Notice of meeting and agenda

Midlothian Integration Joint Board

Venue: **Conference Room, Melville Housing, The Corn Exchange, 200 High Street, Dalkeith, EH22 1AZ,**

Date: **Thursday, 07 June 2018**

Time: **14:30**

Allister Short
Chief Officer

Contact:

Clerk Name: Mike Broadway
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Further Information:

This is a meeting which is open to members of the public.

1 Welcome, Introductions and Apologies

2 Order of Business

Including notice of new business submitted as urgent for consideration at the end of the meeting

3 Declarations of Interest

Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

4 Public Reports

5 Private Reports

No private business submitted for this meeting.

6 Date of Next Meeting

The next meetings of the Midlothian Integration Joint Board will be held on:

- 23 August 2018 at 2 pm - Midlothian Integration Joint Board
- 13 September 2018 at 2 pm – Special Midlothian Integration Joint Board/Development Workshop

Midlothian Integration Joint Board

Thursday 7th June 2018

Financial Out-Turn 2017/18

Item number:	**4.1**

Executive summary

Midlothian Council and NHS Lothian have now provided the IJB with the actual expenditure that will be charged against the IJB's budgets for the 12 months ended 31st March 2018.

The IJB is underspent for the 2017/18 financial year. This is an improved financial position from that reported to the IJB at its December 2018 meeting. This underspend will allow the IJB to create a reserve and carry these unused funds forward into future years. Although the IJB did not have a reserve in its own books at the end of 2016/17, Midlothian Council carried forward c. £1.2m of funds on the IJB's behalf. An element of those funds has been used to support the financial position in the current year along with holding back new funding in 2017/18 to offset the projected overspend as far as possible. The use of these funds masks a continuing underlying and significant overspend in social care and does not alter the continuing need for transformation to more affordable models of care

Proposals for the utilisation of the reserve are detailed in the paper

Board members are asked to:

- *Accept the charges (the service delivery costs) for 2017/18 from the partners.*
- *Note the year-end position for 2017/18.*
- *Note the creation of a reserve for the IJB.*
- *Support the proposals for the utilisation of the reserve.*

Report

Financial Out-Turn 2017/18

1 Purpose

1.1 This report lays out the IJB's out-turn position for 2017/18.

2 Recommendations

2.1 Members are asked to :-

- Accept the charges (service delivery costs) for 2017/18 from the partners (Midlothian Council and NHS Lothian)
- Note the year-end position for 2017/18, this position being unaudited.
- Note the creation of a reserve for the IJB
- Support the proposals for the utilisation of the reserve.

3 Background and main report

Summary 2017/18 Position

3.1 The unaudited 2017/18 out-turn positions have now been provided to the IJB by its partners and this shows an underspend in both 'arms' of the IJB (that is both within those budgets managed operationally by NHS Lothian and by Midlothian Council).
In summary the position is :-

Table 1 – 2017/18 summary

	Budget £000's	Actual £000's	Variance £000's
Health			
Core	59,617	59,270	347
Non-cash Limited	8,706	8,706	0
Hosted	12,755	12,567	188
Set Aside	18,154	18,572	-418
Social Care	38,806	38,267	539
Total	**138,038**	**137,382**	**656**

There is a further carry forward of £243,000 of earmarked social care funding which is not noted above, this is discussed as part of the section on the IJB's reserves.

3.2 For noting, the financial information in table 1 includes 'Non cash limited' (NCL) budgets and expenditure. In the Health system, expenditure to support the delivery of community dentistry, community opticians and community pharmacists is termed as 'non cash limited' but is clearly part of the delivery of primary care services and these functions is delegated to the IJB. However, being NCL there is no budget as such but any expenditure incurred is supported in its entirety by the Scottish Government. The NCL values are not part of the budget setting process, there being no budget, but NHS Lothian has matched the NCL expenditure with income to cover this expenditure.

Main variances and financial pressures

3.3 The overall year-end position within the Health budget of the IJB is an underspend of c. £117,000. This can be analysed as follows :-

3.3.1 Core Health Services

There are two main elements to this position being an improvement in the GP prescribing budgets – improvement in the sense that the opening forecast for prescribing in 2017/18 was an overspend of c. £395,000 where as the actual out-turn was an overspend of c. £150,000. The other elements being a range of slippage (non-recurrent underspends) within GMS and as part of the transition of services from Liberton Hospital into the partnership.

3.3.2 Hosted Health Services

The hosted position shows an overspend within the Learning Disabilities services but being offset with underspends in community dental, rehabilitation services and the UNPACS budget (this is the budget used to support Lothian patients cared for by services outwith NHS Lothian). It should be remembered that although the core services are the actual costs of these services for Midlothian, the hosted services do not reflect the actual IJB usage but the IJB's share of the overall hosted budgets per the NHSL IJB health budget setting model.

3.3.3 Set Aside

The significant pressures being :-

Junior Medical – driven by additional staffing requested to cover rotas for sickness; maternity and vacancies – causing an over-establishment against funded levels. In addition there were significant excess banding payments for non-compliant rotas. New tighter controls regarding authorisation for additional staffing and reviewing rotas before issues arise are not in place to reduce pressure in 18/19

Gastroenterology - significant drug pressure reported on Adalimumab and Aflibercept driving costs as well as overall higher growth than previous year.

General Medicine – Pressure driven by staffing issues (significant at St Johns – where recruitment is difficult) and ongoing bed pressures.

A&E – recruitment issues resulting in additional costs of locums/agency to cover and make safe staffing rotas – especially problematic at SJH.

As with hosted services, these are not the charges specifically for Midlothian patients but reflect the agreed share of the IJB's Set Aside budgets. There is work ongoing within NHS Lothian to review the model to ensure that the costs charged to the IJB reflect the actual usage of set aside services (and hosted services) by Midlothian patients rather than the current proxy measures.

3.4 The Social Care element of the IJB's budget is underspent by £539,000, which is a further improvement from the position reported at the December 2017 meeting. Midlothian Council undertakes quarterly reviews of the financial position along with an analysis of the key financial issues. The finance report presented to the Council at its February meeting shows the following movements in the social care position :-

Report	Forecast £000's	Improvement £000's
Quarter 1	-1260	n/a
Quarter 2	-875	385
Quarter 3	-312	563
Out-turn Actual	539	851

Negative value is an overspend

The issues identified as pressures at the year-end were a significant overspend within adult services, specifically those for clients with Learning Disabilities and Physical Disabilities. This pressure was offset by underspend in services for older people, although there are underlying pressures in some specific services including MERRIT and care at home.

Non-recurrent support – Underlying position

3.5 Work continues on the detailed analysis of the out-turn social care position and this information will be used for operational financial plans. However, using the information available, it can be seen that the underspend reported is, in reality, a recurrent overspend when the non-recurrent support is removed. The table below lays this out :-

	£000's	
Out-turn position	539	
N/R Support above	-601	See appendix 1
N/R Support in year - SCF	-425	
N/R Support in year - ICF	-99	
Operational Position	-586	

Movements from the previous forecast

3.6 At its December 2017 forecast meeting a 2017/18 forecast was presented to the IJB. That forecast was an overall overspend of £923,000, the actual 2017/18 out-turn (albeit unaudited) is obviously a significant improvement.
The January ’17 and March ’18 financial reports to the IJB concentrated on the financial plan and the financial assurance for 2018/19. However a verbal update was provided to the IJB at its May ’18 meeting when it was noted that the out-turn had improved from the previous forecasts and that the actual position may be an overall underspend.

The table below shows the movements between the December forecast and the actual position.

	December '17 Projection £000's	Actual 17/18 Out-turn £000's
Core	250	347
Hosted	62	188
Set Aside	-470	-418
Social Care	-765	539
Total	**-923**	**656**

3.7 The main change between the December forecast and the actual outturn lies within the social care budgets, with a relatively modest improvement in the health budgets.

3.8 As was described above, the health elements of the IJB’s budget has moved in total by c. £275,000. This is driven by a range of small improvements, no-one service having a significant movement.

3.9 When the paper was prepared for the IJB in December 2017, the Q3 forecast for the social care services was not available. The out-turn forecast above (an overspend of £765,000) was an estimate based on the operational management position in the month of December. The Q3 forecast, which was available in February, showed a significant improvement on both the Q2 forecast and the forecast prepared for the December IJB report. As can be seen from the analysis in 3.4, the social care out-turn forecast position improved during the financial year.

3.10 The largest element of the social care budget (c. £32m) is the community care resource panel which is used to procure social care services for both adults and older people. The operational management teams have concentrated their recovery actions during the financial year in improved management and efficiencies within this budget and this work has generated a significant movement between Q4 and the year-end. The total resource panel spend in 17/18 is roughly the same as the total spend in 16/17 which, given the increases in costs and the additional demand, gives a broad illustration of the impact of management actions to manage this budget.

That said, as described above, this position is supported by over £0.9m of non-recurrent resources and the apparent underspend is, in reality an overspend.

Reserves

3.11 The accounting regime within health and the council is different. The health system is required to break-even year on year and may not create reserves (that is balances that can be carried forward from one year to the next) whilst the council financial regime allows the creation of reserves. The IJB is covered by the council financial regime and as such may create reserves. Reserves may flow from two sources :-

- Funds allocated for a specific project which are not used in the year in which they are allocated may be carried forward to the next year to allow the project to be completed. These are generally referred to as 'earmarked' reserves
- Funds arising from underspends at the end of the financial year may be carried forward for use in subsequent years and are generally referred to as 'general' reserves

3.12 The IJB's Integration Scheme deals with the matter of in year underspends as follows – if an underspend is considered to be 'fortuitous' (that is not planned by the IJB) then the underspend may be kept by the partner wherein that underspend was generated. Otherwise, if an underspend is 'planned' then the underspend may be kept by the IJB. Both Midlothian Council and NHS Lothian have agreed that the underspends as reported above may be kept by the IJB.

3.13 There have also been further funds which were allocated to the IJB (from Midlothian Council) which were earmarked for specific purposes and not utilised in 2017/18 these are detailed in appendix 1 – totalling £243,000 which are not included the out-turn position above. These funds will also been taken into the IJB's reserve.

3.14 The IJB will now create both a general reserve and earmarked reserves utilising the underspend as above to create the general reserve (£656,000) along with funds (£243,000) carried forward for specific purposes. The IJB will therefore have reserves totalling £899,000.

Movement in Reserves

3.15 At the end of 2016/17, the Council carried forward a reserve of c. £1.2m on behalf of the IJB and this was reported to the IJB at its June '17 meeting. The breakdown of this 'reserve' is detailed in Appendix 1.

Although these funds were not in the budget offer made by Midlothian Council in February 2017, Midlothian Council allocated these funds to the IJB in 2017/18.

It can be seen from appendix 1 that some of this 'reserve' (for example MELDAP and TEC) are part of the earmarked funds to be carried forward into 2018/19 however, much of the remainder of these funds have been used to underpin the social care position in 2017/18 as is discussed above. .

In summary, the reserves at 31st March 2018 are as follows :-

IJB Reserves at 31/3/18	£000's
Earmarked Reserves	
MELDAP	132
TEC	77
Other	34
General Reserve	656
	899

Proposals for the Utilisation of the reserves in 2018/19

3.16 It is proposed that the reserves are used for five broad purposes in 2018/19. These being :-

3.16.1 Reserves earmarked for specific projects will be used to support these projects – for example the continuation of substance misuse services (using the MELDAP reserve) and the further development of the use of Technology Delivered Care (using the TEC reserve).

3.16.2 Transformation Programme – a programme of work has been developed to further support the transformation agenda which will include a Programme Manager to work with acute and other service staff to deliver agreed outcomes. The initial focus will be on progressing the Mental Health plan and on work to support the IJB's ambition to reduce its bed use in the Acute hospital sites, particularly in relation to the respiratory pathway. This development will require investment as part of a 'spend to save' approach.

3.16.3 Waiting Times – the IJB has a number of community services that are reporting significant waiting times (Psychological Therapies, Substance Misuse, occupational therapy assessment), and projects will be developed to reduce these waiting times and to ensure that the service is sustainable thereafter.

3.16.4 Delayed Discharge – as previously reported to the IJB, there continues to be a need to support timely discharge from hospital and resource will be allocated to support the implementation of the delayed discharge action plan.

3.16.5 The residual element of the general reserve will be used as required to support in-year financial pressures, recognising the continuing underlying and significant overspend in social care.

Impact on 2018/19 and the financial plan.

3.17 The initial drafts of the IJB's three year financial plan provided for a level of underlying financial pressure within the social care services. The plan is being revised to take account of the actual out-turn position and to reflect the use of the reserves as above.

4 Policy Implications

4.1 There are no new policies proposed or described in this report.

5 Equalities Implications

5.1 There are no implications for equalities in this report.

6 Resource Implications

6.1 The resource implications are laid out above

7 Risk

7.1 The issues above are already noted within the IJB's risk register.

8 Involving people

8.1 The IJB is held in public and its papers are publically available.

9 Background Papers

9.1 None

Appendix.

Movement In reserves

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DATE	May 2018

Appendix 1

Movement in Reserves – 2016/17 and 2017/18

	2017/18 Opening	2017/18 Closing	Movement	Notes
Committed Project Funds	£000's	£000's	£000's	
SG Self directed support	316	0	316	N/r support in 2017/18
MELDAP	278	132	146	Element used in year per plan - balance c/fwd
SG Funding TEC	85	77	8	Multi-year project, balance c/fwd
SG (via NHS) Dementia	77		77	Been used in year
7 Pillars (MH)	27		27	Been used in year
Criminal Justice	39		39	Been used in year
Other	73	34	39	Net movement in a range of small projects
	895	243		
16/17 c/fwd funding				
SCF	200	0	200	Used for n/r support
Integrated Care Fund	34	0	34	Used for n/r support
Resource Transfer	51	0	51	Used for n/r support
Total	1180	243		

Additional Reserves from 2017/18 Underspend

Health Underspend	117
Social Care Underspend	539
Total Reserves at 31/3/18	**899**

Reserves used to support the 2017/18 position

SG Self directed support	316
SCF	200
Integrated Care Fund	34
Resource Transfer	51
Total in year support	601

Midlothian Integration Joint Board

Thursday 7th June 2018

Update on 2018/19 Financial Assurance

Item number:	**4.2**

Executive summary

At its March 2018 meeting the IJB considered its financial assurance for 2018/19, that is it examined the budget propositions from its partners and applied its two tests – that of fairness and adequacy. At that date a formal offer had been made (and accepted) by Midlothian Council however an indicative position for NHS Lothian was considered based on the NHS Lothian financial plan that had been presented to NHSL Finance and Resources Committee at its January 20187 meeting. The IJB agreed to accept the NHSL indicative position on the basis that NHS Lothian provided further information on the plans underway to deliver financial balance within the Set Aside budgets and that the final offer was not materially different from the indicative position. A final offer has now been received from NHS Lothian and this paper considers this offer.

Board members are asked to:

1. Accept the NHS Lothian 2018/19 budget proposition
2. Request further information by August laying out plans to bring the Set Aside services back into a break-even position
3. To note the revised indicative financial pressures for 2018/19

Report

Update on 2018/19 Financial Assurance

1 Purpose

1.1 This paper updates the financial assurance for the IJB's 2018/19 budget which was presented to the IJB at its March 2018 meeting, specifically it considered the formal budget proposition that was made by NHS Lothian in April 2018.

2 Recommendations

2.1 Members are asked to :-

1. Accept the NHS Lothian 2018/19 budget proposition
2. Request further information by August laying out plans to bring the Set Aside services back into a break-even position
3. To note the revised indicative financial pressures for 2018/19

3 Background and main report

3.1 At its March 2018 meeting the IJB considered the budgetary offers from its partners for 2018/19 and beyond. This was based on:-

- For social care budget a proposal from Midlothian Council which was accepted.
- For its health budgets, the IJB accepted a proposition based on the NHS Lothian financial plan data based on what was presented to the NHSL Finance and Resources Committee at its January meeting.

3.2 Since that date there has been a further iteration of the NHSL financial plan and NHSL sent the IJB a formal budget proposition in April 2018. This letter is attached as appendix 1.

3.3 The letter from NHS Lothian lays out in some detail the basis of the 2018/19 position. In summary this describes:-

- An overall (for the whole of Lothian) projected financial gap of c. £21m – that is the current NHSL financial plan for 2018/19 does not balance.
- Pay awards are to be fully funded.
- The GP prescribing budgets have been reset at the projected closing position for 2017/18.
- Additional NHSL Investments of £2.0m (£200,000 for Midlothian IJB) have been made to support capacity in Primary Care, which is additional to investment of £2.0m made in 2017/18.
- Another non-recurrent investment of £2.0m (£200,000 for Midlothian IJB) to support developments in GP prescribing both locally within Midlothian and Lothian wide as appropriate

3.16 For noting, the Scottish Government's settlement for 2018/19 included further investments in Primary Care to support the delivery of the new GMS contract, along with investments in Mental Health and Substance Misuse. To date, these investments have not been made available to the Health Boards but when allocated, NHSL will pass on the appropriate elements to the IJBs, as indicated in the letter.

3.17 Appendix 2a compares the position that was reported to the IJB in February 2018 with this letter. There are two main differences:-

- Set Aside – this is less than that value discussed previously. There are two reasons for this – the budgetary movements from the closure of Liberton Hospital are now complete and the appropriate budgets have been transferred to the IJB (now in core) thus reducing the overall Set Aside allocation but increasing the Core allocation. There has also been a further revision to the current IJB health budget setting model which has moved budgets from Set Aside into non-delegated. The Health Budget setting model currently examines each service and the cost centres which hold that service's budget to decide if these budgets are delegated to the IJB. There have been a relatively small number (but with a large financial value c. £20m in total) that have been wrongly attributed as delegated and this has now been corrected. However, this adjustment does not prejudice the IJB's position in 2018/19 as the projected pressures in Set Aside are reduced from the previous position. This is laid out in the appendices – the projected pressure being reduced by c. £190,000.

- The core budget has increased and that element of it which was non-recurrent previously has now been made recurrent. The projected pressures have increased from the previous analysis but that is as a result of further work on the local operational financial plans for the Midlothian HSCP, the previous estimate being understated.

3.18 As IJB members will be aware, the IJB applies two tests to any budgetary proposition – that of fairness (a fair share of the resources available to the partner) and adequacy (which is measured on the ability of the partner to manage the projected financial pressure as laid out in their own financial plans). Given that the current health IJB budget setting model will continue to be used until the new model can be brought into operation then the position in the letter complies with these two tests as described in the March IJB paper. A restatement of the financial pressures along with a comparison of the position laid out in March 2018 is included in appendix 2b – this being a quantification of the 'adequacy' test.

3.19 Both partners have made multi-year financial propositions available and this information will be used to update the IJB's financial plan. A further report on the development and the current shape of the IJB's financial plan will be brought to the IJB's September meeting.

4 Policy Implications

4.1 There are no new policies proposed or described in this report.

5 Equalities Implications

5.1 There are no implications for equalities in this report.

6 Resource Implications

6.1 The resource implications are laid out above

7 Risk

7.1 The issues above are already noted within the IJB's risk register.

8 Involving people

8.1 The IJB is held in public and its papers are publically available.

9 Background Papers

9.1 March finance report to the IJB

AUTHOR'S NAME	David King
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DATE	May 2018

Appendices

1. Letter from NHS Lothian – 26th April 2018
2. Movements between March financial assurance and NHSiL proposition

Lothian NHS Board

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To Chair and Chief Officer of IJB

Date 26 April 2018
Your Ref

Our Ref SG/AMcC/AWW
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Dear Colleagues

Budget Agreement 2018/19 – Midlothian Integration Joint Board

The NHS Lothian 2018/19 Financial Plan was approved by the Board of NHS Lothian on April 4th. The Plan presents a projected financial gap of circa £21m and provides limited assurance on the achievement of a balanced outturn next year.

The Plan includes details on the planned receipt and allocation of resources for 2018/19. NHS Lothian is assuming the following additional funding streams (equating to a total uplift against the baseline allocation of 3.08%):

- £20.3m of uplift (1.5% on the baseline);
- £8.7m of an NRAC parity adjustment (bringing NHS Lothian to within 0.8% of parity, in line with all other underfunded Boards).
- £12.7m of Scottish Government funding to meet the additional cost of the enhanced pay awards for staff on Agenda for Change pay scales.

In distributing additional resources, a number of principles are recognised:

- The importance of maintaining integrity of pay budgets through an equitable application of budget uplift to meet pay awards;
- A need to use recurrent resources against recurrent costs as far as possible, particularly in relation to the baseline recurrent gap;
- A recognition that there will be certain national costs which are inevitable;
- Under the arrangements for financial planning there is an expectation that all Business Units will plan to deliver financial balance against their budgets and therefore there needs to be recognition of the relative efficiency challenge across operational units;
- A reasonable balance of risk for NHS Lothian in the context of its breakeven target.

Recognising these key principles, additional recurrent uplift has been prioritised against the following key areas:

- £24.7m to fully fund pay awards, including Agenda for Change;
- £8.6m to provide a recurrent funding solution to the uplift to prescribing for 2017/18, previously funded through non recurring sources:
- £5.4m to fund the additional costs in the new RHSC Hospital.

GP Prescribing has been a key financial challenge for both the IJB and NHS Lothian in recent years, and I am committed to ensuring the recent improvement in the Prescribing financial position can be sustained. To this end the following adjustments will be made to support Prescribing, in addition to the allocation of the £8.6m recurrent solution identified above:

- An estimated £2.5m of additional funding from non-recurrent sources will be allocated across IJBs to ensure that the total prescribing budget available in 2018/19 will be consistent with the prescribing outturn spend for each IJB in 2017/18. This principle is the same as 2017/18 arrangements;
- A further £2m of non recurrent support has been allocated to support delivery of Lothian-wide Prescribing efficiency initiatives, with £1.3m being allocated on an NRAC basis across the four IJBs, and the balance of £0.7m utilised against specific initiatives and infrastructure support (pending final agreement on its allocation and therefore not forming part of the budget allocation at this stage).

The IJB's share of the £2m Primary Care Investment monies (the second tranche) is also included in IJB budgets for the coming year. The revised baseline budget does not currently include additional expected allocations from the Scottish Government (eg Alcohol & Drug Funding). These balances will be allocated across IJBs once confirmation is received from the Scottish Government.

Table 1 below summarises the impact of these additions on your IJB. Note that the percentage uplift values against your baseline have been included. At this stage GMS has been excluded from this calculation on the basis it will receive additional uplift during the year. In addition, non-cash limited expenditure and budget is also excluded.

Table 1 – Budget adjustments for Midlothian IJB, 2018/19

	Recurrency of Budget	Status	Allocation	Mid Lothian IJB £'000	% uplift on base net of GMS
Baseline Budget 18/19	R	Delegated	Core	44,437	
			Corporate	212	
			Hosted	9,799	
	R	Set Aside		16,252	
	NR	Set Aside		(43)	
				70,657	
	R	GMS		13,341	
Total				**83,998**	
Additional Budget 18/19					
Pay Uplift	R			912	*1.29%*
Investment in Prescribing	R	Recurrency of 16/17		1,352	*1.91%*
	NR	2017/18 Outturn		145	*0.21%*
	NR	Efficiency initiative funding		132	*0.19%*
PC Investment share of £2m	R			200	*0.28%*
Other	NR			148	*0.21%*
				2,889	***4.09%***
Total Budget				**86,887**	

The baseline budget includes the 16/17 and 17/18 Social Care Fund; Drugs and Alcohol Partnership Funding; and adjustments during 17/18 in relation to Liberton Hospital.

Midlothian IJB 2018/19 – 2022/23 Budget

At this stage the Scottish Government has confirmed arrangements to allow for a one-year Plan only. However, assumptions have been made in order to forecast forward into future years and the implications of assumed additional funding streams and their agreed application for Midlothian IJB are shown below. The element of projected uplift is based on the assumption that future years' uplift will cover the cost of pay awards, with the value of pay award consistent with that for

2018/19: this remains subject to confirmation. At this stage, no further assumptions have been made around other uplift values. Table 2 shows the budget values to 2022/23.

Table 2 – Midlothian estimated budget baselines to 2022/23.

		19/20 £'000	20/21 £'000	21/22 £'000	22/23 £'000
Baseline Budget	R	86,505	87,376	88,339	89,329
Additional Budget	R	937	963	990	1,017
Additional Budget	NR	14	0	0	0
Estimated Total Budget:		**87,456**	**88,339**	**89,329**	**90,346**

A more detailed breakdown of these constituent balances is presented in **Appendix 1**.

In addition, there are a number of additional funds which have been included in the Financial Plan for set aside functions, but which have not been included in the future years IJB allocations above as we do not yet have confirmation on how these resources will be allocated across each IJB (eg funding for new medicines). Once agreed, these allocations will further increase the total resources delegated to the IJB.

Finally, I can confirm that support services to the IJB, including Finance, will be provided on the same basis as previously. These resources are not included in the budgets set out above.

You will be aware that we have been working with CFOs to develop a revised cost and budget allocation model. This requires further work and agreement with both NHS Lothian and each of the IJBs, but I look forward to working with you on this important programme as we continue to collectively identify and action opportunities to develop health service delivery within available resources across your IJB.

Yours sincerely

Susan Goldsmith
Director of Finance
cc Chief Finance Officer
Enc

NHS Lothian

APPENDIX 1

IJB Budgets - 2018/19 - 2022/23

	Recurrency of Budget	Status	Allocation	18/19 Mid Lothian IJB £'000	19/20 Mid Lothian IJB £'000	20/21 Mid Lothian IJB £'000	21/22 Mid Lothian IJB £'000	22/23 Mid Lothian IJB £'000
Baseline Budget	R	Delegated	Core	57,778	59,674	60,027	60,390	60,764
			Corporate	212	215	218	222	226
			Hosted	9,799	10,009	10,157	10,377	10,604
	R	Set Aside		16,252	16,608	16,974	17,350	17,735
	NR	Set Aside		(43)	0	0	0	0
Total				**83,998**	**86,505**	**87,376**	**88,339**	**89,329**

The baseline budget includes the 16/17 and 17/18 Social Care Fund; Drugs and Alcohol Partnership Funding; and adjustments during 17/18 in relation to Liberton Hospital

Additional Budget

Pay Uplift	R			912	937	963	990	1,017
Investment in Prescribing	R			1,352	0	0	0	0
Investment in Prescribing	NR			277	0	0	0	0
PC Investment share of £2m	R			200	0	0	0	
Other	NR			148	14	0	0	0
				2,889	**951**	**963**	**990**	**1,017**
Total Budget				**86,887**	**87,456**	**88,339**	**89,329**	**90,346**

Appendix 2

Table A

Movements between March IJB paper and April offer by NHSiL

	March £000's	April £000's	Movement £000's
Core	58,739	59,950	1,211
Hosted	10,371	10,224	(147)
Set Aside	18,188	16,714	(1,474)
	87,298	**86,888**	**(410)**

Table B

Revision of Financial Pressures - March paper to current review

	March projection £000's	April Revised Position £000's	Movement £000's
Social Care	(1,800)	(1,800)	0
Health – Core	(265)	(464)	(199)
Health - Hosted	(80)	(0)	80
Health - Set Aside	(768)	(567)	201
Total	**(2,913)**	**(2,831)**	**82**

Thursday 7th June 2018

Midlothian Primary Care Improvement Plan

Item number:	**4.3**

Executive summary

The purpose of this report is to present the Midlothian Primary Care Improvement Plan for approval by the IJB.

Board members are asked to:

- **Discuss and comment on the Midlothian Primary Care Improvement Plan**
- **Approve the Midlothian Primary Care Improvement Plan**

Report

Midlothian Primary Care Improvement Plan

1 Purpose

1.1 Present the Midlothian Primary Care Improvement Plan (PCIP) to the IJB for approval.

2 Recommendations

2.1 Members of the IJB are asked to:-

2.2 Discuss and comment on the attached Primary Care Improvement Plan.

2.3 Approve the Midlothian Primary Care Improvement Plan prior to submission to the Lothian GP Sub-Committee for approval.

3 Background and main report

3.1 The 2018 General Medical Services Contract and associated Memorandum of Understanding (MoU) requires IJBs and HSCPs to develop a Primary Care Improvement Plan to cover a three-year period from April 2018.

3.2 Initial agreement for the Primary Care Improvement Plan (PCIP) from the GP-Sub Committed is required before 1 July 2018.

3.3 The attached Plan will be taken to the Lothian GP-Sub Committee on June 11th 2018

Assuming that both the IJB and the GP-Sub Committee support the PCIP then the Midlothian HSCP, working with key stakeholders including General Practice will move into an engagement and implementation phase following the timelines set out in the PCIP.

3.4 The Plan and its implementation will transform how care is provided in Midlothian over the next three years. *How* this work progresses is as important as *what* changes are made. Emerging principles from work to develop the PCIP are:

- **Practices are not at the same starting point and will progress at a different pace.** Practices are not starting from a common position across Midlothian. There is variation in culture (values and beliefs) and how workload is managed. Some practices also have greater capacity to progress more quickly to the new way of working. Implementation Plans will be agreed between the HSCP and each practice to describe the agreed actions by both parties that reflect where the practice is starting from.

Examples of variation between practices is demonstrable through prescribing indicator attainment, restrictions on new registrations (now five practices in Midlothian) and results from the national Health and Care Experience Survey.

- **Service redesign will be information-led**. A common understanding of workload is required between practices and the HSCP to support new developments and measure impact. Information is also needed to develop Key Performance Indicators to monitor progress to implementing the PICP.

- **A one-size fits all approach is not the default.** The differences in practices and the communities they support will drive service redesign and lead to different approaches to providing services across Midlothian. Getting a service working well in one community or practice is the priority ahead of developing a consistent Midlothian or Lothian approach. In some situations there will be developments that accord with all PCIP principles and can have a consistent pan-Midlothian or Lothian approach.

3.5 Appendix One contains the final version of the Midlothian Primary Care Improvement Plan. Initial agreement is sought from the IJB and GP-Sub Committee to continue with its development and move into a phase of stakeholder engagement and involvement and implementation of the plan.

4 Policy Implications

The overall policy direction of developing a multi-disciplinary team approach within primary and community care supports the Midlothian IJB Strategic Plan and will contribute to the wider aim of shifting the balance of care from secondary care to community settings.

5 Equalities Implications

5.1 There will be equalities implications from service developments from the PCIP. The models that are developed have the potential to reduce access for certain patient groups (for example if a service is developed away from a practice that a patient needs to travel further to get to).

5.2 There has not been an EQIA undertaken for the Primary Care Improvement Plan. Specific work streams will have an EQIA completed as part of the establishment and evaluation of the work.

6 Resource Implications

Scottish Government confirmed on 23 May 2018 the funding for the Primary Care Improvement Fund element of the wider Primary Care Fund. This is to be used by Integration Authorities to commission primary care services.

The Primary Care Improvement Fund (PCIF) comprises £45.750 million of the £115.5 million Primary Care Improvement Fund. £7.8M has previously been allocated to NHS Boards and used for developments such as pharmacists in GP practices.

2018/19 Allocation to Midlothian Integration Authority

Midlothian's 2018/19 PCIF allocation from the total bundle of £45.750M	£720,229

The £720K allocation consists of £120,376 that forms part of NHS Lothian's baseline funding and £599,854 additional funding allocated from Scottish Government. There are funding commitments from these budgets which will be reviewed in the prioritisation process for investment.

There will be further funding for 'Action 15' of the Scottish Government's Mental Health Strategy. Action 15 is a four-year commitment to deliver 800 more mental health workers in a range of settings, including primary care. £11M is being made available to Integration Authorities in the first year.
The Midlothian IJB will receive an update later this year on how all this funding has been invested in Midlothian.

Funding from Scottish Government to integration authorities will be higher in 2019/20 and 2020/21.

7 Risk

The contract may introduce new risks in finance, manpower, premises and out of hours. These will considered and a risk register for the implementation will be developed.

8 Involving people

The IJB has discussed the issues in primary care and approved primary care priorities. These have been developed together with the GP involvement structures.

A number of papers relating to primary care have been discussed and supported with a wide range of stakeholders at the Primary Care Forward Group, Primary Care Joint Management Group, NHS CMT, NHS Healthcare Governance Committee and NHS Board. HSCPs will be responsible for local engagement and the NHS Board for Lothian wide engagement.

Further stakeholder consultation has taken place with GP practices. A programme of informing, engaging and consulting with key stakeholders will continue during the developing of future services described in the Plan.

9 Background Papers

Appendix 1: Midlothian Primary Care Improvement Plan

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DATE	18th May 2018

Appendix One

Midlothian Primary Care Improvement Plan

Contents

1 Introduction

1.1 **The 2018 General Medical Services** Contract in Scotland was implemented on the 1st April 2018. The contract represents a significant change in how General Practice operates and its relationship with the HSCP and professionals working in the communities served by the practice

1.2 The new contract aims to support the development of the Expert Medical Generalist role for GPs, with a shift over time of workload and responsibilities to enable this. A key enabler for this is investment in a wider multidisciplinary team in support of general practice.

1.3 The new contact offer is supported by a Memorandum of Understanding which requires:

The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs.

1.4 The expected content of the plan and the requirements for the multi disciplinary team are set out in detail in the draft Memorandum of Understanding http://www.gov.scot/Resource/0052/00527517.pdf and the new contract framework (specifically section 4 pages 24-38) http://www.gov.scot/Resource/0052/00527530.pdf . The key requirements and additional local approaches are set out below.

1.5 The contract requires each HSCP to develop a Primary Care Improvement Plan (PCIP) by 1st July 2018. The PCIP is to include clear milestones for the redistribution of GP workload and the development of effective primary care multi-disciplinary working.

1.6 The MOU states the PCIP will:

- *Be developed collaboratively with HSCPs, GPs, NHS Boards and the other stakeholders;*
- *Detail and plan the implementation of services and functions listed as key priorities below with reference to agreed milestones over a 3 year time period;*
- *Give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs.*
- *Provide detail on available resources and spending plans (including workforce and infrastructure);*

- *Outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract.*

1.7 The final funding details have yet to be agreed by the Scottish Government. Much of what follows is dependent on availability of the additional finance.

2 Midlothian Context

2.1 The PCIP has been developed in the context of wider transformation and redesign of services across Midlothian. Most of the existing programmes and tests of change in primary care are described in the *Midlothian General Practice Strategic Programme* and will be incorporated into the PCIP.

Midlothian General Practice Strategic Programme

2.2 The Midlothian IJB agreed in April 2017 a strategic programme for general practice, which was developed in consultation with general practices and community groups. The programme addresses some of the key pressures affecting general practice, namely increased complexity and volume of workload combined with a shortage of trained GPs and other highly skilled professionals. These are the same pressures the new contract seeks to resolve**.** Consequently the established strategic programme forms the foundation for the Midlothian Primary Care Improvement Plan. The key actions from the programme reflected both practical support as well as implementing new ways of working and are:

- General Practice expansion (Newtongrange, Newbyres, Loanhead);
- LEGup Support for list size growth;
- Midlothian wide Practice Catchment review;
- S75 Policy development on House Building;
- *Do I need to see a GP?* communication project;
- Collaborative Leadership in Penicuik;
- Organisation Change and People Development within Practice teams;
- Advanced Nurse Practitioner training ;
- Develop the role of Advanced Physiotherapy within practice teams. During 2017 a new physiotherapy role will be developed and piloted in Midlothian initially working within three practices;
- Extending the provision of practice-based pharmacist and pharmacy technician support;
- Embed the Wellbeing Service in 8 health centres and evaluate the impact of the service;
- Develop and apply the efrailty index to improve the care of people living with frailty;
- Improving the Patient Experience;
- Implementing the Midlothian Prescribing Action Plan.

3 Midlothian approach to implementing the PCIP

3.1 The development of the primary care service redesign in the context of delivery of the new GMS contract should accord with seven key principles described in the Memorandum of Understanding (MoU) (see box).

Safe –Patient safety is the highest priority for service delivery regardless of the service design or delivery model.

Person-Centred - Partnerships between patients, their families and those commissioning and delivering healthcare services work to provide care which is appropriate and based on an assessment of individual needs and values and is outcome focussed, demonstrates continuity of care (in the context of both professionals and services), clear communication and shared decision-making. Having regard to the five principles underpinning the Health and Social Care Standards: dignity and respect, compassion, to be included, responsive care and support and wellbeing.

Equitable – fair and accessible to all.

Outcome focused – making the best decisions for safe and high quality patient care and wellbeing.

Effective - The most appropriate treatments, interventions, support and services will continue to be accessible, provided in the most appropriate place by the right person at the right time to everyone. Changes to service delivery should not result in any diminution of care or outcomes for patients.

Sustainable – delivers a viable long term model for general practice that is resilient in the context of the wider community care setting on a continuous basis; and promotes and supports the development of the skill mix within the practice setting.

Affordability and value for money – Making the best use of public funds; delivering the general practice model within the available resources; with appropriate quality assurance processes

3.2 Midlothian Principles

The following principles will be used to assist in the implementation of the Primary Care Improvement Plan and the allocation of additional support.

- New investment in support to practices will seek to address the imbalance from historical investment. This means that where a practice is benefitting from existing support and another practice does not have this support then the practice without the support will be prioritised for new investment.

- **Service redesign will be information-led**. A common understanding of workload is required between practices and the HSCP to support new developments. The HSCP will not be able to support specific practices without understanding workload and the impact the development will have to the practice.

- **A one-size fits all approach is not the default.** The differences in practices and the communities they support will drive service redesign and lead to different approaches to providing services across Midlothian. Getting a service working well in one community or practice is the priority ahead of developing a consistent Midlothian or Lothian approach. In some situations there will be developments that accord with all PCIP principles and can have a consistent pan-Midlothian or Lothian approach.

- **Practices are not at the same starting point and will progress at a different pace.** Practices are not starting from a common position across Midlothian. There is variation in culture (values and beliefs) and how workload is managed. Some practices also have greater capacity to progress more quickly to the new way of working. Implementation Plans will be agreed between the HSCP and each practice to describe the agreed actions by both parties that reflect where the practice is starting from.

- **All practices will be asked if they want to be involved in testing any service redesign.** Where service redesign needs to be tested in part of Midlothian to assess impact all practices will be asked if they want to be involved and the HSCP will decide which practices to work with based on responses using a fair and transparent selection process.

4 Midlothian HSCP Delivery of the Six Memorandum of Understanding (MoU) Commitments

4.1 The MOU identifies the services developments that should be the priority for HSCPs between 2018 and 2021. Changes to services will only take place when it is safe to do so and when resources have been identified. These are:

- Vaccination Transformation Programme
- Pharmacotherapy services
- Community Treatment and Care Services
- Urgent Care (advanced practitioners)
- Additional Professional roles
- Health and Wellbeing Workers

Vaccination Transformation Programme (VTP)

4.2 The VTP was announced in March 2017 to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing role of those, principally GPs, historically tasked with delivering vaccinations.

4.3 The Lothian Vaccination Transformation Programme Board will lead the transfer of this activity from practices. The HSCP and Local Medical Committee are on the programme board.

4.4 The Midlothian HSCP's vaccination timetable for Midlothian will inform the VTP Board and be assessed against the other PCIPs from HSCPs in Lothian and the principles in the Memorandum of Understanding.

- Travel clinic. In **Year 1** the current workload on practices will be identified and options developed to change the service**.** This work will transfer from practices by end of Year 1.
- There will be no practice in Midlothian continuing to do any childhood immunisations. There are currently 4/5 practices that provide this service. we hope to transfer this workload to the HV and community vaccination team in Year 1.
- Other immunisations (shingles etc) will transfer from Midlothian practices in **Year 2.**
- Flu immunisations will transfer from practices in **Year 3.**

4.5 The process, cost and provision of adequate resource must be developed by the HSCP to ensure safe transfer of workload. The Scottish Government have not yet given us a clear indication of the available budget.

Pharmacotherapy Services

4.6 The new contract includes an agreement that every GP practice will receive pharmacy and prescribing support.

4.7 In Midlothian all practices receive some support from either a pharmacist (75% of practices) or a pharmacy technician (Loanhead, Pathhead and Danderhall Practices currently only receive support from a pharmacy technician). There is significant difference between the support offered by a Pharmacist and a Technician so there is not an equitable distribution of resource between practices.

4.8 The HCSP will continue the programme to increase the pharmacotherapy service to practice teams using the experience gained from the current service. New investment will be prioritised to practices that are without pharmacist support.

4.9 By April 2021 all practices will benefit from the HSCP pharmacotherapy service delivering the core elements in level one described in the following table. This is dependent on the availability of a workforce with sufficient non-medical prescriber capacity.

CORE AND ADDITIONAL PHARMACOTHERAPY SERVICES		
	Pharmacists	**Pharmacy Technicians**
Level one (core)	• Authorising/actioning[15] all acute prescribing requests • Authorising/actioning all repeat prescribing requests • Authorising/actioning hospital Immediate Discharge Letters • Medicines reconciliation • Medicine safety reviews/recalls • Monitoring high risk medicines • Non-clinical medication review Acute and repeat prescribing requests includes/ authorising/actioning: • hospital outpatient requests • non-medicine prescriptions • installment requests • serial prescriptions • Pharmaceutical queries • Medicine shortages • Review of use of 'specials' and 'off-licence' requests	• Monitoring clinics • Medication compliance reviews (patient's own home) • Medication management advice and reviews (care homes) • Formulary adherence • Prescribing indicators and audits
Level two (additional - advanced)	• Medication review (more than 5 medicines) • Resolving high risk medicine problems	• Non-clinical medication review • Medicines shortages • Pharmaceutical queries
Level three (additional - specialist)	• Polypharmacy reviews: pharmacy contribution to complex care • Specialist clinics (e.g. chronic pain, heart failure)	• Medicines reconciliation • Telephone triage

4.10 The HSCP see two distinct roles in practice teams that the pharmacotherapy service provides: prescribing support; and pharmacy support.

Prescribing Support

4.11 Prescribing support is a well established service that practices will be familiar with. It provides practices with advice on safer prescribing or formulary adherence. It is about quality, the budget and cost of prescribing in Midlothian. This service will continue to support practices during implementation of the Plan with pharmacy queries, medicines shortages, reviews of the use of 'specials' and 'off-licence' requests, safety reviews and recalls.

Pharmacy support

4.12 The pharmacy support is the dedicated support that practices receive from the HSCP that has been used for activities such as medicine-reconciliation.

4.13 The ambition of the HSCP to increase this support will be limited by available resource (financial and workforce). The HSCP plan for all practices to receive support up to an average of **6 pharmacist sessions per 8,000 patients**. Where practices already receive support then this would be included in this total. The impact of this capacity on practice workload will be assessed during the plan's

lifespan and support will be increased where this is required and if there is available funding and workforce.

4.14 The established pharmacotherapy service in some Midlothian practices has allowed testing how this service can support and augment the General Practice workload and improve patient experience and outcomes. This has identified the following roles and ways of working which will make up the priorities for this service.

- **The pharmacist will be visible in the practice team but some work will be done remotely**. *How* practice teams and the HSCP services working in them is important to the success and impact of the multidisciplinary team. Practice teams need the pharmacist to be accessible and visible in the practice but work for the pharmacist cannot be batched until the pharmacist is next in the practice because for some of the smaller practices they will be in only one or two days a week. There is some practice work that can be done remotely to provide a daily support to the practice. This will mean that whilst the pharmacist is located in one practice they will also be supporting other practices remotely.

- **All medicines reconciliations from hospital discharge will be completed by the pharmacist.** In some Midlothian practices currently these are completed by the pharmacist *but* only when the pharmacist is physically working in the practice. The future model will allow medicines reconciliation to happen remotely. **By the end of Year 2 most medicine reconciliations for all practices will be completed by a pharmacist.**

- **Pharmacy Technicians will take on prescribing support**, formulary adherence and prescribing improvement projects.

- **Practice Admin teams will be trained to complete 'non clinical medication reviews'.** In some practices in Lothian members of the practice administration team have been trained to take on this role (e.g. if a patient has not used a medication for many months then it is removed from the repeat prescription list). Training will be provided to practices.

4.15 All practices will receive support in Year 1 which will increase in Year 2.

4.16 Level 2 and Level 3 Additional Pharmacotherapy Services

4.17 The new contract requires every practice to benefit from the pharmacotherapy service delivering the core elements of level one. The elements in levels two and three are expected will be provided in some areas in Scotland but this is dependent on workforce availability.

4.18 The HSCP will initially work with a small number of practices to develop the additional services described in these levels. Further support will be provided in

Year 1 to these practices who will work with the HSCP to develop the future model for Level 2 and Level 3 additional pharmacotherapy services and focus on these areas:

- **Care Homes: Medicines Reviews and Polypharmacy Reviews.** All care home residents will be reviewed by the HSCP pharmacist. This has already commenced in Archview Care Home. Learning from this will be used to roll out this **support to all care homes by Year 3.**

- **Patient-facing pharmacotherapy service.** The HSCP plan for all pharmacists in this service to be independent prescribers and to have an active role in practices seeing patients. There are two roles the HSCP will work with a small number of practices first to develop. One is where patients meet with the pharmacist to understand the function of different medications and help to make informed decisions. The second role builds on the Penicuik over 75s de-prescribing project where patients over 75 and on 4 or more medications were invited into the practice for a medicines review. This project is likely to evolve into using the electronic frailty index to identify patients for review.

4.19 Service Model

The Pharmacists and Pharmacy Technicians will be employed by the HSCP and will provide an agreed number of sessions to practices. When the staff are working in the practice they will use the practice's patient record system and work as part of the practice team. To provide daily support to practices it is expected that some of the time allocated to the practice will be provided remotely with the pharmacist working at another site. This is to prevent 'batching' of work and help to manage practice workflow.

The team will work under a single governance structure but have different tasks in different practices as the roles and practices develop at different paces.

4.20 Role of Pharmacotherapy service in Quality Improvement

4.21 There are ten prescribing indicators that are focused on in Midlothian to improve quality. Where improvement is needed against these indicators the pharmacotherapy service provided to the practice will be used to support the practice to do so.

5 Community Treatment and Care Services

5.1 The responsibility for providing many non-GP services will pass from GP practices to HSCPs. These include (but are not limited to):

- management of minor injuries and dressings
- phlebotomy
- ear syringing
- Chronic disease monitoring and related data collection
- suture removal

5.2 It is expected that these services will be available for use by primary care and secondary care. For example, pre-hospital clinic bloods could be carried out for a requesting consultant without having to involve the GP practice staff. The consultant's name would be on the test result to avoid unnecessary GP involvement

5.3 **Year 1 will be used to develop the service model and agree priorities with GP practices.** This model is a significant departure from the current process and will require developments in services, Information Technology and processes in order to transfer this work from practices and remain accessible to primary and secondary care.

5.4 **Service Model**

5.5 There is not a clear model to describe at this stage. There are a range of potential models along a continuum from a single Midlothian service operating from one location to services operating from multiple locations. It should be anticipated that a service operating from multiple locations, including all practice buildings, is highly likely in order to meet the seven key MoU principles and provide convenient access.

5.6 A network of treatment room services is established across Midlothian with variation in how the service is organised. These services will be included in the service review and redesign.

5.7 New ways of working involving Healthcare Support Workers and IT solutions like Surgery Pods will be explored in **Year 1** as a way to increase capacity in practice teams for chronic disease monitoring.

6 Urgent Care (Advanced Practitioners)

6.1 The HSCP will lead the redesign of other services that focus on urgent and unscheduled care. The contract includes the provision of advanced practitioner resource as first response for home visit.

6.2 Consultation with Midlothian practices has identified a wide range of views about how this should develop and which professional is most appropriate to provide urgent care. Some practices are cautious of this model because some patients with the most complex health care require home visits and where it is clinically appropriate for the most senior clinical decision maker to visit the patient. Other practices are more open to a new model and where pilots with paramedics have taken place they have shown to reduce GP work volume with good patient feedback.

6.3 The evidence of the impact of the use of Advanced Nurse Practitioners, Paramedics and Advanced Physiotherapy Practitioners will assist in the service redesign including evidence from within Midlothian.

6.4 Year 1

6.5 Year 1 will be used to develop the service model and agree priorities with GP practices.

6.6 The Lothian Advanced Nurse Practitioner (ANP) training programme will continue to be funded by the HSCP and will double the number of training placements.

6.7 Service Model

6.8 The service model is likely to vary across practices in Midlothian and the following areas could be a priority for the service:

- Frail Patients
- Some patients who are housebound
- Care homes
- Patients with COPD (Chronic Obstructive Pulmonary Disease)

7 Additional Professional Services

7.1 Additional professional roles will provide services for groups of patients with specific needs that can be delivered by clinicians other than GPs, serving as first point of contact in the practice setting as part of the wider multi-disciplinary team. These include (but are not limited to) physiotherapy services and community mental health services.

7.2 Musculoskeletal Advanced Physiotherapist Practitioner (MSK APP)

7.3 All practices in Midlothian consulted during the development of the PCIP see a clear impact on reducing GP workload and support expansion of the current service in Year 1.

7.4 The majority of a GP's musculoskeletal caseload can be seen safely and effectively by an Advanced Physiotherapist Practitioner without a GP referral. Advanced Practitioner Physiotherapists are already well suited to work collaboratively with primary care multi-disciplinary teams and support the GP role as senior clinical leader. Under the new contract HSCPs will develop models to embed a MSK service in practice teams.

7.5 Midlothian started work in 2017 to develop a MSK APP service. The governance structure is established and the new service is working with three practices (Newbattle, Strathesk, and Pathhead) to refine the model. A further three practices (Danderhall, Roslin, Newbyres) will have the service from August 2018. Further recruitment is required to expand the service across the remaining six practices.

7.6 Year 1

7.7 The goal in Midlothian is that by the **end of Year 1 all practices will have MSK APP provision within their practice team** but this is dependent on the availability of workforce and funding.

7.8 MSK APP Service Model

7.9 The Midlothian service has been based on services in Inverclyde and Cumbria indicate that a practice should receive 1 session per 1900 patients.

7.10 The Advanced Practitioner Physiotherapists (APP) are employed by the HSCP within one governance structure and will provide an agreed number of sessions to practices. When the staff are working in the practice they will use the practice's patient record system and work as part of the practice team.

7.11 This new service has implications for the wider health care system. It is expected that referrals to the community physiotherapy service will decrease and the appropriateness of referral to orthopaedic services will increase. The service is likely

to lead to change to established referral pathways, for example the lower back pain pathway because of the impact of placing an experienced physiotherapist in General Practice at the start of these pathways.

7.12 General Practice Mental Health Services

7.13 Community Mental Health professionals, based in General Practice will work with individuals and their families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression. The outcome sought is improved patient care through rapidly accessible, appropriate and timely mental health input.

7.14 The 2017-2027 Mental Health Strategy has the ambition for multi-disciplinary teams in primary care to ensure every GP practice has staff who can support and treat patients with mental health issues and are testing models during 2018. Scottish Government are increasing funding to specifically help CAMHS and direct access to psychological therapies which will have an indirect benefit on General Practice services.

7.15 Service Model

7.16 There is currently limited consensus about the effectiveness of different models which reflects the complexity of mental health presentations within primary care. The Midlothian HSCP anticipate that a multi-professional mental health team is required that is integrated into the Primary Care team and with direct and quick access to community-based mental health teams.

Potential components of the future primary care integrated mental health model

Computerised CBT. The uptake of this evidence-based intervention is lower than in other HSCPs

Midlothian Access Point: The number of locations across is increased across the county to improve access to psychological therapy services. Opportunities to increase access to both the access point the addiction recovery hubs by combining the services will be explored.

The **Wellbeing Service** established in eight practices and planned to expand forms a function within the integrated primary care mental health model

Additional Mental Health professional capacity in practices will be necessary and is likely to include Community Psychiatric Nurses but may also include Mental Health Occupational Therapists, Support Workers or Psychologists.

7.17 The current mental health workload on practices needs to be well-understood in order to develop increased capacity that meets all seven MoU principles. In **Year 1 and into Year 2** up to three practices will be identified to work closely with the HSCP to understand workload and use this data and evidence from services in other areas to develop a service model that will work across Midlothian.

7.18 The practices working with the HSCP will be supported through locum cover to develop the model and will receive support from Community Psychiatric Nurses to learn how this role can work in the primary care team.

7.19 In **Year One** the Wellbeing Service will be extended across all practices. This will have implications for practices currently receiving support from the service because support will reduce unless additional funding is invested in the service to maintain the current level. The Wellbeing service will continue to be developed to respond to the changing demands from new referrals and current service users.

8 Link-Workers

8.1 The Wellbeing Service is well established and is beginning to demonstrate impact on improved outcomes for service users with some evidence of reduction in demand for GP services. The H&SCP have identified additional resource to fund this on an ongoing basis. Midlothian HSCP will use this model and existing third-sector community signposting services (e.g. Red Cross Local Area Coordinators) as our model of developing an additional link worker service.

8.2 A Community Link Worker is a non-clinical practitioner based in or aligned to a GP practice who works directly with patients to help them navigate and engage with services.

8.3 In **Year 1** the Wellbeing service will be extended across all practices in Midlothian. There are eight practices that benefit from this support. To extend the current support to practices will be reduced to spread the service otherwise additional investment is required.

9 Beyond General Practice

9.1 The contract and the Memorandum of Understanding is focused on developing the support and reducing the workload of current practice teams. Developments in practice teams as a result of the Primary Care Improvement Plan and subsequent implementation programme will have implications for and must take cognisance of the wider community health and care system and the functions provided by NHS Lothian.

9.2 Community Services

9.3 There will be significant change required for other community-based services as a result of implementing the PCIP. There will be a large transfer of work from practice teams into existing or new community services. How these services are configured and the capacity in them will be a key factor in the success of this change-programme.

9.4 Interface between General Practice and Hospital

9.5 The new contract highlights the importance of interface working as a core aspect of managing workload. The contract outlines that: *"To ensure effective working between primary and secondary care, we will continue to implement the recommendations of the Improving General Practice Sustainability Advisory Group as set out in its report on November 2016.*

9.6 Within the recommendations there are a number of broad themes including effective primary and secondary care interface working. Interface working will be better achieved through well-functioning primary and secondary care interface

groups. These groups will support NHS Boards and HSCPs to reduce GP workload and provide a better patient experience by removing the need for GP involvement when it is not clinically necessary.

9.7 NHS Lothian has been pioneering in this area, having established a Lothian Interface Group with a small number of GPs and Consultants who are aware of the issues and keen to find solutions. However the group has no operational capability, and is resourced for a small number of meetings but not other substantive work.

9.8 There is much to gain in interface working: improved quality, safety, relationships and the possibility of reducing waste and harm. The HSCP will support closer working between Hospital and Practice through a combination of joint work between formal committees and groups and work to improve the whole system of care for specific patient groups.

9.9 Lothian Unscheduled Care Service/Out-of-Hours Services

9.9..1 The Primary Care Improvement Plan is focused on the services provided in the 2018 General Medical Services Contract in Scotland. The provision of GMS in evenings, overnight and at weekends is not included in the new contract. However, specific actions to improve continuity of patient care which will reduce pressure on the Lothian Unscheduled Care Service (LUCS) should be incorporated into the implementation of the PCIP.

9.9..2 There is specific funding from Scottish Government to develop Out-of-Hours Services in response to the Ritchie Report.

9.9..3 The following areas for action have been identified:

- **Care Homes:** The HSCP will support practices / develop services to ensure optimal day time accessibility of medical and non medical support to care homes in order to reduce OOH calls and ensure that care is mainly provided by staff who can give continuity of care.

- **Palliative Care:** The HSCP will focus on supporting primary care staff to provide excellent palliative services to patients in the community. Ensure that all suitable patients who wish to die at home are able to do so. Ensure that palliative patients have appropriate ACPs to improve continuity of care. Appropriate ACPs will greatly benefit patient continuity and make it possible for OOH services to deliver optimal care. Big steps have recently been made in improving nursing continuity with the change to 8am to midnight cluster district nursing cover(check with Caroline)

- **Mental Health services:** Ensure adequate and prompt Day time access for patients suffering distress due to mental illness. The open access MAP service has been a step in the right direction. We intend to build on this by fully supporting MWAP to sustain

capacity and by developing an enhanced primary care mental health model which will become an accessible port of call for the acutely distressed. Good daytime services are highly likely to reduce OOH contacts for MH issue In most cases.

- **Development of the Urgent Care Resource Hub** will improve coordination of health and care services during evenings, overnight and at weekends. This is a separate work stream with a separate funding stream which will be complementary to and add value to daytime services.

9.10 Population Growth

9.10..1 The population in Midlothian is growing rapidly as a result of new house building. The HSCP has already responded with the development of Newtongrange Clinic and the new Loanhead Practice building which will allow the practice to increase its list-size.

9.10..2 New house building will next put pressure on two specific areas and the HSCP will develop plans in collaboration with affected practices:

Year 1 – Option-appraisal for General Practice Provision in Danderhall/Shawfair

Year 1 – Option-appraisal for expanded General Practice provision covering south Bonnyrigg/ Rosewell areas

Year 2/3 – capital development in Danderhall/Shawfair area

10 Better Care for Patients

Key Points (from 2018 GMS contract)

- GPs will be more involved in influencing the wider system to improve local population health in their communities.
- GP clusters will have a clear role in quality planning, quality improvement and quality assurance.
- Information on practice workforce and activity will be collected to improve quality and sustainability

10.1 The role of Quality Improvement and clinical leadership in Midlothian

10.2 The 2018 GMS contract recognises the importance of quality improvement for primary care and population health. It describes the increasing role of the Quality Cluster, the role of the Quality Cluster Lead and Practice Quality Leads to influence and lead improvement.

10.3 The HSCP has supported the development of the Midlothian Quality Custer by funding additional sessions and recognised the importance of involving GPs in strategic planning though Management GP roles.

10.4 The HSCP will continue to support the cluster and the management GP roles and will expand the opportunity for GPs to improve quality and contribute to new models of care through the following support:

- practices to join the Frailty Learning Collaborative and improve care for people with frailty.
- GPs to join key PCIP work streams (e.g. Mental Health) to develop the new models
- Dedicated support for practice teams to undertake quality improvement projects, and learn from other practices.

10.5 Using information from practices to improve quality and sustainability

10.6 Data and the sharing of information is identified in the MOU as a key enabler for change. The new GMS contract will reduce the risk to GPs of being data controllers by clarifying respective responsibilities within a joint controller arrangement with the Health Board.

10.7 The new contractual provisions will lay the foundations for increased lawful, proactive and appropriate sharing of information amongst professionals for the purposes of patient care.

10.8 Sharing of specific information held by General Practices in Midlothian will be crucial for the implementation of the PCIP. This will be done only where the Practice and the HSCP mutually agree that this is of benefit to patient care. An example of this is the commitment by most practices in Midlothian to share information on their frail population to support the development of an improved system of care through the Midlothian frailty learning collaborative.

10.9 Practices will need to work with the HSCP to support the development of new models of care by sharing workload activity. This is particular important where the future model is unclear (e.g. Urgent Care, Mental Health). The HSCP will work with practices able to share information to develop a shared plan for how these new services will develop.

11 Workforce

11.1 As part of their role as Expect Medical Generalists, GPs will act as senior clinical leaders within the extended multidisciplinary team (MDT). Many of the MDT staff will be employed by the health board within the HSCP. Some MDT members will be aligned exclusively to a single GP practice while others may work across groups of practices.

11.2 Existing practice staff will continue to be employed directly by practices. Practice Managers, receptionists and other practice staff will continue to have important roles in supporting the development and delivery of local services. Practices Managers should be supported and enabled to contribute effectively to the development of practice teams and how they work across practices within Clusters and in enabling wider MDT working arrangements.

11.3 The publication of the recent Scottish Government Document Workforce Planning for Primary Care will help guide our thinking in terms of availabilities of workforce and wider workforce planning.

12 Supporting the changing role of practice managers and reception staff

12.1 There has been an increase in administrative and clerical workload in practices. If GPs are seeing more patients with more complex needs and other members of the Primary Health Care Team are also experiencing an increase in demand, then there is also an impact on reception staff.

12.2 This team are processing more clinical letters, more prescriptions and more test results, as well as supporting co-ordination and continuity of care as part of organising appointments and trying to meet the challenge of managing appointments as demand grows. All of this work contributes to the overall patient experience, supporting the clinical team as well as helping the practice run smoothly.

12.3 The contract identifies key changes in the roles of reception staff and Practice Managers

Reception Staff	
Now:	**New Contract:**
Organising patient appointments	Organising patient appointments
Managing communications to/from the practice	Managing communications to/from the practice
Managing prescription requests/enquires	Managing prescription requests/enquires
Operating call/recall systems	Operating call/recall systems
Administration	Administration
	Supporting patients with information on available services
Practice Manager	
Now:	**New Contract:**
Contract management	Contract management
Contract monitoring	Contract monitoring
Business planning	Business planning
Contract and other regulatory compliance	Contract and other regulatory compliance
Staff management	Staff management
	MDT co-ordination

12.4 Support for Practice Managers

Practice Managers have a wide range of skills and the HSCP will work with practices in Year 1 and NHS Education for Scotland to identify and support training and development needs.

12.5 Reception and Administrative Staff

12.6 As the first point of contact for the Practice, staff have a central role in terms of patient contact and a good patient experience. There are also many 'behind the scenes' responsibilities, such as prescription management, medical secretarial skills and documentation management. Many staff remain with a practice over a significant time period and so offer consistency and continuity within the practice team.

12.7 Key development areas include building on signposting and document management roles and a Primary Care Collaborative, led by HIS has been established to look at these two elements. While Midlothian is not formally part of this work, locally, East Lothian H&SCP are taking part and there are opportunities to share ideas and good practice. Evidence from practices in East Lothian show that changes in the practice to managing documents has reduced GP workload by 6 hours per week.

12.8 Wider Public Engagement

12.9 Following on from the work undertaken last year across Midlothian, which aimed to understand more about how people experience primary care, not surprisingly, the key issue was access. On presenting this back to practice managers, a strong message back was the need for 'patient education' arising from the frustrations of managing increasing demand for appointments.

12.10 In addition to the 'Do I Need to See a GP' leaflet, what else should Midlothian H&SCP consider as a wider campaign? There is the national '#3beforeGP' campaign, which asks people to consider three steps (self care, on-line advice such as NHS Inform and local pharmacist) before contacting their GP practice.

12.11 In addition, NHS24 will develop a national standardised website for each practice in Scotland (at no cost). In addition to individual practice information, the website will reinforce signposting, such as reliable self-care information and promotion of local health and care services.

13 The role of technology including Information Technology

13.1 The MDT will require developments in technology and IT.

13.2 Where technology adds benefit to practices and patients then this should be developed. Areas where technology can add value in Midlothian include: increasing the use of surgery pods which allow patients to record key information (Body Mass Index, Blood Pressure) at the practice without needing an appointment; increasing the use of computerised CBT where clinically appropriate.

13.3 Progress to implement the PCIP will be dependent on IT solutions in some circumstances. For example, potential models to transfer Community Treatment and Care services may include a hub that covers several practices. The hub will need an IT solution that allows staff to access GP patient records and hospital-based services.

14 Budget Planning

14.1 The funding allocated to Midlothian HSCP for the Primary Care Improvement Plan is unknown as of 25th May 2018. Therefore the plan needs to be read within that context.

14.2 The principle that the HSCP will follow for investment in Year 1 is to prioritise development where the service model has already demonstrated the impact on GP

workload. The HSCP will prioritise the Scottish Government funding into the following areas:

- Expansion of the Pharmacy support into practices
- Expansion of the MSK APP service
- Service expansion to transfer Childhood Immunisations from practices
- Support for practices to lead and be involved in quality improvement and developing future models of care in areas where the preferred model is unclear.

Appendix 1: **Process for developing the Primary Care Improvement Plan**

The requirement for engagement in the development of the plans is clearly set out in the MoU:

HSCPs should establish local arrangements to provide them with advice and professional views on the development and delivery of the Primary Care Improvement Plan. Arrangements will be determined locally and will take account of the requirement to engage stakeholders. The HSCP Primary Care Improvement Plan should be agreed with the local GP subcommittee of the Area Medical Committee

HSCPs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users. In relation to the development of the Primary Care Improvement Plan that would include (but not be limited to):

- *Patients, their families and carers*
- *Local communities*
- *SAS and NHS 24*
- *Primary care professionals (through, for example, GP subcommittees of the Area Medical Committee and Local Medical Committees)*
- *Primary care providers*
- *Primary care staff who are not healthcare professionals*
- *Third sector bodies carrying out activities related to the provision of primary care*

In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of patient's needs, life circumstances and experiences it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that patient engagement is a key part of their Primary Care Improvement Plans.

14.3 The HSCP will lead a programme of meetings and events during the development of the Improvement Plan to inform the implementation plan which will start in July 2018 and continue during the three-year timeframe of the PCIP.

14.4 Plans for developing the multi-disciplinary team will require new and expanded roles and changes to existing roles. Staff Partnership involvement in the development of the plans is therefore essential.

14.5 In addition to engagement on the development of the plans, consideration should be given to engagement on the implementation and development of multi-disciplinary teams to ensure that these work effectively at practice and cluster level. This will include the full range of practice staff including practice managers who have

significant existing skills and knowledge in enabling effective working practices for multi-disciplinary teams.

Thursday 7th June 2018

Workforce Planning

Item number:	**4.4**

Executive summary

This report sets out the progress made in workforce planning over the past 6 months. In October 2017, the MIJB agreed a framework for Workforce Planning. This provides a foundation for each service area to shape their workforce for the future, taking account of transformational change, resulting in new models of care and the increasing need to maximise on the effective use of resources. The report, in addition, outlines the proposed plan for workforce action planning in other key service areas.

Board members are asked to:

1. Note the progress to date.
2. Support the plan for future work.
3. Agree to receive a further report in 3 months to provide assurance that workforce planning is progressing with positive effect.

Report

Workforce Planning

1 Purpose

1.1 The purpose of this report is to inform IJB on progress in Workforce Planning across the Midlothian Health and Social Care Partnership.

2 Recommendations

2.1 As result of this report Members are being asked to:-

1 Note the progress to date

2 Support the plan for future work.

3 Agree to receive a further report in 3 months to provide assurance that workforce planning is progressing with positive effect.

3 Background and main report

3.1 Background

Midlothian Integration Joint Board (MIJB) is required to have a Workforce Plan to complement the Strategic/Delivery Plans and Financial Strategy. Scottish Government has produced various supportive reports to enable this work. There has been no guidance as to the specific shape or structure for the Workforce Plan.

In October 2017, MIJB approved the Midlothian Health & Social Care Partnership (H&SCP) Workforce Planning Framework – *Connecting Health and Social Care.* This framework provides a solid foundation for good practice in workforce matters, which are evolving and dynamic and where new influences and drivers demand a fluid and flexible response.

The framework recognises that our workforce is our most valuable asset. In this environment of transformational change, where new models of integrated working and new forms of commissioning are evident, investment in building strong values, strong effective working relationships, a shared culture, the right skills and knowledge and providing clear career pathways are all key elements of workforce planning.

3.2 Progress

The next stage, building upon the Workforce Framework has been the development of action plans for each service area. Each action plan aims to

reflect real connections between the Delivery Plan, the Financial Strategy and the workforce, as well as make connections with NHS Lothian, Midlothian Council, pan-Lothian, Regional and National Workforce Planning developments.

The Joint Management Team requested initial focus for action planning in four key areas, namely:

- Older People Services teams– Dementia, MERRIT and Care at Home Services
- Learning Disability Day Services
- Recovery Hub services

It is worth highlighting the following features of the process to date:

- **Staff involvement** at all levels and across sectors has resulted in rich contributions and a heightened awareness and buy-in to the change agenda. Structured workshops, reflecting the key messages of the Workforce Planning framework have offered staff the opportunity to discuss, share, learn, be creative and innovative together, to shape their service for the future.

- **Review Expert Panels** have provided a strong collaborative approach for the review of Learning Disability Day Services**.** Practitioners, family carers and people with learning disability have come together to make a contribution to the work of reviewing Day Services in Midlothian. A core part of the conversation has been focused on workforce matters.

- **Planning** for the new Recovery Hub has brought focus to practical matters related to a new building base, as well as staff development. There is a very strong sense of collaboration and close working across the service areas.

- **Service Managers and Planning officers** have been key to leading on and coordinating this work, through their ownership and commitment, working alongside the Organisational Development resource.

- **Time** has been the challenge, with delays and rescheduling of workshops with staff resulting from the priority of operational demands. As a result, progress slowed down and keeping focus and enthusiasm for the work, amongst competing demands, has been challenging.

- **The benefits** of taking this approach have been numerous – staff have felt valued and listened to, staff have felt greater understanding of the key drivers and influences on their services and working together on workforce matters has enabled stronger relationships and understanding of the need for a fresh approach to deployment of human resources.

- **Governance** is provided by the Joint Management Team, which receives regular monitoring reports of risks and challenging areas and, of course, innovative and creative solutions.

Table 1: Current Action planning timeframe

CURRENT ACTION PLANNING	Status	Lead	Timescale for Workforce Matters
DEMENTIA	Nearing completion	A Fraser & K Skey	June 2018
MERRIT	Nearing completion	A Fraser	June 2018
CARE AT HOME	Nearing completion	A Fraser	June 2018
LEARNING DISABILITY DAY SERVICES	In progress	D McIntyre & G Kilpatrick	September 2018
RECOVERY HUB	In progress	A White	September 2018

3.3 Proposed programme for New Action Planning Service Areas

To allow for continuous progress across services, a staggered approach is proposed, linking the Workforce Action planning process with key agreed Transformation Project areas. Other transformation areas will need to be considered along with any other key service areas, in due course, such as Community Learning Disability services, Physical Disability and Sensory Impairment services. Organisational Development leadership, support and facilitation will be provided.

Table 2: Proposed programme for next phase of Service Action planning

Transformation Project	Service Area	Lead	Proposed Timescale
DEVELOP A CARE HOME STRATEGY	Care Homes Strengthening Support Systems Reviewing Decision-Making re: Admissions	A Fraser	November 2018
EXPAND COMMUNITY BASED SERVICES IN MENTAL HEALTH	Reduce focus on hospital care	K Skey	December 2018
RESHAPE PRIMARY CARE	All aspects	J Megaw	February 2019
STRENGTHEN PREVENTION AND RECOVERY IN CRIMINAL JUSTICE	Criminal Justice/Community Safety	M Brewer	October 2018
LOCALITIES	Build strength in locality areas, using learning from new effective tried and tested cross sector community responses in Penicuik e.g. people who are isolated/lonely	J Megaw	January 2019

3.4 Collaboration with key partners

Midlothian Workforce Planning will connect with NHS Lothian and Midlothian Council Workforce planning processes and developments. Close collaboration has been built in to the process. Connections on a pan-Lothian, regional and national basis are being maintained to promote understanding, learning and support for all. The Midlothian IJB Workforce Planning framework takes account

of all National Scottish Government Workforce Planning reports and other key drivers and influences. The Workforce Framework is intended to be comprehensive involving voluntary and independent providers of health and care services.

4 Policy Implications

4.1 There are no new policy implications from this report. The Workforce Plan will support the delivery of the Strategic Plan, working within the parameters of the Financial Strategy.

5 Equalities Implications

5.1 Workforce planning across the partnership will seek to address inequalities by promoting better career opportunities for staff.

5.2 Through learning and development and service redesign and related workforce planning, staff will be encouraged to maintain a strong focus on addressing inequalities in service delivery.

6 Resource Implications

6.1 Workforce planning will contribute to the delivery of the IJB's financial strategy. Developing a culture of prevention, self-management, strong and deep collaboration between services and professionals and making best use of community resources will all contribute to better use of both human and financial resource.

7 Risk

7.1 The Partnership is facing significant risks in key areas of service delivery because of lack of available skilled staff. Workforce Action planning will seek to mitigate these risks, having clear plans to address recruitment and retention issues, for example, taking a talent management approach and actively seeking to develop workable succession planning. Workforce Action plans will ensure that our workforce is supported and developed to meet the challenges of their changing roles.

8 Involving people

8.1 All workforce planning to date has been developed in collaboration with Midlothian Council, NHS Lothian and the Independent sector.

8.2 A process of engagement with managers and staff has been established and will continue to support implementation of the Workforce Planning Framework.

9 Background Papers

9.1 The Workforce Planning framework, *Connecting Health & Social Care in Midlothian,* presented to MIJB in October 2017.

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Midlothian Integration Joint Board

Thursday 7th June 2018

Development of IJB Strategic Plan 2019-22

Item number:	**4.5**

Executive summary

This report explains the proposed process for developing the next IJB Strategic Plan. The Strategic Plan should explain how the IJB intends to use its resources to improve the health and wellbeing of the people of Midlothian. The redesign of health and social care should be based on a good understanding of the needs of the local population. In addition, the success of the Plan requires the support and active contribution of all stakeholders including staff, voluntary organisations, unpaid carers, patients, service users and the public. In order to achieve this there is a need to begin the process of developing the 2019-22 Strategic Plan now. This report lays out a proposed timetable for its development

Board members are asked to:

1. *Note and approve the timetable for the development of the next strategic plan.*
2. *Agree the role and contribution of IJB members to the development of the plan.*

Development of IJB Strategic Plan 2019-22

1. Purpose

1.1 This report explains the proposals to develop Midlothian IJB's second Strategic Plan to cover the period 2019-22

2. Recommendations

2.1 To note the key steps and proposed timetable for the production of the 2019-22 Strategic Plan.

2.2 To consider and agree how members of the IJB can contribute to and help lead this process.

3. Background and main report

3.1 Development of 2016-19 Plan

3.1.1 Stakeholder Engagement: During 2014 an extensive programme of consultation and engagement was undertaken with the public; NHS Lothian and Midlothian Council staff; the voluntary sector; and independent providers of health and social care. This programme sought to gather opinions about the quality and design of local services. There was a high level of interest and engagement particularly from user groups and members of the public.

3.1.2 Assessment of Need: A Joint Strategic Needs Assessment was developed using a variety of expert opinion, available data and comparison with other areas, to build up a picture of the health issues affecting the Midlothian population. The Needs Assessment helped to ensure our health and social care services are designed to meet the current and future needs of the population.

3.1.3 Strategic Planning Group: The Public Bodies Act regulations prescribe the need for the IJB to establish such a group with wide representation. The Midlothian Group has overseen the development of the 2016-19 Plan; the production of the Annual Delivery Plans for 2017-18 and 2018-19; and has an ongoing role in monitoring the implementation of these plans.

3.2 Development of 2019-22 Plan

3.2.1 There were a number of lessons arising from the development of the first Strategic Plan:

1. Establishing a sense of ownership is enhanced through involvement at an early stage rather than simply commenting upon a well-developed plan.
2. Creating face-to-face opportunities rather than relying upon written comments or surveys leads to a richer contribution.

3. Reaching the wider population as well as existing interest groups is challenging.
4. Providing material in a clear, easy to read and interesting format makes it much more likely people that people will read and understand written documents.

3.2.2 The Strategic Planning Group is well established with a much stronger sense of purpose and is well placed to lead the development of the next Strategic Plan.

3.2.3 The Joint Needs Assessment, compiled in 2015, is comprehensive and informative but needs to be updated.

3.2.4 A programme of engagement should be planned as soon as possible to allow forward notice and maximum participation.

3.2 Key Documents

3.3.1 The development of the Strategic Plan will entail the compilation of the following documents:

- Updated Joint Needs Assessment: Outlining the health and care needs of the Midlothian population.
- Engagement Strategy: National guidance requires the development of an engagement strategy for the purposes of compiling the Strategic Plan.
- Summary of Feedback from Users and Unpaid Carers: Following extensive consultation, a summary report will be compiled outlining the main concerns and ideas from the public.
- Locality Plans: The regulations require that each IJB area designate a minimum of two localities. The rationale for this was to ensure that services become more locally sensitive and that greater emphasis is placed upon capacity building and coproduction. The IJB previously agreed that, given Midlothian's relatively small size, the IJB would designate two localities – East and West Midlothian- whilst recognising that many services will be provided across Midlothian.
- Housing Contribution Statement: In recognition of the key role of housing in the delivery of more effective health and care services, the regulations require the compilation of a Housing Contribution Statement.
- Draft Versions of the Strategic Plan: The regulations require that first and second drafts of the plan must be produced to allow for a period of formal consultation.
- Equality Impact Assessment: This will identify any risks to equality groups arising from the draft plan.
- Easy Read Version of the Strategic Plan: An accessible summary for dissemination to staff, voluntary organisations and independent providers. This is recognition of the need to ensure that we are able to develop a shared vision and approach to the delivery of health and care in Midlothian.

The timetable for the development of these documents is outlined in appendix 1.

4. Policy Implications

4.1 The Public Bodies (Joint Working) Act requires the IJB to prepare a Strategic Plan laying out how it plans to deliver the key health and care outcomes for the Midlothian population.

5. Equalities Implications

5.1 One of the key sections and main objectives of the Plan is to address, more effectively, the Health Inequalities experienced by people in Midlothian. A rapid impact assessment will be undertaken in December 2019 to consider how best to ensure that there are no unintended adverse implications for equality groups arising as a result of the Plan and its proposed implementation.

6. Resource Implications

6.1 The delivery of the Strategic Plan is not dependent on new resources but rather a redistribution of the total resources available to the partnership-approximately £127m per annum. However, it must be acknowledged that shifting resources from hospital and care home provision to community based services, and placing more emphasis on prevention will be very challenging in light of the continuing financial constraints facing health and social work. Nevertheless, the IJB has been given the responsibility of bringing about a transformation of services to ensure that, in the longer term, the needs of the growing and ageing population can be met.

7 Risks

7.1 There is a risk that, as a result of the financial pressures facing both NHS Lothian and Midlothian Council, the capacity to support and enhance preventative services will be jeopardised. Similarly, the continuing pressures on the acute hospital services will make it very challenging to shift resources from there to strengthen community-based services.

8 Involving People

8.1 The development of the Plan will be informed by extensive consultation and engagement with staff, the public and other key partner organisations.

9 Background Papers

Appendix 1 **Preparation of IJB Strategic Plan 2019-22**

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PREPARATION OF MIDLOTHIAN IJB STRATEGIC PLAN 2019-22

Purpose: The IJB has a three year Strategic Plan 2016-19. The preparation and approval of a new Strategic Plan taking effect from April 2019 will be a complex exercise involving analysis of the needs of the population and engagement will all stakeholders including the public. This paper outlines the key steps and an outline timeline.

Timescales: National Guidance stipulates the preparation of a first and second draft of the Plan. The second draft must be provided to both the Council and the Health Board for comment. Following consideration of the second draft by partner agencies, a final plan must be produced, and then approved by the IJB. In order to distribute the Plan to key partners in advance, IJB approval should be obtained by early March 2019. To achieve this timescale a first draft will be required by November 2018 for consideration by the Strategic Planning group on 19th November 2018.

Key Deliverables:

1. Scottish Government Guidance on Strategic Commissioning Plans require the preparation of a communication and engagement plan. The Midlothian IJB has an overarching Engagement Strategy. This needs to be adapted to plan activities during 2018-19 in preparing the Strategic Plan.

2. A Joint Strategic Needs Assessment must be prepared. The goal of this document is to assess the care needs of the local population in order to improve the physical and mental health and wellbeing of individuals and communities. Midlothian IJB produced and published Joint Needs Assessment prior to the production of the 2016-19 Strategic Plan. This will need updated

3. In view of the crucial role of housing to people's health and wellbeing and ability to manage independently, there is a requirement to provide a Housing Contribution Statement. Midlothian IJB approved its Midlothian Housing Contribution Statement as part of its 2016-19 Strategic Plan

Engagement: There are many stakeholders with a legitimate interest in the preparation of Midlothian IJB's next Strategic Plan.

1. **General Public and Service Users:** We are all users of the Health Service be it primary care, hospitals or specialist services. There are approximately 2800 people are users of social care services in Midlothian.

2. **Unpaid Carers:** There are estimated to be as many as 8,000 people in Midlothian who undertake a caring role as a relative or friend and 2100 who care for 50 hours or more every week. Their contribution is crucial.

3. **Staff:** Staff are crucial to the delivery of high quality services. Their views are vital and include those who work in localities and staff based in more specialist settings

including acute hospitals. NHS Lothian provide a range of services across Midlothian, referred to as hosted services, including for example, podiatry and dietetics. We need to discuss with them opportunities to strengthen these services in Midlothian

4. **Voluntary Organisations** Our communities thrive because of the work of voluntary organisations. A large proportion of social care is delivered through voluntary organisations- 35% of the adult care budget is used to commission these services locally. They are often close to communities and a source of innovative ideas in reshaping social care services.

5. **Independent Sector:** The majority of local care homes and a significant proportion of care at home is provided by private companies. Their role is vital in caring for and supporting some of eth most vulnerable people in our communities

6. **Community Planning Partners** It is increasingly recognised that improving health and wellbeing is dependent upon a wide range of agencies be it access to employment, maximising income, working with people who come to the attention of the police often in crisis or the fire service preventing accidents in the home.

Schedule:

June –July: Arrange engagement with staff, the public, voluntary and independent organisations and community planning partners. (This will include face-to-face meetings and written communication.)

June –September: Update the Joint Needs Assessment

September- October: Undertake engagement activities

October- November: Prepare first draft

19th November: Seek comments from Strategic Planning Group

November –December: Prepare second draft

December- February 2019: Formal Consultation

13th December –NHS Lothian Strategic Planning Committee

18th December- Midlothian Council

7th March 2019: Seek IJB Approval

March 2019: Publish and disseminate Strategic Plan

Thursday 7th June 2018

Chief Officer's Report

Item number: **4.6**

Executive summary

The paper sets out the key service pressures and service developments happening across Midlothian IJB over the previous 4 weeks and looks ahead to the following 4 weeks.

Board members are asked to:

1. *Note the issues and updates raised in the report*
2. *To agree that the draft annual accounts are approved by the Audit & Risk Committee meeting on 20 June 2018*

Chief Officer's Report

1. Purpose

1.1 This report provides a summary of the key activities within health and social care over the previous month and future key developments.

2. Recommendations

2.1 To note the issues and updates raised in the report

3. Background and main report

Service Developments

Highbank Intermediate Care Facility

The Care Inspectorate recently undertook an inspection of Highbank, which provides intermediate care and assessment to people over 65 years and is a key strand of supporting a shift in the balance of care. As it was a follow-up report, the Inspection focused on 2 keys, Quality of Care & Support and Environment. In terms of Quality of Care & Support, this was graded as being 4 (Good), noting staff were warm and caring towards residents and encouragement by staff for residents to do their physiotherapy exercises to support rehabilitation. The grade for Environment was 3 (Satisfactory) and this reflects that Highbank was originally built as a Care Home over 30 years ago and is no longer fit for its new purpose of delivering high-quality, person-centred care, assessment and rehabilitation. There is a currently a business case being developed to request capital funding to enable the reprovision of Highbank to ensure it can meet the needs of Midlothian residents and to better reflect the changing model of care.

Quality Issues

Springfield Bank Care Home – the Care Home continues to be managed under the Large Scale Investigation (LSI) protocol as part of our Adult Support and Protection Procedures. At the recent LSI meeting, it was reported that a significant number of improvement actions have now been completed and there is evidence to suggest that good progress is being made. There is a further meeting planned in June to review the situation and the existing moratorium of admissions remains in place.

Voluntary Sector Summit

Following an approach by the voluntary sector reference group within Midlothian, an event was held on 30 May with key voluntary sector colleagues and the H&SCP management team to look at how we can work together more effectively and efficiently as well as building new partnerships, creating new ways of working. A verbal update on outputs from this event will be provided to the IJB.

IJB Annual Report

Under the legislation, there is a requirement for the IJB to publish an Annual Report (and to make this publicly available) by the end of July each year. However, ISD Scotland are not able to provide performance data against the core suite of indicators until the end of June. The two options would either have been to publish the annual report with data that is over 12 months out of date or to publish the annual report without IJB approval due to the next meeting not being until 23 August – this has previously been raised as an issue by Audit. This has been highlighted with Scottish Government and we have agreed that in order to comply with good governance, the annual report will be held back to allow for approval by the IJB prior to publication. A holding statement will be published on the website to this effect.

IJB Annual Accounts

Following the financial out-turn for the year end by each of the Partners, the work has now begun on preparing the annual accounts. The timescales for this process is publication of a draft by the end of June and the final, audited, version signed off by the end of September. There is a special meeting of the IJB to consider and approve the final accounts planned for 13 September 2018.

Unfortunately, due to timescales associated with producing the financial accounts by each of the Partners, it has not been possible to prepare the draft annual accounts for this meeting of the IJB. Given the timescales noted above for the production of the draft annual accounts, the IJB is asked to agree that the draft accounts are approved at IJB Audit & Risk Committee on 20 June 2018.

Involving Carers

The Midlothian IJB remains committed to ensuring there is full engagement with carers at all levels of the IJB, including participation in the Board and across policy, planning and service development. The Coalition of Carers in Scotland have produced a further report examining carer involvement in IJB, which highlights areas of good practice and areas for further development. The H&SCP Planning Officer and Integration Manager met with the report authors to discuss our local arrangements. As ever, there are areas within Midlothian that we could improve but there are many examples demonstrating where we are doing well to support carer involvement in the IJB. The report is attached as an appendix for information.

4 Policy Implications

4.1 The issues outlined in this report relate to the integration of health and social care services and the delivery of policy objectives within the IJBs Strategic Plan.

5 Equalities Implications

5.1 There are no specific equalities issues arising from this update report.

6 Resource Implications

6.1 There are no direct resource implications arising from this report.

7 Risks

7.1 The key risks associated with the delivery of services and programmes of work are articulated and monitored by managers and, where appropriate, reflected in the risk register.

8 Involving People

8.1 There continues to be ongoing engagement and involvement with key stakeholders across the Partnership to support development and delivery of services.

9 Background Papers

None

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Appendix: Equal, Expert and Valued – Edition Two

coalition
of carers in Scotland

EQUAL, EXPERT *and* VALUED

Enhancing Carer Representative involvement on Integration Joint Boards

SECOND EDITION:
Update Report, February 2018

Background

The Carers Collaborative is a project that seeks to evaluate, support and improve carer representation on Integrated Joint Boards (IJBs). The Collaborative has gathered evidence and facilitated events since March 2016, involving 46 Carer Reps from 29 local authority areas. The first 'Equal Expert and Valued' report was published in February 2017. It identified good practice and set out recommendations to enhance carer involvement on IJBs. This update report is based on a further year's research, revisiting evidence and presenting new resources to improve carer representation.

AIM

This update report, published while IJBs are making plans for the Carers (Scotland) Act 2016, aims to:

- Contribute constructive insights and recommendations
- Provide resources and ideas for improving carers' involvement on IJBs
- Help Integration Authorities benchmark and continue improving their practice
- Start conversations and stimulate further progress.

Methodology

The Carers Collaborative met four times between January and November 2017, providing a forum for Carer Representatives to explore evidence and practice. Representatives and other IJB members also completed self-assessments against the **'Equal and Expert'** best practice standards, with a comprehensive scoping exercise also being conducted by an independent researcher. The scoping exercise reviewed every Integration Authority's most recent strategic plan, annual report, committee papers and minutes for references to carers, carer outcomes, carer involvement and the Carers Act.

Note on language: The report typically uses the words 'Carer Reps' or 'representatives' to refer to Carer Representatives. These are usually unpaid carers (or former carers), but in some areas staff from local carers centres fulfil the role.

Introduction

The requirement for carer representation in planning and commissioning public services is increasing. The Public Bodies (Joint Working) Scotland Act 2014 requires Integration Authorities to include a Carer Representative on their IJB[1]. The Carers (Scotland) Act 2016[2] extends the expectation of carer engagement to other areas of Health and Social Care planning. Scottish Government guidance on Health and Social Care commissioning states that services should be

> "Planned and led locally in a way which is engaged with the community (including those who look after service users and those who are involved in the provision of health and social care)". [3]

In 2013 the Coalition of Carers in Scotland developed 'Equal and Expert: 3 Best Practice Standards for Carer Engagement'.[4] While good practice is evident in some areas, the standards have not been consistently applied. In 2017 the Scottish Government's Health and Sport Committee described this as a 'piecemeal' approach.[5]

This report offers positive and practical insights to help improve standards and consistency. It begins by defining Carer Representatives' role and purpose before examining evidence for the three Equal and Expert standards. The three standards are:

STANDARD ONE: Carer engagement is fully resourced

STANDARD TWO: Carers on strategic planning groups represent the views of local carers

STANDARD THREE: The involvement of carers on strategic planning groups is meaningful and effective

A national overview of involvement practices is followed by local good practice examples. The report concludes with a review of progress towards the recommendations made in 2017, with straightforward suggestions for improving involvement.

1. Public Bodies (Joint Working) Scotland Act 2014
2. http://www.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Implementation/Carers-scotland-act-2016
3. Scottish Government (2015) Strategic Commissioning Plans Guidance
4. http://www.carersnet.org/policy-legislation/best-practice-standards-for-carer-engagement/
5. Are they involving us? Integration Authorities' engagement with stakeholders Scottish Parliament Health and Sport Committee Published 12 September 2017 SP Paper 188

Defining the Role: who are Carer Representatives and what do they do?

This section of the report is based on mapping and scoping activities carried out during the three Carer Collaborative meetings. It aims to put a spotlight on good practice and to draw attention to practice that can be improved.

The first 'Equal, Expert and Valued' report identified that although the Public Bodies Act requires Integration Authorities to involve *'a person who the integration authority considers to be representative of'* carers[6], the purpose of doing so is not specified. This led to the requirement being interpreted and implemented in quite different ways. The report recommended that Carer Reps have a clear remit, roles and expectations. A draft role description is now available[7], identifying three main functions, the principles behind them, and the resources required to support them:

CONTRIBUTE TO GOOD GOVERNANCE

- Contribute to discussions and provide advice and scrutiny from carers' perspective.
- Contribute to ensuring that Integration Authorities implement their statutory obligations.
- Add relevant items to the meeting agenda, to be discussed and minuted. Mechanisms should be in place for this.
- Be prepared to raise relevant points and question meeting papers and accompanying evidence appropriately, for example about the extent to which the recommendations are inclusive of, or impact on, carers.

REPRESENT CARERS – AND THE IJB

- Champion carers' involvement as *Equal and Expert*[8] partners at all levels and link in with other champions and carers to enlarge the pool of views being collected and represented locally.
- Access their 'constituency' of carers via carer networks, local forums (including social media where appropriate) to encourage and maintain links with the IJB.
- Nominate a Depute to represent the role in the case of absence.
- Ensure their involvement is reflective of the views of the widest range of carers by engaging as fully as possible with other carer representatives.

HAVE ROLES OUTWITH IJB MEETINGS

- Join one or more sub committees/working groups (such as Audit and compliance committees), where appropriate and where carer capacity allows. IJBs should be upfront about expected time commitment, to enable planning and informed decisions.
- Take part in appropriate training and induction.
- Play an active role in IJB & HSCP events.
- Be active in local carers group(s)

6. Public Bodies (Joint Working) Scotland Act 2014
7. http://www.carersnet.org/wp-content/uploads/2018/01/Download-the-Role-Description-Here.pdf
8. http://www.carersnet.org/policy-legislation/best-practice-standards-for-carer-engagement/

Equal and Expert: Overview of evidence

This section presents an overview of the 'Equal and Expert' Carer Engagement standards, and the extent to which they were evident in IJB practice from the Collaborative's work and research.

STANDARD ONE: CARER ENGAGEMENT IS FULLY RESOURCED

IJBs vary in their commitment to resourcing engagement. Good practice examples include IJBs providing full-Board development sessions, paying out of pocket expenses and providing replacement care. Practice appears to be improving in giving Representatives time to read and prepare meeting papers, but in many areas still falls short.

KEY:

- **Several good examples – overall practice is good**
- **Some good examples exist - but experience is mixed**
- **Limited examples – some local good practice may exist but overall practice is poor**

STANDARD ONE: CARER ENGAGEMENT IS FULLY RESOURCED		
Outcomes 1. Carer Representatives will feel confident in undertaking the responsibilities of their role and be able to express clearly and fully the views of other carers. 2. The strategic groups will benefit from the views of carers being regularly and directly represented and will produce work which address the needs and meets the aspirations of carers more fully.		
Evidence of implementation Carers in representative roles will:		
1. Receive training and a full induction.	Some areas involve Carer Reps in IJB Development sessions and others arrange regular support meetings before IJB meetings to allow discussion of agenda items (East Renfrewshire, Midlothian). However, most Carer Reps still report that they receive no training or induction.	
2. Be supplied with the information they require timeously.	Only a third of Carer Reps report receiving papers 7 days in advance. Getting 300+ page papers within 2-3 days of meetings is still common, as is the practice of issuing previous meeting minutes only days ahead of the next one.	
3. Be mentored.	More than two thirds of Carer Reps have not been mentored. In our research, two IJBs provide mentoring through an Engagement Officer (Midlothian; Perth and Kinross). Carers Centres sometimes provide informal mentoring.	
4. Be able to obtain the views of other carers via a strong network of carers.	Carer Reps in all but one area reported having access to networks like carer forums, Carers Voice Groups and Carer Reference Groups. Time is more of an issue than opportunity.	
5. Have the full costs of their work in and for the strategic groups met – this includes the costs of any substitutionary care that is required.	From 20 self-assessments, only 5 areas have a written expenses policy. 4 do not pay expenses. 5 cover travel and parking costs, 6 provide additional resources such as subsistence, tea and coffee but only two reportedly provide lunch (Moray; Perth & Kinross) or printing costs (Angus; Midlothian). Five areas provide replacement care.	

CHANGES SINCE 2016/17 REPORT:

Several areas have made efforts to issue meeting papers in a timelier way. More Carer Reps appear to be better connected to local networks. The common absence of induction and training is a concern: Carer Rep posts were unfilled in five IJBs at the time of writing, an increase on 2016 (three vacant posts). There is concern among Carer Reps about potential difficulty in recruiting (and retaining) their replacements without improvements in resourcing.

Spotlight on expenses

'I have never been asked about expenses...No-one has ever asked about who is caring for my daughter when I am at meetings.'
Carer Representative

'We expect the integration authorities to ensure that those who participate in the process can do so without detriment.'
Cabinet Secretary for Health and Sport
[Are they involving us? Integration Authorities' engagement with stakeholders Scottish Parliament Health and Sport Committee Published 12 September 2017 SP Paper 188]

There are costs involved for any member of an IJB. To avoid being worse off, they and Carer Reps should receive out-of-pocket expenses such as travel and printing costs. However, there are additional costs in being a Carer Rep:

- Time away from the caring role (preparing for, travelling to and attending meetings)
- Replacement care – the stress and cost of finding and/or paying someone else to provide care. (Some Carer Reps use Direct Payments to purchase replacement care to attend IJB meetings, leaving less for proper breaks from caring)
- Time and cost of consulting and communicating with other carers
- Loss of income and time off work (or other commitments)

There are positive signs of improvement since 2016, but carer involvement is still under-resourced by most Integration Authorities. Sometimes this is due to limited budgets, sometimes to do with limited understanding of carers' lives, and occasionally both. The true costs of involvement are only rarely understood or provided for. Whatever the reasons, lack of appropriate expenses is becoming an impediment to involvement. It is also an equalities issue, excluding carers who cannot afford to finance the public duties they carry out on behalf of Integration Authorities.

STANDARD TWO: CARERS ON STRATEGIC PLANNING GROUPS REPRESENT THE VIEWS OF LOCAL CARERS

In 2016/17, this was the best evidenced of the three standards. There is still good evidence that Carer Reps receive quality resources and support from carers' centres, including access to local carer networks. Local engagement is growing, but in some areas Representatives struggle to reach carers, and to encourage more carers to take on representative roles.

STANDARD TWO: CARERS ON STRATEGIC PLANNING GROUPS REPRESENT THE VIEWS OF LOCAL CARERS		
Outcomes 1. Carers on strategic groups will be: (a) representative of the various communities of carers (b) able to express in informed ways the views of a range of carers 2. The other partners on the strategic groups will know with confidence that they are learning of the views of a range of carers. 3. The work produced by the strategic groups will fully take into account the views of carers		
Evidence of implementation		
1. Carer organisations will be properly resourced to establish and support a strong carer network, which offers a variety of ways for carers to get involved	Some Carers Centres are funded to support Carer Reps and facilitate access to carer networks. Changes in funding have increased support in some areas (e.g. Argyll and Bute; Shetland) but reduced it in others (e.g. Inverclyde).	
2. The number of carers involved in exchanging views through the network will grow.	Local carer engagement is growing but progress is slow. Carer Reps are often seeking new ways of reaching carers. Midlothian, for example, use social media and online videos for this.	
3. The diversity of carers involved in the network will be broad.	Experience is mixed, with some Carer Reps reaching diverse groups but others struggling to engage new or different audiences.	
4. There will be a continual emergence of new carers willing to undertake representative roles.	All areas report difficulty in attracting potential Carer Reps or deputies, listing time, expense, workload and 'tokenism' as barriers.	
5. The information provided through and by the supported network will be of a high quality.	Carer Reps value the information they get from carer networks, though experience of having it recognised by IJBs is mixed. Some Carer Reps are known to have stepped down in the last year because of the demands of the role.	

CHANGES SINCE 2016/17 REPORT:

The most significant challenge is in the lack of new carers emerging who are willing to undertake representative roles. As with Standard One, resourcing is identified as the primary obstacle. The last year has also seen changes in the funding environment. Some Carers Centres have increased resource for carer outreach and engagement, others are reviewing services due to changes in commissioning or funding.

STANDARD THREE: THE INVOLVEMENT OF CARERS ON STRATEGIC PLANNING GROUPS IS MEANINGFUL AND EFFECTIVE

There are signs that Carer Reps's expertise (and equality) are becoming better recognised, with some structures and meetings becoming more inclusive. Challenges persist in contributing to agenda setting. Carer Awareness Training has not taken place to the extent that was anticipated in 2016. Overall, Integration Authorities continue to overlook the importance of measuring the impact of policies – and involvement – on carers.

STANDARD THREE: The involvement of carers on strategic planning groups is meaningful and effective (This standard was written before the emergence of IJB 'Strategic Planning Groups'. It should be taken to mean any strategic forum, including the IJB itself.)		
Outcomes 1. Carers will be treated as equal and expert partners in strategic groups. 2. The views of Carer Representatives will be evident in the strategic decisions taken and the plans that are developed. 3. Carers will be treated as equal and expert partners in the provision of care.		
Evidence of implementation		
1. Carers will be placed on the right strategic planning groups including at the top level of governance structures.	Carer Reps are generally well involved in Strategic Planning Groups and IJB sub-committees. Some Carer Reps chair committees (e.g. in Argyll and Bute and Midlothian, Carer Reps chair the Audit Committees). But several have had limited opportunities to join SPGs, and some are unable to give more time to join extra committees. Best practice would feature different carers at different levels, with good structures for communication and involvement.	
2. Other partners in strategic groups will have had Carer Awareness training so that the perspectives brought by carers are understood and accepted as the statements of people who are "equal and expert" partners.	Several areas planned to provide Carer Awareness training, but few have. Good practice examples include Carer Reps delivering Carers Awareness Sessions to the IJB (Argyll & Bute; East Lothian); Carer Reps briefing on carer issues during business meetings; and an IJB (Fife) whose agenda features a regular 'Personal Story', including carers' experiences.	
3. Meetings will be open and inclusive, allowing time for discussion and contributions from all members of the group. Language will be accessible and jargon will be avoided.	Although agendas are still reported to be full, and meetings full of jargon, Carer Reps appear to have more opportunities to contribute. One IJB uses support group meetings to ask Reps for feedback and include this as a standing item on the agenda (Midlothian).	
4. Sufficient time will be given for preparation. Papers will be sent out in advance in a timely fashion and Carer Representatives will have the opportunity to clarify any information in advance.	See above – some improvements in receiving IJB papers, but SPG and other papers are often last-minute. Some areas welcome contact with authors or Integration Manager to clarify information.	
5. The agenda will be jointly owned with all group members having the opportunity to place items on it or raise issues of concern.	Most IJBs still lack processes for contributing to agendas, and/or transparency about how agendas are set. Good practice examples include East Dunbartonshire, where there is a set item on IJB board agendas for service users and carers; and Shetland, where weekly sub-committee meetings consider items raised by members.	
6. All plans and policies produced by strategic groups will be 'carer proofed' so that the impact on carers is explicitly stated to ensure that carers needs and aspirations have been fully considered.	There was very little evidence of this. Some IJBs require report authors to note the consideration of (and impact on) carers, but this is perceived as cursory.	
7. Through their network carers will be supplied with information about the opportunities for participation in strategic planning groups.	Carer Reps remain very knowledgeable about the systems and structures in which their work takes place. With the move to Locality planning and Carers Act implementation, some areas are stepping up actions to inform, recruit and train more carers.	
8. The outcomes of carer engagement will be evaluated.	No evidence of IJBs measuring the outcomes of carer involvement. In a small number of areas, other carer engagements are evaluated (e.g. following community consultations). See below for more information on carer outcomes.	

CHANGES SINCE 2016/17 REPORT:

Carer Reps appear to be more integrated in IJBs and their associated Planning Groups and committees (see below). Further change may follow as IJBs adjust to locality planning, the Carers Act and the Community Empowerment Act, albeit that the structural and resource barriers identified above may still need to be removed.

Spotlight: Strategic Planning Group involvement

‘I am on all the relevant groups - for all the difference it makes.’

Carer Representative

The 2016/17 report identified that Carer Representative effectiveness was improved when they were included in Strategic Planning Groups. SPGs were perceived as the place where agendas were set and decisions made.

Over the last year, Carers have had some modest success in being represented on these groups. At a Carer Collaborative meeting in 2017, five out of 13 participants were on an SPG. Four of these could suggest agenda items. Carer Representative’s independence and experience has also been recognised in some areas, for example by being invited to Chair their Finance, Audit and Risk committees. Reasons posited for increased involvement included changes in IJB membership and personnel; Joint Inspection from the Care Inspectorate; and anticipation of the Carers Act.

However, changes are underway which might again change the level and nature of Carer Rep involvement. The move to locality planning is likely to require IJBs to review their structures and representation. As noted in the 2016/17 report, local networks of carers ‘underneath’ and around the IJB will help Carer Reps’ ability to represent carers more effectively.

In some areas SPGs appear to be in abeyance, with no meetings having taken place for several months. And in the Carer Collaborative meeting mentioned above, only one of the 13 Representatives felt that communication between their SPG and IJB was effective. SPG involvement may not live up to the hopes Carer Reps had for it.

Scoping carer inclusion: IJB plans, reports and outcomes

As with the 2016/17 report, a scoping exercise sought to create a picture of national practice, analysing every Integration Authority's Strategic Plan; Annual Report; and IJB meeting minutes. References to carers (and Carer Representatives) were used as simple indicators of the extent to which carers and carers' outcomes had been identified and prioritised by Integration Authorities.

Year	Strategic Plans available	Annual Reports available	Meeting minutes available	IJB minutes referencing carers	IJB meeting dates available
2016	30	n/a	28	17 IJBs – with 29 total references to carers	26
2017	31	31	31	30 IJBs - with 89 references to carers	31

OBSERVATIONS

All Integration Authorities now have publicly available Strategic Plans and records of meetings. This is useful for Carer Rep involvement, allowing time for meeting preparation, carer engagement etc. The increase in minutes referencing carers is mainly due to preparations for the Carers Act (23 areas record planning for the Carers Act - 8 do not).

All annual reports measure progress towards National Health and Wellbeing Outcome Six[9], comparing local achievement with the Scotland-wide result of 41% carer satisfaction[10]. 18 areas report achievements above 41% (two areas claim 99% carer satisfaction), with 10 below, and three at exactly 41%. These figures raise questions as to whether reporting is accurate, consistent and meaningful. The usefulness and validity of the 41% benchmark is also doubtful. 41% hardly represents 'success' - and Outcome 6 is the lowest performing outcome in the National Health and Wellbeing survey.

Some areas appear to use additional measures to Outcome Six. Scottish Government guidance on data collection for the Carers Act[11] may encourage IJBs to use additional indicators, allowing for a more rounded picture of carer outcomes to emerge. As noted above, no Integration Authorities measure the outcomes of carer involvement, though the three Standards above provide a useful template should they wish to do so.

9. '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'. www.gov.scot\Topics\Health\Policy\Health-Social-Care-Integration\National-Health-WellbeingOutcomes
10. Health and Care Experience Survey 2015/16 - National Results, A National Statistics Publication for Scotland published by the Scottish Government, May 2016 http://www.gov.scot/Resource/0050/00500340.pdf
11. Carers Census Data Specification, Scottish Government, 2017 http://www.gov.scot/Topics/Statistics/Browse/Health/DataSupplier/CarersData

Recommendations to improve Carer Representation

This section reviews progress towards the recommendations in the 2016/17 report and identifies next steps for improving carer representation.

2017 Recommendation	Progress	Next steps – 2018+
1. Include Carers' Representatives in decision making 1.1 Find ways to involve carers in consultation and decision-making 1.2 Include Carer Reps in different IJB groups	Carers appear to be better represented and consulted within IJB structures, but still lack decision-making authority and opportunities to contribute to agendas.	IJBs can continue to improve carer involvement in SPGs, locality groups and carer networks. However, recruiting and retaining Carer Reps will require improving practice regarding training and expenses. As noted in our previous report, good practice would involve providing Carer Reps with email addresses and publicising these for easy contact. The benefits and outcomes of carer involvement can be measured using 'Equal and Expert'.
2. Increase awareness and profile 2.1 Raise profile of Carer Reps 2.2 Raise IJB awareness of carers	IJBs have generally not followed through on intentions to run Carer Aware training. The profile of Carer Reps has increased, with better access to carer networks.	
3. Value and resource Carer Representatives 3.1 Value Carers Representatives and their contributions 3.2 Train and support Carer Representatives 3.3 Resource representation 3.4 Ensure Carer Representatives have a clear remit	Training, induction and expenses remain absent for Carer Reps in most IJBs. This now affecting retention and recruitment.	Develop and publish expenses policies for IJB Representatives. Improve practice regarding providing subsistence and replacement care. Use or adapt the suggested role description to provide clarity on roles, remits and expectations.
4. Share practice and learning 4.1 Share practice between IJBs 4.2 Improve communication	IJB networks now explore similar issues to those in the Carer Collaborative (e.g. Chief Officers' Ministerial Group). Agendas and minutes are more publicly available than 2016/17. Papers remain lengthy and often last-minute.	Continue with efforts to issue papers sufficiently in advance to allow Carer Reps to read and prepare, particularly minutes of previous meetings. Develop clearer links between IJBs and their sub-committees, including Locality Planning as it develops. Improve transparency as to how agendas are formed and create opportunities for Representatives to contribute. Some IJBs use 'Any other business' to do this.
5. Make meetings better 5.1 Create structures to allow agenda items to be raised 5.2 Make meetings, minutes and papers accessible	Some IJB meetings have become more accessible, with less jargon and more opportunities for carers to contribute. Links between SPGs and IJBs remain unclear, as does the process for tabling agenda items.	

SPOTLIGHT: LOCAL PRACTICE – INVOLVING CARERS IN PREPARATIONS FOR THE CARERS ACT IN EAST LOTHIAN

East Lothian HSCP has set up a Carers Strategic Group as one of seven groups leading work towards achieving its strategic outcomes. The Group will lead the development of a Carers Strategy and workplan in line Carers Act requirements. In the East Lothian IJB Annual Report 2016/17 the HSCP Director David Small commented that,

> 'The planning groups give us the opportunity to make sure that stakeholders are equal partners in planning, enabling us to develop innovative, flexible and responsive answers that really meet the health and social care needs of people in East Lothian.'

Local preparations for the Carers Act have also been informed by carers and carers' organisations. For example, a Carers Strategy Team worked with Carers of East Lothian to develop a new outcome-focused, strengths-based tool to pilot the new Adult Carer Support Plans. Feedback from a carer engagement event was used to develop the Eligibility Criteria Framework, based the National Carer Organisations framework contained in the Draft Statutory Guidance[12].

The IJB chair also met individually with the IJB Carer Representative. This led to an IJB development session, organised by the Carer Representative, to increase understanding of issues affecting carers, and to inform IJB members of the provisions of the Carers Act.

SPOTLIGHT: LOCAL PRACTICE – 'CARER AWARE' IN DUMFRIES & GALLOWAY

Dumfries and Galloway HSCP provide Carer Aware training to help staff understand who carers are, what they do and the support available for to them. The aim of this training is to help staff to identify carers and be better informed about issues impacting on their lives. NHS D&G and D&G Council have also achieved Carer Positive status, a Scottish Government funded initiative to recognise employers who offer the best support to carers, for demonstrating a genuine commitment to supporting staff who have to balance work with a caring role.

A recent development day also helped IJB members to get to know each other, beyond just their day jobs. It also helped IJB members recognise each other's expertise and to agree some simple actions that would improve the Board's functioning. A 'buddying' session as part of the day proved so popular that a buddying away day is now being considered.

SPOTLIGHT: LOCAL PRACTICE – ACHIEVING AND MEASURING CARER OUTCOMES IN ARGYLL & BUTE

Improving the support to unpaid carers is one of six priority areas for Argyll and Bute HSCP. In turn, every Locality Planning Group has a section in their action plan focusing on unpaid carers. Argyll and Bute's 2016/17 Annual Report[13] notes that only one Health & Wellbeing outcome (Outcome 6) is being used to measure carers' experience. Although local results are in line with the Scottish average, the report acknowledges that more needs to be done. The IJB is therefore working with Carer Reps and the local carers' network to develop additional performance measures to supplement the existing Outcome 6 measure.

In developing their annual report, the HSCP asked a range of people who may have an interest to give feedback as 'critical friend reviewers' (e.g. on content, readability, etc). In 2016/17 two of these reviewers were unpaid/family carers.

12. Carers (Scotland) Act 2016 – Draft Statutory Guidance: Local eligibility criteria, Appendix A. Scottish Government, 2017
13. https://www.argyll-bute.gov.uk/sites/default/files/ab_hscp_annual_performance_report_21072017_5.pdf

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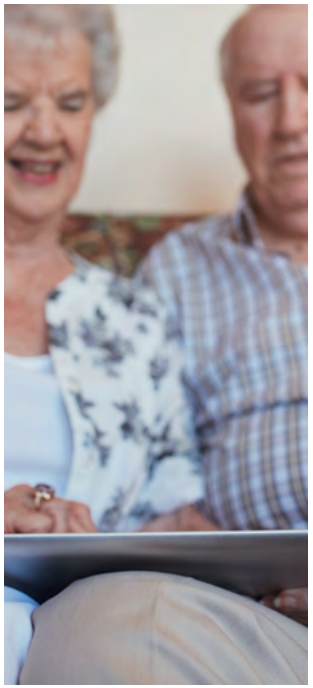

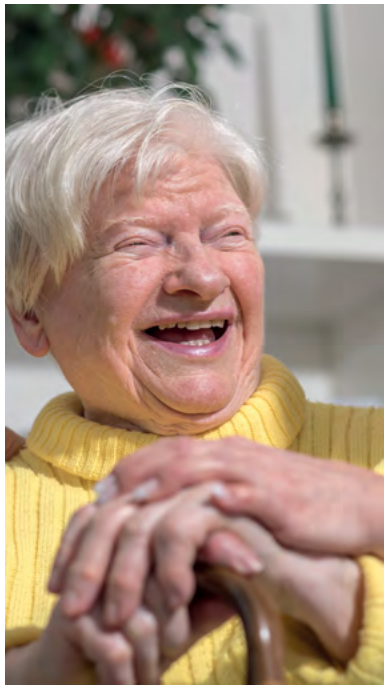

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