the Partnership in conjunction with both partners would aim to produce a balanced budget at Year End. Mrs Proctor also highlighted that the prescribing budget was particularly volatile as it

was demand led but that they would continue to engage with primary care and pharmacy colleagues to manage and mitigate this issue.

Thereafter there were questions on Living Wage underspend, in which Mr Dickie advised that funds had not been accrued yet as a decision had not been taken by the Board on how funds should be utilised. And on the level of Mental Health overspend, which Mrs Proctor explained was largely due to the challenges in recruiting and retaining quality staff and added that lead officers would continue to monitor this position.

The Committee resolved:-

(i) to note the report on the period 3 position in relation to the IJB budget and the information on areas of risk and management action that was contained therein;

(ii) to note that the Executive Team would be required to agree a plan to reduce the level of anticipated overspend to a break even position for financial year end; and

(iii) to request that the Chief Officer raise Prescribing as an issue for discussion at the next IJB Chief Officers meeting and thereafter to provide an update to the Committee's next meeting on these discussions and instances of best practice.

IMPLEMENTATION OF THE NATIONAL LIVING WAGE TO CARE WORKERS

5. The Committee had before it a report by Gill Mutch (Senior Accountant, ACC) and Alison MacLeod and Jean Stewart-Coxon (Commercial and Procurement Services, ACC) which sought Committee approval to increase rates paid to external providers from 1 October 2016 to help implement the Living Wage commitment made by the Scottish Government and Local Government as part of the 2016-17 grant settlement.

The report recommended:-

that the Committee –

(a) Agree the proposal of a 6.4% uplift to all rates for purchased services across all client groups and for all hours worked (except those already covered by the National Care Home Contract) from 1 October 2016 to the IJB; and

(b) Agree that the Committee's proposed course of action be recommended to the IJB for final approval, and to note that a formal direction would need to be provided to Aberdeen City Council to release the additional payments on the agreed basis.

Judith Proctor spoke to the report and explained that the implementation of the living wage for care providers had been a provision of the grant settlement between Scottish Government and Local Governement but noted that no central direction had been produced on how this uplift would be passed onto providers and staff. Mrs Proctor highlighted that the Partnership was heavily dependent on external care providers but advised that the Partnership couldn't compel providers to deliver the living wage on a voluntary basis. She noted that the report recommended a 6.4% uplift for all external providers as this would align with the 2016-17 National Care Home Contract increase and would promote fair working practices particularly for providers that were existing living wage employers.

Thereafter there were questions on the IJB's adoption of Unison's Ethical Care Charter; and how the IJB could receive assurance that the proposed uplift would be used by providers to pay staff the living wage or to fund relevant training and development opportunities for care staff. Judith Proctor also advised the Committee that Bon Accord Care would not receive the proposed uplift as they were subject to the Council's terms and conditions and they had been notified of this position.

The Committee resolved:-

(i) to agree the proposal of a 6.4% uplift to all rates for purchased services across all client groups and for all hours worked (except those already covered by the National Care Home Contract) from 1 October 2016 to the IJB;

(ii) to agree that the Committee's proposed course of action be recommended to the IJB for final approval, and to note that a formal direction would need to be provided to Aberdeen City Council to release the additional payments on the agreed basis; and

(iii) to Instruct the Chief Officer to ensure the implementation of the Living Wage and Fair Working Practices through appropriate contract monitoring processes and to provide assurance to the IJB that this had been implemented by the end of the financial year.

DECLARATIONS OF INTEREST

Judith Proctor declared a pecuniary interest in the following item and chose to withdraw from the meeting during consideration of this item.

2015-16 ANNUAL ACCOUNTS (UNAUDITED)

6. The Committee had before it a report by Paul Dixon (Accounting Manager, ACC) which provided the Committee an overview of the Board's 2015-16 unaudited annual accounts and to enable scrutiny of and approval by Committee of the content of the Annual Governance Statement.

The report recommended:-
that the Committee –

(a) Approve the Annual Governance Statement as included in the Board's unaudited annual accounts for the financial year 2015-16;

(b) Approve the accounting policies contained within the unaudited annual accounts 2015-16;

(c) Consider the Board's unaudited annual accounts 2015-16; and

(d) Note that the Board's unaudited annual accounts had been submitted to Audit Scotland on 30 June 2016.

Jimmie Dickie summarised the annual accounts and noted that this was an initial iteration of the IJB's position and there was limited movement to update the committee on. He added that Finance colleagues would continue to monitor the Board's financial position and provide regular updates to the Committee.

The Committee resolved:-

(i) to approve the Annual Governance Statement as included in the Board's unaudited annual accounts for the financial year 2015-16;
(ii) to approve the accounting policies contained within the unaudited annual accounts 2015-16; and
(iii) to note that the Board's unaudited annual accounts had been submitted to Audit Scotland on 30 June 2016.

2016-17 AUDIT PLAN

7. The Committee had before it a report by David Hughes (Chief Internal Auditor) which sought Committee approval of the Internal Audit Plan for the Aberdeen City IJB for 2016-17, subject to ACC's Internal Auditors being appointed as Internal Auditors to the IJB on 30 August 2016, and the protocol for sharing the results of Internal Audit outputs.

The report recommended:-
that the Committee –
(a) Approve the Internal Audit Plan for 2016-17, subject to Aberdeen City Council's Internal Auditors being appointed as Internal Auditors to the Aberdeen City IJB on 30 August 2016; and
(b) Agree to the sharing of Aberdeen City IJB Internal Audit reports with Aberdeen City Council's Audit, Risk and Scrutiny Committee and NHS Grampian's Audit Committee.

David Hughes spoke to the report and explained that the Audit Plan was part of the process which would formalise auditing arrangements for the IJB and its two partners. He advised that it was a limited plan as the primary focus of Internal Audit was on the arrangements put in place by the City Council and NHS Grampian to monitor and support the IJB and ACH&SCP.

The Committee resolved:-
(i) to approve the Internal Audit Plan for 2016-17, subject to Aberdeen City Council's Internal Auditors being appointed as Internal Auditors to the Aberdeen City IJB on 30 August 2016; and
(ii) to agree to the sharing of Aberdeen City IJB Internal Audit reports with Aberdeen City Council's Audit, Risk and Scrutiny Committee and NHS Grampian's Audit Committee.

DECLARATIONS OF INTEREST

The Chair declared an interest in the following item by virtue of his position as a Board member of Quarriers but chose to remain in the meeting during consideration of this item.

ALEO GOVERNANCE HUB UPDATE: BON ACCORD CARE

7. The Committee had before it a report by the Clerk which reported to Committee the outcome of the most recent ALEO Governance Hub meeting in

relation to Bon Accord Care. The minutes from the 9 May 2016 meeting were appended to the report.

The report recommended:-
That the Committee note the report and the contents of the minute of the ALEO Governance Hub meeting of 9 May 2016 in relation to Bon Accord Care.

Judith Proctor advised that the ALEO Governance Hub would now be meeting on a quarterly basis and the minutes of the Bon Accord Care meetings would be presented to this Committee. She added that appropriate scrutiny of Bon Accord Care was important as 10% of the IJB's budget was assigned to services provided by the ALEO.

The Committee resolved:-
To note the report and the contents of the minute of the ALEO Governance Hub meeting of 9 May 2016 in relation to Bon Accord Care.
PROFESSOR MIKE GREAVES, Chairperson.

Aberdeen City Health & Social Care Partnership
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AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

Minute of Meeting

25 October 2016
Community Health and Social Care Village, Aberdeen

Present: Professor Mike Greaves (NHS Grampian) Chairperson; and Councillors Ironside CBE and Young (for items 1-8); and Rhona Atkinson (NHS Grampian).

Also in attendance: Judith Proctor (Chief Officer, Aberdeen City Health and Social Care Partnership (ACHSCP)), Alex Stephen (Chief Finance Officer, ACHSCP), Kevin Toshney (Acting Head of Strategy and Transformation, ACHSCP), Jimmie Dickie (Accountant, Aberdeen City Council (ACC)) (for items 6 and 7), David Hughes (Internal Audit), Gail Woodcock (Integrated Localities Programme Manager, ACHSCP) (for item 9), Kenneth O'Brien (Service Manager, ACHSCP) (for item 10) and Iain Robertson (Clerk, ACC).

Observing: Hannah Campbell and Hilary Merrett (Good Governance Institute (GGI)).

Apologies: Tom Cowan (Head of Operations, ACHSCP) and Jillian Evans (NHS Grampian).

OPENING REMARKS

1. The Chair opened the meeting and welcomed Rhona Atkinson onto to the Committee as a voting member representing NHS Grampian. He also advised that officers from the Good Governance Institute would be observing today's meeting. Thereafter members introduced themselves.

The Board resolved:-
To note the information provided.

MINUTE OF PREVIOUS MEETING – 11 August 2016

2. The Committee had before it the minute of the previous meeting of 11 August 2016.

The Committee resolved:-
To approve the minute as a correct record.

BOARD ASSURANCE FRAMEWORK

3. The Committee had before it the Board Assurance Framework for members' consideration.

The Committee resolved:-
To note the Board Assurance Framework.

CORPORATE RISK REGISTER

4. The Committee had before it the Corporate Risk Register for members' consideration.

Alex Stephen (Chief Finance Officer, ACHSCP) advised that an additional column had been added to the Strategic Risk Register which set out whether performance had improved, deteriorated or remained the same for each indicator. Otherwise there were no other substantive changes to the Corporate Risk Register.

The Committee resolved:-
To note the Corporate Risk Register.

COMMITTEE MEETING DATES 2017-18

5. The Committee had before it a report by Sarah Gibbon (Executive Assistant to the Chief Officer) which proposed a meeting schedule for the Audit and Performance Systems Committee for 2017-18.

The report recommended:-
That the Committee agree the 2017-18 meeting dates as outlined in the report.

The Clerk appended a revised report and advised that the following meeting dates should be considered by members:-

11 April 2017;
20 June 2017;
12 September 2017;
21 November 2017; and
6 February 2018.

The Committee resolved:-
To agree the meeting dates as outlined in the revised report.

TERMS OF REFERENCE: SIX MONTH REVIEW

6. The Committee had before it a report by Alex Stephen (Chief Finance Officer, ACHSCP) which presented the Terms of Reference which required to be reviewed on a six monthly basis.

The report recommended:-
That the Committee consider the current Terms of Reference and recommend any potential changes to the IJB.

Alex Stephen spoke to the report and proposed that item 13 be revised to provide authority to the APS Committee to approve the Partnership's unaudited and audited annual accounts from September 2017 onwards. He advised that legislation was in place to allow the IJB to delegate this power to the Committee and added that similar practice had been adopted by Aberdeen City Council.

The Committee resolved:-
(i) to recommend to the IJB that item 13 of the Terms of Reference be revised to delegate the power to approve the Partnership's unaudited and audited annual accounts to the APS Committee; and
(ii) to instruct officers to prepare a developmental timetable for 2016-17 and 2017-18 and present this to the Committee's next meeting.

PERIOD FIVE FINANCE REPORT

7. The Committee had before it a report by Gillian Parkin (Finance Manager, NHSG) and Jimmie Dickie (Finance Business Partner, ACC) which summarised the current year revenue budget performance for the services within the remit of the IJB as at period five. The report advised on areas of risk and management action relating to the revenue budget performance of IJB services.

The report recommended:-
That the Committee note the report on the period five position in relation to the IJB budget and the information on areas of risk and management action that was contained therein.

Alex Stephen spoke to the report and advised that the Partnership's projected overspend was currently £1,027,000 at Year End but anticipated a reduction to an estimated £800,000 by period six. He explained that this was largely due to prescribing costs which were challenging to manage as these were demand led but noted that the Partnership had entered into discussions with pharmacists and primary care colleagues to gauge if efficiencies could be made. Mr Stephen highlighted that proposals to incentivise primary care staff to alter their prescribing approaches through a spend to save scheme were being developed.

Thereafter there were questions on the use of transformation funding to cover overspends and Alex Stephen advised that the Partnership had been drafting a financial strategy that would assess all its financial options. With regards to prescribing, he explained that the volume and cost of medicines had increased and the reduced value of the pound may exacerbate this issue in future periods. Judith Proctor (Chief Officer, ACHSCP) informed members that a workshop session on prescribing would be scheduled for a future IJB meeting and noted that it was a long term issue with multiple factors out with the Partnership's control. The Committee

also discussed the anticipated level of Scottish Government funding for 2017-18 and the community justice element of the Partnership's budget, to which members recommended a workshop session be arranged to increase the IJB's awareness of this delegated service.

The Committee resolved:-

(i) to note the report on the period five position in relation to the IJB budget and the information on areas of risk and management action that was contained therein; and

(ii) to recommend that a workshop session be arranged for IJB members on community justice.

RESERVE STRATEGY

8. The Committee had before it a report by Alex Stephen which proposed a Reserves Policy for the consideration of the Committee.

The report recommended:-

That the Committee consider and comment on the proposed Reserves Policy, prior to being submitted to the next IJB meeting for approval.

Alex Stephen spoke to the report and explained that the Partnership had the capacity to carry funds forward into the next financial year which was common practice for local authorities but a new way of working for the NHS. He advised that the reserves strategy would aim to strike a balance between financial security and the delivery of services and anticipated that between 1% and 2% of the budget would be earmarked as reserves for a risk fund. Mr Stephen informed the Committee that reserves would not be allocated to a separate fund but earmarked within the general fund and would be presented to the IJB to ensure transparency. He explained that if the risk reserve were to be used it would be their intention to replenish them.

Thereafter there were questions on the Partnership's current financial position and its capacity to accumulate reserves; and members advised officers to be mindful as the adoption of a prudent approach with respect to reserves may have an adverse impact on the level of funding allocated to the Partnership.

The Committee resolved:-

To recommend to the IJB that the Reserves Policy be approved.

PERFORMANCE REPORT

9. The Committee had before it a report by Jillian Evans (Head of Health Intelligence, NHSG) and Kevin Toshney (Acting Head of Strategy and Transformation, ACHSCP) which provided the Committee with a progress report on the development of the partnership's performance management framework, reported on the partnership's performance to date against the national outcomes and their suite of national and local indicators and outlined the improvement activity that had been taken forward.

The report recommended:-

that the Committee -

(a) Note the progress that had been made to date in developing the partnership's performance management framework; and

(b) Note the partnership's performance against the national outcomes and the associated suite of national and local indicators.

Kevin Toshney advised that the Partnership had adopted a tiered approach with regards to its performance management framework and explained that the framework would record how the Partnership had been performing in relation to its delegated functions and against the nine national health and wellbeing outcomes. Mr Toshney noted that the framework was a working document and would be subject to regular revision and that in due course the Partnership would develop bespoke, local indicators. He also noted that benchmarking was ongoing at regional and national levels and Sir Harry Burns had been commissioned to review the framework. Judith Proctor advised that the framework had recorded an improvement in delayed discharge performance and would be further developed to capture unmet social care need, care at home and hosted service performance. She explained that the Partnership had begun to use Tableau software to support business intelligence and that IJB members would be provided access to the system. She also suggested that the Committee may find it beneficial to arrange deep dive sessions that would focus on specific areas of performance at future meetings.

Thereafter there were questions on the low survey response rates and the representativeness of the data; the Partnership's response to the Care Inspectorate's report on the joint inspection of services for older people; the development of an acute care at home business case; and delayed discharge performance.

The Committee resolved:-

(i) to note the progress that had been made to date in developing the partnership's performance management framework;

(ii) to note the partnership's performance against the national outcomes and the associated suite of national and local indicators; and

(iii) to request that officers review and prioritise performance areas that would be suitable for deep dive sessions at future Committee meetings.

TRANSFORMATION PROGRESS REPORT

10. The Committee had before it a report by Gail Woodcock (Integrated Localities Programme Manager, ACHSCP) which provided an update on the progress of the Transformation Programme.

The report recommended:-

that the Committee –

(a) Note the ongoing process and progress in developing and delivering the Transformational Programme;

(b) Note that a paper would be developed for the consideration of the IJB in respect of the requirement to issues directions to Aberdeen City Council and NHS Grampian in respect of areas of transformation; and

(c) Request further updates on transformation progress.

Gail Woodcock spoke to the report and provided updates on the level of investment and areas of progress and challenge for the six areas of strategic investment as set out in the Strategic Plan. She advised that the transformation programme would be a long term investment to support cultural and generational change. The six areas for strategic investment were:

Acute care at home;
Supporting management of long term conditions;
Modernising primary and community care;
Cultural/organisational change;
Strategic commissioning and development of social care; and
Information and communication technology and technology enabled care.

Thereafter there were questions on the Partnership's capacity to deliver the level of transformation as outlined in the report; and the role of the voluntary sector in supporting transformational change with regards to providing operational support at locality level.

The Committee resolved:-

(i) to note the ongoing process and progress in developing and delivering the Transformational Programme;
(ii) to note that a paper would be developed for the consideration of the IJB in respect of the requirement to issues directions to Aberdeen City Council and NHS Grampian in respect of areas of transformation; and
(iii) to request further updates on transformation progress.

WINTER PLAN

10. The Committee had before it a report by Kenneth O'Brien (Service Manager, ACHSCP) which provided a brief description of the context and process behind the creation of the current winter plan for the partnership; documented the testing arrangements put in place in regards to the 2016-17 winter plan; and set out the monitoring arrangements for the winter plan.

The report recommended:-
that the Committee –

(a) Review and approve the 2016-17 winter plan for the ACHSCP and its onward transmission to NHSG for inclusion in the Grampian-wide winter plan;
(b) Endorse the review arrangements for the ACHSCP winter plan for over the 2016-17 winter period; and
(c) Approve the publication of the finalised 2016-17 winter plan on the Partnership's website.

Kenneth O'Brien spoke to the report and outlined the consultation process and the rigorous desktop testing schedule that had been undertaken. Members welcomed the plan and were pleased with the robustness of the testing regime but noted that officers should be mindful that tests could not replicate certain practicalities and emotions that would only be prevalent in a live event.

The Committee resolved:-

(i) to approve the 2016-17 winter plan for the ACHSCP and its onward transmission to NHSG for inclusion in the Grampian-wide winter plan;
(ii) to endorse the review arrangements for the ACHSCP winter plan for over the 2016-17 winter period; and
(iii) to approve the publication of the finalised 2016-17 winter plan on the Partnership's website.

ALEO GOVERNANCE HUB UPDATE: BON ACCORD CARE

11. The Committee had before it a report by the Clerk which provided an update on the significant matters raised at the Bon Accord Care ALEO Governance Hub meeting on 15 August 2016.

The report recommended:-
that the Committee –
(a) Consider the issues raised in the report and identify any areas of concern; and
(b) Note the report and the assurance summary in relation to Bon Accord Care.

The Clerk explained that a report, assurance summary and minutes had been submitted to the Council's Audit, Risk and Scrutiny Committee on 27 September 2016 and had been presented to the APS Committee for scrutiny of Bon Accord Care's service performance.

The Committee resolved:-
To note the report and the assurance summary in relation to Bon Accord Care.
PROFESSOR MIKE GREAVES, Chairperson.

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Aberdeen City Health & Social Care Partnership
A caring partnership

Clinical and Care Governance Committee
Meeting of Tuesday 16th August 2016, 10.00 to 13:00
Meeting Room 5, Health Village

Members

Councillor Alan Donnelly(**Chair**)	(AD)	Integration Joint Board Member
Councillor David Cameron	(DC)	Integration Joint Board Member
Dr Nick Fluck	(NF)	Integration Joint Board Member
Mr Jonathan Passmore	(JPa)	Integration Joint Board Vice Chair

Attendees

Miss Ashleigh Allan	(AA)	Clinical Governance Facilitator, Quality Governance Risk Unit
Mr Tom Cowan	(TC)	Head of Operations, Aberdeen City Health & Social Care Partnership
Dr Howard Gemmell	(HG)	Patient and Service User Representative
Ms Sarah Gibbon	(SG)	Executive Assistant to Judith Proctor
Mrs Brenda Lurie	(BL)	Clinical Effectiveness Team Leader Quality Governance Risk Unit
Dr Stephen Lynch	(SL)	Interim Clinical Lead & Chair of Clinical and Care Governance Group, Aberdeen City Health & Social Care Partnership
Ms Laura McDonald	(LMc)	Chair of Joint Staff Forum & Partnership Representative
Mrs Judith Proctor	(JPr)	Chief Officer, Aberdeen City Health & Social Care Partnership
Mr Alex Stephen	(AS)	Chief Finance Officer, Aberdeen City Health & Social Care Partnership

Attending

Pauline Malloy	(PM)	Senior Analyst, Health Intelligence, NHS Grampian
Ms Kate McKay	(KM)	Business Manager, Education & Children's Services ACC
Mrs Lynn Morrison	(LM)	Allied Health Professional Lead, Aberdeen City Health & Social Care Partnership *(for Heather Macrae)*
Ms Anne Murray	(AMu)	Admin Support

Apologies

Ms Jillian Evans	(JE)	Head of Health Intelligence, NHS Grampian
Ms Heather Macrae	(HM)	Lead Nurse, Aberdeen City Health & Social Care Partnership
Ms Bernadette Oxley	(BO)	Head of Children's Social Work / Chief Social Work Officer
Mr Kenneth Simpson	(KS)	Chief Executive of VSA, 3rd Sector Representative for IJB

No.	ITEM	ACTION by
Welcome and Apologies (as listed above)		
	Standing Items	
1.0	Minute of Previous Meeting – 24th May 2016 - adopted as correct. Noted that list of attendees should include person's titles e.g. Dr, Mr, Mrs, etc.	
2.0	Business Statement (1st August 2016) – copy of update circulated to the Committee. Noted that item no. 3 could not be progressed until the "final determination" was received. Expected shortly, within next two months.	
Reports for Committee Consideration		

No.	ITEM	ACTION by
3.0	Health & Care Experience Survey 2015-16 Summary Report TC spoke to the report whilst KM attended to answer questions about the survey methodology and results. The Committee discussed the following; - The survey content and its relevance to the local population, - The need for the current and future survey sample populations to truly represent and/or reflect the growing, changing and/or diverse local population. - The response rate for Aberdeen City was 14% (3361/23713 patients surveyed) which is considered reasonable figure especially when compared against the national response rate of 18%. - There is need to ensure that the responses received truly reflect and/or represent local patient experiences. - The difficulty comparing surveys year on year and using collated data to check and assist improve community based health services and care. Concerns - Challenge of how to use the information to improve and/or streamline the patient path and/or experience. Committee was assured that this is already part of the wider NHSG performance framework. - Current resource pressures in Primary Care are encouraging innovative changes to the delivery of care in the Community. - Care/Caring Experience/Carers – the survey confirms that this is an area which needs serious consideration and investigation however the Committee were reminded that these areas are being considered as part of the Evaluation Framework which will confirm the impact of transformation on the partnership and partnership work. JP would like to include in this work some of the survey questions and responses and use these to build on/improve local Care and Carer support. Noted that the Patient Experience Survey is run every two years. The Committee was given assurance that the findings in this report are being considered by the Chief Officer and her team and being used in tandem with other such reports and findings as one of a suite of performance reports.	
Clinical & Care Governance Matters		
4.1	Summary Report This paper, which preceded the other reports in this section, was submitted with the intention of assuring the Committee that there are robust clinical governance mechanisms in place across the Health and Social Care Partnership. However there is recognition of the need to develop a single reporting framework that better reflects the more integrated approaches Health and Social Care now have and also best fit their clinical and care governance agendas. **The Committee approved the following recommendations** - Committee was asked to note the content of the report - Committee asked to endorse the proposal to create a Short Life Working Group to develop a reporting framework	

No.	ITEM	ACTION by
4.2	Minute of Clinical & Care Governance Group – 20th April 2016 The Committee noted that the agendas and minutes of the Clinical & Care Governance Group (CCGG) reflected the range, scale, diversity and depth of work covered by the Group. The attendance record also confirmed the commitment of all of the Group members. Points discussed and considered: - Due to the level, range and depth of work covered by the Group, the Committee may wish to consider delegating an agreed level of authority to the Group and by doing so enable the Group to provide fullest support. - The Committee does not need to see the level and/or detail of work covered by the Group but does need to be aware of and/or assured of any issues, ongoing work, investigations, etc. This will include the need to test and/or check the clinical & care governance "Assurance and Escalation Framework". - Both the Committee & Group must ensure coherence to the Board Strategic Plan, Strategies, Work and/or Projects. - If and when there are strands that cross over services these should be pulled together and reported collectively to the Committee e.g. IT issues, Staffing Resources, etc.	
4.3	Report from Clinical & Care Governance Meeting 20th July 2016 BL spoke to the paper submitted. The report was divided into two parts: - Part 1 set out, in summary format, the main "High Risk" items as well as some items of "Good Practice". - Part 2 set out, in table format, "New Areas of Concern", "Progress Against Areas of Concern Previously Reported", "Adverse Events" and "Progress on Implementing Recommendations from Ombudsman Cases". Table headings include "Level of Risk", "Corporate Risk", "Issues for Concern" and "Planned Action/Outcomes". **July update** Summary Sheet - Main items for discussion a) Recruitment & Retention of Nursing, Medical and Allied Health Professionals remains area of concern and high risk b) District Nursing - Items of good practice a) Despite the challenges Health Visiting received positive feedback from UNICEF on the 30th June from the assessment of the "baby friendly initiative accreditation". b) Recent audit of Cardiac Rehabilitation Service indicated that the vast majority of patients were very happy with the service provided and found the cardiac rehabilitation programme to be a relevant and valuable experience. Main Report The following items/headings were highlighted. a) Paediatric Dental General Anaesthesia services – as steps were put in place to address the current issues and problems the level of risk has dropped to low meaning this item can be removed from the report. b) Ombudsman Cases section – provides an update on outcomes and/or any	

No.	ITEM	ACTION by
	information, action and/or steps taken or put in place. c) List of Achievements/Good Practice – several listed, see report for details. **Headings discussed** Recruitment & Retention/Housing – there are a number of ongoing initiatives concentrating on attracting staff to Grampian and one of these includes provision of affordable housing. General Practice/staffing (all types) – the current staffing shortages together with the national difficulty attracting and/or retaining existing staff are forcing General Practice to reconsider how it delivers current services and also the type/s of contract it offers to existing and/or new staff. To ensure the continued safe delivery of care and/or services there is a move to increased use of other Health professionals to deliver services if and when appropriate e.g. Nurses, Pharmacists, Physicians Associates, etc. Part-time contracts are also being issued to encourage current staff to remain. Education/Medical Graduates – NF is due to meet with several local School Headmasters to discuss how the Education Sector can assist their pupils prepare to apply to Medical School/s. There are several successful courses which help recruit staff into the NHS (e.g. Physician Associates) but funding remains an issue for all students. Some Colleges and Universities are offering students bursaries, financial assistance and/or guaranteed employment to attract/retain them and Aberdeen is considering offering same. Outcomes of Staffing Issues – NF highlighted the need for Services to include the impact of staffing issues in their report/s to ensure that quality and safety are not compromised and ensure no harm. Transformation/Retention/Retirement/Career Breaks – all of these headings can and are affecting staff and/or staff morale. Steps are in place to keep staff informed, where possible be involved in testing and discussing new models of service delivery, etc. Some work ongoing work e.g. Torry & Kincorth Initiatives, NHSG considering the Buurtzorg Model, etc **Action/s** – the next workshop, scheduled for September, will cover social work/children's services. The headings discussed above will form 'part of a future workshop'	**BL/AA**
4.4	DATIX Lite Inadequate/Poor Discharges paper submitted was discussed. Definition/s of an Inadequate or Poor Hospital Discharge – BL researched this area but had difficulty finding a definition, she did instead locate an audit (England 2015) which investigated and identified the reasons behind patients having poor experience/s. These same patients were also asked "what they would have expected as part of a good experience". See report for details DATIX Lite reporting – the report confirms the under use of the system by and in General Practice. A list of themes has also been identified from previous DATIX Lite reports and this list will be used by the Clinical & Care Governance Group and	

No.	ITEM	ACTION by
	Discharge Group to monitor trends, what is happening regards feedback to GPs, etc. Any work undertaken around/under DATIX Lite will be reported to the Chief Officers Executive Group. DATIX and/or DATIX Lite – are the systems used within Grampian to record and report service issues, etc. Discussions are ongoing to role DATIX Lite out across the 3 IJBs and there are further discussions to make DATIX Lite an integral part of DATIX which will include introduction of reminders to Consultants to feedback to GP/GP Practices. **Action** – updates, where and when available, to be taken to the Committee. Discussion It was noted that feedback from the Acute Sector had improved but there is still room for improvement. It was suggested that certain conditions/situations should have a "must report" status against them. Finally, with the roll-out of the New GP Contract which focuses on quality and quality issues, GPs should be encouraged to increase their use of DATIX Lite.	**SL/BL**
Care Governance Data		
5.1	Reports The following reports, some of which are quite detailed, were circulated to the Committee with the aim of assuring all that there are mechanisms in place to review the Health and Social Care governance information, data and/or trends. Work is ongoing to review the existing reports, their content, format and/or structure so they fit the reporting requirements of this Committee.	
5.2	Incident Report NHS This is a quarterly report, extracted from DATIX, which is taken to the Clinical & Care Governance Group for review. Appendix 1 is detailed update. BL spoke to the report noting the following points - Abusive, violent, disruptive or self harming behavior – there was an increase of 26 on the previous quarter total however it was noted that many of these incidents are caused by underlying medical conditions and NHSG provides training and support to staff around management of aggression in the workplace to help reduce the number occurring. - Medication – every 6 months the Lead Pharmacist reviews medication incident/s and provides a report to the CCGG. Opportunities for sharing learning will be discussed with Pharmacy colleagues across the Health & Social Care Partnerships. - Pressure Ulcers – Community Nurses are recording pressure ulcers on Datix and this reflects the positive reporting cultures. - Explanations for Incident/s & Severity – moderate and extreme incidents are reviewed by the CCGG. - Action/s taken – it was agreed that these should now be checked, reviewed and learning shared. Outcomes should also be shared. Noted that "Negligible Incidents" seem to be steadily increasing, but this could reflect the increased use of the system by staff to record all levels of incidents.	

No.	ITEM	ACTION by
5.3	Feedback Report NHS (Summary) The CCGG use this report to review feedback, both positive and negative, received. The report does not include feedback from contracted General Practices as this is done annually at the Practice Review Meetings. The CCGG is exploring how themes regarding patient feedback might be captured across the Partnership from the Practice Review meetings.	
5.4	Social Work Data Summary Report KM took the Committee through the report circulated. On this occasion a full report was submitted but in future summary reports will be provided. Health & Safety - Quarterly reports are taken to the Adult Health & Safety Committee which consists of Senior Managers, Corporate H&S staff, Trade Union representatives. This Committee reviews and monitors compliance, accidents & incidents and staff absence. - Two systems are used to record incidents – noted that **Staff** issues are recorded on the "HR system" and **Client** issues are recorded on "careFirst". - Staff Absences – short term absences are falling, but long term absences seem to be increasing and are linked to psychological issues. Work ongoing to support staff and help them back to work. Complaints Rights and Enquiries - The Complaints Rights and Enquires Team sits within the Social Work Business Management Team and is responsible for the administration of statutory process related to social work complaints, freedom of information requests, subject and 3rd party access requests, responds to enquiries from elected members, MP and MSPs. Noted that work is ongoing to review the current processes and procedure with the aim of streamlining these with the other organisations/authorities within the Partnership. The deadline for completion will be the date that the Social Work complaints legislation is repealed in 2017. The Committee discussed the Health & Social Care reports and how the Partnership will be able to compare, match and/or benchmark each Sector or Area against each other. Noted that there will be mechanisms in place to assist with some of this work, thought that HR or Occupational health may be able to assist but it was confirmed that the Scottish Improvement Services provide the benchmarking indicators used by Social Care. **Action** – JPr to check with HR and Occupational Health if they have information on benchmarking, etc.	**JPr**
6.0	Items to Report to the Integration Joint Board Not covered	
7.0	AOCB - none	
8.0	Date of Next Meeting – Clinical & Governance Committee Meeting - 1st November 2016 - 10.00 to 12:00,	

No.	ITEM	ACTION by
	room to be confirmed a) Clinical & Care Governance Committee Workshop – held on 21st September 2016 at Health Village b) GP Event – 14th September, all Committee members welcome.	

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Aberdeen City Health & Social Care Partnership
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Clinical and Care Governance Committee
Meeting of Tuesday 1st November 2016, 10.00 to 13:00
Committee Room 4, Town House

Members

Councillor David Cameron	(DC)	Integration Joint Board Member
Dr Nick Fluck	(NF)	Integration Joint Board Member
Mr Jonathan Passmore	(JPa)	Integration Joint Board Vice Chair

Attendees

Miss Ashleigh Allan	(AA)	Clinical Governance Facilitator, Quality Governance Risk Unit
Mr Tom Cowan	(TC)	Head of Operations, ACHSCP
Dr Howard Gemmell	(HG)	Patient and Service User Representative
Ms Sarah Gibbon	(SG)	Executive Assistant to Judith Proctor
Mrs Brenda Lurie	(BL)	Clinical Effectiveness Team Leader Quality Governance Risk Unit
Dr Stephen Lynch	(SL)	Interim Clinical Lead & Chair of Clinical and Care Governance Group, ACHSCP
Ms Heather Macrae	(HM)	Lead Nurse, ACHSCP
Ms Bernadette Oxley	(BO)	Head of Children's Social Work / Chief Social Work Officer

Attending

Pauline Malloy	(PM)	Senior Analyst, Health Intelligence, NHS Grampian
Ms Kate McKay	(KM)	Business Manager, Education & Children's Services ACC
Ms Beverley Johnson	(BJ)	Administrative Support

Apologies

Councillor Alan Donnelly	(AD)	Integration Joint Board Member
Kenneth Simpson	(KS)	Chief Executive VSA
Laura MacDonald	(LM)	Staff-side representative
Judith Proctor	(JP)	Chief Officer, ACHSCP

No.	ITEM	ACTION by
Welcome and Apologies (as listed above)		
	Standing Items	
1.0	Minute of Previous Meeting – 16 August 2016 - adopted as correct. Matters Arising – Referring to 5.4 'Social Work Data Summary Report,' Kate Mackay pointed out that it had not been noted in the minute, but it was requested, to look at benchmarking and sickness absence for social care services. While it is not formally possibly to do this they are putting an arrangement in place informally with other local authorities willing to share their data. Data is being collated and will be incorporated in the report for the next meeting.	**KM**
2a	Business Statement (16 August 2016) – copy of update circulated to the Committee.	

No.	ITEM	ACTION by
2b	The Committee noted that: - Item 2, work is ongoing, a report is due February 2017 - Item 3, ongoing, due March 2016. Committee Meeting Dates approved as: - 28 June 2017 - 3 October 2017 - 9 January 2018 - 20 March 2018	**SG** **BL**
Reports for Committee Consideration		
3.0	<u>Joint Inspection of Services for Older People in Aberdeen City Summary Report</u> Heather MacRae spoke on the report and the summary of key information. Eight recommendations were put in place, a small sub group has been established to take these forward. An initial first draft Inspection Action Plan has been produced, which the Committee had before them. Ms. MacRae advised that many of the actions have already been delivered on. A communication plan has also been written to ensure robustness. Areas of improvement suggested: • List actions required that will deliver improvements. • List which recommendations have been acted on, and completed. • An assurance role was also sought, and overseeing of the action plan. • Connectivity's with other related work i.e. staff training/development. • In item 3, Finance, reword 'there are no immediate financial implications' to '*potential* financial implications. The committee acknowledges the work that went into the inspection at a time when it was inconvenient, a time of huge change and that staff did step up and deliver an overall good outcome. Thanks and recognition should be expressed to colleagues. <u>The Committee</u> • Noted that the report, following the JIOPS, has been published. • Endorsed the developing action plan. • The committee debated overseeing its implementation, due to meetings only take place every 6 months, and agreed; • The C&CG Group will monitor the implementation of the action plan and provide assurance updates to the committee.	**HM** **C&CG Group**
Clinical & Care Governance Matters		
4a	<u>Overview of papers from the ACHSCP Clinical & Care Governance Group</u> The Committee noted the contents of the report and endorsed the proposal to review and revise the current reporting template.	

No.	ITEM	ACTION by
4b	Minute of Clinical & Care Governance Group – 20th July 2016 The Committee noted the minutes of the Clinical & Care Governance Group (CCGG).	
4c	Report from Clinical & Care Governance Meeting 19th October 2016 The committee noted the report. Dr Lynch provided an update on the situation regarding the 2c Salaried Practice, Northfield and Mastrick. There have been ongoing issues with its medical workforce for a number of years. Two GPs have resigned in the last six months. As a result, some temporary additional support is being provided by the way of two clinical leads working closely with them and management support is in place working with the admin team. A report has been written by an independent practice manager to identify issues with the practice moving forward. An Action Plan is being developed. The practice has been put out to tender. All 5,500 patients have been informed by way of a letter.	
Care Governance Data		
5a	Overview of Care Governance Data Reports The following reports were circulated to the Committee with the aim of assuring all that there are mechanisms in place to review the Health and Social Care governance information, data and/or trends. The Committee: • noted the Care Governance Data reports as presented in the appendices, and • Endorsed the review of care governance data being undertaken with streamlined reports being presented to future committees.	
5b	Incident Report NHS This is a quarterly report, extracted from DATIX, to provide the committee with an overview of incidents from 1st July to 30 September. The committee acknowledged the report provided the assurance required.	
5c	Feedback Report NHS (Summary) The CCGG use this report to review feedback, both positive and negative, received. The committee acknowledged that the report provides the assurance required.	
5d	Analysis of Performance Information for Social Care Services The committee noted the contents of the report.	

No.	ITEM	ACTION by
5e	Adult Social Care Health & Safety Update Report The committee noted the contents of the report.	
6.0	Items to Report to the Integration Joint Board Mr Passmore asked an update be provided to IJB on the inspection report, current situation, and recommendations.	
7.0	AOCB - none	
8.0	Date of Next Meeting – Clinical & Governance Committee Meeting - - 07.03.2016 10.00 to 12:00, room 5 at the Health Village.	

Aberdeen City Health & Social Care Partnership

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Aberdeen City Health and Social Care Partnership

Strategic Risk Register 2016/17

Risk Summary:

1. There is a risk of significant market failure in Aberdeen City
2. There is a risk of financial failure , that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and project an overspend
3. Failure of the IJB to function, make decisions in a timely manner etc
4. There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance in through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.
5. There is a risk that the governance arrangements between the IJB and its partner organisations (ACC and NHSG) are not robust enough to provide necessary assurance within the current assessment framework – leading to duplication of effort and poor relationships
6. There is a risk that services provided by ACC and NHS corporate services on behalf of the IJB do not have the capacity, are not able to work at the pace of the IJB's ambitions, or do not perform their function as required by the IJB to enable it to fulfil its functions
7. There is a risk that the IJB and the services that it directs and has operational oversight of fail to meet performance standards or outcomes as set by regulatory bodies
8. There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care.
9. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system
10. There is a risk that the IJB does not maximise the opportunities offered by locality working

Risk Rating	Low	Medium	High	Very High
Risk Movement	Decrease	No Change	Increase	

- 1 -	
Description of Risk: There is a risk of significant market failure in Aberdeen City	
Strategic Priority: Outcomes, safety and transformation	**Lead Director:** Acting Head of Strategy and Transformation
Risk Rating: low/medium/high/very high **HIGH** **Risk Movement:** increase/decrease/no change **NO CHANGE**	**Rationale for Risk Rating:** • Previous experience of provider failure in City and wider across Scotland • Discussion with current providers and understanding of market conditions across the UK • Impact of Living Wage on profitability depending on some provider models **Rationale for Risk Appetite:** • 3rd and independent sectors key strategic partners in delivering transformation and improved care experience and we have a low tolerance of risk of market failure.
Controls: Robust market and relationship management with the 3rd and independent sector and their representative groups, creation of a Director of Strategic Commissioning role as part of the wider strategic transformation programme, market facilitation programme and	**Mitigating Actions:** • Creation of capacity and capability to manage and facilitate the market • Development of provider forum to support relationship and market management

robust review of all contracts and our commissioning model.	• Risk fund set aside with transformation funding • Additional SG funding toward the Living Wage and Fair Working Practices
Assurances: Market management and facilitation Audit and Performance Systems Committee overview	**Gaps in assurance:** Market or provider failure can happen quickly despite good assurances being in place
Current performance: No current issues to report	**Comments:** Market remains subject to change

- 2 -	
Description of Risk: There is a risk of IJB financial failure with demand outstripping available budget. There is a risk that the IJB cannot deliver on priorities and statutory work, and that it projects an overspend.	
Strategic Priority: Outcomes and transformation	**Lead Director:** Chief Finance Officer
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** • Analysis of demographic change and growth in demand year on year • Analysis of current budget pressures known and expected in the Public Sector in Scotland and the UK • Understanding of financial pressures on both partner organisations (ACC and NHS Grampian)
Risk Movement: increase/decrease/no change*:* **NO CHANGE**	**Rationale for Risk Appetite:** The IJB has a low risk appetite to financial failure and understands its requirement to achieve a balanced budget. However the IJB also recognises the significant range of statutory services it is required to meet within that finite budget and has a lower appetite for risk of harm to people.

Controls: Chief Finance Officer has been appointed and this role is important in ensuring sound financial information and supporting sound financial decision making, Budget reporting and escalation. There is an Integration Scheme in place with provision for the management of finances in partners with ACC and NHS Grampian and a Strategic plan and Transformational Commissioning plan agreed by the IJB in April 2016. Transformational plans include investment to save over a three year period.	**Mitigating Actions:** NHS and ACC will 'underwrite' the IJB's budget in year 1 of its formal operation – however this needs to be seen in the context of the pressures on those partners' budgets. Whilst the IJB has agreed a forward Transformational plan, there is a risk that we are unable to deliver transformation and efficiencies at the pace required. **Financial information is reported regularly to both the Audit & Performance Systems Committee, the Integration Joint Board and the Executive Team.**
Assurances: • Audit and Performance Systems Committee oversight and scrutiny of budget under the CFO • Board Assurance Framework.	**Gaps in assurance:** • None known
Current performance: Pressure on the prescribing budget of approximately £1.3 million causing some concern. This has been balanced by using funds from the transformation fund, whilst officers review the issue and develop a recovery plan.	**Comments:** • Regular and ongoing budget reporting and tight management control in place
- 3 -	
Description of Risk: There is a risk that the IJB fails to function properly within its Integration Scheme, Strategic Plan and Schemes of	

<table>
<tr><td colspan="3">delegation in particular reference to being able to make appropriate decisions in a timely manner and meet its required functions.</td></tr>
<tr><td colspan="2">Strategic Priority: Outcomes, safety and transformation</td><td>Lead Director: Chief Officer</td></tr>
<tr><td>Risk Rating: low/medium/high/very high

MEDIUM</td><td rowspan="2">Rationale for Risk Rating:
Failure of the IJB to function is a fundamental risk which would impact on all strategic priorities. Capacity of Executive Group while recruitment to full complement in structure, a potential risk

Rationale for Risk Appetite:
Zero appetite.</td></tr>
<tr><td>Risk Movement: increase/decrease/no change

NO CHANGE</td></tr>
<tr><td>Controls:
Experience of operating in shadow form
Agreed etiquette of the board and risk appetite statement allowing for balance of timely decision taking with effective challenge and scrutiny
Performance reporting mechanisms</td><td colspan="2">Mitigating Actions:
Recruiting to further senior posts in the structure
Operation of Executive team focussing on priorities</td></tr>
<tr><td></td><td colspan="2"></td></tr>
</table>

Assurances: • Board Assurance Framework • Audit & Performance Systems Committee	**Gaps in assurance:** • None known
Current performance: • Meeting requirements • Increasing workload experienced following 'go live' and in relation to need to support IJB's committees – being mitigated by further recruitment to senior posts	**Comments:**
- 4 –	

Description of Risk: There is a risk that the outcomes expected to be delivered by hosted services are not realised and that the IJB fails to identify non-performance through its own systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.	
Strategic Priority: Outcomes and transformation	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **MEDIUM** **Risk Movement:** (increase/decrease/no change): **NEEDS INPUT**	**Rationale for Risk Rating:** • Considered medium risk due to the reporting arrangements being relatively new and needing testing in the first full year of operation **Rationale for Risk Appetite:** • The IJB has some tolerance of risk in relation to testing change.
Controls: • Integration scheme agreement on cross-reporting • NE Strategic Partnership Group	**Mitigating Actions:** • This is discussed regularly by the three North East Chief Officers

• Operational risk register	• Regular discussion regarding budget with relevant finance colleagues
Assurances: Audit & Performance Systems Committee	**Gaps in assurance:** None currently known
Current performance: No issues to report	**Comments:**
- 5 –	

Description of Risk: There is a risk that the governance arrangements between the IJB and its partner organisations (ACC and NHSG) are not robust enough to provide necessary assurance within current assurance framework – leading to duplication of effort and poor relationships.	
Strategic Priority: Outcomes, safety and transformation	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Considered medium as arrangements are complex and mitigations untested in the 'go live' environments **Rationale for Risk Appetite:** The IJB has zero appetite for failure to meet its statutory requirements.
Risk Movement: (*increase/decrease/no change)* **NEEDS INPUT**	
Controls: • Scheme of delegation • Integration Scheme	**Mitigating Actions:** • Consultation and engagement between bodies • Consideration being given by Chief Officers regarding

• Current governance committees within IJB and NHS • North East Strategic Partnership Group	development of Service Level Agreements or other mechanism
Assurances: • Agreement on regular reporting on hosting at each IJB • Regular Chief Officer meetings across Grampian area • Chief Officer a member of both NHS Grampian Senior Leadership Team and Aberdeen City Council's Corporate Management Team	**Gaps in assurance:** • Potential gaps around standard interpretation of schemes
Current performance: • No current issues to report	**Comments:**
- 6 –	

<table>
<tr><td colspan="2">Description of Risk: There is a risk that the services provided by ACC and NHS Corporate Services on behalf of the IJB do not have the capacity or are unable to work at the pace of the IJB's ambitions. There is a further risk that they are unable to perform their function as required by the IJB to enable it to fulfil its functions.</td></tr>
<tr><td>Strategic Priority: Outcomes and service transformation</td><td>Lead Director: Chief Officer</td></tr>
<tr><td>Risk Rating: low/medium/high/very high
HIGH</td><td rowspan="2">Rationale for Risk Rating:
Given the wide range and variety of services that support the IJB from NHS Grampian and ACC there is a possibility of under or non-performance
Depending on which area this is in (e.g. corporate finance, legal services) the consequences are considered significant
Rationale for Risk Appetite:
There is a zero tolerance in relation to not meeting legal and statutory requirements.</td></tr>
<tr><td>Risk Movement: (increase/decrease/no change)
NEEDS INPUT</td></tr>
<tr><td>Controls:
IJB Strategic Plan
IJB Integration Scheme</td><td>Mitigating Actions:
Regular reporting at both Executive Management Team and Senior Operational Management team</td></tr>
</table>

• Agreed risk appetite statement • Role and remit of the North East Strategic Partnership Group in relation to shared services	• Regular and ongoing Chief Officer membership of ACC Corporate Management Team and NHS Grampian Senior Leadership Team • Consideration in relation to Service Level Agreements being undertaken by the 3 North East Chief Officer. • Creation of Business Management Team with the partnership with representatives from all corporate services.
Assurances: • Executive Group reviews performance of corporate services' support regularly • Chief Finance officer role ensure liaison in relation to financial services • Chief Officer regularly discusses these service provisions with Corporate Directors	**Gaps in assurance:** • None currently significant though note consideration relating to possible future Service Level Agreements
Current performance: • No issues to highlight	**Comments:**
- 7 –	

<table>
<tr><td colspan="3">Description of Risk: There is a risk that the IJB and the services that it directs and has operational oversight of fail to meet performance standards or outcomes as set by regulatory bodies and that, as a result, harm or risk of harm to people occurs.</td></tr>
<tr><td colspan="2">Strategic Priority: Outcomes, safety, transformation of services</td><td>Lead Director: Director of Finance and Business</td></tr>
<tr><td>Risk Rating: low/medium/high/very high
HIGH</td><td rowspan="2">Rationale for Risk Rating:
Risk felt to be moderate, given controls with potential risks in need of mitigation due to go-live implications

Rationale for Risk Appetite:
The IJB has zero tolerance of harm happening to people as a result of its actions or inaction.</td></tr>
<tr><td>Risk Movement: (increase/decrease/no change)
NEEDS INPUT</td></tr>
<tr><td colspan="2">Controls:
• Clinical and Care Governance Committee and Group Audit and Performance Systems Committee</td><td>Mitigating Actions:
System re-design and transformation</td></tr>
</table>

• Risk-assessed performance plans and actions • Development of KPIs reported	
Assurances: • Executive Group reviews processes and performance regularly • Joint meeting of IJB Chief Officer with two Partner Body Chief Executives • Audit & Performance Systems Committee • Clinical and Care Governance Committee	**Gaps in assurance:** • Formal performance systems not yet developed. • Audit & Performance Systems Committee has met twice • Intelligent Board performance model
Current performance: Council and NHS performance systems remain in place with single reporting in development.	**Comments:**
- 8 –	

<table>
<tr><td colspan="3">Description of Risk: There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care.</td></tr>
<tr><td colspan="2">Strategic Priority: All</td><td>Lead Director: Chief Officer</td></tr>
<tr><td>Risk Rating: low/medium/high/very high

HIGH</td><td rowspan="2">Rationale for Risk Rating:
Newness of the organisation and agenda for system transformation pose risk of reputational damage

Rationale for Risk Appetite:
Willing to risk certain reputational damage if rationale for decision is sound.</td><td></td></tr>
<tr><td>Risk Movement: (increase/decrease/no change)

NEEDS INPUT</td><td></td></tr>
<tr><td colspan="2">Controls:
Executive Management Team
IJB and its Committees</td><td>Mitigating Actions:
Clarity of roles
Staff and customer engagement</td></tr>
</table>

• Operational management processes and reporting • Board escalation process	• Effective performance and risk management
Assurances: • Role of the Chief Officer and Executive Team • Role of the Chief Finance Officer • Performance relationship with NHS and ACC Chief Executives • Communications plan / communications officer	**Gaps in assurance:** None known at this time
Current performance: • Chief Finance Officer appointed on a permanent basis • Communications officer in place to lead reputation management	**Comments:**
- 9 –	
Description of Risk:	

Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system	
Strategic Priority: All	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **HIGH**	**Rationale for Risk Rating:** This is the overall risk – each of our transformation programme workstreams will also be risk assessed with some programmes being a higher risk than others **Rationale for Risk Appetite:** The IJB has some appetite for risk relating to testing change and being innovative. The IJB has zero appetite for harm happening to people.
Risk Movement: (*increase/decrease/no change)* **NEEDS INPUT**	

Controls: • Strategic Transformation and Commissioning programme management and governance • Audit and Performance Systems Committee • Transformation programme board in place	**Mitigating Actions:** • Programme approach being taken in terms of the transformation programme • Recruitment taking place into senior and key project and programme management posts

• Recruitment to key senior posts agreed	• Regular reporting to Executive Management Group • Regular reporting to Audit and Performance Systems Committee
Assurances: • Executive Management and Committee Reporting • Programme Management approach • IJB oversight • Board escalation process •	**Gaps in assurance:** • Executive Management team developing financial model for transformation programme to track delivery of change and efficiencies – this is in developing and as such, a gap.
Current performance: No issues to report	**Comments:**
- 10 –	
Description of Risk	

There is a risk that the IJB does not maximise the opportunities offered by locality working	
Strategic Priority: All	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **HIGH** **Risk Movement:** (*increase/decrease/no change)* **NEEDS INPUT**	**Rationale for Risk Rating:** Considered medium in relation to ability to work at the pace required until all senior and locality posts recruited to in the new structure **Rationale for Risk Appetite:** The IJB has some appetite to risk in relation to testing innovation and change. There is zero risk of financial failure or working out with statutory requirements of a public body.
Controls: • Transformation programme and programme board • Audit and Performance Systems Committee	**Mitigating Actions:** • There is a localities development programme manager in place supporting this work • Agreed operational structure that reflects the importance of

	localities and roles which support transformational potential of working at this level
Assurances: • Regular Transformational Programme Board reports to Executive Management Team and to Audit and Performance Systems Committee • Programme Management approach • Agreement to recruit to Director of Strategic Commissioning role which will lead on the transformation at Executive level •	**:Gaps in assurance** • None currently known
Current performance: • Programme agreed at April's IJB and current milestones being met	**Comments:**

Appendix 5: The IJBS Risk Appetite

Level of Risk	*Risk Tolerance*
Low	Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented. Chief Officers/Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.

Medium	Acceptable level of risk exposure subject to regular active monitoring measures by Managers/Risk Owners. Where appropriate further action shall be taken to reduce the risk but the cost of control will probably be modest. Managers/Risk Owners shall document that the risk controls or contingency plans are effective. Chief Officers/Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Chief Officers/Managers/Directors/Assurance Committees will periodically seek assurance that these continue to be effective.
High	Further action should be taken to mitigate/reduce/control the risk, possibly urgently and possibly requiring significant resources. Chief Officers/Managers/Risk Owners must document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Chief Officers/Managers/Directors/Executive and Assurance Committees will periodically seek assurance that these continue to be effective and confirm that it is not reasonably practicable to do more. The IJB's may wish to seek assurance that risks of this level are being effectively managed. However the IJB's may wish to accept high risks that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public
Very High	Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Chief Officer/Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. The IJB's will seek assurance that risks of this level are being effectively managed. However the IJB's may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public

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Last Updated 23.09.16 Aberdeen City Health and Social Care Partnership - Operational Risk Register

Strategic Priority	Description of Risk	Context	Impact	Date Last Assessed	Controls	Gaps in Control	Likelihood	Consequences	Risk Assessmen	Assurances	Risk Owner/ Handler	Comments
Workforce	The is a risk that the Partnership will not have the supply and quality of workforce to meet operational requirements	A combination of demographic, labour market and transformational change is currently putting some aspects of operational delivery under strain, but conversly impacting positively in other areas. These factoes vary by discipline and sector. As we bring together two organisations, disparities between pay and grading structures will become more apparent which may lead to discontent.	Unable to deliver core services - including statutory responsibilities and national local targets. Risk of harm/ adverse conditional for those using Partnership services, alongside reputational damage. Lack of capacity could have an adverse effect on strategic priorities and transformational change.	01.09.16	Established workforace plance in some operational areas and new workforce plans being developed to link in to developing structures . Mechanism for staff communication and feedback. Recruitment and Retention initiatives. Support Mechanisms for employee health and wellbeing. Established support for training and development of staff.	Lack of consistency in strategic workforce planning which is linked to the transformation agenda for the partnership. Ongoing challenges around harmonising workforce developnment, recruitment and retention across two distinct organisations. Lack of joined up terms, conditions and renumeration (not currently possible due to legislative context). Lack of consistent monitoring of sickness absence and staff turnover.	Possible	Moderate	Medium	Standing item on monthly SOMT agenda. Changes in Risk register reported by Director of Operations (DOO) to Chief Officer (CO) throug Excutive Group Changes in risk register reported by DOO to Audit and Performance Systems Committee and report to IJB. Any clinical and care risks that arise as a result of infrastructure would also be reported to the Clinical and Care Governance Committee. Clinical and Care Governance reports risks (including those arising from infrastrucutre) to the IJB outwith meeting structures CO will appraise Chair/Vice Chair of IJB of any signifcant changes to risk register.	DOO	Harmonising terms and coniditions is not possible within the current scope of the partnership.
Workforce	There is a risk of challenge with regard to staff working under the different terms and conditions of the partner organisations	As we bring together two organisations, disparities between pay and grading structures will become more apparent.	Potential unrest between staff which could impact on team working and morale	01.09.16	New external staff can choose which terms and conditions they work under. Existing staff are protected (and restrained) by the current matching process.	As teams become more integrated, the differences between terms & conditions become more apparent	Possible	Major	High	Joint working group set up who are working well together. The group is looking at job matching/profiling and is pulling a paper together to help managers who will potentially have to manage staff with terms and conditions that the manager is not familiar with	Judith Proctor	
External Provision	There is a risk that the partnership will be unable to commission the range of external provision required to provide safe and effective services.	A combination of demographic, labour market and economic factors mean that the social care market is currently unable to supply the level of care required. The downturn in the oil industry is yet to affect this market. The current market is already fragile with providers leaving the market.	Unable to deliver the range and level of care services required in the city. The fragile market puts new providers off coming into the city.This impacts negatively on Delayed Discharge figures, general patient flow and national and local targets and increases adverse public protection and other risks.		1. Care Academy 2. Working with providers to look at different models of care delivery. 3. Community Capacity Building (ABCD) 4. Living Wage + ongoing scrutiny of current commissioned rates. 5. Active market management.	We lack control over the local economy that would make Aberdeen a more attractive place to be a paid carer. Ongoing difficulties in selling caring as a career option. Community Capacity Building is in its infancy and is likely only to yield 'control' divideneds in the medium/long term. Financial resources to support market (living wage and other) are finite, and may not reflect current cost presures and needs.	Possible	Major	High	Regular monitoring of current market and provider status via contract arrangements. Changes in Risk register reported by Director of Operations (DOO) to Chief Officer (CO) through Executive Group Changes in Risk register reported by DOO to Audit and Performance committee Audit and Performance committee report to IJB. Outwith meeting structures CO will appraise Chair/Vice Chair of IJB of any significant changes to the risk register	Director of Joint Operations	Recognised that although external provision is being risk assesed globally. Some sectors and areas of the various markets will exhibit greater fragility and risk then others.

Strategic Priority	Description of Risk	Context	Impact	Date Last Assessed	Controls	Gaps in Control	Likelihood	Consequences	Risk Assessmen	Assurances	Risk Owner/ Handler	Comments
	There is a risk of a GP practice/s ceasing the provision of General Medical Services (example of Brimmond MG in 2015)	A number of factors conspire to challenge the sustainability of General Practice, including GP + Nurse retirals, workforce availability, increasing demand, small business model, evergreen mortgages. There is an increasingly complex mixed economy of ownership models by GP's (third party developments +Hubco). Restrictions of current GMS legal regulations reduces the potential pool of providers. Review of dispensing GP Practices which (if dispensing is withdrawn) will further impact on viability of a City practice with a branch surgery in Aberdeenshire.	The statutory duty to provide General Medical Services will be compromised if there is additional failure. If another independent entity cannot be secured to deliver essential medical services, technically NHS Grampian, through the Partnership, would be expected to take over the service directly – ie. provide a salaried service. The challenges facing the Partnership in securing workforce would be the same as those facing a GP practice. There is also likely to be significant reputational harm and public/political anxiety related to any service failures.		Connected into system wide recruitment initiatives. Strong Primary Care Development Team, working in tandem with GP Clinical Leads. Good working relationships and links with local practices – issues brought to light through team. Commitment by Partnership to ongoing modernisation and transformation in primary care which is ongoing. National contract negotiations for GP's ongoing - to potentially relieve existing pressures. Scottish School of Primary Care now live and supporting new models of care - including training/development/governance. (Links with national workforce initiatives).	Independent contractor status – we do not have direct control; we do not have access to practice accounts / business situation. (looming crisis not always apparent). Many of the current controls are long-term in regards to their potential ability to ameliorate the risks involved. Some elements encouraging retirals (SPPA) are outside of Partnership control. Revalidation for GP's to maintain GMC registration is not attractive, post-retirmenst, but not locally controllable.	Possible	Major	High	Regular monitoring of GP status via Primary Care Development Team. Changes in Risk register reported by Director of Operations (DOO) to Chief Officer (CO) through Executive Group Changes in Risk register reported by DOO to Audit and Performance committee. Audit and Performance committee report to IJB. Outwith meeting structures CO will appraise Chair/Vice Chair of IJB of any significant changes to the risk register. Any clinical and care risks that arise as a result of GP practice failure would also be reported to the Clinical and Care Governance committee Clinical and Care Governance Committee reports clinical and care governance risks (including those arising from infrastructure) to the IJB	Director of Joint Operations	
Infrastructure	There is a risk that the infrastructure to support operational requirements fails or is inadequate	Infrastructure required to support operational services delivery includes: IT systems and supporting processes including information sharing and premises. The infrastructure is largely that which is provided by ACC and NHSG. The inherited IT infrastructure has significant gaps to support service functions and to enable robust data collection and reporting against local and national outcomes/targets A robust IT platform is essential to support integrated working and information sharing. We have two separate business support systems which need to interface either through realignment or the establishment of new integrated business processes Premises; some of which are no longer fit for purpose; some do not have the potential to support multidisciplinaryworking environments in support of our locaility model	Disruption to delivery of core operational services - including statutory responsibilities and national/ local targets. Risk of harm if information necessary to support decision making is not available Risk of being unable to report against local or national outcomes/ targets Impact on transformational agenda and decision making if there is a lack of robust data to support this Premises limitations adversely impacting on service capacity and waiting times and ability to redesign services/workforce to support integrated working in our locality model		AHSCP Infrastructure workstream being established ; IT, Capital/Premises and Business processes ATOS commissioned to carry out scoping work to inform future IT strategy Community health premises group Primary Care Capital Development programme board Carefirst development including Multi-Agency View (MAV) to support information sharing Pan-grampian workstreams supporting IT development /information including Joint Data Sharing Group Roll-out plan for Trak-care for AHPs Planning for community nursing Vision system development underway	Absence of a pan-Grampian overview around IT to support IJB developments Revised Memorandum of Understanding (MOU) re Information sharing and Service Level Agreement (SLA) with Information services Division (ISD) awaiting sign-off AHSCP Infrastructure workstream at early stages and yet to have an impact on desired developments Lack of capacity within ehealth and support services to drive infrastructure improvements at pace Lack of a city-wide partnership premises strategy	Possible	Moderate	Medium	Standing Item on monthly SOMT agenda Changes in Risk register reported by Head of Operations (HOO) to Chief Officer (CO) through Executive Group Changes in Risk register reported by HOO to Audit and Performance committee Audit and Performance committee report to IJB Any clinical and care risks that arise as a result of infrastructure would also be reported to the Clinical and Care Governance committee Clinical and Care Governance Committee reports clinical and care governance risks (including those arising from infrastructure) to the IJB Outwith meeting structures CO will appraise Chair/Vice Chair of IJB of any significant changes to the risk register	Head of Joint Operations	The partnerships infrastructure is largely that which has been inherited from ACC and NHSG. Ongoing collaboration required with partners to support our transformational change. Future opportunities for collaboration across all sectors i.e. 3rd, Independent, Housing as appropriate with respect to premises and data sharing.

Strategic Priority	Description of Risk	Context	Impact	Date Last Assessed	Controls	Gaps in Control	Likelihood	Consequences	Risk Assessmen	Assurances	Risk Owner/ Handler	Comments
Governance	There is a risk that our governance systems fail or are inadequate which would lead to operational and/or strategic failures	Effective governance systems are required to ensure we operate safely, effectively and within an agreed framework. There are different governance processes in partner organisations. Framework for new governance structures and systems within the partnership have been agreed by the IJB, but these are not yet fully established during this transition period	Services may be unsafe, ineffective, lack control.Could result in reputational damage.If there is an external view that governance arrangements are inadequate, the partnership may become subject to additional external scrutiny, and intervention	11/04/2016	Existing robust policies and procedures within the partnership organisations which we continue to work to. As new governance arrangements are embedded, all staff will be updated on any changes. Partnership controls include service level risk registers/management plans. Partnership assurance processes including IJB, Audit & Performance Systems Committee, Clinical and Care Governance Framework, Financial management systems, HR systems, Schemes of delegation, Professional and Management governance structures.(Some of these controls sit with the IJB, some with our partnership bodies.)	Committees still in very early stages and roles and remits yet to be finalised. In transition period, application of existing policies and procedures could be perceived as inequitable for staff in the same team working to different policies	Possible	moderate	medium	Ensure this is a standing Item on monthly SOMT agenda. Changes in Risk register reported by Head of Operations (HOO) to Chief Officer (CO) through Executive Group Changes in Risk register reported by HOO to Audit and Performance committee Audit and Performance committee report to IJB. Any clinical and care risks that arise as a result of governance would also be reported to the Clinical and Care Governance committee. Chief finance officer role around financial assurance. Chief Social Worker over-arching governance role in relation to SW practice. Clinical and Care Governance Committee reports clinical and care governance risks to the IJB. Outwith meeting structures CO will appraise Chair/Vice Chair of IJB of any significant changes to the risk register.	Risk Owner: Head of Joint Operations Risk Handler: Sally Wilkins/Lynn Morrison	
Protection of People	There is a risk that the partnership will be unable to effectively meet its obligations to protect and support the community - including those most at risk within society	The partnership has very specific statutory duties in relation to supporting and protecting the people of Aberdeen. These are wide ranging, but include duties relating to the protection of children, adults at risk, and the general public, which are all undertaken on a multi-disciplinary partnership basis.	The greatest impact is likely to be on those who are at most risk but there are also significant risks to the general public. There is a risk of serious reputational harm to the partnership.	18.08.2016	Multi-agency procedure and protocols are in place that address the specific duties and responsibilities for public protection across the partnership. Public Engagement strategies are in place to promote wider public awareness of protection of people and early intervention.	"Ownership" and awareness of the protection of people agenda is not yet consistent across all sectors and disciplines within the partnership - resulting in operational gaps. Public awareness of the protection of people agenda is also not consistent across the population of Aberdeen. As yet, the Partnership does not monitor specifically how other risks (such as workforce concerns) directly impact on the protection of people agenda. Capacity in the systems for earlier intervention at lower thresholds remains limited.	Possible	Major	High	Chief Officer, Chief Executives and CSWO oversight. Staff training and development, focusing on promoting good practice. ASP Internal review. Multi-agency learning review. Community Justice Partnership is emerging. Independent functioning of the aPC, MAPPA, multi-agency invovlement in management of risk.	SMW	This will inevitably continue to be a hgih priority for the Partnership. The emerging senior leadership team provides the opportunity to promote and support this agenda.
Health and Safety	There is a risk that the Partnership will be unable to meet its statutory responsibilities to protect the health and safety of staff and citizens.	The scale of the workforce and variety of services (particularly community based settings) that is out with their immediate control means that the Partnership is required to effectively manage multiple and variable risks to both employees and patients/clients.	A breach in health and safety may result in physical or psychological harm resulting in death, sickness absence or claim against the organisation. This could result in financial and reputational damage for the organisation and potentially lead to a disruption of service and loss of capacity. A breach in health & safety may result in both physical/psychological harm to individuals and environmental harm to physical assets. Beyond the immediate impact to indiviudals and property there is also the real possibility of financial and reputational damage to the organisation and possible disruption of service and loss of capacity.		ACC and NHSG already have well established policies/procedures in place that will be reviewed to ensure that they meet the needs of the organisation. Absence management systems are in place. Healthy Working Lives programme in place. Datix is in place to capture risk (NHSG only at present) and risk registers are regularly monitored and reviewed. Established support for training and development of staff	Need to review/harmonise policies within organisation and to recommend the establishment of an Aberdeen Health and Social Care Partnership Health and Safety Committee. Recommend review of need for additional separate Community Health and Social Care Health & Safety Groups. Risk reporting and capturing is not currently consistent across organisations. There is a need to harmonise risk reporting via Datix.	Unlikely	Moderate	Medium	Standing item for review/discussion at SOMT.		

Strategic Priority	Description of Risk	Context	Impact	Date Last Assessed	Controls	Gaps in Control	Likelihood	Consequences	Risk Assessmen	Assurances	Risk Owner/ Handler	Comments
Environmental Factors	Catastrophic environmental issues, failure of external support systems and/or pandemic episodes resulting in inability to deliver services and/or keep staff and citizens safe from harm.	The organisation may suffer the effects of severe weather, fire, power failure, fuel shortage, terrorism or the threat of pandemic illness that may impact on its ability to deliver key/life and limb services and keep staff and citizens safe from harm.	Disruption to services, an inability to deliver core services, the short/long term loss of buildings, key infrastructure, such as ICT systems failure and/or the inability to deploy staff within the organisation, including contracted providers responsible for service delivery.	14/04/2016	Local Resilience Partnership; Up-to-date Winter Weather Policies, Major Infections Disease Plan, Business Continuinty Plans & Business Impact Assessments in place for all Service Delivery Units; Staff & Management training, competence & confidence in application through learning & feedback opportunities. Formal Senior Managers & Executive Level on-call rotas covering all aspects of the Partnership. ACC's Emergency Planning Policy & Procedure (link on intranet site),; UK Government Planning of Emergencies (www.scot.gov.uk); Scottish Government Guidance on	Some BCPs and staff competence require refresh; Training for new staff; No formal SW Management on-call rota in place; Transitional state - need to ensure staff remain clear of arrangements during this time of change. Control Rooms - identifiction/information connecting both organisations' Control Rooms; Media Communication Strategy; Overarching Governance Structure; Sharing of Plans IM&T/Facilities & Estates.	Unlikely	Moderate	Medium	Outcome of recent flooding incident debrief exercise awaited; Planning and training refresh planning in hand; IJB Partners building relationships & learning about each others arrangements/systems; Implementation of IJB Management Structure arrangements under way. Plans are regularly reviewed and updated. In the absence of formal SW Management on-call rota, SW Seniors' contact details have been made available.	IJB Business Manager	
Business Processes	There is a risk that existing health and LA systems, processes and policies are not flexible enough to adapt to joint working. This in turn could lead to businesses processes becoming overcomplicated, inefficient and not cost effective by trying to integrate the 2 systems.	The Business processes of the partner organisations (NHSG & ACC) are designed to serve the needs of each organisation. Neither of the systems in its entirety is fit for purpose for the partnership.	Complicated business processes that staff have to follow could result in a disruption to services as well as duplication.	**26/07/2016**	IT infrastructure and datasharing group has been established. Work is progressing on using NHSG DATIX system to record complaints & incidents and to manage risk. Production and review of this risk register	Workstream hasn't completed its programme of work yet.	Possible	Moderate	Moderate	Standing Item on SOMT agenda. Existing systems can be utilised until H&SCP systems have been devised and tested.	Director of Operations (DOO)	
	There is a risk that There is a risk that the IT systems will be unable to support the business processes to integrate successfully	IT capability is crucial to efficient, effective business processes that are fit for purpose. Currently IT provision and support is provided by either NHSG or ACC. The support to the business processes is good but the respective IT departments may be limited in their ability to provide support for any changes.	Changes that are required to provide first class business processes to the H&SCP could be delayed/not happen.		ATOS have looked at our IT requirements and how the existing systems can be enhanced to achieve the desired aim and a report has been produced.	Some recommendations of ATOS are only achievable in the longer term due to financial and governance issues.				2 year workplan produced and being progressed.		
	There is a risk that there will be inadequate resources to provide the business support to localities.	There is a definitive amount of funding available to support the work of the Partnership including business processes.	Inefficient business processes could lead to increased costs. Reputational harm could result due to inefficient systems If workable IT solutions are not achieved in a reasonable timescale there is a risk that individuals will develop their own solutions and unsupported adhoc systems will be		Director of Finance appointed (DOF). Finance Workstream has been established and is fully functional	We do not know how much it will cost to run a locality and this may differ in each locality as requirements may vary. There is not an integrated governance and assurance system in place.	Possible	Moderate	Moderate	There are regular meetings of the joint finance teams.	Director of Operations (DOO)	
	There is a risk that partner organisations will make decisions that affect the Partnership without	Business teams remain part of partner organisations. Decisions are made which withdraw resource from the Partnership.	Loss of control of funds. Loss of support in core business areas e.g. HR		None.	No controls in place.	Possible	Moderate	Moderate	None	IJB Business manager	
Financial	There is a risk that the IJB will overspend on its budget	The council & NHSG have delegated budgets to the IJB and expect them to achieve a balanced budget. Demographic pressures, pressures in the care provider market and local labour market may all impact on the ability to be able to achieve a balanced budget.	Services may need to be reduced in order to make savings to achieve balanced budget. Reputational risk if the IJB overspends. Impact on future years funding levels.	**15/03/2016**	Regular monitoring of budgets and forecasting will assist in controlling expenditure levels within funds available, give assurance as to the likelihood of any overspend and enable timely advice to be given to the Board to take relevant decisions.	Lack of certainty in the legal and procurement framework that will allow the IJB to enforce payment of the Living Wage within contractual arrangements Inaccuracies and inconsistent updating of financial packages in Carefirst system leads to difficulties in being able to provide accurate forecasts in a volatile						

Strategic Priority	Description of Risk	Context	Impact	Date Last Assessed	Controls	Gaps in Control	Likelihood	Consequences	Risk Assessmen	Assurances	Risk Owner/ Handler	Comments
	2016/17 budget savings not achieved	In setting the budgets for 2016/17 a significant level of savings targets have been approved. There are also prior years savings which are only being achieved due to staff turnover savings and lack of available care provision.	Potential impact on overall financial position which could then lead to reduction in services which would impact on service users.	**15/03/2016**	Regularly monitor and track achievement of savings targets, financial monitoring and controls	As a newly established model of working there may be gaps that have not yet been exposed.						
	Failure to deliver on Scottish Government's expectations around Living Wage and additional capacity and transformation	Significant sums of additional money have been allocated by the SG to allow for increases in capacity and transformation and a specific requirement to implement Living wage across social care providers	Reputational damage. The Scottish Government anticipates that this can be achieved by 1 October 2016, but this will not be without a range of challenges to overcome. Given that achievement of this policy was made one of the conditions of the agreement on the 2016/17 local government funding settlement there is a risk that sanctions may be taken if this cannot be achieved.	**15/03/2016**	Legal framework that will empower the IJB to be able to achieve the Living wage targets. Financial monitoring of the appropriate use of the additional funds	Lack of certainty in the legal and procurement framework that will allow the IJB to enforce payment of the Living Wage within contractual arrangements.						

Probability					
	High – Score 4 75-100% chance of occurring within 1 year.	4	8	12	16
	Medium – Score 3 50-75% chance of occurring within 1 year.	3	6	9	12
	Low – Score 2 25- 50% chance of occurring within 1 year.	2	4	6	8
	NEGLIGIBLE – Score 1 0 – 25% chance of occurring within 1 year.	1	2	3	4
Impact →		**Minor Score 1**	**Important Score 2**	**Significant Score 3**	**Major Score 4**

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Exempt information as described in paragraph(s) 1, 8 of Schedule 7A
of the Local Government (Scotland) Act 1973.

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