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24 March 2021

NOTICE OF MEETING

A meeting of the **ARGYLL AND BUTE HSCP INTEGRATION JOINT BOARD (IJB)** will be held **VIA SKYPE** on **WEDNESDAY, 31 MARCH 2021** at **1:00 PM**, which you are requested to attend.

BUSINESS

1. **APOLOGIES FOR ABSENCE**

2. **DECLARATIONS OF INTEREST (IF ANY)**

3. **MINUTES** (Pages 5 - 14)
   Integration Joint Board held on 27 January 2021

4. **MINUTES OF COMMITTEES**
   (a) Clinical and Care Governance Committee held on 14 January 2021 (Pages 15 - 20)
   (b) Audit and Risk Committee held on 23 February 2021 (Pages 21 - 24)
   (c) Finance and Policy Committee held on 26 February 2021 (Pages 25 - 28)

5. **CLINICAL AND CARE GOVERNANCE COMMITTEE HELD ON 18 MARCH 2021** (Pages 29 - 36)
   (a) Finance and Policy Committee held on 19 March 2021 (Pages 37 - 42)
   (b) Strategic Planning Group Action Note of 4 March 2021 (Pages 43 - 52)

6. **CHIEF OFFICERS REPORT** (Pages 53 - 56)
   Report by Chief Officer

7. **INTEGRATION JOINT BOARD MEMBERSHIP UPDATE AND INTERIM ARRANGEMENTS FOR THE CHIEF OFFICER** (Pages 57 - 60)
   Report by Business Improvement Manager

8. **CULTURE UPDATE**
   (a) NHS Highland Board Culture Update (Pages 61 - 114)
   Report by Director of HR and OD

(b) Staff Governance Report for Financial Quarter 3 2020/21 (Pages 115 - 132)

Report by Head of Customer Support Services

9. IMPLEMENTATION OF THE WHISTLEBLOWING STANDARDS (Pages 133 - 144)

Report by Director of HR and OD

10. COVID-19 PUBLIC HEALTH UPDATE (Pages 145 - 176)

Report by Associate Director of Public Health

11. FINANCE

Reports by Head of Finance and Transformation

(a) Budget Monitoring as at 28 February 2021 (Pages 177 - 204)

(b) Covid-19 Response and Financial Implications (Pages 205 - 218)

(c) Budget Outlook 2021-22 to 2023-24 (Pages 219 - 232)

(d) Financial Risks 2021-22 (Pages 233 - 240)

(e) Budget Consultation Findings (Pages 241 - 256)

(f) Budget Savings 2021/22: Assessing Equality and Socio-Economic Impact (Pages 257 - 268)

(g) Budget Proposals 2021-22 (Pages 269 - 286)

12. INTEGRATION JOINT BOARD PERFORMANCE REPORT - MARCH 2021 (Pages 287 - 296)

Report by Head of Strategic Planning and Performance

13. CARE HOME AND HOUSING UPDATE (Pages 297 - 308)

Report by Head of Older Adults Service and Community Hospitals

14. SUICIDE PREVENTION STRATEGY (TO FOLLOW)

Report by Chief Officer

15. AMENDMENT TO CIVIL CONTINGENCIES ACT 2004 TO INCLUDE INTEGRATION JOINT BOARDS AS CATEGORY 1 RESPONDERS (Pages 309 - 314)

Report by IJB Standards Officer

16. REVIEW OF THE HEALTH AND SOCIAL CARE INTEGRATION SCHEME (Pages 315 - 378)

Report by IJB Standards Officer

17. DATE OF NEXT MEETING

16 June 2021 at 1.00pm via Skype

Contact: Hazel MacInnes Tel: 01546 604269

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Agenda Item 3

MINUTES of MEETING of ARGYLL AND BUTE HSCP INTEGRATION JOINT BOARD (IJB) held VIA SKYPE on WEDNESDAY, 27 JANUARY 2021

Present: Councillor Kieron Green, Argyll and Bute Council (Chair)
Sarah Compton-Bishop, NHS Highland Non-Executive Board Member (Vice Chair)
Councillor Robin Currie, Argyll and Bute Council
Councillor Gary Mulvaney, Argyll and Bute Council
Councillor Sandy Taylor, Argyll and Bute Council
Jean Boardman, NHS Highland Non-Executive Board Member
Professor Boyd Robertson, Interim Chair, NHS Highland
Dr Gaener Rodger, NHS Highland Non-Executive Board Member
Fiona Broderick, Staffside Lead, Argyll and Bute HSCP (Health)
Linda Currie, Lead AHP, NHS Highland
Elizabeth Higgins, Lead Nurse, NHS Highland
Julie Lusk, Chief Social Worker/Head of Adult Services, Argyll and Bute HSCP
Joanna Macdonald, Chief Officer, Argyll and Bute HSCP
Donald MacFarlane, Assistant Clinical Dental Director, NHS Highland
Angus MacTaggart, GP Representative, Argyll and Bute HSCP
Margaret McGowan, Independent Sector Representative
Kirsteen Murray, Chief Executive, Argyll and Bute Third Sector Interface
Judy Orr, Head of Finance and Transformation, Argyll and Bute HSCP
Elizabeth Rhodick, Public Representative
Dr Nicola Schinaia, Associate Director of Public Health, Argyll and Bute HSCP
Fiona Thomson, Lead Pharmacist, NHS Highland

Attending: Caroline Cherry, Head of Adult Services, Argyll and Bute HSCP
Charlotte Craig, Business Improvement Manager, Argyll and Bute HSCP
David Forshaw, Principal Accountant, Argyll and Bute Council
Jane Fowler, Head of Customer Support Services, Argyll and Bute Council
Pam Dudek, Chief Executive, NHS Highland
Fiona Hogg, Director of HR and Organisational Development, NHS Highland
Hazel MacInnes, Committee Services Officer, Argyll and Bute Council
Pippa Milne, Chief Executive, Argyll and Bute Council
George Morrison, Head of Finance, NHS Highland
Patricia Renfrew, Head of Children and Families, Argyll and Bute HSCP
Stephen Whiston, Head of Strategic Planning and Performance, HSCP
Alison Ryan, Service Planning Manager, Argyll and Bute HSCP
Mandy Sheridan, Unit Manager, Argyll and Bute HSCP
Tim Allison, Director of Public Health and Policy, NHS Highland

The Chair advised of a request he had received to change the order of business to take item 6(b) of the agenda (Culture Update – NHS Highland Board Report by Director of HR and OD) before 6(a) of the agenda (Culture Update – Report by Head of Customer Support Services). He advised that he was agreeable to this request and sought agreement from the Board in this respect. The Board agreed.

The Chair advised of an additional item that had been circulated (BUDGET CONSULTATION 2021/22) and advised of his intention to take this item after item 9(d) of the agenda following the other Finance items. This additional report had been requested by the Finance and Policy Committee at their meeting on 22 January 2021. The Board agreed.

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Rebecca Helliwell, Associate Medical Director.

2. DECLARATIONS OF INTEREST

There were no declarations of interest intimated.

3. MINUTES

The Minutes of the meeting of the Integration Joint Board held on 25 November 2020 were approved as a correct record.

4. MINUTES OF COMMITTEES

(a) **Clinical and Care Governance Committee held on 19 November 2020**

The Minutes of the meeting of the Clinical and Care Governance Committee held on 19 November 2020 were noted.

(b) **Audit and Risk Committee held on 11 December 2020**

The Minutes of the meeting of the Audit and Risk Committee held on 11 December 2020 were noted.

(c) **Finance and Policy Committee held on 11 December 2020**

The Minutes of the meeting of the Finance and Policy Committee held on 11 December 2020 were noted.

(d) **Clinical and Care Governance Committee held on 14 January 2021**

The Minute was not made available in time for the Board and the Chair of the Committee provided the Board with a verbal update from the meeting.

(e) **Finance and Policy Committee held on 22 January 2021**

The Minute of the meeting of the Finance and Policy Committee held on 22 January 2021 was noted.

5. CHIEF OFFICER'S REPORT

The Board gave consideration to a report from the Chief Officer covering a range of issues including the Extension of Guardian Service, Additional Funding for Cancer Screening, Maternity Survey, Argyll and Bute Suicide Prevention Group, Electric Fleet by 2025, Stop Smoking Advisors and Cool2Talk Service for Young People.

Decision

The Integration Joint Board -

1. Noted the content of the report by the Chief Officer.

2. Formally recorded their thanks to staff at all levels of the Health and Social Care Partnership, GP practices, commissioned, unpaid carers and third sector staff for their ongoing efforts during the Covid-19 pandemic.

(Reference: Report by Chief Officer, Health and Social Care Partnership dated 27 January 2021)

6. CULTURE UPDATE

(a) **NHS Highland Board Report by Director of HR and OD**

The Board gave consideration to the Culture Update report that had been presented to the NHS Highland Board on 26 January 2021.

Decision

The Integration Joint Board noted the content of the report.

(Reference: Report by Director of HR and OD dated 26 January 2021, submitted)

(b) **Report by Head of Customer Support Services**

The Board gave consideration to a report providing an update on the important work being carried out, in partnership with Trade Unions and Staff Side, to implement culture change in Argyll and Bute Health and Social Care Partnership.

Decision

The Integration Joint Board –

1. Noted the content of the culture update report.

2. Noted that progress continues to be made to address the findings of the independent Argyll and Bute Culture Survey.

(Reference: Report by Head of Customer Support Services dated 27 January 2021, submitted)

Elizabeth Rhodick and Fiona Hogg left the meeting at this point.

7. COVID-19 PUBLIC HEALTH UPDATE

The Board gave consideration to a report reviewing the work of Public Health in Argyll and Bute relating to COVID-19. The report built upon accounts provided in earlier reports and presented the most timely update possible on how the pandemic was unfolding in Argyll and Bute as well as the improved response in terms of timely access to testing and clinical management.

Decision

The Integration Joint Board noted the COVID-19 current status update, in terms of:

1. Distribution of infection rates in the Argyll and Bute community;
2. COVID-19 testing in the Argyll and Bute community;
3. COVID-19 vaccination in the Argyll and Bute community;
4. Support to the Argyll and Bute community during the peak of the COVID-19 pandemic and its adaptation to the new response phases.

(Reference: Report by Associate Director of Public Health dated 27 January 2021, submitted)

8. NHS HIGHLAND PUBLIC HEALTH REPORT

The Board gave consideration to the Director of Public Health's Annual Report for 2020.

Decision

The Integration Joint Board noted the content of the report.

(Reference: Report by Director of Public Health and Policy dated 27 January 2021, submitted)

The Chair ruled and the Board agreed to adjourn for a 10 minute comfort break from 2.40pm.

The meeting reconvened at 2.50pm and Elizabeth Rhodick re-joined the meeting at this point.

9. FINANCE

(a) Budget Monitoring as at 30 November 2020

The Board gave consideration to a report providing a summary of the financial position of the Health and Social Care Partnership as at 30 November 2020. The Head of Finance and Transformation provided a verbal update on the financial position up to the end of December 2020.

Decision

The Integration Joint Board –

1. Noted the forecast outturn position for 2020-21 is a forecast overspend of £1.890m as at 30 November 2020 and that there is a year to date overspend of £67k as at the same date.

2. Noted the above position excluded any provision for Scottish Government assistance with non-delivery of savings due to Covid-19. It included the Covid funding via NHS Highland announced at end of September and November.

(Reference: Report by Head of Finance and Transformation dated 27 January

2021, submitted)

(b) **Covid-19 Response and Financial Implications**

The Board gave consideration to a report providing an overview of the HSCP's COVID-19 mobilisation readiness and its future planning for living and operating with COVID-19. The report also provided a snapshot of the financial estimates of costs of dealing with the COVID-19 response. The costs, updated on a regular basis, were still subject to considerable uncertainties.

Decision

The Integration Joint Board –

1. Noted the details provided in relation to COVID-19 response and associated mobilisation plan costing.

2. Acknowledged the uncertainties in the cost elements submitted.

3. Noted that the Scottish Government has in principle approved all mobilisation plans, but that approval for individual cost lines had not yet been received.

(Reference: Report by Head of Finance and Transformation dated 27 January 2021, submitted)

(c) **Budget Outlook 2021-22 to 2023-24**

The Board gave consideration to a report summarising the budget outlook covering the period 2021-22 to 2023-24. The budget outlook presented to the Integration Joint Board on 25 November 2020 had been updated.

Decision

The Integration Joint Board noted the current estimated budget outlook report for the period 2021-22 to 2023-24.

(Reference: Report by Head of Finance and Transformation dated 27 January 2021, submitted)

(d) **Financial Risks 2020/21**

The Board gave consideration to a report providing an updated assessment of financial risks to the Board for 2020/21.

Decision

The Integration Joint Board –

1. Noted the updated financial risks identified for the Health and Social Care Partnership.

2. Noted the continuing uncertainties around Covid costs and funding which were described in more detail in a separate report.

3. Noted that financial risks would continue to be reviewed and monitored on a two monthly basis and reported to the Board.

(Reference: Report by Head of Finance and Transformation dated 27 January 2021, submitted)

10. BUDGET CONSULTATION 2021/22

The Board gave consideration to a report presenting the finalised public consultation on the budget for 2021/22 as approved by the Finance and Policy Committee at their meeting on 22 January 2021.

Decision

The Integration Joint Board –

1. Noted that the budget consultation for 2021/22 went live on 22 January 2021 and would run until 19 February 2021.

2. Agreed to promote the consultation widely to maximise responses.

(Reference: Report by Head of Finance and Transformation dated 27 January 2021, submitted)

11. 2021/2022 SOCIAL WORK FEES AND CHARGES

The Board gave consideration to a report providing details of the proposed Social Work Fees and Charges uplifts for 2021/22. A detailed list of proposed charges, including the 2020/21 rates for comparison, was appended to the report.

Decision

The Integration Joint Board endorsed the 2021/22 Social Work Fees and Charges proposals for submission to Argyll and Bute Council for ratification at its 2021/22 budget meeting.

(Reference: Report by Principal Accountant dated 27 January 2021, submitted)

12. HEALTHCARE IMPROVEMENT SCOTLAND - UNANNOUNCED INSPECTION: COWAL COMMUNITY HOSPITAL

The Board gave consideration to a report providing information on an unannounced Hospital Inspection carried out by Healthcare Improvement Scotland at Cowal Community Hospital on 27 October 2020.

Decision

The Integration Joint Board -

1. Noted the unannounced inspection ‘on the day’ and draft report feedback.

2. Noted the content of the published report and improvement plan which became available on 21 January 2021.

3. Welcomed the report and expressed their thanks and appreciation to the staff for all of their work in achieving a positive report in the face of a pandemic.

(Reference: Report by Lead Nurse dated 27 January 2021 and published report dated 21 January 2021, submitted)

13. CHILD POVERTY ACTION PLAN REVIEW 2019-20

The Board gave consideration to a report presenting a review of the Argyll and Bute Child Poverty Action Plan for 2019-20.

Decision

The Integration Joint Board endorsed the report detailing the review of the Argyll and Bute Child Poverty Action Plan for 2019-20.

(Reference: Report by Unit Manager, Children and Families dated November 2020, submitted)

14. ARGYLL AND BUTE CHILDREN'S RIGHTS REPORT 2020-23

The Board gave consideration to a report presenting Argyll and Bute's first joint Children's Rights Report which noted the work to respect the rights of children, young people and their families and to hear and listen to their voices.

Decision

The Integration Joint Board endorsed the report detailing the Children's Rights Report 2020.

(Reference: Report by Unit Manager, Children and Families dated November 2020, submitted)

15. INTEGRATION JOINT BOARD - PERFORMANCE REPORT JANUARY 2021

The Board gave consideration to a report proposing the temporary suspension of normal outcome performance reporting for performance reporting focusing on the remobilisation of health and care services and COVID-19 related activity.

Decision

The Integration Joint Board –

1. Noted the temporary suspension of reporting against the HSCP Health & Wellbeing Outcome Indicators.

2. Noted the change in focus of the performance reporting from current outcome indicators to performance regarding COVID-19 and Remobilisation of Health and Social Care in Argyll and Bute.

3. Noted the current COVID-19 activity within Argyll & Bute, NHS Highland and Greater Glasgow and Clyde.

4. Noted the HSCP performance progress regarding remobilisation of activity in line with NHS Highland performance target for 2020/21 agreed with Scottish Government to 70%-80% of 2019/20 activity.

(Reference: Report by Head of Strategic Planning and Performance dated 27 January 2021, submitted)

16. UPDATE TO COMMITTEE TERMS OF REFERENCE

The Board gave consideration to a report requesting the approval of the updated Strategic Planning Group Terms of Reference as recommended by the group, update to the general provisions on reporting to the IJB and a request to nominate new chair/vice chair of the Finance and Policy Committee.

Third Sector representative member Kirsteen Murray welcomed the updated SPG terms of reference strengthening the role of the Strategic Planning Group and more in line with its role in legislation. Practically this will include reviewing detailed business cases, change plans on behalf of IJB and responsibilities in terms of developing commissioning strategy and the strategic plan.

The member requested clarity on the relationship between the SPG role and the current oversight of the Transformation Board by the Finance and Policy Committee which has oversight of transformation board and plan, in practical terms how did officers see that working?

Officers responded that the Strategic Planning Group ensures the delivery and development of the Strategic Plan and the Transformation Board manages implementation of planned work. Finance and Policy Committee have oversight of any progress of work and impact of policy and financial implications.

The Strategic Planning Group reports to and advises the IJB directly.

There are no delegated powers for decision-making to either the Strategic Planning Group or Finance and Policy Committee and each would provide information to the IJB on recommendation for decision.

Going into the next year committees and groups will be asked to have workplans and if agreed by the IJB to report on such annually. As all terms of reference have now been reviewed and areas of business clarified so this should avoid duplication.

Some areas of activity are cross cutting and this will be managed through the IJB and committee planner.

The terms of reference of the Transformation Board are also currently being reviewed.

The paper formalised overall reporting to the IJB with each governance group fulfilling specific tasks and strengthening governance.

Decision

The Integration Joint Board –

1. Noted the amendments proposed.

2. Approved the Strategic Planning Group Terms of Reference.

3. Approved the amendment to the General provisions on reporting to the IJB.

4. Appointed Kieron Green as chair and Sarah Compton-Bishop as vice chair of the Finance & Policy Committee.

(Reference: Report by Business Improvement Manager dated 27 January 2021, submitted)

17. DATE OF NEXT MEETING

The date of the next meeting was noted as Wednesday 31 March 2021 at 1.00pm.

The Chair advised that this was Boyd Robertson's last meeting of the Board and thanked him for his time on the IJB and for his contribution. Boyd advised that there had been two new non-executive NHS Board Members appointed from the Argyll area who would replace himself and Gaener Rodger on the IJB. Boyd gave thanks to colleagues on the Board, in particular the Chair. It was noted that Gaener's last meeting would be in March.

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Agenda Item 4a

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Clinical and Care Governance Committee
TEAMS
Thursday 14th 2pm-4pm

MINUTE

	Item	Action
1	**WELCOME AND APOLOGIES** **PRESENT** Sarah Compton Bishop (SCB) – IJB Deputy Chair (Chair) Alan Beresford (AB)– Local Area Manager Islay Angus McTaggart (AMc) – Clinical Lead, Islay & Jura Brian Reid (BR) – Senior Manager C&F Caroline Cherry (CC)– Head of Service (Older People) Caroline Henderson (CH) – Acting Locality Manager Oban Hospital Charlotte Craig (CG) - Business Improvement Manager Claire Higgins (CHg) – PA to Lead Nurse Donald MacFarlance (DMcF) - Assistant Clinical Dental Director Elizabeth Higgins (EH)– A&B Lead Nurse Fiona Broderick (FB) – Staff Side Fiona Campbell (FC)-Clinical Governance Manager Fiona Owen (FO)– Local Area Manager Cowal Fiona Thomson (FT) – Lead Pharmacist George Morrison (GM) – Deputy Chief Officer Jaki Lambert (JLt) – Head of Midwifery Jane Williams (JW) – Area Manager Bute Jean Boardman (JB)– IJB Member Joanna Macdonald (JMcD) – Chief Officer Julie Lusk (JL) – Head of Service Kieron Green (KG)– IJB Chair Linda Skrastin – Child Health Manager Nicola Gillespie – (NG) – Service Manager Mental Health Nicola Schinaia (NS) – Associate Director of Public Health Pamela MacLeod (PM) – Professional Lead – Social Work Patricia Renfrew (PR) – Interim Head of Service C&F Paul Chapman (PC) – Falls Lead/Physiotherapy Lead Rebecca Helliwell (RH), Associate Medical Director Sandy Taylor (ST) – Non Exec Member of the Board Sarah Campbell (SC) – Clinical Governance Support Manager	

DRAFT

	APOLOGIES Carol-Anne McDade (CMcD)– Area Manager Helensburgh Catriona Watt (CW) – Area Manager Mid Argyll Donald Watt (DW) – Service Manager Registered Services Linda Currie (LC) – Lead AHP	
2	**Declaration of Interest** None	
3	**MINUTE OF LAST MEETING** November 2020 minute agreed as accurate SCB queried if Winter Planning Co-coordinator recruitment is being progressed. JM confirmed this is in hand and ongoing ***NS – left meeting at 14.05pm to take an urgent call***	
4	**SCHEDULED REPORTS FOR NOTING** **1. Bute and Cowal** JW updated for Bute section of report SCB queries how staff ensures the actions of an SAER are completed. Once the report is produced and ratified the actions go onto DATIX to be monitored. **2. Helensburgh and Lomond** SCB queries if the two DATIX noted on the report are related - FO advised these are not related. SCB asked what AWI means – Adult With Incapacity EH acknowledges the difficulties with the DN team in Helensburgh and confirms the correct folk are sighted on this issue and are dealing with it. JB asked about the decision to delay the second vaccine FO drew attention to recruitment issues ***JL contacted via phone to advise several members of the Committee were in another room and needed brought into the correct room. The meeting was paused at 14.13 and restarted at 14.29*** ST queried what DATIX is – RH advised this is a reporting system CC informed the Committee that FO has been deployed to Helensburgh to help relieve some pressures **3. Mid Argyll, Kintyre and Islay** No rep available to update from Mid Argyll CC highlighted the Radiology SBAR and advised that the situation has improved. CC will ensure CW updates fully at next Committee.	

No rep available to update from Kintyre
JB queries the medicine incident DATIX and asks for more info

JLW left meeting at 14.43

JB requests and re-emphasises the need for someone to be here to talk to each report.

4. Oban, Lorn and Isles

CH talked to tabled report.
SCB queried Coll nursing issues and what is being done to mitigate the risks. CH informs Kate MacCallum, interim Area Manager, is leading on Coll.
PC queries the length of time it takes to get IT equipments – what are the barriers and why is it taking so long. This has been discussed at various meetings including Silver. There is a governance process around it. This is not a money issue but a supply. The correct and appropriate people are sighted and telling with it

5. Mental Health

NG highlights current staffing pressures as main issue. If issues continue throughout the year creative recruitment and different models of care will need to be explored.
Completion of and releasing staff for violence & aggression training still remains an issue.
JB queries why young males would find it more difficult to help for eating disorders than young females. There is no confirmed reason for this, JL suggests it may be because it is hidden.
Significant in depth discussion regarding recruitment challenges and future plans

6. Maternal & Newborn

JLt talks to tabled report.
IT access for new staff is causing delays and issues
SPSP - all huddles have moved to teams
Focus on still births remains throughout covid
Focus on anemia
Moved a lot of care onto Near Me when hands on care is not required
Staff working flexibly

7. LD, PD and Autism

JL left meeting at 15.26 and advised via that chat function that there are no issues/exceptions raised for Learning Disability, Autism or Transitions, Work is progressing across all areas and have recruited a Physio, Occupational Therapist and Social Worker to the team. Jim Littlejohn will be in attendance at the next meeting

	8. Care Home and Care at Home CC spoke to tabled report. Care home assurance work is still ongoing 5 days a week. SAER – review has been carried out and awaiting completion of the report. Complaint is being investigated in relation to Coll Ongoing Adult, Support and Protection investigation. Once report received next steps will be identified. Admissions to Care Homes are challenging due to ongoing pandemic Care Home Oversight Group continues to meet as a pan highland group. ST mentions success relating to Care Home Vaccinations in A&B. ST queries staff testing/vaccinations ***PR left the meeting at 15.33*** ***BR left the meeting briefly at 15.34*** **9. Children and Families** LS talks to tabled report and highlighted the below 1 outstanding complete relating to CAHMS has been completed and was upheld. Staff pressures remain a concern especially in OLI & Mid Argyll. Recruitment is ongoing. Covid Vaccination Programme is using a lot of resource	
5	**CAHMS UPDATE** Report tabled and noted. NHSH Programme Board has been established with A&B HSCP & SG representations. This meeting is Co-Chaired by Patricia Renfrew and Louise Bussell Review commissioned of workforce and workload. PR awaiting draft report. An action plan has been developed following the CAMHS investigation Improvement work is starting to make a difference New CAMHMS manager takes up post on 25th Jan 2021 School Councillor post starts this week JMcD provided the Committee with more information regarding meetings that have taken place	
6	**DEVELOPMENT SESSION** Programme amended due to time. ***BR rejoined meeting at 15.53***	
7	**DATE, TIME AND VENUE FOR NEXT MEETINGS** **<u>2021 dates via Teams starting at 2pm</u>**	

	• March 18th • May 27th • Sept 9th • Nov 11th	

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Agenda Item 4b

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

MINUTES of MEETING of ARGYLL AND BUTE HSCP AUDIT AND RISK COMMITTEE held BY SKYPE on TUESDAY, 23 FEBRUARY 2021

Present: Councillor Sandy Taylor (Chair)

Gaener Rodger, NHS Highland Board Non-Executive Member
Councillor Kieron Green, Argyll and Bute Council

Attending: Joanna Macdonald, Chief Officer, Argyll and Bute HSCP
Judy Orr, Head of Finance and Transformation, Argyll and Bute HSCP
Charlotte Craig, Business Improvement Manager, Argyll and Bute HSCP
Laurence Slavin, Chief Internal Auditor, Argyll and Bute Council
Morven Moir, Finance Manager, Argyll and Bute HSCP
Dafydd Jones, Audit Scotland
Jim Rundell, Audit Scotland
John Cornett, Audit Scotland
David Eardley, Azets Audit Services Limited
Paul Kelly, Azets Audit Services Limited
Lynsey Innis, Senior Committee Assistant, Argyll and Bute Council

1. APOLOGIES FOR ABSENCE

Apologies for absence were intimated on behalf of:-

Sarah Compton-Bishop, NHS Highland Board Non-Executive Member
George Morrison, Depute Chief Officer, Argyll and Bute HSCP
Patricia Renfrew, Head of Children and Families, Argyll and Bute HSCP
Caroline Cherry, Head of Adult Services, Argyll and Bute HSCP
Julie Lusk, Head of Adult Care, Argyll and Bute HSCP
Helen Urquhart, PA to Depute Chief Officer, Argyll and Bute HSCP

2. DECLARATIONS OF INTEREST

There were no declarations of interest intimated.

3. MINUTES

The minute of the previous meeting of the Argyll and Bute HSCP Audit and Risk Committee, held on 11 December 2020 was approved as a correct record.

4. INTERNAL AUDIT REPORT - FOLLOW-UP 2020/21

The Committee gave consideration to a report summarising the progress made by management in implementing the agreed management actions as identified as part of the internal audit plan.

Decision

The Audit and Risk Committee –

1. Noted the progress made by management in implementing agreed management actions.

2. Considered the outstanding actions to be implemented, as detailed in Appendix 2 of the report.

(Reference: Report by Azets Audit Services Limited, dated 23 February 2021, submitted)

5. INTERNAL AUDIT UPDATE

Consideration was given to a report providing an update on the work carried out by Argyll and Bute Council's Internal Audit Team on audits which are of operational relevance to the Committee. A brief update in relation to the two delayed actions relating to the 2020/21 Social Care Contract Management audit was also provided.

Decision

The Audit and Risk Committee reviewed the progress on completion of the internal audit recommendations.

(Reference: Report by Chief Internal Auditor, dated 23 February 2021, submitted)

6. IT STRATEGY AUDIT REPORT

The Committee gave consideration to a report providing an independent assessment of the controls in place to achieve the technology-enabled care aims of the Integration Joint Board (IJB). Discussion was had in relation to the future delivery of the IJB strategy, which links to the HSCP Strategic Plan and to the relevant strategies of Argyll and Bute Council and NHS Highland.

Decision

The Audit and Risk Committee –

1. Noted the content of the report.

2. Recognised the commitment to establish an HSCP ICT and Digital Strategy Group and produce an ICT and Digital Strategy for the IJB.

(Reference: Report by Azets Audit Services Limited, dated 23 February 2021, submitted)

7. INTERNAL AUDIT SERVICE

On 20 October 2020 the Audit and Risk Committee considered and approved the plans for tendering the Internal Audit Service for the IJB. Having noted that these plans had been followed, the Committee gave consideration to a report advising of the result of the tender exercise.

Decision

The Audit and Risk Committee noted the outcome of the tender for the Internal Audit Service and start up arrangements for the new provider.

(Reference: Report by Head of Finance and Transformation, dated 23 February 2021, submitted)

8. DRAFT AB HSCP 2021/22 INTERNAL AUDIT PLAN

Consideration was given to a report presenting the draft 2021/22 A&B HSCP Internal Audit Plan. The report also provided an indicative audit plan for 2022/23 and 2023/24.

Discussion was had on the possibility of carrying out a best value audit of Carers funding in light of the commitment from the Scottish Government of additional funding for 2021/22; the suggested timescales for the Performance Management audit and the possibility of looking into the preparedness of the HSCP on the changes brought about by the implementation of the Children (Scotland) Act 2020. The Chief Officer and the Head of Finance and Transformation agreed to liaise with the Chief Internal Auditor in respect of these discussions.

Decision

The Audit and Risk Committee reviewed the draft 2021/22 A&B HSCP Internal Audit Plan and agreed to provide feedback to the Chief Internal Auditor in advance of a finalised plan being presented to the Committee at its meeting on 20 April 2021.

(Reference: Report by Chief Internal Auditor, dated 23 February 2021, submitted)

9. 2020/21 END OF YEAR TIMETABLE

Having noted their key role in approving the unaudited accounts for issue to Audit Scotland for audit and for public inspection, the Committee gave consideration to a report providing a draft year-end timetable, to ensure that the process of finalisation of the accounts is as smooth as possible and meets statutory deadlines.

Decision

The Audit and Risk Committee considered and provided comment on the draft 2020/21 year end Accounts Timetable for the IJB.

(Reference: Report by Head of Finance and Transformation, dated 23 February 2021, submitted)

10. BEST VALUE IN INTEGRATION JOINT BOARDS

The Committee gave consideration to a report setting out the implications and key messages for the Argyll and Bute Health and Social Care Partnership in light of the introduction of the Accounts Commission's approach to auditing and reporting Best Value in Health and Social Care Integration Joint Boards (IJB).

Decision

The Audit and Risk Committee noted the approach being developed by the Accounts Commission to auditing Best Value in IJBs and the need to make good preparations for these new audits.

(Reference: Report by Head of Finance and Transformation, dated 23 February 2021, submitted)

11. LOCAL GOVERNMENT IN SCOTLAND: FINANCIAL OVERVIEW 2019/20

Consideration was given to a report providing an assessment from Audit Scotland, based on their responsibilities as auditors to Local Government across Scotland, to examine how public bodies spend money and achieve best value for money. It was noted that Part 4 of the report dealt specifically with IJBs and provided an overview of their position in 2019/20.

Decision

The Audit and Risk Committee noted the key messages in the report and considered the implications for Argyll and Bute Health and Social Care Partnership.

(Reference: Report by Head of Finance and Transformation, dated 23 February 2021, submitted)

12. DATE OF NEXT MEETING

The Audit and Risk Committee noted that the next meeting would be held on Tuesday, 20 April 2021.

Agenda Item 4c

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

MINUTES of MEETING of ARGYLL AND BUTE HSCP FINANCE AND POLICY COMMITTEE held BY SKYPE on FRIDAY, 26 FEBRUARY 2021

Present: Councillor Kieron Green (Chair)

Sarah Compton-Bishop

Attending: Joanna MacDonald, Chief Officer, Argyll and Bute HSCP
Judy Orr, Head of Finance and Transformation, Argyll and Bute HSCP
Caroline Cherry, Head of Adult Services, Argyll and Bute HSCP
Charlotte Craig, Business Improvement Manager, Argyll and Bute HSCP
David Forshaw, Principal Accountant, Argyll and Bute Council
Brian Reid, Senior Manager Operations, Argyll and Bute HSCP
Lynsey Innis, Senior Committee Assistant, Argyll and Bute Council
Jim Littlejohn, Locality Manager, Argyll and Bute HSCP (On behalf of Julie Lusk)
Kevin McIntosh, Staffside, Argyll and Bute Council

1. APOLOGIES FOR ABSENCE

Apologies for absence were intimated on behalf of:-

George Morrison, Depute Chief Officer, Argyll and Bute HSCP
Fiona Broderick, Staffside, Argyll and Bute HSCP
Elizabeth Higgins, Professional Advisory Group Representative
Jane Fowler, Head of Customer Support Services, Argyll and Bute Council
Julie Lusk, Head of Adult Services, Argyll and Bute HSCP
Brian Reid, Acting Head of Adult Services, Argyll and Bute HSCP
Councillor Sandy Taylor
Councillor Gary Mulvaney

In the absence of a third voting member, the Chair sought advice from the Business Improvement Manager on the quorum. The Business Improvement Manager confirmed that as Caroline Cherry was in attendance and with the agreement of the Chair she would be in a position to deputise for Liz Higgins as the Professional Advisory Group Representative which would consequently provide for a quorum. On this basis the Chair progressed with the agenda.

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2. DECLARATIONS OF INTEREST

There were no declarations of interest intimated.

3. MINUTES

The Minute of the previous meeting of the Finance and Policy Committee, held on 22 January 2021, was approved as a correct record.

4. BUDGET MONITORING AS AT 31 DECEMBER 2020

The Committee gave consideration to a report providing a summary of the financial position of the Health and Social Care Partnership as at 31 December 2020. The report noted the ongoing uncertainty around the financial impact of the Covid-19 pandemic.

Decision

The Finance and Policy Committee –

1. Noted the forecast outturn position for 2020-21 is a forecast overspend of £1.660m as at 31 December 2020 and that there is a year to date underspend of £254k as at the same date.

2. Noted the above position excludes any provision for Scottish Government assistance with non-delivery of savings due to Covid-19 which is now looking likely. It includes the Covid funding via NHS Highland announced at end of September and November.

(Reference: Report by Head of Finance and Transformation, dated 26 February 2021, submitted)

5. BUDGET MONITORING AS AT 31 JANUARY 2021

Consideration was given to a report providing a summary of the financial position of the Health and Social Care Partnership as at 31 January 2021. The report noted the considerable uncertainty around the financial impact of the Covid-19 pandemic and advised that final funding was announced on 5 February – which was after the January ledger had closed for Social Work, but was in time to be processed for Health in the January allocations.

Decision

The Finance and Policy Committee –

1. Noted the forecast outturn position for 2020-21 is a forecast underspend of £456k as at 31 January 2021 and that there is a year to date underspend of £1.516m as at the same date.

2. Noted the above position includes provision for Scottish Government assistance with non-delivery of savings due to Covid-19 for Health which is now confirmed, but the assistance for Social Work of £2.228m is not yet included as it was announced after the month end close.

(Reference: Report by Head of Finance and Transformation, dated 26 February 2021, submitted)

6. COVID-19 RESPONSE AND FINANCIAL IMPLICATIONS

Consideration was given to a report providing an overview of the HSCP's Covid-19 mobilisation readiness and its future planning for living and operating with Covid-19. The report provided a snapshot of the financial estimates of the costs of dealing with the Covid-19 response and noted that the cost estimates were updated on a regular basis and subject to considerable uncertainties. Discussion was had in relation to the use of additional monies, identified from the vacancy savings, to offset some of the costs associated with covid.

Decision

The Finance and Policy Committee –

1. Noted the details provided in relation to the Covid-19 response and associated mobilisation plan costing.

2. Acknowledged the uncertainties in the cost elements submitted.

3. Noted that the Scottish Government has in principle approved all mobilisation plans, but that approval for individual cost lines has not yet been received.

4. Noted that any excess funding received must be carried forward as an earmarked reserve at the year end to be used against Covid costs next year.

(Reference: Report by Head of Finance and Transformation, dated 26 February 2021, submitted)

7. BUDGET CONSULTATION INTERIM FINDINGS

The Committee considered a report summarising the 501 online budget consultation responses received as at 9 February 2021. It was noted that the consultation continued to run until 19 February 2021 and that the report would be updated before being presented to the Integration Joint Board.

Decision

The Finance and Policy Committee noted the interim findings from the Budget Consultation and agreed to ensure that these are fed into considerations when discussing the separate report on the agenda detailing savings options to deliver a balanced budget in 2021-22.

(Reference: Report by Head of Finance and Transformation, dated 26 February 2021, submitted)

8. BUDGET SAVINGS 2021/22: ASSESSING EQUALITY AND SOCIO-ECONOMIC IMPACT

Consideration was given to a report outlining the work undertaken to ensure that due regard is given to equalities, islands and the Fairer Scotland Duty in the decision-making process relating to budget savings. The report presented a strategic EQIA for the savings programme to advise on overall impact. Discussion was had in

relation to the impact on service users in respect of care home and learning disability proposals.

Decision

The Finance and Policy Committee –

1. Noted the findings from the summary Equality and Socio-Economic Impact Assessment (EQIA) and agreed to ensure that these are considered when discussing the savings options to deliver a balanced budget in 2021-22.

2. Agreed to recommend to the IJB that savings options 2122-6; 2122-7 and 2122-13 be removed from consideration as part of the budget process from 2021/22.

3. Approved publication of the individual EQIAs to go on Council and NHS Highland websites.

(Reference: Report by Head of Finance and Transformation, dated 26 February 2021, submitted)

9. DATE OF NEXT MEETING

The date of the next meeting was noted as Friday, 19 March 2021 at 1:30pm.

Argyll and Bute HSCP Clinical and Care Governance Committee

18th March 2021 – 2pm
Via TEAMS

Minute

	Item	Action
1.0	**WELCOME AND APOLOGIES** **PRESENT** Sarah Compton Bishop (SCB) – IJB Deputy Chair (Chair) Alan Beresford (AB)– Local Area Manager Islay Angus McTaggart (AMc) – Clinical Lead, Islay & Jura Catriona Watt (CW) – Area Manager Mid Argyll Caroline Cherry (CC)– Head of Service (Older People) Caroline Henderson (CH) – Acting Locality Manager Oban Hospital Carol-Anne McDade (CMcD)– Area Manager Helensburgh Charlotte Craig (CG) - Business Improvement Manager Claire Higgins (CHg) – PA to Lead Nurse Donald Watt (DW) – Service Manager Registered Services Elizabeth Higgins (EH)– A&B Lead Nurse Fiona Broderick (FB) – Staff Side Fiona Campbell (FC)-Clinical Governance Manager Fiona Hogg (FH) – Director of HR & OD *joined meeting at 1430 & left 1500* George Morrison (GM) – Deputy Chief Officer Jayne Lawrence-Winch (JLW) – Area Manager Cowal *left meeting at 1600* Joanna Macdonald (JMcD) – Chief Officer *left meeting at 1502* Julie Hempleman (JH) – Lead Officer for Adult Protection *JH joined meeting at 14.30* Kate MacCallum (KMacC) – Interim Area Manager OLI Community Kieron Green (KG)– IJB Chair Linda Currie (LC) – Lead AHP Linda Skrastin – Child Health Manager Nicola Gillespie – (NG) – Service Manager Mental Health Nicola Schinaia (NS) – Associate Director of Public Health – *left meeting at 14.51* Pamela MacLeod (PM) – Professional Lead – Social Work Rebecca Helliwell (RH), Associate Medical Director Sandy Taylor (ST) – Non Exec Member of the Board	

	APOLOGIES Jaki Lambert (JLt) – Head of Midwifery Jane Williams (JW) – Area Manager Bute Jean Boardman (JB)– IJB Member Julie Lusk (JL) – Head of Service Fiona Owen (FO)– Local Area Manager Cowal Patricia Renfrew (PR) – Interim Head of Service C&F Paul Chapman (PC) – Falls Lead/Physiotherapy Lead Brian Reid (BR) – Senior Manager C&F	
2.0	**PREVIOUS MINUTES** Correction – Sandy Taylor mentioned twice in attendance list - remove duplication Minutes agreed as accurate and approved.	
3.0	**MATTERS ARISING** **Nil** *Council staff were experiencing IT issues during the committee meeting which some delayed committee members joining.*	
4.0	**QUALITY AND EFFECTIVENESS OF CARE** **4.1 INSPECTIONS** **HEI/OPAH Formal Report** EH asked the committee to note the final HEI Inspection Report and Improvement Action Plan. The report has been tabled at Argyll & Bute IJB and NHSH Clinical Governance Committee. Updated on the progress of the improvement action plan will come to future meetings. Report and Action Plan noted by committee. **Adult Protection Inspection** JH informed the committee that the Scottish Government have indicated they will resume the Adult Protection Inspection programme. JH highlighted the following points; − Scottish Ministers requested the Care Inspectorate, Healthcare Improvement Scotland, and Her Majesty's Inspectorate of Constabulary in Scotland carry out a joint inspection of adult support and protection in 26 partnership areas in Scotland. − The Care Inspectorate will lead this programme. − This joint inspection follows from the joint inspection of adult support and protection in six partnership areas published in July 2018.	

- The purpose of this joint inspection is to seek assurance that adults at risk of harm in Scotland are supported and protected by existing national and local adult support and protection arrangements.
- JH updated the committee on the preparation that is currently being undertaken for the forthcoming Adult Protection Inspection.

JH asked the committee for a commitment that every professional in attendance at today's meeting will participate in this inspection and be part of the ongoing protection of adults at risk of harm.

JH highlighted that Adult Protection is everyone's business and there is a requirement ensure that the HSCP staff work together to protect those who are most vulnerable. In order to achieve this the following will need to take place;

- Council Officers will be required to undertake sufficient training to carry out their roles and responsibilities.
- Ensure that senior managers commit to all staff groups receiving the appropriate training
- Ensure health and other colleagues are confident about reporting harm
- Ensure providers both working in care homes and care at home highlight harm at the earliest stage
- Ensure the public are able to identify harm and know how to report that harm when they have a concern

JH took the committee through a presentation that detailed;

- The inspection process
- What will be inspected and how it will be done
- Details of staff survey that will be undertaken
- Process of submission of evidence
- Sampling of records process
- Details of onsight activity
- How findings will be reported back

JH informed the committee that a communication strategy is in place.
EH encouraged committee member to explore training material available on TURAS.

4.2 Egress Reporting System
JH spoke to tabled paper and provided assurance that the issues identified in the paper have been resolved.

The committee noted actions contained with presented paper.

4.3 Adult Protection Chairs
JH spoke to tabled paper. The issue identified in the paper have now been resolved and all managers have signed up for the training. All areas will now have sufficient chair capacity.
The committee noted the measures within the presented paper in relation to training of senior managers to chair adult protection case conferences.

5.0	**SAFETY & EXPERIENCE** **5.1 HSCP Health and Safety Group Action log (for noting)** The committee noted the action log and information contained within it. **5.2 CAMHS (Child and Adolescent Mental Health Services)** LS took the committee through ten areas where action was required. LS highlight the following points; − Improvement work is ongoing in the CAMHS service. − There continues to be difficulties in recruiting to a CAMHS psychiatrist. − The team are working the Scottish Government to look at different models in relation to the CAMHS psychiatrist role. − HSCP have approved additional resource for the CAMHS service, posts will be recruited to soon. − The CAMHS leadership team continue to meet regularly and is working on pathways and protocols. − Julie Kidson has joined the team as CAHMS manager. CAMHS will remain a standing agenda item on this committee and updated brought to each meeting. Thanks and compliments was extended on behalf of the committee to all those involved in this work. **5.3 Care Home Assurance in Covid** CC spoke to tabled paper. CC updated the committee in relation to the future role of the assurance and oversight function for care homes within Argyll and Bute and highlighted the following points; − There are 17 Care Homes with A&B − Care Home Task Force was established in April 2020 and continues to meet weekly. This is a multiagency membership. − Safety Huddle/Assurance Group meets daily. This is a multiagency membership. This meeting is minuted for audit purposes. This group provides a wide range of functions and these are detailed in the tabled paper. − NHS Highland established the Oversight Function by Chief Officers, Directors of Nursing, Directors of Public Health and Chief Social Work Officers discharge oversight of their assurance function. This group has dealt with escalations from Argyll and Bute and North Highland. − This group (post pandemic) will be developed as a Care Home and Care at	

Home oversight group.

The committee noted the assurance and oversight functions in place across Argyll and Bute contained within the paper.

5.4 Quality Patient Safety Report (QPS)

AMacT spoke to tabled paper and highlighted the following;

- the purpose and function of the Argyll & Bute HSCP Quality and Patient Safety group.
- the process and performance with regard to complaint handling and the commissioning of Significant Adverse Event Reviews.
- the identification of a theme around Violence and Aggression incidents in Victoria Hospital on Bute and acknowledge that a plan has been developed to address this.
- the commissioning of a Fatal Accident Inquiry involving Children and Families service provided by Argyll & Bute HSCP. All staff will be supported during this process.
- the current complaints compliance performance rate dropped recently. This is due to the complex nature of the complaints. All complainants have been kept fully informed of delays and have agreed to the extensions.

All incidents will be taken to QPS as a starting point but dependant on the incident and service the resulting review, if required, will extend further than Significant Adverse Event Reviews and may including Adult & Child committee process.

QPS is an involving process and some further work is required in regards to the 'closing the loop' process.

QPS report will remain a standing agenda item.

5.5 Covid-19 HSCP Update

EH spoke to tabled report. The report was a joint effort from key HSCP staff members who lead on the various subjects discussed in the paper.

EH highlighted the following:

- Vaccination Programme status. Staff vaccinations are being undertaken by staff vaccinator teams. The vaccinations for the Argyll and Bute public are being undertaken by the GP practices. There is work ongoing to plan for the next cohorts and provide support to the GP practices where required.
- Vaccination Governance arrangements. A NHSH Covid-19 Vaccination Clinical Governance group has been established and chaired by Nicola Schinaia. The group meets weekly and part of its function is to scrutinise and discusses any incidents relating to the vaccines. These incidents are also discussed at local QPS groups.
- Lateral Flow Testing (LFT) which is the testing of asymptomatic staff. A weekly update is taken to the A&B Huddle.

	− Remobilisation Plans. An updated paper will be tabled at the March IJB. A weekly report is also tabled at the A&B huddle weekly.	
6.0	**EXPERIENCE** **6.1Culture Fit for the Future** FH informed the committee that the Culture updates are taken directly to the IJB (Integration Joint Board). FH updated that a detailed paper will be taken to the IJB on 31st March. There will be a further detailed update to the May IJB along with information on the Healing Process. ST enquired if there is evidence that some individuals who have been through the process may still not feel satisfied or as if they have had a satisfactory conclusion to their experience. . FH reflected there have been some experiences reported to her where this indeed may be the case. This is recognised as a complex and emotional experience for those engaging with process. Many committee members welcomed the open conversation that are now happening across the HSCP and there was praise for the Courageous Conversation training. It was recognised that significant work has been undertaken, but that this is long term work **6.2 Whistleblowing Standards** FH provided the committee with a verbal update on the Whistleblowing Standards an highlighted the following points; − The Whistleblowing Standards are a legal requirement for NHS Boards. − A Whistleblowing Standards Implementation group has been established and has representation from Argyll & Bute HSCP. − There is a Whistleblowing communication campaign planned to ensure all staff are aware of what the standards are and what they mean for them. − Staff should feel confident to raise concerns and the campaign is designed to empower them to feel able to do so. − There are TURAS modules on Whistleblowing which has a lot of relevant information. Bert MacDonald, Whistleblowing Champion had plans to visit Argyll & Bute however the current lockdown status meant this could not take place. Bert has been given names of individual staff members within Argyll & Bute and he is in the process of meeting virtually with them. Committee members were encouraged to speak with Bert. **6.3 Care Opinion** FC spoke to tabled paper and updated on how Care Opinion is used. Discussion took place regarding exploring ways of using it wider across the HSCP.	AMacT, FC

	AMacT, FC and CC to discuss way forward further outwith meeting.	and CC
7.0	**OTHER WORK IN PROCESS** **7.1 Review of HSCP Clinical and Care Governance Framework** A meeting for the review of HSCP Clinical and Care Governance Framework is planned for 21st April 2021. This meeting will be attended by; − Lead Nurse − Associate Medical Director − Clinical Director − Interim Head of Service C&F x 2 − Head of Service Mental Health − Head of Service Older People − Clinical Governance Manager	
8.	**SCHEDULED REPORTS FOR NOTING** It is expected that all papers will be read prior to the meeting and therefore for this item, only exception questions will be taken.	
	1. Cowal & Bute No one available to present tabled report. EH praised the presentation of the Bute training figures	
	2. Helensburgh and Lomond CMcD presented tabled reported and highlighted the following point; − Significant staffing pressure across all adult teams SCB highlighted the positive feedback within the report	
	3. Mid Argyll CW presented tabled reported and highlighted the following points; − Radiography SBAR. Authors of SBAR were keen to have it noted at this committee. CW to submit to Senior Leadership Team.	
	4. Kintyre No one available to present tabled report. SCB highlight the staffing pressures noted in the paper.	
	5. Islay AB presented tabled reported and highlighted the following points; − Complaint update - referral has been made to independent Adult	

	Protection Committee. Issues have been reported to Police Scotland.	
	6. Oban, Lorn & Isles CH presented tabled reported and highlighted the following points; − Recruitment process issues − GI service across NHSH is under pressure − Improvement work in relation to Death Certificate process − Slightly behind on training and there will be an ongoing focus to improve − Positive feedback highlighted in report	
	7. Mental Health NG presented tabled reported and highlighted the following points; − Issues in completing Violence & Aggression training − Staffing pressures EH requested a more details paper on these issues to next Committee.	
	8. Maternal & Newborn CD presented tabled reported and highlighted the following points; − Jaki Lambert is presenting to the SLT next month on Ockenden Report	
	9. LD, PD and Autism Nil return	
	10. Care Homes & Care at Home DW presented tabled reported and highlighted that the template didn't fit well with his service. DW amended template to provide relevant information.	
	11. Children & Families LS presented tabled reported and highlighted the following points; − Lack of CAMHS consultant − Staffing pressures in Children Community Nursing service. Mitigation has been put in place.	
9	**AOCB** Nil	
10	**FUTURE MEETINGS** **<u>2021 dates via Teams starting at 2pm</u>** • May 27th • Sept 9th • Nov 11th	

Agenda Item 5a

A&B HSCP | Transforming Together
Argyll & Bute Health & Social Care Partnership

MINUTES of MEETING of ARGYLL AND BUTE HSCP FINANCE AND POLICY COMMITTEE held BY SKYPE on FRIDAY, 19 MARCH 2021

Present: Councillor Kieron Green (Chair)

Sarah Compton-Bishop
Elizabeth Higgins
Councillor Gary Mulvaney
Councillor Sandy Taylor

Attending: Joanna MacDonald, Chief Officer, Argyll and Bute HSCP
George Morrison, Depute Chief Officer, Argyll and Bute HSCP
Judy Orr, Head of Finance and Transformation, Argyll and Bute HSCP
Caroline Cherry, Head of Older Adult Services and Community Hospitals, Argyll and Bute HSCP
Charlotte Craig, Business Improvement Manager, Argyll and Bute HSCP
Jim Littlejohn, Locality Manager, Argyll and Bute HSCP
David Forshaw, Principal Accountant, Argyll and Bute Council
Fiona Broderick, Staffside, Argyll and Bute HSCP
Louise Beattie, Service Improvement Officer, Argyll and Bute Council
Donald Watt, Service Manager Registered Services, Argyll and Bute HSCP
Dr Nicola Schinaia, Associate Director of Public Health, Argyll and Bute HSCP
Graham Bell, Non-Executive Member from NHS Highland (Observer)
Dafydd Jones, Audit Scotland (Observer)
Lynsey Innis, Senior Committee Assistant, Argyll and Bute Council

1. APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting and in particular Dafydd Jones from Audit Scotland and Graham Bell who was the new Non-Executive Director from NHS Highland, both of whom were attending the meeting on an observation basis.

Apologies for absence were intimated on behalf of:-

Jane Fowler, Head of Customer and Support Services
Julie Lusk, Head of Adult Services, Argyll and Bute HSCP
Stephen Whiston, Head of Strategic Planning and Performance, Argyll and Bute HSCP
Brian Reid, Acting Head of Adult Services, Argyll and Bute HSCP
Kevin McIntosh, Staffside, Argyll and Bute Council

2. DECLARATIONS OF INTEREST

Sarah Compton-Bishop declared a non-financial interest in relation to the Jura Progressive Care Centre, as discussed at agenda item 10 (Budget Proposals 2021-22) by virtue of having a family member resident within the Centre.

3. MINUTES

The Minute of the previous meeting of the Finance and Policy Committee, held on 26 February 2021, was approved as a correct record.

4. BUDGET MONITORING AS AT 28 FEBRUARY 2021

The Committee gave consideration to a report providing a summary of the financial position of the Health and Social Care Partnership as at 28 February 2021. The report included information on the Covid-19 funding announced on 5 February 2021 for both Health and Social Work.

Discussion took place in terms of the reporting format and in particular to the level of information contained within appendix 3c. It was agreed that in addition to this information, future reports would be provided in respect of each of the four work streams on a cyclical basis with the Head of Older Adult Services and Community Hospitals agreeing to provide the first of these reports in relation to older adult care at the next meeting of the Committee.

Decision

The Finance and Policy Committee –

1. Noted the forecast outturn position for 2020-21 is a forecast underspend of £2.016m as at 28 February 2021 and that there is a year to date underspend of £4.055m as at the same date.

2. Noted the above position includes provision for Scottish Government assistance with non-delivery of savings due to Covid-19.

3. Noted that £2.65m is included in Social Work annual budget and forecasted expenditure which relates to funding from Scottish Government and is intended to be carried forward into next year. They also noted that there is a £0.8m in Health reserves similarly expected to be carried forward in relation to Covid funding, as well as £1.6m new allocations received this month for Primary Care Improvement Fund (PCIF - £1.418m) and Action 15 of the Mental Health Strategy (£217k).

(Reference: Report by Head of Finance and Transformation, dated 19 March 2021, submitted)

5. COVID-19 RESPONSE AND FINANCIAL IMPLICATIONS

Consideration was given to a report providing an overview of the HSCP's Covid-19 mobilisation costs and its future cost planning for living and operating with Covid-19. The report provided a snapshot of the financial estimates of the costs of dealing with the Covid-19 response. It was noted that the cost estimates are updated on a regular basis, and are still subject to considerable uncertainties.

Decision

The Finance and Policy Committee –

1. Noted the details provided in relation to Covid-19 response and associated mobilisation plan costing for 2020-21 and subsequent years.

2. Acknowledged the uncertainties in the cost elements submitted.

3. Noted that the Scottish Government has in principle approved all mobilisation plans, but that approval for individual cost lines has not yet been received.

4. Noted that any excess funding received must be carried forward as an earmarked reserve at the year end to be used against Covid costs next year.

(Reference: Report by Head of Finance and Transformation, dated 19 March 2021, submitted)

6. FINANCIAL RISKS 2021-22

Having noted the process of identifying and reporting financial risks to the IJB, the Committee gave consideration to a report providing an updated assessment of the risks for 2021/22. The report noted the considerable uncertainty around levels of Covid funding from Scottish Government for next year.

Decision

The Finance and Policy Committee –

1. Considered the updated financial risks identified for the Health and Social Care Partnership.

2. Noted that there are continuing uncertainties around Covid costs and funding which are described in more detail in a separate report.

3. Noted that financial risks will continue to be reviewed and monitored on a two monthly basis and reported to the Board.

(Reference: Report by Head of Finance and Transformation, dated 19 March 2021, submitted)

7. BUDGET OUTLOOK 2021-22 TO 2023-24

Consideration was given to a report summarising the budget outlook covering the period 2021-22 to 2023-24. The report noted that the outlook was based on three different scenarios, best case, worst case and mid-range and presented a single scenario for 2021-22.

Decision

The Finance and Policy Committee –

1. Considered the current estimated budget outlook report for the period 2021-22 to 2023-24.

2. Noted that there was a separate report on the agenda detailing savings options to deliver a balanced budget in 2021-22.

(Reference: Report by Head of Finance and Transformation, dated 19 March 2021, submitted)

8. BUDGET CONSULTATION FINDINGS

The Finance and Policy Committee finalised the budget consultation and it was subsequently launched on Friday 22 January 2021 for a 4 week period, closing on 19 February 2021. It was made available online and promoted through social media, and through Community Councils, the Third Sector Interface and the Community Planning Partnership. When it closed, 625 responses had been received. Consideration was given to a report summarising these findings.

Decision

The Finance and Policy Committee noted the findings from the Budget Consultation and agreed to ensure that these were fed into considerations when discussing the separate report on the agenda detailing savings options to deliver a balanced budget in 2021-22.

(Reference: Report by Head of Finance and Transformation, dated 19 March 2021, submitted)

9. BUDGET SAVINGS 2021/22: ASSESSING EQUALITY AND SOCIO-ECONOMIC IMPACT

The Committee gave consideration to a report outlining the work undertaken to ensure that due regard is given to equalities, islands and the Fairer Scotland Duty in the decision-making process relating to budget savings. The report also presented a strategic EQIA for the savings programme to advise on overall impact.

Decision

The Finance and Policy Committee –

1. Noted the findings from the summary Equality and Social-Economic Impact Assessment (EQIA) and agreed to ensure that these are considered when discussing the savings options to deliver a balanced budget in 2021-22.

2. Noted that the EQIA relating to transfer of clients from in house run care home, which was no longer fit for purpose, to private sector care home within the same locality is reported on separately in the Care Homes and Housing Update.

(Reference: Report by Head of Finance and Transformation, dated 19 March 2021, submitted)

10. BUDGET PROPOSALS 2021-22

A report presenting the savings proposals identified by the Strategic Leadership Team in order to deliver a balanced budget in 2021-22 was considered by the Committee.

Decision

The Finance and Policy Committee agreed to recommend the following to the IJB:

1. Approve the management/operational savings at Appendix 1 amounting to £3.658m in 2021-22 and £2.688m in 2022-23.

2. Approve the policy savings at Appendix 2 amounting to £561k in 2021-22 and £1.263m in 2022-23.

3. Approve the removal of £85k previously agreed savings – reference 1920-32 £44.5k and 1920-33 £40.7k both relating to the management restructure as set out at paragraph 3.2.6 of the report.

4. Approve the proposed investment in financial sustainability totalling £517k in 2021/22 and 2022/23 set at 3.3.6 and the proposed extension of the existing investment of £330k for a further year in 2022-23 as set out at paragraph 3.3.7 of the report.

5. Note that in approving the above savings and financial investment this will deliver a balanced budget in 2021-22.

6. Note the financial consequences of the actions set out at paragraph 3.14 in the Care Homes and Housing paper for 2022-23 and beyond.

7. Instruct the Chief Officer to accept the funding from NHS Highland and Argyll and Bute Council and issued formal Directions (see drafts at Appendix 3) delegating resources back to the Partners.

8. Note the high level timetable for the budget preparation 2022-23 set out at paragraph 3.5.1 of the report.

(Reference: Report by Head of Finance and Transformation, dated 19 March 2021, submitted)

11. CARE HOMES AND HOUSING UPDATE

Consideration was given to a report summarising the progress to date of the Care Home and Housing Programme Board.

Decision

The Finance and Policy Committee –

1. Approved the Programme Management Approach to progressing the Care Home and Housing Transformation work.

2. Approved the work stream approach and the short and longer term priorities set out at paragraph 3.3 of the report.

3. Approved the options appraisal scoring framework set out at paragraphs 3.10 to 3.12 of the report.

4. Agreed to ask the IJB to delegate authority to Finance and Policy Committee to approve the outcome of the options appraisal.

5. Agreed the approach to the financial implications set out at paragraph 3.15 of the report.

6. Noted the progress of the Care Home and Housing Programme Board detailed within the report.

(Reference: Report by Head of Adult Services – Older Adults and Community Hospitals, dated 19 March 2021, submitted)

12. DATE OF NEXT MEETING

The date of the next meeting was noted as Friday, 23 April 2021 at 1:30pm.

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

ACTION LOG: STRATEGIC PLANNING GROUP ARGYLL AND BUTE

4th March 2021 by MS Teams

1. **Membership and attendance:**

Name	Position	Status
Jean Boardman (JB)	Non-Executive Director of Highland NHS Board & Member of the IJB- A&B	Present (Chair)
Alison McGrory (AMcG)	Health Improvement Principal	Present
Duncan Martin (DM)	Public Representative	Present
Kirsteen Murray (KM)	Chief Executive Argyll & Bute TSI	Present
Kristin Gillies (KG)	Senior Service Planning Manager	Present
Alison Ryan (AR)	Service Planning Manager	Present
Cllr. Kieron Green (CKG)	Chair, IJB	Present
Sarah Compton Bishop (SCB)	Vice Chair IJB	Present
Julie Hodges (JH)	Independent Care Providers Sector Leader A&B	Apologies
Charlotte Craig (CCR)	Business Improvement Manager, A&BHSCP	Apologies
Douglas Whyte (DW)	Area Housing Manager	Apologies
Emma Mason (EM)	Strategic Planning Department Secretary	Present
Stephen Whiston (SW)	Head of Strategic Planning and Performance	Present
Fiona Broderick (FB)	Staff side Representative	Present
George Morrison (GM)	Deputy Chief Officer, A&BHSCP	Present
Judy Orr (JO)	Head of Finance and Transformation	Present
David Forshaw (DF)	Finance A&B Council	Apologies
Sarah Griffin (SG)	Senior Information Analyst	Apologies
Nicola Schinaia (NS)	Associate Director of Public Health	Present
Elizabeth Higgins (EH)	Lead Nurse	Present
Charlie Gibson (CG)	Head of People and Change	Apologies
Margaret McGowan (MMcG)	Independent sector representative, Scottish Care	Present
Alastair MacGregor (AMacG)	Director of ACHA	Apologies
Jim Littlejohn (JLJ)	Service Manager- LD, Autism, PD & Transitions	Apologies
Michael Roberts (MR)	Public Representative	Apologies
Rebecca Helliwell (RH)	Associate Medical Director	Apologies
Fiona Sharples (FS)	Organisation Development Lead	Apologies

Name	Position	Status
Linda Currie (LC)	Lead Allied Health Professional	Apologies
Niall Kieran (NK)	Marie Curie - Divisional General Manager	Apologies
Joanna MacDonald (JMacD)	Chief Officer, Argyll and Bute HSCP	Present
Anne MacColl-Smith (AMS)	Procurement and Contract Manager	Apologies
Caroline Cherry (CCH)	Head of Adult Services	Apologies
Edmund McKay (EMcK)	Health Improvement Scotland	Apologies
Julie Lusk (JL)	Chief Social Work Officer and Head of Adult Services	Apologies
Gaener Rodger (GR)	Non-Executive Director	Apologies
Patricia Renfrew (PR)	Head of Service, Children, Families Health (Int)	Apologies
Brian Read (BR)	Acting Head of Service Children & Families & Justice Social work	Present
Donald Watt (DW)	Service Manager (Resources)	Apologies
Maggie Clark (MC)	Health Improvement Lead	Present

No	ACTIONS	LEAD PERSON	DATE
1.	**Welcome/Intro/Apologies** JB Introduced the meeting and welcomed everyone to the meeting. Apologies noted as above. **ACTION-** Group agreed to all SPG meetings to be recorded for note taking purposes.	**J. Boardman** **E.Mason**	
2.	**Action Note of last meeting (attached)** Action note from previous SPG on the 28th January 2021 noted and agreed.	**J. Boardman**	

3.1	**Revised Route Map for JSP and JSCS** KG presented to the group the revised route map and discussed, in detail, the stages and timeline. KG spoke about the priorities, strategic objectives and key market messages going forward to set the plan for 2022/2025. KG recommended that the Joint Strategic Plan and Commissioning Strategy are aligned and put together as a joint document, in 2022, to take the HSCP forward in its strategic planning agenda. Engagement and planning process with stakeholders will be vital. The group approved the Route Map and the recommendation. KG highlighted an extension of our current existing contacts, grants and the budget has been confirmed and approved by the IJB for 2021. This gives us vital time to do all of this ground work in terms of planning for the future, working with all providers and understanding what changes are required for our commissioning to improve going forward. JO- More engagement from NHS Highland Procurement team required. KG- Confirmed discussed at the new commissioning working group meeting to link up with the team in North Highland. DM- Co-production -Community organisations engaged with at the early stage not clear enough in route map. KG- Reassured group that part of the commissioning work is to facilitate the co-production going forward, dedicated to ensure engaging. The process is to agree key market messages, work with 3rd sectors and others to co-produce services linking in to LPG's which we hope to get reinstated. Liaising around our engagement plans. KM- TSI supporting third sector reps regular events taking place for people to come and communicate. Adult group popular as can hear information on what HSCP are doing. Engagement section on TSI website with all the outcomes of meetings for 3rd sector to access. Children's JSNA not aware of this coming back to SPG NS was previously going to find out about this **ACTION-** NS -the Children and Families JSNA has been carried out. Need to go back and check these are still relevant as today. Update group at next meeting. DM- Confirmed not a third sector public user. JMacD- Thanked everybody involved and acknowledged a huge amount of work has been done to get to where we are.	**K.Gillies** **N.Schinaia**	**3rd Jun 21**

3.2	**Draft Themes/Strategic Priorities and Market Messages for Strategic Commissioning Strategy 2022-25 (Section 5)** AR presented the draft Strategic Commissioning Strategy which will be underpinned by collaboration; co-working; outcome focussed approach; sustainable funding (3 years minimum) and equity of access to services AR discussed in detail Section 5; key market messages, themes and priorities which has been updated and refreshed following discussions with a number of stakeholders, working groups and the key policy drivers. AR opened up the group for discussions and questions. JO- Recognised that the IJB does not have an ICT & digital strategy and this is now planned, linking in to the strategies of our two partners. Most areas don't have additional resources have to do better with the resources we have. One exception is the Carers Act funding was announced by SG additional £516k for this area. AMcG- Obvious gap to add in inequalities sensitive practice, how we ensure targeting resources in a way they are going to have the most impact. To link in with the updated equality and diversity impact assessment. **ACTION-** AR to add in to plan JMacD- Thanked Alison for this excellent piece of work. JMacD currently chair of National Self Directed Support and Consistency Steering Group, which has a fantastic representation, the majority are third sector and voluntary providers, looking at the philosophy of self-directed support Long way to go in Argyll and Bute. It's about choice, flexibility, control and engaging with the communities. The principles weaves it way through the Derek Feely report who met with the group around engaging with the most vulnerable in communities and people with disabilities. Building independence and rights of adults and children. To be really overt in inequalities in what we are attending on challenging inequalities remoteness, poverty agendas etc. SW- Finance aspect annual funding. Three year plan to continue with estimated forecast. KM- May only have annual funding, but we don't say we won't build a hospital because we don't have confirmed long-term funding small and relatively vulnerable supplier organisations need certainty too for their planning. **Group agreed to sign off the route map and the alignment for Joint Strategic Plan and Strategic Commissioning Strategy for 2022/25.**	**A.Ryan** **A.Ryan**	

4.	**Update from SC Working Group** AR informed the group there is now a Strategic commissioning working group. The remit of the working group will be to input into the drafting of the Joint Commissioning Strategy and individual Commissioning plans. One informal meeting has taken place to bring the people together to network and share. Gives an opportunity for the service improvement leads who are currently working on the different projects under the transformation agenda. Colleagues from public health, procurement, commissioning and finance are all included. The group can be expanded, if appropriate. AR asked the group for their thoughts around the working groups proposed structure with the development of the individual strategies for commission plans to be developed under these. Highlighted strategies important to have in place to ensure no gap, asked if the group was aware if these strategies taking place. KG aware that these strategies are being created however some are established and some not which can impact of the work. JO Clarified time scales around some of the strategies; Care homes and housing- paper going to the March 2021 IJB which will set out time scales. Care at home strategy expected to be developed over the next six months. The Learning Disability and Mental Health strategy drafts are in place and are progressing. Carer's area LC has a strategy and plan to be updated with the additional resources. Digital strategy due to be completed by 31st March 2022. **Group approved the working groups proposed structure**	**A.Ryan**	

5.	**Transformation Priorities** JO presented to the group the Transformation Boards Priorities. Summarised the 5 areas of focus for next year and 3 areas of ongoing focus ➢ Primary Care Improvement Plan ➢ Children's Services ➢ Learning Disability ➢ Care Homes and Housing ➢ Community Hospitals ➢ Increased support for Carers ➢ Community assets approach ➢ Digital services The role of the SPG to make sure they are happy with the direction of travel for theses 5 areas of focus and the governances. The Transformation Board is reporting to the Finance and Policy committee on a monthly basis to ensure progress maintained across these areas. JO- Opened up for discussion and asked the group for approval for those 5 areas of focus and the governance arrangements. SW- Highlighted all the transformation objectives link with our commissioning objectives and the current Joint Strategic Plan. DM- Will the New IT systems link in with all of Scotland for seamless record transfer etc. SW- Confirmed moving that way the digital approach complex. Developing the systems, interfaces and portal allowing to link in. KM- TOR benefit from more clarification about the difference between finance and governance. SPG responsibility to advise IJB in strategic issues. JO- Covering report aimed to clarify this at 3.12 and 3.13. SPG responsibility scope of work undertaken is aligned to the Strategic plan. Once signed off the 5 areas of focus for next year and approved then moves to the finance and policy committee to ensure that progress is made on the agreed transformation areas. If there was a requirement to change the scope that's when it would come back to the SPG for approval. **Group approved the 5 key areas 2021/2022, the Governance arrangements and updated TOR.**	**J.Orr**	

6.	**NHS Highland Social Mitigation Strategy draft** AMcG presented the NHS highland social mitigation draft strategy to the group. Public health are the agents for developing the document which has been in development since summer last year where there was siting of the recovery phase moving out of the pandemic. This will be a Highland wide resource, Director of Public Health taking to the NHS highland board on 30th March 2021. Proposing strategy adopted at that meeting. AMcG stated that it pulls together the themes and strategy. We have good building blocks in place- Child poverty plan, Suicide prevention plan, Living well strategy, Drugs and alcohol strategy. The social mitigation strategy is about identifying what the new impacts on population, health and health outcomes and what we as an organisation have to do with the building blocks and out with. Themes within the strategy • Income maximisation • Reducing child poverty • Fair Work Practice in employment and recruitment • Mental health improvement • The impact of drugs and alcohol use • Improving equality of opportunity and reducing inequalities • Equalities sensitive practice and targeting those most in need • Building capacity and working to build healthy and supportive communities Action plan within the draft don't want the board to sign off all the actions as lots of work that has to take place and follow through from the strategy in terms of how we as a group and the other groups take forward meaningful actions. Content of action plan robust but not going to be adopted like that by the board, we will see different versions being updated. JO- Overlaps with our child poverty strategy have these been cross referenced. AMcG- some cross referenced but not in terms of the detail, one of the reasons why we don't want the full plan to be indorsed by the board as know there is already work taking place. SW- Work done around the needs assessment for adults and the linking of that will pick up a lot of this. Capturing this in the needs assessment, commission process and planning going forward. KM- So many pieces of this work happening already in Argyll and Bute Community planning, development team, Building Back Better etc. Concerned overlap's of groups that are already working on these, would go forward with all the duplication and overlap without it being worked out. Massively duplicating NHS Highland board hasn't got the strategy responsibility for place shaping in Argyll and Bute.	**A.McGrory**	

	AMcG- Acknowledged concerns. This is a NHS highland wide response as how we as an organisation deliver our services to respond to those changing needs as a result of the pandemic. Had lengthy conversations in terms of the overlap with building back better, areas community planning groups having a core responsibility and marry up. **ACTION-** Mapping exercise produced previously by planning team in the strategies and how they are visually reported, connected and overlapped with each other. Would be helpful to revisit this and update with where we are now. Group noted the NHS Highland Social Mitigation Strategy. Group and are in agreement with the concerns raised, that it requires further work and needs to know how it fits in with governance process and the work with other partners.	**A.Ryan**	
7.	**Building Back Better Strategy** KM gave a summary of the Building Back Better Strategy Argyll and Bute Council has the responsibility from the Scottish Government to put together a recovery plan. One of the work streams is Building Back Better: Strengthening Communities, lead by Rona Gould, the Community Planning Manager. AMcG is the representative for the HSCP. There has been communication with communities, people who don't normally go to community councils, people with problems with their mental health, homelessness, victims of domestic abuse etc who are not picked up through the normal mechanisms. Started as consultation exercises which lead into the design of some workstreams. Poverty work stream lead by Fergus Walker which brings together all the workstreams which were currently on going in various places, violence against women, homelessness, drugs and alcohol, benefits, period poverty etc. To focus on the aspects of poverty with a joined up approach. Food work stream lead by Jane Jones council involves distribution chain and a variety of things covered within the workstream. Jane has been asked to do advisory work with Scottish Government as have acknowledged the remarkable work being achieved. Feedback communication going out to the communities. Conversation that this may sit better with community planning partnership as progressed to longer term work. Management committee next week to propose sitting with CPP. JO- Would support BBB being under the CPP	**K.Murray**	

8.	**Living Well** MC updated the group on the Living Well Strategy which was endorsed by the IJB in October 2019. 5 year implementation plan to take forward. Lot of the work taking place with staff, community groups, stake holders etc Grew into a prevention strategy which brings together the common themes into one place. Pandemic delayed the strategy. Re-prioritised the priorities in August that felt supported the people in the recovery in communities. Living Well underpins some of the things talked about at today's meeting. Looking at how we can embed the Living Well Strategy into the commissioning work to drive forward and join up with other strategies.	**M.Clark**	
7.	**AOCB** KM- This is KM last meeting. Well done everyone fantastic to see the work going into a positive direction and the joining up of systems. Group also thanked KM for all her contribution. KG asked group to note the schedule for CMFWG, CMFSG and SPG	**All**	
10.	**Next full Strategic Planning Group:** 3rd June @ 2pm MS Teams		

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item:**

Date of Meeting: **31 March 2021**

Title of Report: **Chief Officer Report**

Presented by: **Joanna Macdonald, Chief Officer**

The Integration Joint Board is asked to:

- Note the following report from the Chief Officer

Extension of Guardian Service

Earlier this year an independent and confidential Guardian Service was launched for NHS Highland staff, including those working in Argyll and Bute. The Guardian Service was extended from 1 January 2021 to cover Argyll and Bute Council staff working for the HSCP.

The service is independent and confidential and is for staff to discuss matters relating to patient and service user care and safety, whistleblowing, bullying and harassment, and workplace grievances. The guardians are external to the HSCP and more information on the services they provide is available on their website at www.theguardianservice.co.uk

The Guardians have now arranged a series of online sessions from March – May to enable staff to meet them virtually and find out more about the services they offer. This information has been widely distributed to staff.

Mid Argyll Midwifery Team

The Mid Argyll Midwifery Team recently welcomed midwife Lorna Young to their ranks. Lorna's role as an integrated rural midwife means she is part of a team of six midwives covering Mid Argyll and she provides care to local women and their families in the unit and at their home.

Lorna, who is originally from Lochgilphead, completed work experience during her final school years with the Mid Argyll midwives, and joined them again during her student midwife clinical/training placements. Most of her training was completed with Greater Glasgow and Clyde Health Board where she remained based for four years after she qualified as a midwife.

A Big Thank You to all Vaccinators

The Chief Officer would like to thank all staff, including GPs and their teams, for the amazing work they have been carrying out over the last few months to ensure that COVID-19 vaccinations can be delivered across Argyll and Bute.

The speed at which the vaccine programme has been arranged has been absolutely fantastic and the lengths that staff are going to ensure that everyone who is eligible is offered a vaccine highlights the commitment they have to their local communities.

Mid Argyll Hospital Receives Donation

Mid Argyll Hospital has recently received a kind donation of an ECG monitor which was donated by a local resident who was keen to use some funds they had received to donate the monitor to the hospital.

Cardiology patients under the care of the hospital will benefit from this new technology which allows them to record their heart beats using the monitor and an associated app. The device can be used to help diagnose and monitor symptoms of irregular heartbeat and patients meeting the criteria for home health monitoring can now be monitored in the comfort of their own home.

Drone Delivery Flights in Argyll and Bute

The HSCP has been continuing to work closely with Skyports to carry COVID test samples and other medical materials on drone delivery flights between medical facilities within Argyll and Bute.

The use of delivery drones means that access to hard-to-reach areas can be greatly improved. The time taken to transport materials can also be significantly reduced, in some areas from 36 hours (for a road and ferry journey) to 15 minutes.

The drone delivery service will initially operate between Lorn & Islands Hospital in Oban, Mid-Argyll Community Hospital in Lochgilphead, Easdale Medical Practice in Clachan Seil and the Mull & Iona Community Hospital in Craignure.

Both a scheduled service and an on-demand service will be run, with orders able to be placed by NHS staff through an online system developed by digital consultants Deloitte.

Lorn & Islands Hospital Receives Generous Donations

Lorn & Islands Hospital has received a generous donation of eight televisions, a tablet, electrical kitchen equipment, toiletries and board games, all from a local fundraiser on Mull.

During what has been a challenging time for everyone the staff at the hospital have really appreciated the support they have received from local communities, businesses, volunteers and organisations.

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: 31 March 2021

Title of Report: Integration Joint Board Membership update and interim arrangements for the Chief Officer

Presented by: Charlotte Craig

The board is asked to:

- Note transition of the chair
- Note the contribution of members who are moving on and offer thanks and welcome new members.
- Approve appointment to vacant committee roles
- Note interim arrangements for the Chief Officer
- Note status of recruitment to carer and public representation

1. EXECUTIVE SUMMARY

1.1 As referenced at the Argyll & Bute IJB in January 2021 the chair and vice chair will transition roles with Sarah Compton-Bishop becoming Chair and Councillor Kieron Green becoming vice chair.

1.2 A vote of thanks for the contribution of Kirsteen Murray Chief Executive of the Third Sector Interface is moving on to a new role. Takki Sulaiman is joining the IJB on 31 March 2021 as the new Chief Executive of the TSI.

1.3 A vote of thanks to Dr Gaener Rodger and Professor Boyd Robertson. They will be replaced by Susan Ringwood and Graham Bell as NHS non-executive Board representatives and voting members and a warm welcome is extended to them.

1.4 After a number of stakeholder meetings with agencies supporting carers and they are supporting the recruitment and wider participation of carers through carer representation.

1.5 The public representative has been promoted and again it will be supported to be a representative role.

1.6 Additional support for public representatives and carers will be provided as required.

2. INTRODUCTION

The paper notes the change in membership and roles within the IJB, the interim arrangements during the period of recruitment for the Chief Officer.

3. DETAIL OF REPORT

3.1 Councillor Kieron Green has been Chair of the IJB for two years and in line with the standing orders the chair will rotate between the council and health representative with Sarah Compton-Bishop taking on the role of the chair from 1 April 2021 for a period of two years.

3.2 The IJB has a change in membership. Kirsteen Murray, Chief Executive of Third Sector Interface and representing the third sector is moving on. This role will be filled by Takki Sulaiman, the incoming Chief Executive of TSI.

3.3 NHS Highland has appointed two new non-executive members replacing Dr Gaener Rodger and Professor Boyd Robertson to represent Argyll & Bute, Graham Bell and Susan Ringwood. We extend a warm welcome to the new members. There is a requirement for the IJB to appoint members to vacant committee positions for Finance & Policy Committee, vice chair of the Audit and Risk Committee.

3.4 There will be a requirement for the appointment of the incoming TSI Chief Executive to the Strategic Planning Group.

3.5 Carer and public representatives have been outstanding despite a number of recruitments through 2019 and 2020. Engagement with carers centres and proposals for additional support are aimed at seeking to have a supported and representative carer voice for Argyll & Bute. The public representative will be circulated through the media and networks. Any existing applications will be considered within the pool of applicants.

3.6 The Chief Officer Joanna Macdonald is moving to a new post and recruitment to fill this post has commenced with appointment pending a successful process. George Morrison Deputy Chief Officer and Head of Finance will act as interim Chief Officer until the new appointment is in post. George also has the remit as Culture Group chair to ensure that this work continues to have the prominence required.

3.7 We would like to offer our thanks to our members who have offered their time voluntarily as part of the Argyll & Bute Integration Joint Board. Communities are highly invested in their health and social care services and often the IJB are in the position of making difficult decisions. Our thanks go to both our outgoing members for providing constructive and appropriate challenge and the skills they have brought which have supported this during their membership. Also to welcome our incoming members.

4. RELEVANT DATA AND INDICATORS

Terms of reference.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

Establishment and maintenance of good governance and leadership of the Health and Social Care Partnership.

6. GOVERNANCE IMPLICATIONS

There is a requirement to ensure that membership is supported to ensure representation and quoracy to ensure the business of the IJB can be delivered.

6.1 Financial Impact

No financial impact

6.2 Staff Governance

No impact on staff governance

6.3 Clinical Governance

No impact on clinical and care governance.

7. PROFESSIONAL ADVISORY

Professional advisory received on supporting appropriate governance.

8. EQUALITY & DIVERSITY IMPLICATIONS

The recruitment process includes supports the principles of equality and diversity. The IJB will seek to ensure members of communities have a route to representation in the development and planning of health and social care services.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Compliant.

10. RISK ASSESSMENT

Supporting governance ensures representation to allow a collective decision making approach ensuring capacity for quoracy.

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

We have sought greater involvement in recruitment for lay members to support greater representation for communities.

12. CONCLUSIONS

IJB members offer their time on a voluntary basis, we would like to offer our thanks to those that have participated in supporting the business of the IJB and welcome our incoming members.

We also seek to provide assurance on arrangements for the ongoing leadership and support of staff.

13. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

Author Name Charlotte Craig
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NHS Highland

Meeting:	**NHS Highland Board**
Meeting date:	**30 March 2021**
Title:	**Culture Update**
Responsible Executive/Non-Executive:	**Fiona Hogg, Director of Human Resources & Organisational Development**
Report Author:	**Emma Pickard, External Culture Advisor**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Board strategy / plan

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

NHS Highland have now received the first two reports from the Independent Review Panel (IRP) of the Healing Process. They make recommendations for the Board to consider in addressing the organisational factors which are reported to have contributed to the experiences shared with them by former and current NHS Highland colleagues who have experienced bullying in the period up to 31 December 2019. In line with the Healing Process guidance, their reports are shared in full (as Appendix 1 and 2 respectively).

These have been combined with the findings of Root Cause Diagnostic sessions carried out in both Argyll & Bute and North Highland into a consolidated report, prepared by Emma Pickard, our External Culture Advisor (Appendix 3).

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This paper is the first of two papers, the second will be presented to the May 2021 NHS Highland Board meeting and will include a detailed update on our progress against all of these recommendations and those of the Sturrock Report, as well as details of the Culture Programme Plan for the next 12 months and beyond. However, a report of progress against the IRP recommendations to date is also included as part of this month's update (Appendix 4).

2.2 Background

The Independent Review Panel (IRP) of the Healing Process provides the Board with Quarterly reports on their recommendations. The first of these reports was compiled after the first 26 participants had been to a panel, and the second after a further 58 participants. Panel participants can be former or current employees, and around 55% of the participants in these reports were former employees, and 45% current employees.

It is important to note the IRP and the Healing Process is unique in that it focuses solely on harm and healing and seeking to find resolution for those who have experienced bullying at NHS Highland in the past. It does not seek to corroborate evidence or experiences; it takes the information it is presented with by one party. There is also no time limit on how far in the past experiences occurred, but it is only able to cover the period up to 31 December 2019.

This context is important when reading the reports, in that the situations they describe may be in the past, others may have different recollections or experiences and work may have already taken place to address and resolve these. However, the learnings and themes from these experiences are aligned with other feedback, including the Sturrock report and the recent Root Cause Diagnostic work, which is also included in the report attached.

2.3 Assessment

The attached report (Appendix 3) sets out the areas which NHS Highland needs to address to ensure the past experiences will not be repeated and the organisation moves forward with culture transformation and our aspiration to be a "Great Place to Work" for everyone. Many of these actions are already in progress and some have already been completed and others are planned as part of the Culture Programme or other activity.

Appendix 4 summarises the progress made to date against the IRP recommendations. The IRP reports are included in full in Appendix 1 and 2, with redaction where we believe an individual or situation could be identified and could cause harm.

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NHS Highland recognises and accepts the recommendations of the IRP and is committed to investing the necessary time, effort and resources to addressing these recommendations and delivering our wider Culture programme plans for the benefit of all NHS Highland colleagues. Whilst noting the significant progress already made against a number of the recommendations, there is an ongoing, substantial and long-term programme of work which is being put in place address this completely.

This work is embedded into our 2021-2 Strategy, Vision and Objectives, with our aspiration to be a “Great Place to Work” which will be achieved through delivery of our 5 key objectives; Growing Talent, Leading by Example, Being Inclusive, Learning from Experience and Improving Wellbeing.

We will bring a full update on the progress against these recommendations as well as those of the Sturrock report, plus our detailed Culture programme plans for the next 12 months and beyond, to the May 2021 Board meeting. We will be refreshing the format of the Board reporting, to align this to show delivery against the areas of the Culture plan, along with key risks and issues.

Future IRP recommendations will also be shared with the Board, the next report will be due to be considered at the July 2021 Board meeting.

2.3.1 Quality/ Patient Care

Successful delivery of the Culture Programme is critical to effective patient care.

2.3.2 Workforce

The Culture Programme will ensure colleagues are engaged, motivated, clear on their roles and priorities and working to our values.

2.3.3 Financial

Additional funding has been secured to deliver our Culture Programme. Improving our culture will realise reductions in sickness absence and staff turnover, and reduce time and effort spent on disciplinary and grievance processes.

2.3.4 Risk Assessment/Management

No additional risks have been identified.

2.3.5 Equality and Diversity, including health inequalities

Fairness, along with dignity and respect are core principles of our Culture Programme where our values will be embedded in all we do as an organisation

2.3.6 Other impacts

None.

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2.3.7 Communication, involvement, engagement and consultation

The Culture Programme communication and engagement plan will be brought to the Board as part of the May 2021 update on the Culture Programme. We continue to engage with a range of stakeholders on this topic, including Partnership, Whistleblowers, the Culture Oversight Group and Staff Governance Committee.

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Executive Directors Group, Monday 22 March 2021

Confirmation received from EDG on 22 March 2021

2.4 Recommendation

- **Discussion** – Examine and consider the report on the recommendations of the IRP and Root Cause Diagnostic and progress made to date with these.

3 List of appendices

The following appendices are included with this report:

- Appendix No1, IRP Organisational Learning Report 1, November 2020
- Appendix No2, IRP Organisational Learning Report 2, March 2021
- Appendix No3, Consolidation of Lessons Learned and findings of the Independent Review Panel
- Appendix No4, IRP recommendations

DRAFT

NHS Highland Healing Process

Independent Review Panel Report on Organisational Learning

Report One: November 2020

Background

The Independent Review Panel (IRP) was set up as part of the NHS Highland Healing Process. The Panel works to the Independent Review Panel: Guidance Framework (the "Guidance").

The Guidance provided five possible outcomes from the IRP. Outcome 1 is an apology and/or a Recommendation for Organisational Learning. The apology outcome is self-explanatory and not the subject of this report. In relation to Organisational Learning, which is the subject of this report, this is where the IRP, having listened to the participant's experiences, often in conjunction with the participant, identifies areas where it believes NHSH could improve its practices, occasionally for the benefit of the participant but more commonly (the participant having left NHSH) for the benefit of others, both to reduce the risk of harm and to create opportunities for positive innovation. As part of the Guidance the IRP may therefore make recommendations to NHSH that organisational learning is implemented, with NHSH delegating responsibility for action as appropriate.

During the course of individual meetings, participants have, given their experience, indicated areas for organisational learning. In addition, members of the IRP on hearing a series of testimonies, have identified themes in relation to organisational culture, behaviour, systems and processes, which would benefit from improvement. This report sets out the IRP's recommendations on organisational learning from the initial hearings in August to 30th September, 2020.

The IRP has been invited to produce a report on Organisational Learning on a quarterly basis. The next Report will be in January, 2021, covering the period to 31st December, 2020, and then in April, covering the period until 31st March, 2021. Further reports will be produced should the IRP continue to consider participants' experiences beyond 31st March 2021, as is likely.

In the majority of cases participants have been keen to ensure that confidentiality is not breached, and members of the IRP are aware of their responsibility in this. Therefore, this report is written in a way to protect confidentiality. However, those whom we met were very keen that NHSH takes on board the organisational learning they feel is critical to the organisation moving forward and rectifying past failings.

2

This Report is produced in accordance with the Healing Principles defined in the Guidance. The IRP is not a judge and jury of the facts. The IRP deals with harm and healing taking into account the viewpoint of the individual accessing the healing process only. Accordingly it would not be fair for the IRP to make a determination of fault in circumstances where it has not heard opposing points of view. As such, while the IRP can make recommendations based on its understanding of the participant's personal experiences, it is beyond the IRP's scope to find, for example, that another individual or NHSH itself is to blame. The IRP's recommendations on Organisational Learning must be read and understood in this context.

1. The Need for Demonstrable Action – Our First Recommendation

The members of the IRP recognise that actions relating to some of the learning may already be in place as a result of the Sturrock Report or other subsequent analysis. However, being independent of NHSH the IRP is not aware of existing actions or initiatives already in place and would wish reassurance that the issues the IRP highlights through this process result in appropriate action or that they are already being addressed.

The Guidance makes it clear that responsibility for action on Organisational Learning is with NHSH and that NHSH is required to maintain a record of all IRP recommendations for Organisational Learning and provide a public quarterly status report in the 24 months after the Healing Process closes on actions taken in response to such recommendations.

The IRP believes it would be in accordance with the Healing Principles for NHSH to develop an action plan to address the IRP's recommendations on Organisational Learning, and that our recommendations and associated action plan are reported to the NHS Board at all of its meetings going forward and shared openly with all staff within NHSH along with an honest account and appraisal of progress, challenges and areas of difficulty.

This report sets out areas for organisational learning and associated recommendations for action. These are set under the headings of Organisational Culture and Behaviour and Systems and Processes. Under each heading there are areas for improvement, and under each area for improvement a recommendation based on the experience and knowledge of the IRP.

At the outset, the members of the IRP need to record that we have heard testimony that bullying behaviour is still evident within NHS Highland particularly on the part of longer serving managerial/supervisory staff whose careers had progressed under the former leadership of the organisation.

We recognise that there will be many legacy issues and that culture change takes time. However, we would encourage the new senior leadership of NHSH to take action in relation to this through demonstrating the expected values and behaviours they wish to see in the organisation, which will improve patient care and safety and, just as importantly, staff safety and wellbeing, while working within the context of challenging targets and finite staffing and financial resources.

It will also be important that a series of metrics are put in place to monitor progress. NHSH may already have adopted such metrics. We are aware that many NHS organisations have developed "a balanced scorecard", which report on patient and

service outcomes; organisational learning and growth, including HR metrics, such as numbers of grievances, disciplinary cases, absence levels, occupational health referrals, and the I-matter engagement score; financial performance; and internal business processes such as complaints, Freedom of Information requests, and Data Access requests.

Our first recommendation therefore is:

- **An action plan be developed to capture the organisational learning identified through the IRP process, and that progress be monitored by the NHSH Board through regular reports and metrics, which can be tracked to monitor improvement, and capture the desired change in culture. (Recommendation 1)**

2. Organisational Culture and Behaviour

2.1 General

Testimonies have referred to an organisational culture in NHS Highland which was centralist and dictatorial with little delegated decision making. This left senior clinical leaders and their managers feeling disenfranchised and disempowered. A number of early testimonies came from the acute sector. Raigmore Hospital appears to have been managed on a hospital wide basis with little delegated authority to divisions/directorates or departments. This centralist approach meant that accountability for decision making was unclear and confused. It was apparent to the panel that the pressure to achieve targets, patient waiting times, service improvement and financial targets led to a culture focused on outcomes and not on what is seen as often the "softer" organisational behaviours required to deliver effective patient care and support staff deliver their best and which research proves is the critical factor to achieving positive outcomes in these areas.

If the organisation follows the principles laid out in the work of Prof. James Reason and The Hon Sir Charles Haddon-Cave[1], it will be able to commit to engendering a generative and participatory safety culture, in what is said, what is done and more importantly what is believed. Such a culture needs to have four primary elements – The Just Culture – referred to later in this report, the Reporting Culture, the Flexible Culture and the Learning Culture, which should include a fifth element the Questioning Culture, being the defence against assumptions and the mechanism for delivering rigour in the organisation's change to both patient and staff safety.

These five elements when combined form a proactive, safety-conscious, informed and engaged organisation.

The centralist culture often manifested itself in inappropriate behaviour. This inappropriate behaviour was exhibited at the level of the senior leadership of the organisation but was then replicated at other levels. Poor behaviour was tolerated. As a result, individual members of staff often felt isolated and exposed. Members of staff who felt under considerable pressure, bullied others to achieve results and ultimately this resulted in serious harm to the wellbeing of colleagues. We heard of examples of inappropriate language in meetings and other interactions. This even on occasion included the non-executive directors of NHSH Board.

There was a fear of raising complaints – doing so was perceived to be career limiting.

[1] Professor James Reason: Managing the Risks of Organisational Accidents, 1997 & The Hon Sir Charles Haddon-Cave: The Nimrod Review (28th October 2009)

This extremely poor organisational culture was extensively covered in the Sturrock Report, but the members of the IRP have heard very detailed personal accounts of the impact this had on people, and we would strongly encourage a culture change programme to address this, based on widely accepted, and owned values and behaviours.

Therefore, the panel recommends that:

- **An ongoing cultural improvement development programme should be put in place for all clinical leaders and managers, including members of NHSH Board. (Recommendation 2)**
- **Individual performance development plans based on agreed actions for individuals should be put in place and performance improvement monitored through effective performance appraisal with the organisation's Values being a key part of the monitoring of the metrics. (Recommendation 3)**

2.2 Leadership

Staff at various levels of leadership in the organisation were perceived to be supportive of the organisation's poor culture, compliant and unwilling to challenge. The panel has now heard many instances where leaders were reactionary and not dealing with difficult relationship issues. We appreciate that we are meeting a self-selecting group of staff but individuals have been significantly harmed by those in managerial/supervisory positions. Often cited responses to difficult issues being raised included "denial", "anger", and "lack of acceptance".

One approach highlighted to us is that of a "just culture", if this could be developed this would mean that if mistakes occur the focus is not on blame. If a "just culture" were to be adopted, individuals would feel more able to report mistakes and the organisation would learn. Several individuals have reported that when incidents happen, investigations were held which were protracted, processes were not followed and outcomes were unclear. Most individuals speaking to us, had felt unsupported within NHSH when raising concerns.

The development of a "just culture", would mean that the use of HR processes such as discipline would be minimised. Genuine mistakes or errors arising from pressure at work, too few staff, and lack of training or competence would be treated as an opportunity for learning. This would encourage concerns to be raised without fear of retribution and be seen as a positive opportunity for staff to learn and improve.

The panel therefore recommends:

- **That the concept of a "just culture" be explored and any learning from this be incorporated into the cultural improvement development programme. Progress should be evidenced through a visible decrease in referrals to HR processes. (Recommendation 4)**

2.3 Equality and Diversity

Despite its geography NHS Highland serves a relatively small population, which is dispersed through a large number of distinct communities. In such areas, relationships extend well beyond the workplace. We heard that this can lead to a series of issues. Resentment of "outsiders" on occasion, less tolerance of diversity, e.g. homophobia or "nepotism" in recruitment practices. We heard one example of a parent being the senior manager of their child.

While the challenge of recognising equality and diversity is a wider societal issue, the responses by NHSH to these issues may require to be more bespoke, given the nature of small communities. The culture within NHSH, as with other NHS organisations needs to be one which promotes equality and diversity.

The IRP therefore recommends:

- **Recruitment processes should be thorough in ensuring that the best candidate is selected, avoiding – and being seen to avoid - any bias, and that those selected have personal values that match those of the organisation. Transparency is key. NHS Scotland has developed a value-based recruitment process which should be adopted for all posts. (Recommendation 5)**
- **Once new starts are in place, induction processes should include training on equality and diversity. (Recommendation 6).**
- **(Recommendation 7) The adoption of seven key principles, which have been proven in having effectiveness in this area:**
  - **Acknowledge the challenge – avoid the temptation to "ascribe more weight to positive information about the service than to information capable of implying cause for concern" (Francis 2013[2]);**
  - **See workforce equality as integral to service improvement not just compliance – as an integral part of providing better services and improving staff well-being, not as a separate discrete task;**

[2] Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, Chaired by Robert Francis QC

- **Insist on detailed scrutiny of data from Employee Staff Records and national staff survey data to identify the specific challenges that Health Boards as a whole, or individual departments or services or occupations may have. Accept that while data can identify patterns and hotspots of good and poor practice – root cause analysis may well be needed to understand it;**
- **Ensure that the narrative underpinning strategy is specific to each organisation and work to ensure it is understood not just by Boards but by managers and front line staff;**
- **Learn from previous failed approaches. A system which relied on individual members of staff raising concerns, complaints or grievances was not a strategy that was ever going to be effective. Leadership means organisations must take prime responsibility, for example, for talent management and career development and be proactive in developing staff and challenging discrimination, in a radical break with the culture of allowing panels to appoint "people like us" or those who might "best fit in";**
- **Specific interventions must be evidence driven and able to answer the question "why do you think this will work?" since unless that question can be answered replication is hit and miss;**
- **Above all, accept that accountability is crucial. Unless leaders model the behaviours expected of others and face uncomfortable truths, and insist on evidenced interventions with locally developed targets, the best intentions will not bring about change.**

2.4 Command and Control

References have been made to the Highland Quality Approach which NHS Highland had adopted. However, unintended consequences of a quality management approach is that quality control can become the focus, and we heard testimony that managers were focussed on a command and control approach. This became the way of working for many, and kindness and compassion to individuals were lost when difficulties occurred or mistakes happened. There was a reluctance to report "bad news", to the extent that NHSH Board was not able to identify where things were going wrong and improvement was required. We heard that difficult issues were discussed in private "Board Development" sessions. We heard that hierarchical power was used to ensure delivery. Senior staff told us that edicts and targets from Scottish Government led to senior and middle managers behaving in ways that reflected a top down target driven approach. While targets and outcomes are important, we believe they need to be delivered in a way that engages staff.

It is recognised in research that managers will default to a command and control style of leadership because it gives them a sense of power and a belief that if staff are left to their own devices they will do something that will reflect badly on the organisation. In these circumstances fearful managers tell staff what to do, and how to do their jobs and by codifying policies and rules for every conceivable situation they believe problems will be prevented. From what individuals have told us, this seems to have been the culture within NHSH. A culture of fear of job security was created. Managers mistreated those they managed, failed to recognise their contributions, and delivered undue criticism. There was a lack of transparency and information sharing. Information was seen as power.

The panel therefore recommends that:

- **The culture going forward should be one based on engaging and empowering, and valuing contribution through effective appraisal and feedback. This can be monitored through the NHS Scotland i-matter engagement process which all Boards are required to use and report on. (Recommendation 8)**

If NHSH Board does make the decision to bring in the five cultural elements outlined in section two it will need to consider implementing an effective programme of analysis, resolution and reporting that is able to join up these different elements to provide real critical analysis and intelligence to its decision making.

2.5 The HR Function

The HR function was the subject of significant criticism, in that it appeared to have become a function which used its processes to support the culture and management practices as set out above rather than ensuring equity and fairness by applying more professional HR practice to improve the effective management of staff and support an improved organisational culture. We heard that serious issues were not dealt with timeously or effectively and that the established HR policies tended to be used to reinforce the bullying culture. A review of the adequacy and deployment of HR resources together with skills development programme would improve the HR service and no doubt increase the confidence of HR staff to challenge poor management practice. It would also assist the individuals within the HR function to have more fulfilling roles, and be a more credible support to managers and staff.

The department needs to shift its emphasis and focus to support the change in culture needed to do things in the "Human Way" which has a life-changing impact on people, which in turn benefits every part of the organisation.

This means that it has to adopt the mantra that "People Matter Most". It means they see the person first and the job role second. It means that it realises that the challenges facing the organisation in this case will not be solved by the staff handbook and its existing policies. These problems are only solved by deeply listening to, connecting to and inspiring people. Skills that have been forgotten, lost or not been available in NHSH.

Training and facilitation will be needed, probably using external expertise so the HR team knows how to challenge the bureaucracy that does nothing but sap the human spirit. It means moving away from outdated HR process driven models which currently are about nothing more than compliance and control. Courage needs fostering to have honest conversations to help people develop better self-awareness and responsibility for performance. Currently people are hiding behind the veil of confidentiality where it is not always applicable.

The HR team needs help and support to embrace and develop a new mindset. It means the willingness to use new language to shape a new culture. It means the Leadership team have to take the leap of faith and start to trust the staff and the staff to put trust in their leaders. The organisation must never treat people as mere resources.

The panel therefore recommends that:

- **The HR function should be subject to a wide-ranging review to ensure that there are sufficient staffing resources within the HR function and that these resources are effectively deployed and members of staff in the HR function understand their roles in supporting changes to organisational culture. (Recommendation 9)**

3. Systems and Processes

3.1 HR Systems and Processes

Given the way in which the culture had developed, we heard that the HR systems and processes were being used to reinforce the established organisational culture rather than provide a check or balance or challenge to inappropriate behaviour. Human Resources Policies were not implemented appropriately, there was a lack of action when grievances or issues around inappropriate behaviour were raised. Where investigations were initiated they took inordinate amounts of time. The brief for the investigation was not always shared with staff being subject to them. Outcomes of investigations in some instances were not communicated with all parties (e.g. those involved in a Dignity at Work complaint or grievance). Staff who were being investigated for potential disciplinary action could be suspended from duty for significant amounts of time. Procedures and processes were not progressed effectively or efficiently. While line managers have the direct responsibility for the management of their staff it is critical that practice is monitored and HR provides appropriate support to managers and staff. HR processes need to be performance managed in relation to timelines and ensure appropriate outcomes. HR staff need to work closely with Trade Unions or individuals involved in the process to ensure that any unnecessary delays are avoided. In other organisations a case management system is followed and monitored and this can help avoid unnecessary delay.

In order to regain trust in HR processes a suggestion put forward by a number of participants was to have an independent element in dealing with complaints and grievances and we feel this requires to be seriously considered.

Current NHS Scotland HR policies based on the PIN Policies lead almost immediately to an adversarial approach to Dignity at Work complaints and grievances. Some organisations we are aware of have moved away from grievance policies to resolution policies in which all parties commit to a resolution process, and acceptance of outcomes. NHS Wales is adopting a Healthy Working Relationships approach, which includes a new "Respect and Resolution" HR policy. These policies tend to be based on effective mediation.

Many of the individuals who spoke with us who experienced bullying have participated in "Facilitated Discussions" or Mediation. Unfortunately, in most instances this has added to harm rather than assisted in dealing with issues where relationships have broken down. A favoured outcome seems to be redeployment of the individual who has requested an intervention, and the person viewed as the perpetrator of the harm remains largely unaffected.

Most of the facilitated discussions, or mediation appears to have been carried out by members of the HR Department. It is not clear what level of training individuals have had in such interventions. More significantly it was not clear what level of authority they had in ensuring that any outcomes agreed were followed through effectively and implemented. Use of root cause analysis might also provide a method to assess the real cause of difficulties.

The panel therefore recommends:

- **A HR case management system is adopted so that all HR processes can be monitored and performance managed. Regular reports on the application of HR policies should be provided to the Staff Governance Committee and Area Partnership Forum. (Recommendation 10)**
- **Serious consideration is given to external independent involvement in Dignity at Work complaints as the default response. (Recommendation 11)**
- **A change from grievance to a resolution based approach, adopted through the HR Policies. (Recommendation 12)**
- **Where mediation is thought to assist, it should be formally entered into by both parties, and be facilitated by a trained neutral mediator, and seek to deal with the relationship difficulties rather than take what might be viewed as the easier option of removing the complainant. (Recommendation 13)**

3.2 Financial Processes

We heard testimony that financial processes were unclear. Budgets do not appear to have been sufficiently devolved to allow leaders and managers to make decisions affecting their services. It is recognised that NHSH was under very significant financial pressure and this appears to have resulted in financial decision-making being taken at Executive team level with, for example, parts of budgets being removed to effect cost savings with little or no engagement of individuals with leadership roles responsible for these budgets. This led to lack of trust in financial decision making and a lack of clarity over the basis for these decisions. Posts disappeared from staffing establishments with little explanation. This contributed to the poor organisational culture. In an environment where permanent savings are a mechanism of cost control, it is important that leaders and managers are involved in financial planning and decision making. Staff at all levels need to be able to at least be aware of the priorities and objectives of NHSH, and if possible to contribute. Many will no doubt disagree

with the decisions being taken but at least there will be greater understanding and awareness, and confidence can be restored in the financial decision making process.

The panel therefore recommends that:

- **The budget allocation process should be reviewed with clarity of budget holder's responsibility and delegated authority within the overall financial plan and financial governance arrangements. (Recommendation 14)**

3.3 NHSH Board

The panel heard that some clinical leaders had little or no interaction with NHSH Board. There was also a suggestion that information relating to clinical services may have been withheld from NHSH Board. It would seem important that members of NHSH Board or its Sub Committees, particularly the Clinical Governance Committee, should be aware of the range and nature of clinical services and issues they may be facing.

The IRP therefore recommends that:

- **NHSH Board, in addition to regular Board meetings, should receive regular briefings where Board members can receive information from those directly providing front line services. (Recommendation 15)**

3.4 Reviews of Services

We heard that reviews of clinical services were undertaken quite regularly to improve performance and/or achieve improved efficiency. The impression given was that these reviews were not carried out in a way which ensured effective engagement of those within the services affected by the reviews. Where these reviews resulted in organisational change, it was unclear if the processes put in place to support were widely understood. We also heard that reviews on occasion were undertaken by close colleagues of those initiating the service review, which compromised objectivity.

The panel recommends:

- **A protocol for service reviews be agreed, and, where they are necessary, they should have a clear remit, engage all stakeholders and be led by an independent expert in the service being reviewed. (Recommendation 16)**

3.5 Accommodation

This may seem unimportant, but we heard that when estate was rationalised, staff were redeployed into inappropriate accommodation. We heard of one clinical service being moved into accommodation which made it impossible to see patients in their

base and unable to provide services effectively. The staff themselves were able to avail themselves of more suitable accommodation.

The panel recommends that:

- **When estate is being rationalised a full appraisal of the needs of the service should be undertaken before a move into alternative accommodation is made. (Recommendation 17)**

3.6 Trades Unions

We heard various reports of trade union representatives being very helpful and supportive. However, we have also heard of situations where trade union representatives were less than supportive.

The role of the Employee Director was mentioned on several occasions. This is not a criticism of the individuals who held this role, but it would appear that their role as Chair of the Staff Side and a board member was compromised by them continuing to take on cases of individual representation. There should be clarity over the role of the Employee Director, who in the IRP's view should not be involved in representing individuals.

The IRP therefore recommends:

- **Training in dealing with bullying and harassment should be made available to all accredited Trades Union representatives (Recommendation 18)**
- **The role of the Employee Director should be clarified to ensure effective leadership of the staff side, and effective representation at Board level. (Recommendation 19)**

3.7 Occupational Health

The majority of cases we have heard so far have involved referrals to Occupational Health, sometimes on numerous occasions. We are left with an impression that a referral to Occupational Health was being used in a way which allowed managers and HR staff to rely on occupational health assessments to avoid dealing with the root causes of an issue, but even then in many instances occupational health recommendations were ignored especially when they involved workplace adjustments or adjustments to working locations or patterns. NHSH Board was at risk, on occasion, of being in breach of disability discrimination provisions of the Equality Act.

Ill health, and in particular mental ill health, diagnoses were used to initiate capability processes. This had a further detrimental effect on individuals and added to harm to

individuals. The IRP acknowledges that in some circumstances this management intervention will be necessary unfortunately.

The extensive use of the Occupational Health service itself must have put it and its leadership under considerable pressure. The service, had it been able to contribute effectively at a senior leadership level, would have been able to highlight the bullying culture within the organisation and influence the organisational culture, and in particular, call-out the way in which HR processes were being used inappropriately and in support of the bullying culture.

It was reported to us that poor mental health was seen as a weakness in the organisation and that individuals were perceived as being weak as a result of stress, anxiety or other mental health conditions, and that a mental health diagnosis of individuals was used to support the failure to deal effectively with bullying behaviour.

The panel recommends that:

- **The role of Occupational Health in supporting the organisational culture should be explicit, and the Occupational Health Lead should report to a Director and provide regular reports to the NHS Board. (Recommendation 20)**
- **Training for managers on recognising the signs of mental health issues and on appropriate interventions should be provided. (Recommendation 21)**

If the Board does bring in and implement an effective reporting, resolution and analysis reporting programme that is able to join up the different elements to provide real critical analysis and intelligence to its decision making, then Occupational Health could use intelligence gathered from this to work with HR on the appropriate well-being programmes that are needed. These would be focused, as the intelligence that can be gathered from such technology based systems now available provides an accurate diagnosis of the issues and avoids organisations' responses being reactive to what they think is the diagnosis rather than what is the actual and real diagnosis and condition.

3.8 Use of Suspension from Duty

We heard several instances where suspension from duty was used to remove someone from the workplace where a complaint had been raised. In one extreme case an individual was suspended for a period of 3 years. Suspension should clearly be carefully considered.

The panel recommends:

- **There should be a clear procedure relating to decisions to suspend staff with the circumstances being carefully considered. Suspensions should be regularly reviewed and reported to the Board. This would be supported by the HR case management system referred to in recommendation 10. (Recommendation 22)**

4. Conclusion

The members of the IRP commend this, the IRP's first, Organisational Learning Report to NHSH. Further reports will be provided. We have now a number of testimonies which could support Organisational Learning as case studies.

We are conscious that this report is of its nature critical, but it is the intention that this is used positively to improve NHSH as an organisation to the benefit of all its staff and patients.

Building trust will be critical and some real thought and consideration needs to be given about how to do that effectively. To define trust, the organisation will need to go beyond the usual practical kinds of considerations. A deeper version involves more of an emotional response. This includes feelings for employees such as knowing that leaders are on "their side," they will be treated fairly and with respect and setbacks will be viewed favourably or at least not with particularly negative consequences.

We believe that in order to change the culture of NHSH and instil positive behaviours, these recommendations are a crucial part of ensuring that the learning from the Healing Process participants will be a force for positive change and demonstrate that their experiences have been genuinely listened to.

November 2020

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NHS Highland Healing Process

Independent Review Panel Report on Organisational Learning

Report Two: March 2021

Background

The Healing Process Independent Review Panel (IRP) presented its first organisational learning report to the Chief Executive of NHS Highland (NHSH) in November, 2020. This identified a series of themes which the IRP considered it was necessary for NHS Highland to take action to address if it was not already doing so. This followed 26 individual meetings the panel had with registrants to the healing process. Our first report had 22 recommendations.

This report is based on a further 58 meetings with individual registrants in the period from 1st October, 2020 to 31st January, 2021.

The members of the IRP have had time to reflect on the way in which organisational learning might be used to best effect. Given that the recommendations do not relate to individual cases but are based on the themes emerging through many testimonies, the IRP is particularly conscious that presenting NHSH with another set of recommendations which would require action may have the effect of dissipating their impact.

This report focuses on four key recommendations which require to be addressed comprehensively by the organisation to effect organisational change.

1. Cultural Development Programme
2. Leadership and Management Capability
3. Governance
4. Management Oversight of Clinical Services in Remote and Rural Settings.

We appreciate that there will be governance and reporting structures in place to monitor activity in response to the Sturrock Report recommendations and our work as the IRP. It would be helpful for members of the IRP to be advised of these so that we can reassure participants in the Healing Process, that recommendations from the Sturrock Report and our reports are being implemented.

The IRP has a responsibility on behalf of those who have taken the time, and courage, to re-live their experiences with us, to ensure that the actions NHSH is taking in

relation to our organisational learning reports are visible not only to the NHS Board and its governance committees but also to staff, patients and the wider population. The members of the IRP recognise that this will of necessity have to be done in a way that maintains the independence of the IRP but builds on the co-production principle which underpinned the healing process.

Like our first Report, this Report is produced in accordance with the Healing Principles defined in the Guidance. The IRP is not a judge and jury of the facts. The IRP deals with harm and healing taking into account the viewpoint of the individual accessing the healing process only. Accordingly it would not be fair for the IRP to make a determination of fault in circumstances where it has not heard opposing points of view. As such, while the IRP can make recommendations based on its understanding of the participant's personal experiences, it is beyond the IRP's scope to find, for example, that another individual or NHSH itself is to blame. The IRP's recommendations on Organisational Learning must be read and understood in this context.

1. Cultural Development Programme (Report2: Recommendation 1)

Our first Organisational Learning Report recommended that a cultural development programme should be put in place for all clinical leaders, managers and members of the NHS Board (Report 1, Recommendation 2).

We cannot understate the impact the culture within NHSH (often described to us as toxic) has had on individuals, many of whom have been left with post-traumatic stress disorder, severe anxiety disorders, depressive illness, and in some cases suicidal ideation. The IRP has taken time to review the outcomes of previous high-profile inquiries into failures in care and staff safety in the NHS, in addition to the Sturrock Report, to ensure our recommendations build on the best evidence for effective change. If NHSH were to implement fully the findings of Sturrock and take account of previous NHS inquiries, this would address many of the organisational learning issues leading to harm raised by those who have been affected by the culture in NHSH.

Our first report referred to the work of Prof. James Reason and The Hon. Sir Charles Haddon-Cave, and the need for the organisation to commit to engendering a generative and participatory safety culture with five primary elements:

- the Just Culture,
- the Reporting Culture,
- the Flexible Culture,
- the Learning Culture, and the
- Questioning Culture.

A combination of these five elements combine to form a proactive, safety conscious, informed and engaged organisation, which is what NHSH requires to move to.

This mirrors the Francis Review, *Freedom to Speak Up*, which set out 6 principles for a healthy organisational culture:

- *A culture of safety* – where all staff feel safe to raise concerns and the culture shifts from focusing on blame to focusing on addressing the issue and learning from it.
- *A culture of raising concerns* – where speaking up should be something that everybody does and is encouraged to do. There needs to be a shared belief particularly by supervisors, line managers and HR staff that staff raising concerns is a positive rather than troublesome activity and that concerns are treated seriously and are dealt with appropriately. HR processes need to be

responsive and supportive to those raising concerns not punitive and obfuscating.

- *A culture free of bullying behaviour* – this will require to be worked toward systematically by calling out and dealing with inappropriate behaviours. There should be root cause analysis of bullying behaviours in the same way there is of adverse incidents to enable their causes to be addressed. In addition, there is a requirement for honest and direct feedback to individuals about the impact of their behaviour and, if inappropriate behaviour continues, it is dealt with through disciplinary action. Too often the IRP heard cases where the complainant was moved rather than the bully; occupational health was used inappropriately to deal with the impact of bullying and their advice was often ignored; and HR processes (capability and redeployment) were used to attempt to remove the complainant from their post or indeed the organisation rather than deal with the behaviours.

- *A culture of visible leadership* - there needs to be visible leadership at all levels of the organisation starting with the Chief Executive and Board members. Clinical and managerial leaders need to demonstrate that they encourage and welcome the raising of concerns. Board members need to be accessible and demonstrate through their actions the importance they place on engaging with staff at all levels.

- *A culture of valuing staff* – giving public recognition of jobs well done, encouraging staff to highlight concerns and take actions as a result of these to improve patient care and services. The benefits to patients and the public from the improvements made in response to the issues identified should be celebrated.

- *A culture of reflective practice* – there should be opportunities for all staff to engage in regular reflection of concerns in their workplace. This should be reinforced with teams given the time and space to reflect, where issues are explored, systems are analysed to resolve problems and successes shared.

This change in culture and behaviour the IRP wishes to see take effect will require active and consistent staff engagement.

The panel recommends:

- **that the recommendations in the Sturrock Report and the IRP's Organisational Learning Reports are implemented in full and that by**

regular feedback to the IRP, the Whistleblowing Group, NHSH employees, and the wider public, NHSH show that this is the case and that the actions being taken are being translated into culture change that is seen by staff as positive and that the Culture Programme is being shaped by the voices of affected staff (Report 2: Recommendation 1)

2. Leadership and Management Capability (Report 2: Recommendation 2)

In his report, John Sturrock referred to the role of managers and leaders at all levels on re-setting the culture. The IRP heard testimony that individuals who were part of the bullying culture remain in post or in some instances have been promoted. As part of the organisational culture change it will be necessary to address some deficiencies in the capability of existing managers and leaders, both in general managers and clinical leaders.

Inquiries such as the review of the Bristol Paediatric Surgery service carried out by Professor Ian Kennedy in 2001, highlighted poor teamwork, and a lack of effective leadership…staff were not encouraged to share their problems or to speak openly.

A systematic review of existing capability of all managers and clinical leaders is required with a view to putting in place effective personal development plans, supported by relevant training, for all managers and leaders.

Following on from this, a leadership development programme is necessary in order for the organisation to thrive and grow and plan for any gaps that are identified in the aforementioned review.

This will require sufficient resources to be made available for such a review (to cater for the impact of the additional work, on top of existing priorities). There is also a need to ensure there will be the provision of effective and transparent feedback to the managers and clinical leaders involved. This needs to be done in the right way or those subjected to the review will feel bullied by it and it will have negative consequences rather than positive ones.

This should include the development of clear HR processes to ensure effective recruitment and promotion, with appropriate induction and training to support those recruited or promoted to leadership positions. Such individuals should then be supported through effective annual review and appraisal.

We heard some references to the continued existence of collegiate leadership in clinical leadership. Most NHS organisations have moved away from this adopting the NHS Scotland standard of values-based recruitment to leadership positions. This may already be underway in NHSH but needs to apply throughout the organisation. This will take time and resource.

There is the need to rebuild confidence in managers within NHSH. Managers and leaders need primarily, in addition to other skills, to be effective people managers, handling effectively diversity and difference in a workforce motivated by varying factors which influence their working and living in the NHS Highland area. They need to be able to handle concerns effectively and be able to give appropriate feedback and

take ownership of managing and engaging with their teams and staff without a default reference to the hierarchy within NHSH, or HR or Occupational Health.

The panel recommends:

- **a systematic review of existing capability of all managers and clinical leaders be undertaken with a view to putting in place effective personal development plans, supported by relevant training, for all managers and leaders (Report 2: Recommendation 2(a))**

The panel recommends:

- **that a leadership development programme to address the following areas in order for the organisation to thrive and grow and also plan for any gaps that are identified:**

  - **Cognitive and critical thinking needed to reason, plan, adapt and learn**
  - **The leadership DNA in terms of how that is reflected in the way individuals think, act and feel**
  - **The unique knowledge, skills and abilities required to excel in the leadership of people and teams**
  - **The capacity and willingness to continually learn from experience. Achieving growth through proactive use of feedback and self-reflection.**
  - **The ability to innovate and be a positive force for change and progress.**
  - **Confidence building. (Report 2: Recommendation 2(b))**

The panel recommends:

- **that the NHS Scotland standard of values based recruitment to leadership positions is fully adopted/implemented. (Report 2: Recommendation 2(c))**

3. Governance (Report 2: Recommendation 3)

NHSH will have governance systems in place covering the three pillars of clinical, staff and corporate governance. However, deficiencies in clinical and information governance processes were highlighted to the IRP. These include inappropriate accessing of clinical data of patients and staff members (particularly prevalent in small rural and island communities); lack of effective appraisal and personal development planning; a lack of systematic clinical involvement in service reviews and development; some deficiencies in the management of the Consultant Discretionary Points process; lack of systematic professional support and supervision; no systematic approach to the review and learning from significant adverse incidents; lack of clarity on patient safety reporting.

The IRP also heard of instances where patient safety concerns being raised by staff members resulted in HR processes being instigated to manage the staff member. This is inappropriate and sends a clear message to staff that patient safety is not a priority or taken seriously by NHSH. It is not always clear that there is systematic review of serious adverse events using root cause analysis.

The panel recommends:

- **The Clinical Governance Committee reviews the governance and reporting of information governance incidents, patient safety reporting and the reporting and monitoring of adverse events with benchmarking against other health boards in Scotland. (Report 2: Recommendation 3)**

4. Management Oversight of Clinical Services in Remote and Rural Settings (Report 2: Recommendation 4)

A theme has come through in relation to the management of services and staff in remote and rural communities. The IRP heard that leadership of services in these areas tends to be "remote" and lacks visibility. Difficult issues are not dealt with effectively or timeously. Professional staff are left without adequate supervision and a feeling that they are not engaged or taken seriously when issues are raised. We heard particularly concerning issues regarding *rural general hospital*, and primary care services on *two islands* and in North Highland. Raigmore was described by one participant as being an "island" within the mainland. It is not evident that NHSH has sufficient oversight of the governance of clinical services in the Argyll & Bute Integration Joint Board (IJB). The IJB is not a legal entity and NHSH still has governance responsibilities for the services delivered by the IJB.

Whilst we understand that the geography of NHSH is such that it is remote compared to other NHS mainland Boards, we believe oversight of services in remote and rural communities should be more visible and reported to the NHSH Board as well as the Argyll & Bute Integration Joint Board.

The IRP was also made aware that staff who are not from the area often locate in the NHSH area for lifestyle choices. Panel members heard that integrating into the NHS in such settings is not always easy. In these circumstances it will be necessary to tailor recruitment, induction, and ongoing support to reflect this. Whilst the "Once for Scotland" approach to many issues adopted by Scottish Government and NHS Scotland should be followed, there may be instances where we would encourage NHSH to ensure a more bespoke approach is taken to address the particular circumstances and issues faced in the remote and rural communities served by NHSH.

The fact that staff work and live in small communities' presents unique challenges in managing relationships in the workplaces. Nepotism and favouritism in recruitment and promotion have been referred to. The members of the IRP have been particularly struck by the way in which if relationships deteriorate in the workplace this spills over into everyday life, with individuals reluctant to leave their homes for fear of meeting others or being subject to reprisals. A lack of openness and transparency with the community when things go wrong adds to this feeling.

The panel therefore recommends that:

- **An assessment of the resources required to provide visible and meaningful leadership for services in remote areas should be**

undertaken, and changes made to existing management and leadership arrangements. This will also require an analysis of the support required for staff working in small communities to be undertaken and additional support put in place, including appropriate professional supervision where this is lacking (Report 2: Recommendation 4)

5. Conclusion

The IRP has now seen over 90 individuals who have accessed the Healing Process. The themes we reported in our first report are still being brought to us by staff members and the issues raised are not only historical but being experienced up to 2020. Worryingly, many individuals do not see that any positive changes have been made during 2020, which the IRP appreciates is a time-period beyond our remit.

The IRP urges the NHSH Board to focus on our recommendations and ensure that positive developments are reported through staff governance routes to all staff members and that leadership is active and visible to ensure staff feel engaged and that their contributions are valued and they are encouraged to confidently speak up and raise concerns without fear of reprisal or bullying.

Importantly, there should be full participation and direct involvement of trades unions' and professional bodies' representatives and the Area Partnership Forum as well as local partnership fora in taking forward the recommendations in the IRP reports.

Enabling staff to be part of the solutions to the culture and behaviour that has been endemic across NHSH would make a huge difference to staff confidence that measurable change can be achieved and sustained for the future.

March 2021

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Appendix 3

Consolidation of Lessons Learned and findings of the Independent Review Panel

1. The purpose of this document is to consolidate lessons and learnings from both the first two reports of the Independent Review Panel (IRP) and the root-cause diagnostic sessions that have been carried out as part of the Culture Programme.

2. The Independent Review Panel is one of the options available in the NHS Highland Healing Process, to support those who experienced bullying whilst working for NHS HIghland in the past. In listening to and understanding the experience and circumstances from the applicant's perspective, it is tasked with finding the resolution that is most likely to aid healing for the individual and organisation. The IRP deals with "harm" and "healing" taking into account the view point of the individual accessing the Healing Process only. It does not deal directly with "fault" and "loss". The IRP makes recommendations based on its understanding of the applicant's personal story only.

3. The Independent Review Panel has heard testimony from a number[1] of former and current members of staff who have suffered harm, and the evidence gathered has been consolidated into a set of themes and recommendations. Root cause diagnostic sessions[2] have been held in both North Highland and Argyll and Bute, focused on identifying the systemic failures which led to the requirement for the Sturrock review; and the lessons to be learned from these failures. The numbers of current or former staff involved in the IRP or the root-cause sessions therefore total 105, with the focus being on the events and issues across a substantial time period up until the end of 2019.

4. Whilst the findings and recommendations from these two sources are not identical, there is sufficient synergy for them to be consolidated into an integrated set of analysis and actions. There are, however, a set of specific findings for Argyll and Bute which were identified during the root-cause sessions held with primarily colleagues from Argyll and Bute. The first two reports from the Independent Review Panel are included in Appendix 1 and 2; and an assessment of progress made against each of the recommendations in Appendix 4 to this document.

5. It is clear from these sources, and the significant evidence gathered by Sturrock, that the cultural issues in NHS Highland developed and became embedded over a period of years, with a number of opportunities to address the issues missed or ignored. Changes in leadership from 2004 – 2010 were identified in the root

[1] The first two IRP reports which have informed development of this document includes testimony from 84 individuals, around 55% former employees and 45% current employees..

[2] 21 current and former colleagues from across North Highland and Argyll and Bute participated in the root cause diagnostic sessions

cause sessions as the catalyst for deteriorating behaviours across the organisation, with a sense of a different way of working becoming the 'norm'. A number of red flags were raised in the following years: the Area Clinical Forum (ACF) response to the Francis Report in 2013 identified issues of bullying; the 2015 Polley Review recommended strengthening the NHS Highland Board Governance, a Board diagnostic review in Jan 2017 highlighted dissonance between CEO and Board and the Executive team and the NEDs, which led to the resignation of three NEDs in 2016/2017, followed by challenge from the Chair of ACF around handling of concerns raised by radiology clinicians. The 2018 Brown and Walsh Report identified further cultural issues and the GP Sub-Committee, Area Medical Committee and ACF presented allegations of bullying again in 2018. The Gallanders report was commissioned by NHS Highland in 2018, identifying issues across the organisation, but it wasn't until the subsequent Whistle-blowing that the Sturrock review was commissioned by the Scottish Government.

6. Argyll and Bute (A&B) colleagues identified that it was the merger with NHS Highland in 2006 that signalled a change in the A&B culture. It has been noted by prior reports, including Sturrock, that the integration was poorly executed, and the impact of this remains to this day.

7. The findings from the root-cause analysis and the IRP have been categorised into the following themes, and each are explored in turn:

    a) Governance and Decision-Making
    b) Organisation and Behaviours
    c) Systems and Processes

There is no one factor that caused the cultural and behavioural issues faced by NHS Highland. Large organisations are complex systems, with people, processes, roles, structures, rewards and information reinforcing or enabling a certain 'way of doing things'. That is why the scope of the Culture programme must be broad; with interventions to address all of these aspects.

A) Governance and Decision-Making

8. The failure of organisational governance is possibly the most significant root cause, with those overseeing NHS Highland unable or unwilling to address the cultural issues that had been raised. An imbalanced Executive / Non-Executive relationship was cited, with the NEDs unable to effectively hold the Executives to account, compounded by a perceived failure of the Scottish Government to address the known issue of Board effectiveness. The Committees of the Board were also hindered in executing their duties as reports and information were 'diluted' as they progressed through the many layers of governance with a general reluctance (or fear) to report bad news.

9. A lack of organisational strategy, and a clear plan for decision-making throughout this period led to a focus on tactical, rather than strategic activity. An increasing sense of pressure to achieve financial and clinical targets was cascaded from Government, to the Executives, down to managers and staff at

all levels of the organisation. A lack of engagement from those impacted by key decisions was identified, leading to less robust decision-making and reduced support across the organisation for the direction of travel. A “centralist” and “dictatorial” decision-making culture was cited, leading to disenfranchisement and disempowerment.

10. This sense of disempowerment was still evident in the groups engaged in the workshops. Colleagues reported a lack of consistency and clarity of authority and autonomy across the different staff groups and service areas, with the freedom to act being very manager or team dependent. Staff reported feeling held back from making change or progress, and the desire to feel “unlocked”.

11. Colleagues in A&B described a highly complex governance model, which exists to this day, with the HSCP ‘squashed’ between North Highland, A&B Council and NHS Greater Glasgow and Clyde. There remains a lack of clarity as to ownership for decision-making, with significant frustration from staff at the multiple sign-offs required for decisions which can take months (or even years). The financial pressures have exacerbated this hierarchy, but the cost of decision-making (in terms of absence of progress or change and the multiple review processes) should be considered.

12. As noted by both Sturrock and the A&B Culture Survey, there remain issues in the A&B relationship with “Headquarters” (Inverness). There is a sense from staff that “nothing happens without approval from Inverness”, or “things only get progressed if they come from Inverness”.

B) Organisation and Behaviours

13. The centralised approach to decision-making that evolved over this time period impacted role clarity and accountability, with unclear remits for managers and senior clinicians. This issue was exacerbated by the fact that managers often lacked the skills and knowledge to perform their duties effectively, owing to insufficient training, learning and development. A loss of NHS Highland-wide induction (beyond e-learning) was noted as an issue, as new managers and clinicians joining the organisation were not introduced to the vision, values and ways of working in a common way.

14. As the organisation came under increasing pressure to juggle service and financial targets, inappropriate behaviour became more prevalent, with poor behaviour being tolerated and stress cascaded down the line. A focus on command and control became the way of working for many, with a loss of focus on kindness and compassion.

15. There is a sense there was ‘complicity’ across the organisation in accepting poor standards of behaviour. Unions and Professional bodies were not sufficiently proactive in challenging the status quo, and leaders at various levels were perceived to be compliant, possibly due to fear of repercussions or challenge. Threats of reporting colleagues to Professional Bodies (e.g. the GMC) were tools used to avoid challenge or disagreement.

16. Colleagues described a reluctance to speak up or challenge the status quo, either because they felt repeatedly ignored or for fear of repercussions, such as being side-lined or missing out on opportunities to progress. A lack of speaking truth to power therefore promulgated across the organisation, with those who did speak up viewed as “trouble-makers”.

17. Sturrock covered the geographical challenges faced by NHS Highland extensively in his report, with the particular issues related to the fact relationships often extend well outside the workplace. These challenges were also identified in the Argyll and Bute culture survey. Staff can be discouraged from speaking up or raising concerns, for fear of the repercussions this could have on their lives outside work. The Healing panel heard that the remote and rural working environments can lead to less tolerance of diversity; with a lack of inclusive behaviours and people coming from outside the area finding it difficult to assimilate. It was also reported that poor mental health was seen as a weakness in parts of the organisation, and individuals were seen as being weak as a result of stress, anxiety or other mental health condition.

18. The structure of NHS Highland remains confusing or “murky” for staff. There is a lack of clarity of structures and leadership teams, even at quite a senior level, and many individuals could not identify the management chains to which they belonged beyond their immediate locality. The lack of widely shared organisation charts and governance arrangements compounds this, but the issue goes wider than this as it relates to the wider sense of identity and belonging across the organisation.

C) Systems and Processes

19. The systems and processes which should support positive ways of working failed to apply checks and balances to the emergent culture. People metrics and processes did not highlight the behavioural issues across the organisation; with cases taking a significant time to progress and a lack of organisational trust in the people process efficacy. Staff who were being investigated for potential disciplinary action could be suspended from duty for significant periods of time.

20. Departments, teams and individuals in distress were not visible at an organisational level, and there was no aggregate organisational temperature, as the annual iMatter survey failed to surface the cultural issues (due to question design and a reluctance in some areas to complete this). Occupational Health was reported to be extensively used throughout this period, meaning that the service was aware of the issues, but was unable to highlight the bullying culture in the organisation at a Board level.

21. The recruitment and promotion processes have been identified as lacking transparency, with promotion being used as a “reward” for compliance within the organisational system. Nepotism was identified as an issue in both the A&B Culture Survey and the recent A&B root cause workshops. It was also identified

that talented individuals left the organisation, or chose to not progress, given the perceived need to compromise integrity.

22. A lack of equity in career deal was identified, with inconsistent approaches to investment (both time and money) applied to learning and development and differing approaches to flexible working across types of job families and teams. Staff noted that learning often had to be undertaken in their own time and at own expense.

23. Financial processes and decision-making also impacted trust and created a sense of disempowerment. Whilst it needs to be recognised that NHSH was under significant financial pressure, this translated into a lack of budget devolution (therefore affecting service accountability) and parts of budgets being removed without engagement from those affected. The lack of a 'strategy-led' approach to cost savings was noted as an issue, with staff citing the flat savings targets applied across services as impacting the ability to innovate and execute longer term service re-design and improvement. Service transformation was stated to mean a requirement for cost saving; typically executed without clarity of vision and strategic direction.

24. Finally, a lack of support and transparency of process for Whistle-blowing (also at a national / professional body level) meant that the raising of concerns was challenging, and individuals who did try to escalate issues were discouraged or unsupported to progress.

Lessons Learned and Recommendations

25. The recommendations from the IRP are included in Appendix 4, with commentary on the actions taken and planned to address the recommendations. The consolidated recommendations from the IRP and root – cause analysis are summarised below under the same headings as the findings:

a) Governance and Decision-Making
b) Organisation and Behaviours
c) Systems and Processes

a) Governance and Decision-Making

The recommendations are as follows:

- The NHSH Board, in addition to regular Board meetings, should receive regular briefings where Board members can receive information from those directly providing front line services
- Evaluate clinical and care governance across the organisation; ensuring clarity and transparency of the network of committees and decision-making accountabilities
- Improve organisational engagement in decision-making processes; with clearer options appraisal and decisions aligned to the organisational values

- Improve the clarity and functioning of core governance forum across the organisation with stream-lined committee structures and a focus on vital decisions and supporting paper-work
- Improve the support and processes for Whistleblowing, including improving the profile of the Whistleblowing champion
- Develop a collaborative, realistic (and integrated) strategy and plan that is clinically based, involving all services in design
- An action plan be developed to capture the organisational learning identified through the IRP process, and that progress be monitored through regular reports and metrics, which can be tracked to monitor improvement, and capture the desired change in culture.
- The budget allocation process should be reviewed with clarity of budget holder's responsibility and delegated authority within the overall financial plan and financial governance arrangements.
- A protocol for service reviews be agreed, and, where they are necessary, they should have a clear remit, engage all stakeholders and be led by an independent expert in the service being reviewed
- Where estate is rationalised, a full appraisal of the needs of the service should be undertaken before a move into alternative accommodation is made

b) Organisation and Behaviours

The recommendations are as follows:

- That the concept of a 'just culture' be explored and any learning from this be incorporated into the cultural improvement development programme. Progress should be evidenced through a visible decrease in referrals to People processes
- An ongoing cultural improvement development programme should be put in place for all clinical leaders and managers, including members of NHSH Board
- The culture going forwards should be one based on engaging and empowering, and valuing contribution through effective appraisal and feedback. This can be monitored through the NHS Scotland i-matter engagement process which all Boards are required to use and report on
- Invest in civility and behavioural change, rewarding the right behaviours that are aligned to our values
- Embed the NHS values in a meaningful way across the organisation; focusing on dignity and respect in the workplace
- Improve the interface between clinicians and managers, clarifying decision-making accountabilities and creating greater visibility of managers on the front-line
- Design and implement proper and authentic patient engagement, and embed within the approach to strategy and service design
- Increase leadership visibility and engagement, and demonstrate active listening across the organisation
- Design and roll-out a system for peer supervision or support, enabling managers to connect with one another across the organisation
- Develop a clear articulation of the organisation structure and governance models, and ensure all staff are briefed and supported in understanding how the organisation 'works'

- Clarify accountabilities and discretion to act across grades and job families; with a drive to empower individuals and teams. Role model delegation and empowerment at senior levels to foster culture change.
- Focus on creating a culture where it is acceptable to say “no” (or to de-prioritise other activity) when additional work is needed / requested, through role modelling by senior leaders (saying no; not sending work out of hours)
- Training in bullying and harassment should be made available to all accredited Trades Union representatives
- The HR function should be subject to a wide-ranging review to ensure that there are sufficient staffing resources within the HR function and that these resources are effectively deployed and members of staff in the HR function understand their roles in supporting changes to organisational culture
- The role of the Employee Director should be clarified to ensure effective representation of the staff side, and effective representation at Board level
- The role of Occupational Health in supporting the organisational culture should be explicit, and the Occupational Health Lead should report to a Director, and provide regular reports to the NHS Board
- The adoption of seven key principles, which have been proven in having effectiveness in this area (i.e. equality and diversity – listed in Appendix 4)
- Training for managers on recognising the signs of mental health issues and on appropriate interventions should be provided

c) Systems and Processes

The recommendations are as follows:

- Recruitment processes should be thorough in ensuring that the best candidate is selected, avoiding – and being seen to avoid – any bias, and that those selected have personal values that match those of the organisation, Transparency is key. NHS Scotland has developed a values-based recruitment process which should be adopted for all posts.
- Once new starts are in place, induction processes should include training on equality and diversity.
- An HR case management system is adopted so that all HR processes can be monitored and performance managed. Regular reports on the application of HR policies should be provided to the Staff Governance Committee and the Area Partnership Forum.
- Serious consideration is given to external independent involvement in Dignity at Work complaints as the default response
- A change from a grievance to a resolution based approach, adopted through the HR policies
- Where mediation is thought to assist, it should be formally entered into by both parties, and be facilitated by a trained neutral mediator and seek to deal with the relationship difficulties rather than take what might be viewed as the easier option of removing the complainant.
- There should be a clear procedure relating to decisions to suspend staff with the circumstances being carefully considered. Suspensions should be regularly

reviewed and reported to the Board. This would be supported by the HR case management system referred to.

- Improve the support offer for those who speak up or raise concerns.
- Individual performance development plans based on agreed actions for individuals should be put in place and performance improvement monitored through effective performance appraisal with the organisation's values being a key part of the monitoring of the metrics
- Creation of safe spaces for people to feel vulnerable and share, linked to a wellbeing and support offer
- Greater use of values-based reflective practice and supervision (along the models used in effective clinical supervision)
- Improve the monitoring of culture and bullying, including sharing, using and acting upon the information provided in complaints
- Develop and roll-out a consistent approach to improvement, which includes the ability to learn from other NHS Boards and organisations
- Clarify the learning and development offer (including dedicated time and financial support) for all cohorts of staff to develop greater consistency of career deal
- Greater proactivity through longer term planning, supported by effective service design and workforce and financial planning.
- COVID has enabled us to move forwards with improved technology and different ways of working; we need to ensure we take this forwards and use technology to enable more efficient ways of working
- Better planning for projects and changes; ensure before starting a pilot or a project that the scope is clear and understood and that financing is available for wider roll-out if successful.

Future Activity and Next Steps

26. As indicated in Appendix 4, a number of the recommendations either have been addressed or are in 'progress' It is planned to give a full update on progress made against recommendations, and in particular those made in the Sturrock Review, at the Board meeting in May. This will be accompanied by the 21/22 Culture Programme plan and the pipeline of activity for future years.

27. However, there are also a number of recommendations made by the IRP that will require further action from NHS Highland. Those that are not currently within scope of the Culture Programme include the following:
    a. Development and roll-out of a performance management and development approach across NHS Highland
    b. A wide-ranging review of the HR function and resource alignment
    c. A review of the delegated authority and accountability for financial decision-making
    d. Roll-out of a consistent and engaging approach to service design / service reviews
    e. A review of clinical governance and the committee structures

f. An assessment of the resources required to provide meaningful clinical and managerial oversight in remote and rural areas.

28. As noted in Appendix 4, the NHS Scotland approach to performance management is under-developed at present so this recommendation cannot be fully addressed in the upcoming financial year. Recommendations c – f listed above will be referenced as part of the 3-5 strategy development process which will commence in 21/22. Resourcing and structure of the HR function is also under review with additional capacity planned.

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Appendix 4: Independent Review Panel Recommendations

1. The purpose of this document is to provide an assessment of the extent to which the recommendations made in the first two Healing Process Independent Review Panel (IRP) report are fully addressed, in progress or yet to be addressed. It is important to note that the members of the panel are independent to NHS Highland and so will not be aware of the action taken post Sturrock, so recommendations were made without that context. In addition, the experiences referenced by panel attendees range over a large timescale and many have left the organisation some years ago, so their experiences are at a point in time.

2. The first report of the IRP makes 22 recommendations and is based upon the evidence given by 26 current or former members of staff; and the second report makes a further 4 recommendations based upon the testimony of 58 individuals. The table below summarises each of the IRP recommendations and classifies them as addressed, in progress or not yet addressed. For those that are either in progress or not yet addressed, further commentary is provided as to the route for addressing the recommendation.

First IRP report recommendations

Rec #	Detail	Status and proposed timeframe	Route(s) to resolution / further activity required
1	An action plan be developed to capture the organisational learning identified through the IRP process, and that progress be monitored through regular reports and metrics, which can be tracked to monitor improvement, and capture the desired change in culture.	In progress (This will be an ongoing activity for the duration of the Culture Programme as further learning is identified)	It is important to assimilate the different sources of organisational learning (IRP, root cause diagnostic, Sturrock recommendations, Culture programme lessons) in order to avoid multiple separate sets of activity and recommendations. To address this, the Culture programme root cause diagnostic priority scope will be widened to 'Organisational Learning' and this will become the custodian of all identified lessons and improvements.
2	An ongoing cultural improvement development programme should be put in place for all clinical leaders and managers, including members of NHSH Board	In progress (Management Development is a 3 year programme to include all in supervisory positions; Board Development	A revised leadership and management development framework and set of learning modules is under development and will include a suite of development aimed at improving ways of working. This will take significant time to cover all managers and leaders (2 years). Additional development will be targeted at the NHSH Board, including ongoing development of the Executive Directors, to complement the existing programme of board development which has been underway since mid 2019. Our NHS Scotland online learning system contains targeted

Appendix 4: Independent Review Panel Recommendations

Rec #	Detail	Status and proposed timeframe	Route(s) to resolution / further activity required
		21/22)	Board development support which is being utilised as part of this.
3	Individual performance development plans based on agreed actions for individuals should be put in place and performance improvement monitored through effective performance appraisal with the organisation's values being a key part of the monitoring of the metrics	Not yet addressed 21/22 for exec objective setting 22/23 for start of wider performance management implementation	Performance management in NHS Scotland is not where it should be, with the national programme to address this delayed due to Covid. However, this is in place for the Executive and Senior manager cohort with national oversight of ratings. Starting in performance year 21/22 NHSH will focus on clear cascade of objectives down from Board – Executives – Senior Leaders, so that there is a clear sense of priority and focus, linked to the vision, values and board objectives which are currently being finalised. This will be built on the following year.
4	The concept of a 'just culture' be explored and any learning from this incorporated into the cultural improvement development programme. Progress should be evidenced through a visible decrease in referrals to people processes	In progress Complete within 21/22 as Culture Programme priority	The concepts of justness are part of 4 of the current Culture priorities (Civility Saves Lives, People Processes, Leadership and Management Development and most clearly within Values and Behaviours). The Culture Metrics and Tools priority is accountable for defining and implementing an approach to measuring culture improvement, including case data.
5	Recruitment processes should ensure that the best candidate is selected, avoiding – and being seen to avoid – any bias, and that those selected have personal values that match those of the organisation, Transparency is key. NHS Scotland has developed a values-based recruitment process which should be adopted for all posts.	In progress 2 year programme to embed values based recruitment (complete 22/23)	The Recruitment Review completed last summer made a suite of recommendations relating to improving the rigour of current selection approaches. These recommendations have been reviewed and prioritised for implementation by a partnership group (Recruitment, Managers and Staffside). A resourced plan and timeline for implementation will be created and shared. The route for oversight of the improvements is within scope of the Director of HR and OD's function and governance.
6	Once new starts are in place, induction processes should include training on equality	In progress	Statutory and Mandatory training includes equality and diversity modules so all new starts are required to complete this learning.

Appendix 4: Independent Review Panel Recommendations

Rec #	Detail	Status and proposed timeframe	Route(s) to resolution / further activity required
	and diversity.	Ongoing – requires regular reporting / tracking.	Ensuring inclusive thinking and behaviours is a key element of our values and behaviours workstream as well as leadership and management development.
7	The adoption of seven key principles, which have been proven in having effectiveness in this area (i.e. equality and diversity): 1. Acknowledge the challenge 2. See workforce equality as integral to service improvement not just compliance 3. Insist on detailed scrutiny of data from Employee Staff Records / national staff survey to identify specific challenges 4. Ensure the narrative underpinning strategy is specific to each organisation 5. Learn from previous failed approaches 6. Specific interventions must be evidence driven 7. Accept that accountability is crucial (and leaders model the behaviours expected of others)	In progress Ongoing Staff Governance Standard monitoring Inclusion actions as part of remobilisation plan to be delivered during 21/22 Longer term strategy to be developed and implemented	NHS Scotland has a commitment to equality and diversity within the Staff Governance Standard, to which NHS Highland works. We are also creating a plan for addressing key diversity and inclusion actions over 21/22 as part of our Remobilisation Plan. There is a Embracing Equality, Diversity & Human Rights Policy in place, although this is due for review nationally in Phase 2 of Once for Scotland, which has been delayed due to Covid Within Values and Behaviours work we will pay specific attention to diversity and inclusion and prompting a conversation around inclusive behaviours.
8	The culture going forwards should be one based on engaging and empowering, and valuing contribution through effective appraisal and feedback. This can be monitored through the NHS Scotland i-matter engagement process which all Boards are	In Progress Culture Metrics and tools to deliver within 21/22;	Whilst roll-out of the new values and behaviours, and an improved approach to internal communications and engagement should foster a culture of engaging and empowerment, there is currently no widely used system / tool for feedback and measurement. The i-Matter process whilst giving annual metrics on key figures is not tailored to NHSH's specific needs. An additional tool / survey is therefore planned

Appendix 4: Independent Review Panel Recommendations

Rec #	Detail	Status and proposed timeframe	Route(s) to resolution / further activity required
	required to use and report on		for Spring to give real-time insights into organisational temperature and this forms part of the Culture Metrics priority.
9	The HR function should be subject to a wide-ranging review to ensure that there are sufficient staffing resources within the HR function and that these resources are effectively deployed and members of staff in the HR function understand their roles in supporting changes to organisational culture	Not yet addressed To finalise and implement first phase restructure by end June 2021 and communicate with the organisation around this	The understanding of the role and responsibility of HR within NHS Highland is confused, with many colleagues and managers expecting all people related matters to be addressed by the team, when this is a management responsibility. A review of the organisation of the function is underway, with additional senior roles being created and a business partner model implemented. Launch elements of this model from April 2021 will support better understanding and engagement of the organisation, along with the development of the team and clarity of roles and working practices. This will be complemented by the ongoing people processes workstream, which is a partnership group implementing the recommendations of our recent external review.
10	An HR case management system is adopted so that all HR processes can be monitored and performance managed. Regular reports on the application of HR policies should be provided to the Staff Governance Committee and the Area Partnership Forum.	In progress To complete Dec 2021	The definition, procurement and implementation of an HR case management system is within scope of the 'People Process' Culture priority. It is important to note that this is expected to take until the end of 2021 to implement, due to commissioning and procurement timelines.
11	Serious consideration is given to external independent involvement in Dignity at Work complaints as the default response	In progress To be reviewed as part of people process review 21/22	CMP are already used to support investigations where this is appropriate and this has been in place for 2 years. The model for investigation is within scope of the People Process review. External support is required at present given capacity; this could be reviewed in the future, to make use of specially trained internal resource who are allocated time to do this.
12	A change from a grievance to a resolution based approach, adopted through the HR	In progress	This is embedded in the Once for Scotland policies and is a key part of our training of managers. The focus of improving and embedding the

Appendix 4: Independent Review Panel Recommendations

Rec #	Detail	Status and proposed timeframe	Route(s) to resolution / further activity required
	policies	Focus for People Processes 21/22	approach to 'early resolution' is the first priority of the People Process priority and is currently underway.
13	Where mediation is thought to assist, it should be formally entered into by both parties, and be facilitated by a trained neutral mediator and seek to deal with the relationship difficulties rather than take what might be viewed as the easier option of removing the complainant.	In progress To be scoped / costed during 21/22	Mediation and facilitation is currently offered both internally and externally, where appropriate as part of our early resolution focus. External support has been in place and regularly used since 2019 and we will continue to review this as part of the people process review. .
14	The budget allocation process should be reviewed with clarity of budget holder's responsibility and delegated authority within the overall financial plan and financial governance arrangements.	Partially Addressed Financial Planning process to be reviewed during 21/22	Much work has been done with regards to financial understanding, with mandatory online training for all budget holders, updated standing financial instructions and an annual budget review process. In addition, all budget holders are engaged in our Financial Recovery Programme and driving identification and delivery of recurring cost improvement and service efficiency targets. The financial planning process and how budgets are allocated and the alignment with the wider strategy development process requires assessment, and will be reviewed during 21/22.
15	NHSH Board, in addition to regular Board meetings, should receive regular briefings where Board members can receive information from those directly providing front line services	Not yet addressed – but will commence 2021	This has been identified by the Board as a desirable process and will be scheduled into the 2021 calendar of meetings. This should also include the celebration of staff achievements which started in January 2021.
16	A protocol for service reviews be agreed, and, where they are necessary, they should have a clear remit, engage all stakeholders and be led by an independent expert in the	In progress Detailed approach to be implemented in	The approach to service design and involvement has been identified by both Sturrock and the root cause diagnostic as an area needing focus and work on this has already started. The Scottish Government has a well-developed approach to service

Appendix 4: Independent Review Panel Recommendations

Rec #	Detail	Status and proposed timeframe	Route(s) to resolution / further activity required
	service being reviewed	2021/22	design which can be drawn upon; and has already been piloted in Caithness. A community engagement manager is in place to support this approach and the our protocol will be developed and implemented as standard practice in future redesigns including the ongoing Lochaber programme.
17	Where estate is rationalised a full appraisal of the needs of the service should be undertaken before a move into alternative accommodation is made	In progress	We have aligned our estates utilisation programme planning with our financial recovery and service redesign, led by our new Director of Estates, Facilities and Capital planning who took up post in November. A process is currently being developed whereby the Estates & Facilities directorate will be responsible for coordinating all accommodation moves with an emphasis on stakeholder engagement.
18	Training in bullying and harassment should be made available to all accredited Trades Union representatives	Addressed	The Once for Scotland policy training (including bullying and harassment) is open to all for completion (including TU representatives). Rates of completion will tracked and reported upon. The People process review will also consider how to further upskill all parties in managing these processes.
19	The role of the Employee Director should be clarified to ensure effective representation of the staff side, and effective representation at Board level	Addressed	There are nationally set parameters for this role and the Employee Director participates in all board training and development alongside the other non-executive and executive Board members. They also engage in the national forums for this role. They meet regularly with the Chair, Chief Executive and HR Director. The current incumbent will step down in 2021 and a full induction programme for the new Employee Director will be put in place, as for all new non-executive directors.
20	The role of Occupational Health in supporting the organisational culture should be explicit, and the Occupational Health Lead should	Addressed	The Lead for Occupational Health reports to the HR Director and is part of their leadership team. The role of OH is very clear and the support available to staff has been widely publicised throughout the

Appendix 4: Independent Review Panel Recommendations

Rec #	Detail	Status and proposed timeframe	Route(s) to resolution / further activity required
	report to a Director, and provide regular reports to the NHS Board		recent focus on staff wellbeing. Feedback on the service is extremely positive. The service lead regularly attends partnership forums and other colleagues briefing sessions to provide tailored proactive advice and support on a range of issues. Reports from OH are part of the workforce report submitted to Staff Governance Committee.
21	Training for managers on recognising the signs of mental health issues and on appropriate interventions should be provided	In progress Further supported by Leadership and Civility actions in plan for the coming year.	There is a significant focus on mental health and wellbeing and through national and local systems. We promote the available training on the national portal and TURAS system including psychological first aid and through our weekly wellbeing emails. Managers can access support from OH and also from our EAP provider to assist in managing this. This will also be embedded in the modules of the leadership and management development programmes as well as our implementation of the Civility Saves Lives peer support approach.
22	There should be a clear procedure relating to decisions to suspend staff with the circumstances being carefully considered. Suspensions should be regularly reviewed and reported to the Board. This would be supported by the HR case management system referred to in recommendation 10.	Completed Case management system addressed in 10.	The process and number of suspensions was the subject of review in early 2020 and as a result suspensions have reduced from around 50 in 2018 to around 3 short term suspensions in the last 6 months. A clear process is in place, and the HRD and Executive Director have to approve any suspension, which is a short term measure until appropriate redeployment or supervision can be put in place. The development of manager capability to manage these processes will also be addressed by both the People Processes and Leadership and Management Development priorities. The case management system is in progress but there is a manual reporting process as part of the Staff Governance workforce reports.

Appendix 4: Independent Review Panel Recommendations

Second IRP report recommendations

Rec #	Detail	Status and proposed timeframe	Route(s) to resolution / further activity required
1	That the recommendations in the Sturrock Report and the IRP's Organisational Learning Reports are implemented in full and that by regular feedback to the IRP, the Whistleblowing Group, NHSH employees, and the wider public, NHSH show that this is the case and that the actions being taken are being translated into culture change that is seen by staff as positive and that the Culture Programme is being shaped by the voices of affected staff	In progress	The publication of the first two IRP reports, the consolidated lessons learned and the activity being taken to address the feedback is the first step in the response to the findings of the Panel. The recommendations have each been reviewed and discussed by the Executive team; and as described in this document many are within scope of the current Culture programme priorities. The Culture programme will continue to evaluate the priorities against the recommendations of the IRP; and adapt the focus and scope as necessary. It is also important for the Culture programme to improve communications and engagement with staff, through more regular updates and the planned implementation of an engagement tool to track cultural improvement across the organisation.
2	A systematic review of existing capability of all managers and clinical leaders be undertaken with a view to putting in place effective personal development plans, supported by relevant training, for all managers and leaders (Recommendation 2(a)) That a leadership development programme to address the following areas in order for the organisation to thrive and grow and also plan for any gaps that are identified**:** • Cognitive and critical thinking needed to reason, plan, adapt and learn	Not yet addressed (2022 onwards) In progress	As outlined in the assessment of the first IRP report; the performance management / PDP processes within NHS Highland (and Scotland) require further development. The plan is for all leaders and managers across the organisation to undertake development over the course of the next 2-3 years; but given the significant numbers of people holding management roles this will take time to implement. A leadership and management development programme is under development and will be available for all those in management roles. The first modules will be available for staff to undertake in May; and there will be a rolling programme of development and evaluation. Additionally; it is planned to give every team a cultural development package over the course of 2021/22; which will support the

Appendix 4: Independent Review Panel Recommendations

Rec #	Detail	Status and proposed timeframe	Route(s) to resolution / further activity required
	• The leadership DNA in terms of how that is reflected in the way individuals think, act and feel • The unique knowledge, skills and abilities required to excel in the leadership of people and teams • The capacity and willingness to continually learn from experience. Achieving growth through proactive use of feedback and self-reflection. • The ability to innovate and be a positive force for change and progress. • Confidence building. (Recommendation 2(b)) That the NHS Scotland standard of values based recruitment to leadership positions is fully adopted/implemented. (Report 2: Recommendation 2(c))	In progress	development of effective team working and ensuring the NHS Highland values and behaviours are embedded across the organisation. Values based recruitment has already been piloted in the recruitment of some clinical posts; and the intention is to role this out more widely across the organisation over the course of 2021/22.
3	The Clinical Governance Committee reviews the governance and reporting of information governance incidents, patient safety reporting and the reporting and monitoring of adverse events with benchmarking against other health boards in Scotland.	Not yet addressed (2021/22)	A review of the current clinical governance arrangements has been identified by the NHS Highland Board as an area of focus during the forthcoming financial year. The recommendations of the panel will be considered as part of the development of the terms of reference for that review.
4	An assessment of the resources required to provide visible and meaningful leadership for services in remote areas should be	Not yet addressed	Over the course of 2021/22 the strategy for the next 3-5 years will be developed collaboratively with colleagues from across the organisation. As part of the strategy development process; the design of services

Appendix 4: Independent Review Panel Recommendations

Rec #	Detail	Status and proposed timeframe	Route(s) to resolution / further activity required
	undertaken, and changes made to existing management and leadership arrangements. This will also require an analysis of the support required for staff working in small communities to be undertaken and additional support put in place, including appropriate professional supervision where this is lacking.		and structures to support service delivery will be evaluated. The design and delivery of remote and rural services will form a key part of the strategy development process. The recent restructure into “Acute” and “Community” structures across NHS Highland will also support the review of existing management and oversight arrangements.

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item:**

Date of Meeting: 29 March 2021

Title of Report: Staff Governance Report for Financial Quarter 3 (2020/21)

Presented by: Jane Fowler, Head of Customer Support Services (ABC)

The Integrated Joint Board is asked to:

- Note the content of this quarterly report on the staff governance performance in the HSCP
- Take the opportunity to ask any questions on people issues that may be of interest or concern;
- Endorse the overall direction of travel, including future topics that they would like further information on.

1. EXECUTIVE SUMMARY

1.1 This report on staff governance performance covers financial quarter 3 (October – December 2020) and the activities of the Human Resources and Organisational Development (HROD) teams. In the last quarter, there has been a focus on improving culture, supporting employee health and wellbeing, workforce planning, improving recruitment processes and managing employee relations cases.

2. INTRODUCTION

2.1 This report focuses on how staff governance supports the HSCP priorities and meets the staff governance standard. Staff Governance is defined as "A system of corporate accountability for the fair and effective management of all staff." The Standard requires all NHS Boards to demonstrate that staff are:

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

2.2 In the context of health and social care integration, we also consider the following:

- Adopting best practice from both employers
- Development of joint initiatives that support integration
- Compliance with terms and conditions and employing policies

3. PROGRESS AND CHALLENGES

3.1 Culture

3.1.2 Argyll and Bute HSCP Culture Group is co-chaired by the Depute Chief Officer and the Argyll and Bute Staffside Rep. The Group of around 30 volunteers from across the HSCP met twice during the report period and agreed priorities for improving the culture. Group members are participating in 6 priority workstreams with colleagues in NHS Highland to drive forward culture change across Highland and Argyll and Bute. Two of the six workstreams are led by members of Argyll and Bute Culture Group. The priority workstreams are:

3.1.3

- Values and Behaviours – embedding these throughout
- Civility Saves Lives – equipping people with the skills to have effective team-based discussion
- Leadership and Management Development Programme – the above two priorities link to this; development of skills and tools for all managers
- People Process Review – providing clarity of roles and responsibilities, improving overall performance and reporting and improving incidence of early resolution
- Root Cause Diagnostic – identifying system failures and their impact, taking forward lessons learned
- Culture Metrics and Tools – develop, implement and review a suite of metrics; provide managers with culture dashboard to assess where support is needed.

3.1.4 In addition to these priority workstreams, the Group is working on the redevelopment of drop-in forums to have a culture focus and different themes. The Group also recognised that the new management structures in place are part of the culture change in the HSCP.

3.1.5 Courageous Conversations sessions continue to be delivered and can be booked by teams as well as individuals.

3.2 Wellbeing

3.2.1 HSCP Guardian Service

The Guardian Service continues to be available for all employees working in Argyll and Bute – both from the Council and the NHS. The service is independent and confidential and is for staff to discuss matters relating to patient and service user care and safety, whistleblowing, bullying and harassment, and workplace grievances. The guardians are external to the HSCP and will provide information and emotional support in a strictly confidential, non-judgemental manner. The ‘Speak Up’ Guardian Service

can be accessed 24/7. Initial feedback on the launch of the service to council employees is that take up is very low and there have been no matters raised yet which have required escalation to management. We await the first formal report on activity.

3.2.2 Argyll and Bute HSCP Wellbeing Group

A focus on supporting and enhancing staff wellbeing and resilience continues to be vital, encouraging conversations about wellbeing and self-care, and raising awareness and signposting to resources available. The NHS Highland Wellbeing Group is looking into how it goes forward in relation to the culture programme and the previously established strategy group. The Argyll and Bute HSCP Wellbeing Group continues to meet monthly and plan on how best to support and maintain focus on staff wellbeing and align this with the culture programme. The Resilience Engine pilot continues with five teams involved. The Culture Champions, Jane Fowler, Fiona Hogg and Jennifer Swanson continue to ensure that information from the national resilience network is cascaded to HSCP teams.

3.2.3 A focus for quarter 4 is to:

- Continue to promote and signpost staff to wellbeing resources
- Continue testing of the Resilience Engine Self Coaching Guide approach and plan for focus group evaluation.
- Start testing a Spaces for Listening approach (a structured process which creates a space to share thoughts and feelings and experience an equality of listening)
- Consider staff wellbeing and how this aligns with the culture programme and the priorities for 2021/22.

3.3 Learning and Development

Personal Development Plans (PDP) and Performance Review and Development (PRD) must be completed annually and one-to-one meetings carried out regularly to review performance and achievements as well as identifying any training needs. The Organisational and Workforce Development (OD) team continue to support managers and staff on how to access and complete these with training available remotely instead of face-to-face. Given the pressures on teams as a result of the Covid pandemic, the Council is allowing for an extension to PRD completion to the end of April this year. Ensuring these important conversations take place is a key part of building a strong and supportive culture.

3.3.1 Statutory and Mandatory training is essential to the safety and quality of services that the HSCP delivers. HSCP Council training levels remained stable over quarter 3. The OD and HR team continue to support compliance with Statutory/Mandatory training for NHS and Council staff. Managers and staff are responsible for ensuring that all statutory and mandatory training is up-to-date to ensure 100% compliance rates as non-completion presents a risk to the organisation and is contractual to employment. There are still improvements to be made on completion rates and this has been raised at NHS Highland Board level.

3.3.2 The Social Work Training Board currently identifies and approves training necessary to meet statutory and service requirements to ensure registered service compliance, and monitors progress of SVQ candidates in social work services. Representation is from managers across all Social Work professional areas. It meets every two months and has recently appointed the new Professional Lead Social Work post holder as Chair of the board.

3.3.3 The Council's training centre delivers SVQs for council staff and the OD team is exploring ways to improve SVQ accessibility for NHS staff.

3.4 Leadership and Management Development

3.4.1 A manager induction programme is planned to start in FQ4 with spotlight sessions each month. This will be delivered remotely to support participation from all parts of Argyll and Bute.

3.4.2 NHS Highland Leadership and Management Development programme and the Council's Argyll and Bute Manager programme will be open to all HSCP managers to undertake during 2021. These programmes will focus on developing people management skills as well as policies and procedures.

3.4.3 Once for Scotland people policies courses are being delivered remotely for all managers to ensure up-to-date knowledge of the new NHS Scotland policies.

3.5 Resourcing: Recruitment and Redeployment

3.5.1 Following agreement with SLT, Children and Families and Justice began to pilot the online authorisation process for vacancies on JobTrain and TalentLink in November 2020. This is working well and we have received positive feedback as well as some suggestions on how we can support the roll-out to further services in the next few months. The newly appointed Resourcing Officer will agree a timeline in with service managers with a view to establishing all services online.

3.5.2 The team are facing a significant demand for recruitment and this is currently a focus of attention in terms of resources. Challenges with timeous PVGs and Occupational Health assessments are adding to delays in recruitment, which impacts on services and teams.

3.5.3 Fortnightly vacancy monitoring will continue until all services are using online authorisation for establishment posts therefore we want to move to all services using the online process as quickly as possible.

3.5.4 There have been some delays to recruiting due to Disclosure Scotland checks currently taking around 6 weeks to complete on both NHS and Council sides and only strictly Covid-related posts can be fast-tracked. This has been communicated to recruiting managers to ensure that prospective candidates are aware.

3.6 Workforce Planning

3.6.1 HROD has continued to support managers with workforce planning conversations to identify challenges, issues and risks in relation to staffing and service delivery. This work will help to prepare for the 3 year workforce plans.

3.6.2 As agreed by SLT, a Strategic Workforce Planning Group has been established to focus on producing 3 year workforce plans for publication by 31 March 2022. The Group, chaired by the Lead Nurse, will meet monthly and will be supported by the NHS Highland workforce planning team as well as HROD in Argyll and Bute. We are focused on providing high level workforce data to the Scottish Government on receipt of the interim workforce planning template. The deadline for providing three year workforce plans to Scottish Government is 31 March 2022.

3.6.3 We received guidance from Scottish Government in March on Workforce planning requirements for this year, to be submitted by 30th April 2021. The team is currently prioritising work to complete this and progress will be reported in the FQ4 report.

3.7 Management Restructures

The Children, Families and Justice Management Restructure was completed in August 2020, and the Adult Services Restructure was completed at the end of September 2020. Due to the significant changes within Adult Services (no longer a geographical split, but by functional area) the statistics for this reporting period can no longer be comparable to previous reporting periods. This is reflected in some of the data in the appendices. Recruiting to the last of the management posts is almost complete.

4. RELEVANT DATA AND INDICATORS

4.1 Attendance

4.1.1 HSCP absence levels remained stable over quarter 3 with the following percentage absence:

For NHS employees:

- October: 4.38%
- November: 4.58%
- December: 4.6%

4.1.2 Amongst Council employees the rates of absence have decreased over the quarter, although they remain higher than the average absence rate for other council employees. The rate of return to work interviews has improved over the quarter, as has the timescale for holding these. This improvement has been supported by the Wellbeing Team who continue to work with managers to reduce and manage absence.

4.1.3 HR Business Partners, HR Advisers and Council Wellbeing Advisors continue to support managers in supporting employees. Training for Once for Scotland Attendance Management Policy has begun and managers have fed back positively on its content. HR with NHSH Occupational Health advice are closely monitoring Covid related absences in particular “long Covid” and its prevalence. We will report on this particular issue in a future report once we obtain further information across the HSCP.

4.2 Redeployment

4.2.1 All NHS vacancies are considered for both Primary and Secondary redeployment lists as they arise. The HR team have been very busy working in partnership with the Area Manager and Staffside Rep in securing permanent, temporary and shadowing opportunities within Lochgilphead area following the previous closure of Knapdale Ward in Mid Argyll Hospital as part of the Dementia Services Review. As a result, 9 members of staff were removed from the Primary list taking the numbers down to 32 with the aim of reducing this further in the coming quarters.

All Council vacancies are also considered against the redeployment list as part of the authorisation process to avoid redundancy. There are currently no Council employees in the HSCP at risk of redundancy.

4.3 Employee Relations (ER)

4.3.1 In Q3 a significant number of NHS ER cases were completed including 7 Bullying & Harassment cases which involved 2 investigations undertaken by our external partners CMP. The numbers of employee relations cases amongst NHS staff remains much higher than the numbers for Council employees.

For the Council, there are two ongoing Council disciplinary cases with one concluded in Children, Families & Justice. Cases include 1 Bullying & Harassment case with an investigation undertaken by our external partners CMP. For Grievances, there are three bullying and harassment cases, two of which were against NHS colleagues. There was one new case for Children, Families & Justice and two concluded cases in the period.

4.3.2 New cases are still coming forward at this time which demonstrates that staff are feeling able to raise their concerns and confident that they will be investigated. Early resolution continues to be the priority for all Employee Relations issues that are raised in the workplace. Formal investigation will only take place when this has been exhausted and/or is not appropriate.

4.4 Temporary and Fixed Term Contracts

4.4.1 The table and graph at Appendix 5 show the number of Fixed Term and Temporary contracts in place across the HSCP. The trend of the graph shows that there has been a steady reduction in the number of posts in this category and that this has stabilised over the last quarter. This is an important indicator in team stability, which supports our employees and managers to build teams, invest in learning, support and improvements and build stable team culture.

4.5 Partnership Working

4.5.1 Partnership working with Trades Unions and Staff Side remains an important element of our staff governance. A regular programme of governance meetings, including our Joint Partnership Forum and Staff Liaison Group are programmed in throughout the year and continue to be the route for strategic engagement and change management. The regular weekly/fortnightly meetings established during the pandemic are continuing, and provide a constructive forum for raising and resolving any issues that emerge. The newly reformed Transformation Board has staff side and TU representation and will be the conduit for all change projects to be presented to TU/Staff Side for formal engagement and consultation. At a recent meeting of the NHS Highland Organisational Change Oversight Group, the arrangements that have been put in place in A&B for engagement and consultation on change affecting employees was commended.

5. WORK PLANNED FOR THE NEXT 3 MONTHS

5.1 Update on work for FQ3 and plan priorities for FQ4:

AB HSCP Culture Group – develop Culture Plan 2021	FQ4
Continue delivery of Courageous Conversations, management development; improvement to people processes	Ongoing
Use results of iMatter and Everyone Matters and support managers and teams to improve on areas identified	FQ4
Continue to support Staff Health and Wellbeing activities to align with Council and tackle HSCP sickness absence	Wellbeing Group established; work ongoing
Progress to 100% of all vacancies on JobTrain – plan roll out with service managers – anticipate slight delay due to staff changes and considerable resourcing workload	Pilot completed in FQ3 Plan rollout FQ4
Progress workforce planning; eESS training required for HROD and all managers (NHSH to deliver)	Ongoing
Deliver Once for Scotland to all managers and then staff – delivered remotely via MS Teams	Ongoing

6. CONTRIBUTION TO STRATEGIC PRIORITIES

6.1 This report has outlined how the staff governance work contributes to strategic priorities.

7. GOVERNANCE IMPLICATIONS

7.1 Financial Impact

A reduction in sickness absence will reduce costs.

7.2 Staff Governance

This staff governance report provides an overview of work that contributes to this theme.

7.3 Clinical Governance

None.

8. EQUALITY & DIVERSITY IMPLICATIONS

Equality and Diversity implications are considered within the NHS People and Change and Council HROD teams as appropriate when policies and strategies are developed.

9. RISK ASSESSMENT

Risks are considered medium. Individual HROD risks identified on the Risk Register. Risk assessments have been completed in relation to remobilisation.

10. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The Everyone Matters pulse survey was reported in this quarter.

11. CONCLUSIONS

It is recommended that the Integration Joint Board:

- Note this quarterly Staff Governance update;
- Take the opportunity to ask any questions on people issues that may be of interest or concern;
- Endorse the overall direction of travel, including future topics that they would like further information on.

12. DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

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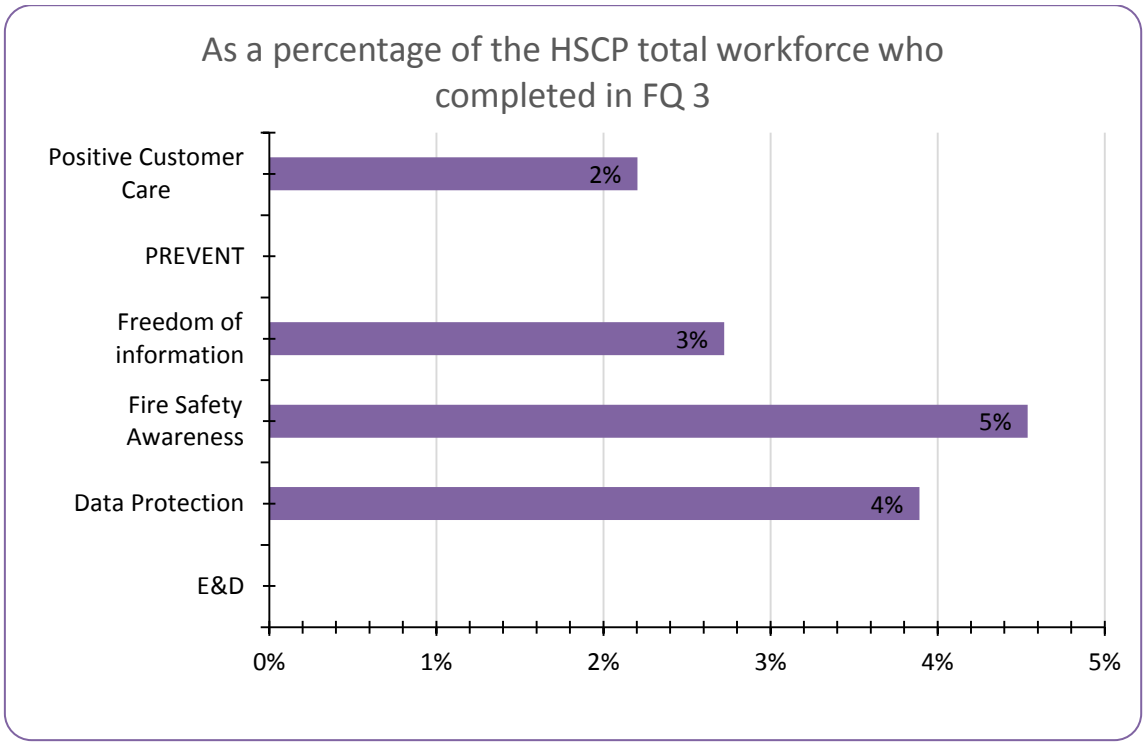
Jo McDill, HR&OD Officer, Argyll and Bute Council
Dorothy Ralston, HR&OD Officer, Argyll and Bute Council

Appendix 1 – Council Training Completed (FQ 3)

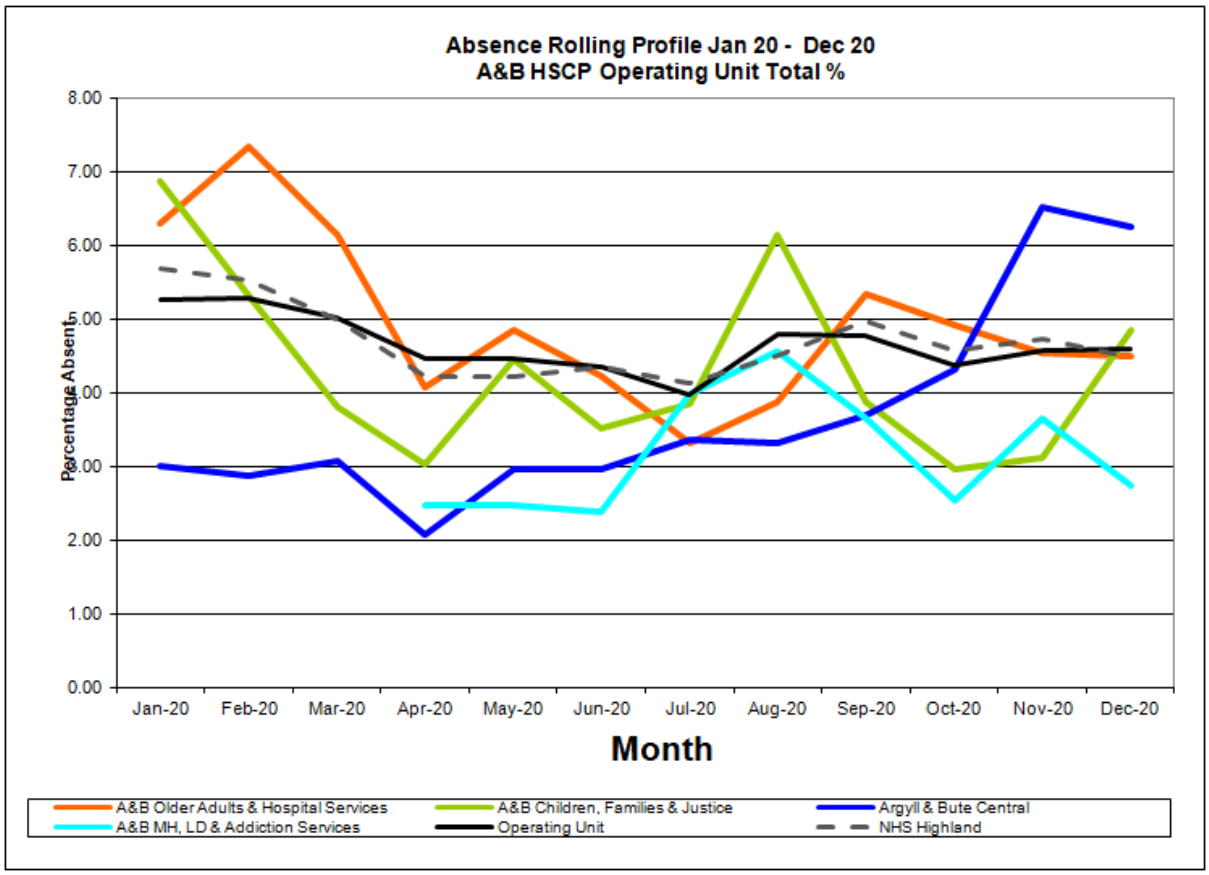
Mandatory course	Number of employees completed course	As a percentage of the HSCP total workforce (771)	Number completed in FQ 3	As a percentage of the HSCP total workforce who completed in FQ 3
E&D	62	8%	0	0%
Data Protection	325	42%	30	4%
Fire Safety Awareness	167	22%	35	5%
Freedom of information	85	11%	21	3%
PREVENT	67	9%	0	0%
Positive Customer Care	75	10%	17	2%

(HSCP total workforce end Q3: 771)



Appendix 2 – HSCP Absence rates

NHS

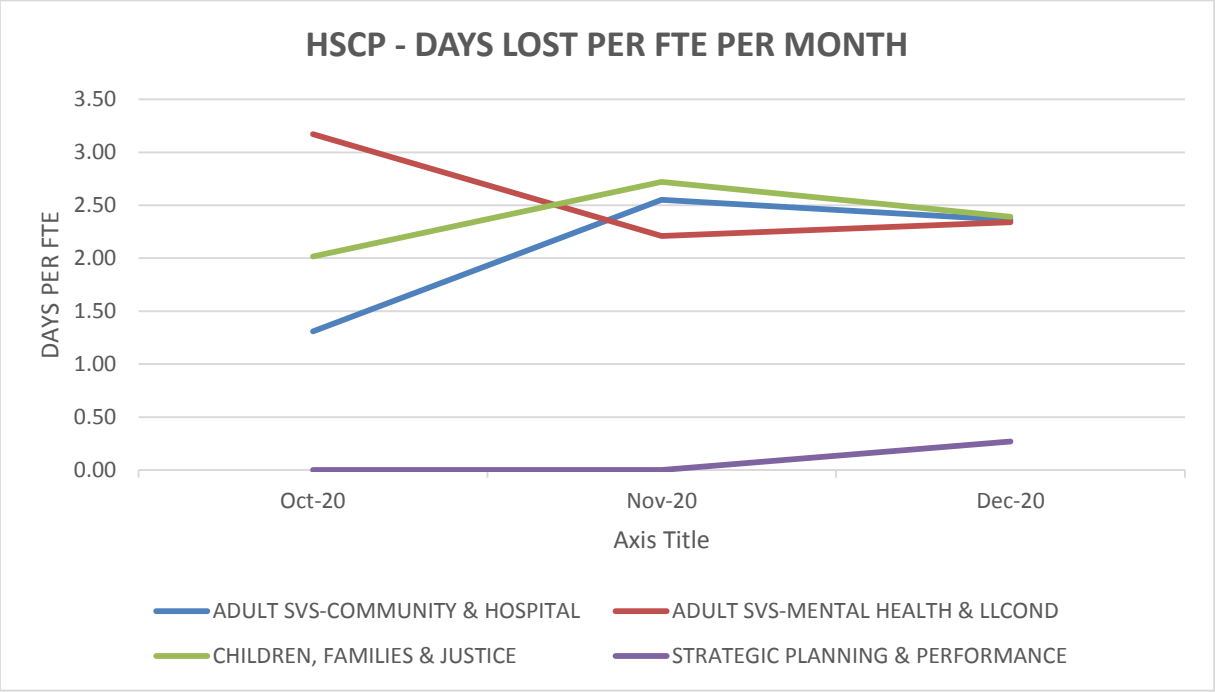


Council: A & B Social Care Staff – Oct 20 to Dec 20

The data shows some improvement in attendance levels in Adult Services, although these remain relatively high in comparison with other Council services and higher than the average Local Government Benchmarking Framework attendance levels.

Focussed work continues by both HR and Wellbeing Teams to support managers to get employees on long term absence back to work and to tackle short term absence. Stress related absence remains the predominant cause for absence in social work and social care teams.

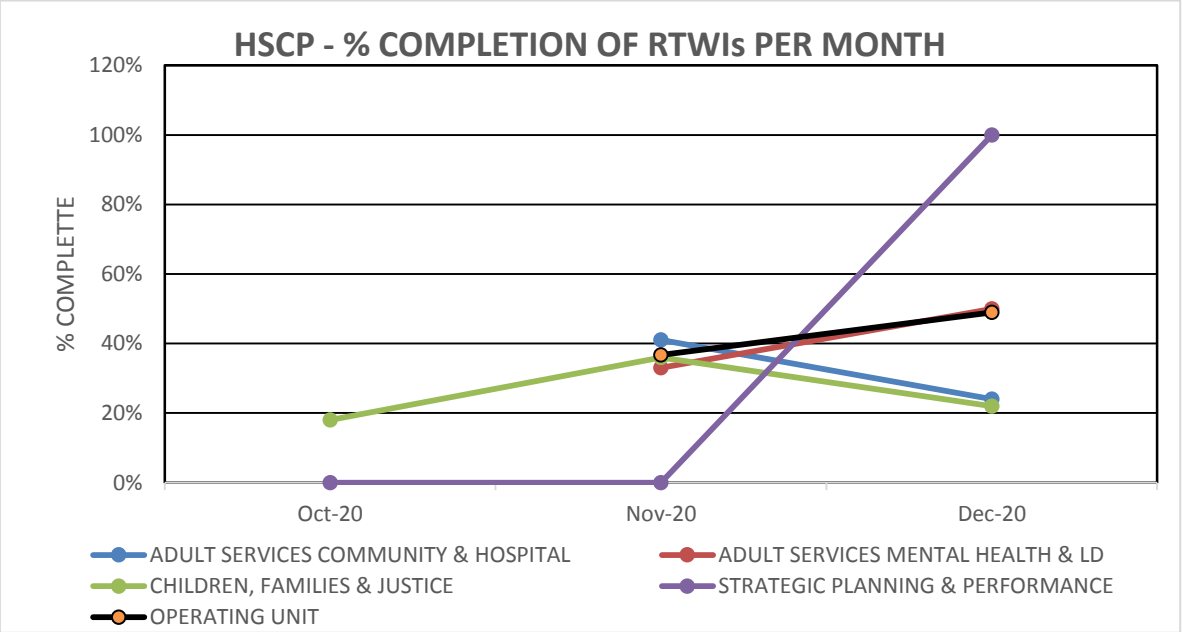
	Oct-20	Nov-20	Dec-20
ADULT SVS-COMMUNITY & HOSPITAL	1.31	2.55	2.36
ADULT SVS-MENTAL HEALTH & LLCOND	3.17	2.21	2.34
CHILDREN, FAMILIES & JUSTICE	2.02	2.72	2.39
STRATEGIC PLANNING & PERFORMANCE	0.00	0.00	0.27



Appendix 3 – Return to Work Interview Data (Council Staff) FQ3

The table detailed below shows the completion rates for Return to Work Interviews (RTWI) across the partnership for Council staff. The target is 100% completion within 3 days of the employee returning to work.

Below the table is a graph depicting the trends in completion rates since October 2020. There was an increase in November for the number of RTWIs completed and a decrease on the time taken to complete the RTWIs. The Wellbeing Advisors continue to encourage managers to improve this approach.



Appendix 4 – Recruitment and Redeployment Activity (Q3)

Attracting and retaining suitable applicants predominantly within nursing and some AHP roles remains challenging across all areas particularly Oban, Lorn and Isles locality. The HSCP Communications Team continues with uploading and sharing posts and information relating jobs throughout the UK to relevant groups and contacts on social media. Further work is planned to highlight health posts via www.abplace2b.scot.

The Council's Communications Team continues to promote vacancies on social media.

NHS Vacancies

	October		November		December	
	New	Re-Ad	New	Re-Ad	New	Re-Ad
Adult Services EAST	18	0	7	3	8	4
Adult Services WEST	35	5	15	5	7	6
Children & Families	3	0	2	1	4	0
Corporate Services	5	2	3	1	0	0
Totals	61	7	27	10	19	10
	68		37		29	

Council Social Work/Care vacancies

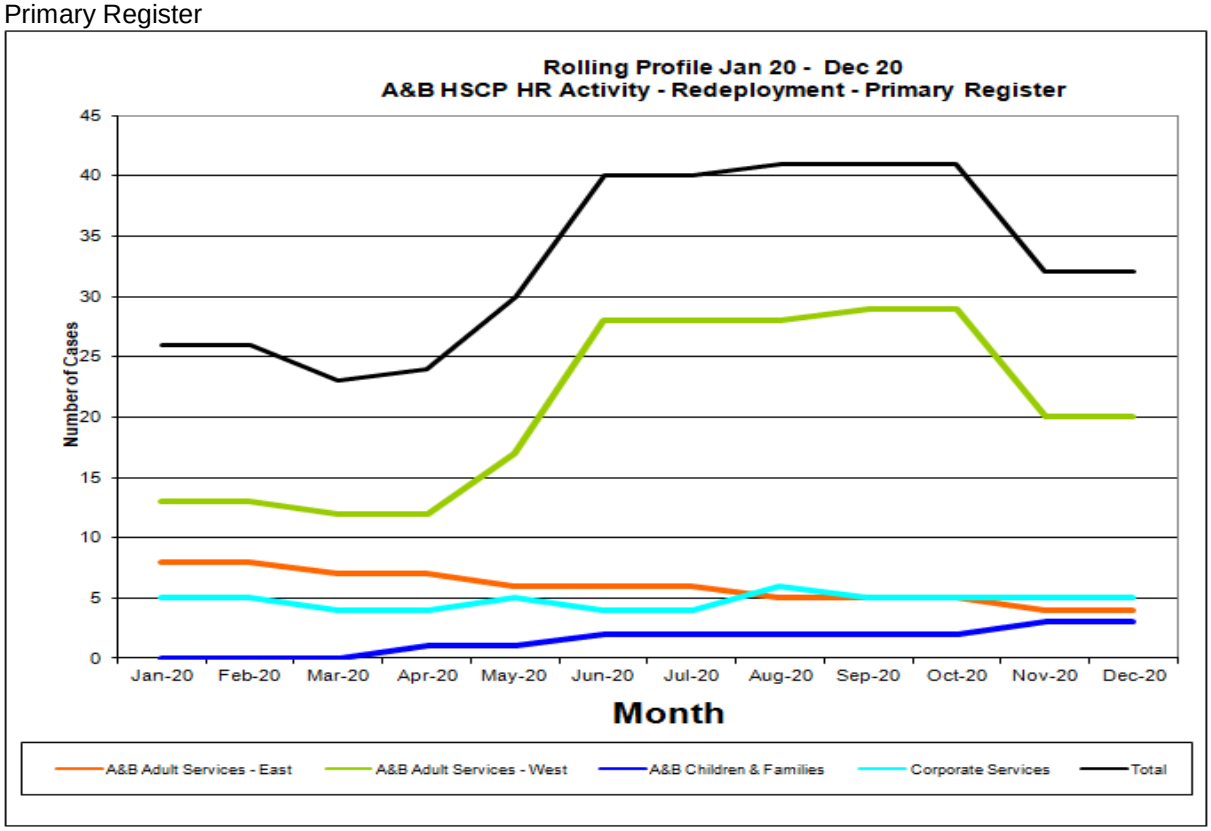
The breakdown of Council vacancies (detailed by Internal/Ring-fenced and External job adverts) for Q3 is detailed in the table below.

	Oct 2020		Nov 2020		Dec 2020	
	Internal/RF	External	Internal/RF	External	Internal/RF	External
Adult Services Community & Hospital	0	5	2	11	4	4
Adult Services Mental Health & LD	2	1	2	0	0	0
Children, Families and Justice	4	3	3	6	1	4
Strategy P&P	0	0	0	0	0	0
(HSCP PL3 DIRECTORATE)	0	0	0	0	0	1
Totals	6 (2 x Temp/ Casual	9	7 (2 x Temp/ Casual	17	5 (3 x Temp/Casual	9 (3 x Temp/casual

	4 x Perm)	(3x Temp/ Casual 6 x Perm)	5 x Perm)	(11 x Temp/ Casual 6 x Perm)	2 x Perm)	6 x Perm)
	15		**24**		**14**	

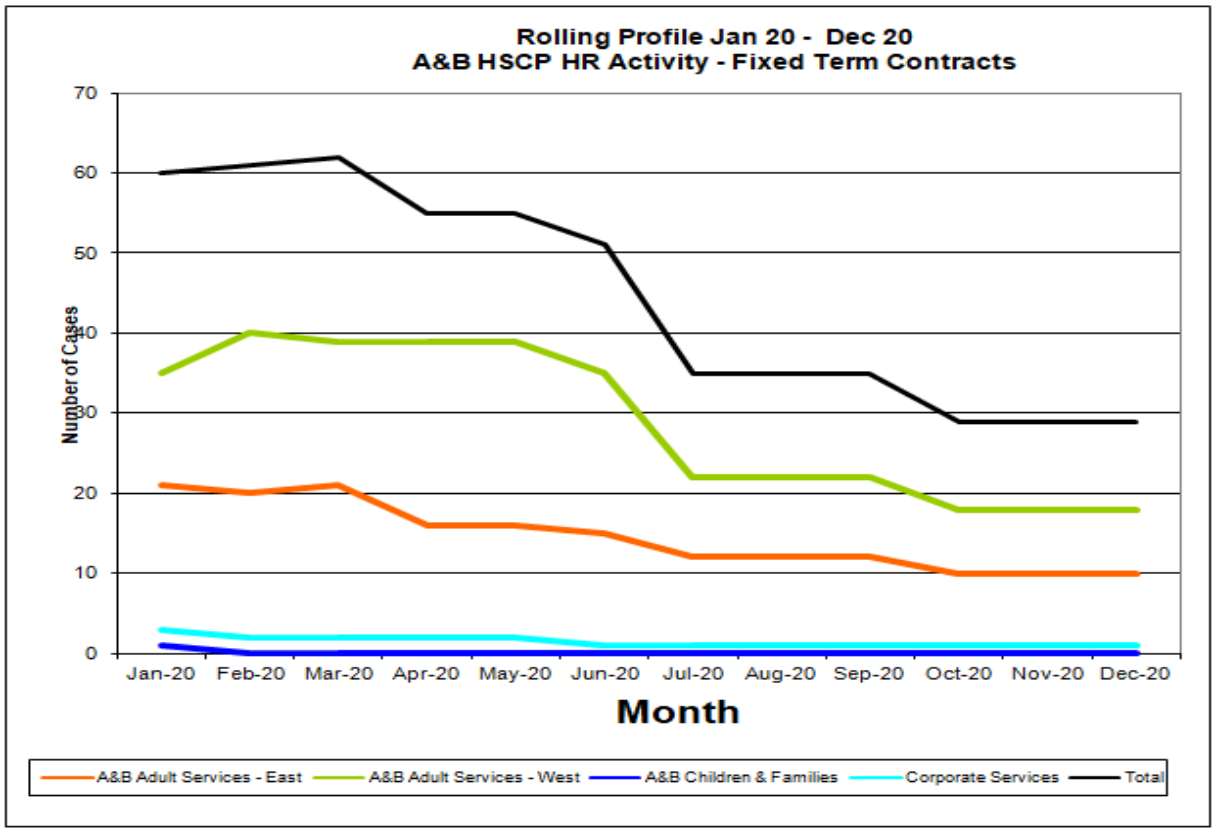
NHS Redeployment

Primary Register



Appendix 5 – Permament, Fixed Term and Casual Contracts (Q3)

NHS and Council Social Work/Care Temporary/Fixed Term Contracts

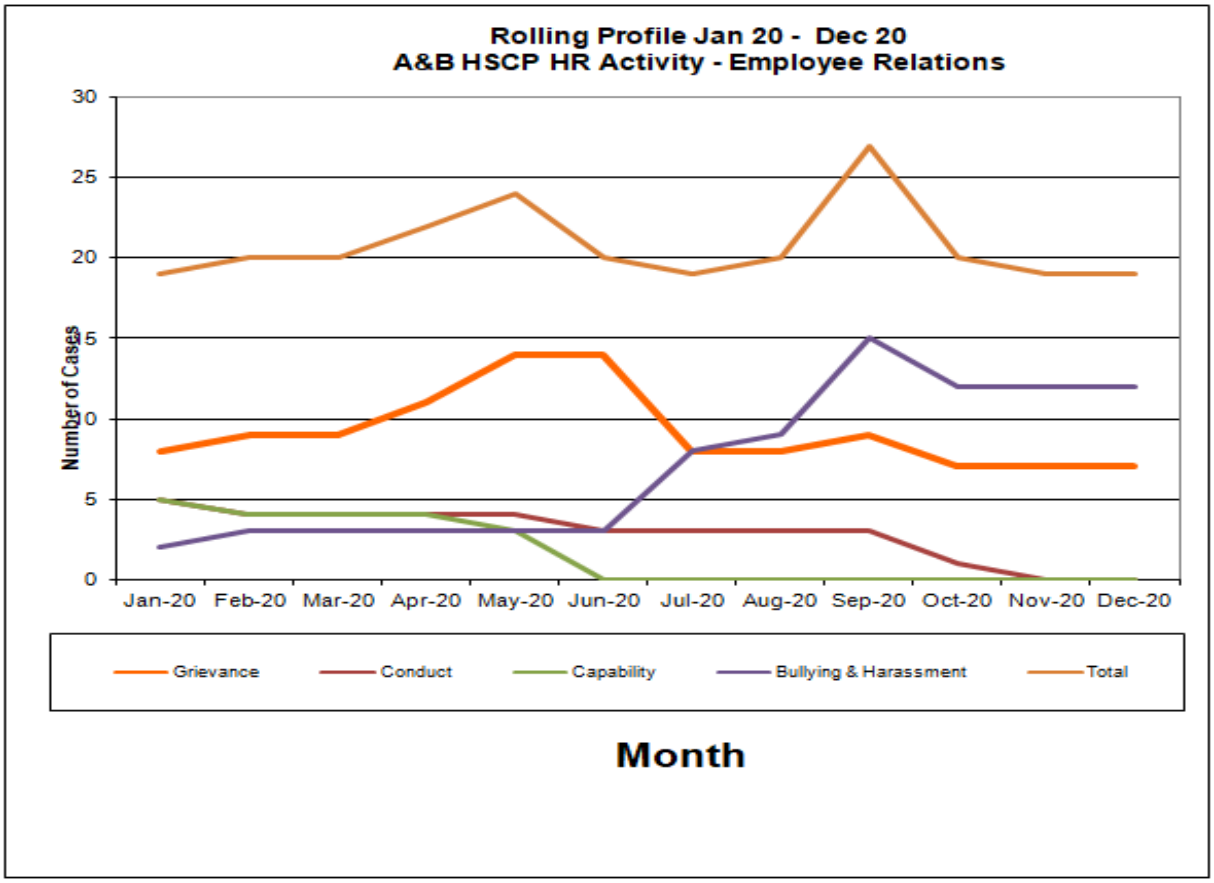


Council Social Work/Care Casual Workers

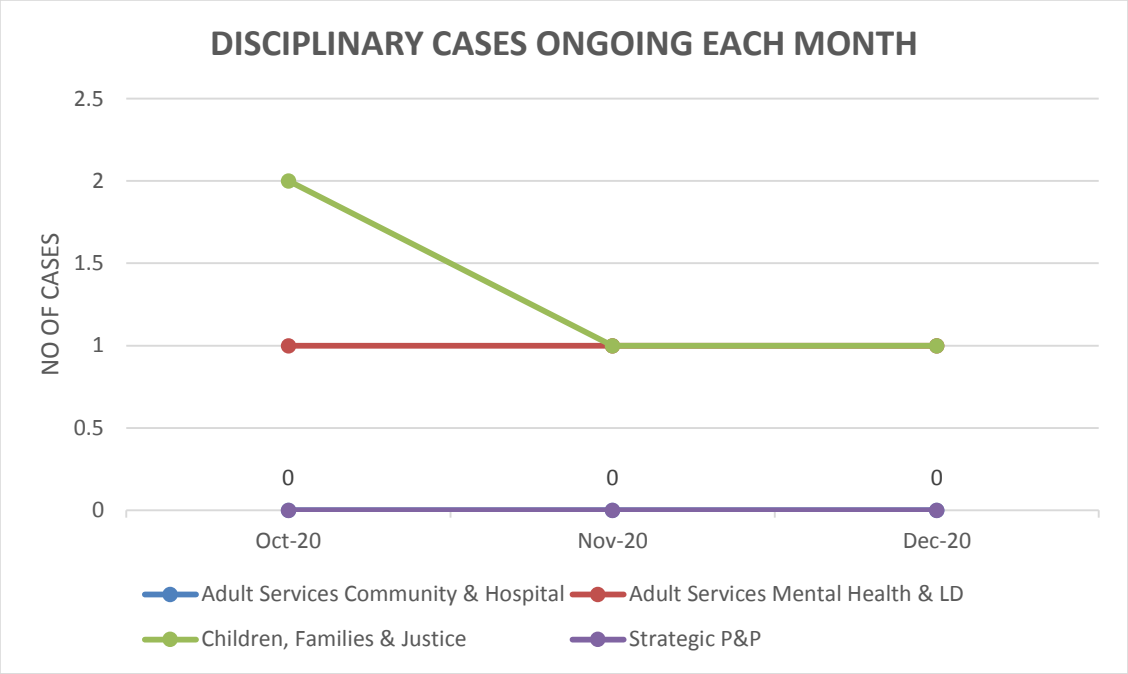
Total Number of Casual Workers (some also on Perm/Temp contracts)	Oct 20	Nov 20	Dec 20
Adult Services Community & Hospital	Data not available	587	610
Adult Services Mental Health & LD	Data not available	144	146
Children, Families and Justice	183	186	189
OVERALL TOTAL	**(183)**	**917**	**945**

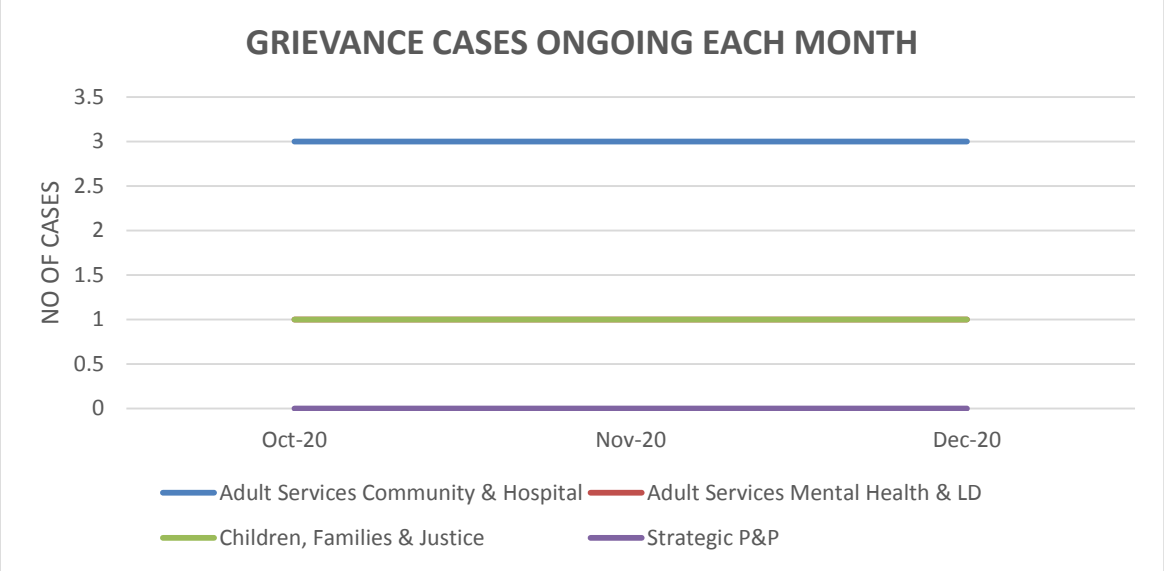
Appendix 6 – Employee Relations Cases

NHS ER cases



Appendix 6: Council Social Work/Care ER cases





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NHS Highland

Meeting:	**NHS Highland Board**
Meeting date:	**30 March 2021**
Title:	**Implementation of the Whistleblowing Standards**
Responsible Executive/Non-Executive:	**Fiona Hogg, Director of HR & OD**
Report Author:	**Fiona Hogg, Director of HR & OD**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Legal requirement

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report provides an update on the progress made with the implementation of the Whistleblowing Standards across NHS Highland, which come into effect on 1 April 2021. It sets out activity already completed, in progress and planned and any specific challenges or risks we face in implementation and compliance with the standards.

For clarity, information on the scope of the standards is included below.

2.2 Background

The National Whistleblowing Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS service providers to handle concerns that are raised with them and which meet the definition of a 'whistleblowing concern'.

All NHS organisations will be required to follow the National Whistleblowing Principles and Standards with effect from 1 April 2021. By the go-live date, any organisation providing an NHS service should have procedures in place that enable their staff, students, volunteers and others delivering health services, to access the National Whistleblowing Standards.

The INWO will then be able to investigate complaints about concerns that have been through the local whistleblowing process.

The Standards are applicable across **all NHS services**. This means that they must be accessible to anyone working to deliver an NHS service, whether directly or indirectly. This includes current (and former) employees, bank and agency workers, contractors (including third sector providers), trainees and students, volunteers, non-executive directors, and anyone working alongside NHS staff, such as those in health and social care partnerships.

Whistleblowing is defined in the Public Services Reform (Scottish Public Services Ombudsman) Healthcare Whistleblowing Order 2020 as:

"when a person who delivers services or used to deliver services on behalf of a health service body, family health service provider or independent provider (as defined in section 23 of the Scottish Public Services Ombudsman Act 2002) raises a concern that relates to speaking up, in the public interest, about an NHS service, where an act or omission has created, or may create, a risk of harm or wrong doing."

This includes an issue that:

- has happened, is happening or is likely to happen
- affects the public, other staff or the NHS provider (the organisation) itself.

People also often talk about ‘raising concerns’ or ‘speaking up’. These terms can also refer to whistleblowing. Whatever language is being used to describe it, the whistleblowing definition as set out above is the key. Risks can relate to a wrongdoing, patient safety or malpractice which the organisation oversees or is responsible or accountable for. In a health setting, these concerns could include, for example:

- patient-safety issues
- patient-care issues
- poor practice
- unsafe working conditions
- fraud (theft, corruption, bribery or embezzlement)
- changing or falsifying information about performance
- breaking any legal obligation
- abusing authority

- deliberately trying to cover up any of the above.

A whistleblowing concern is different to a grievance or to other employment policies such as bullying and harassment. These are typically a personal complaint about an individual's own situation in employment.

Healthcare professionals may have a professional duty to report concerns. Managers and all staff (including students and volunteers) must be aware of this, as it can affect how and when concerns are raised. However, the processes for handling concerns should be the same for any concern raised.

The Standards are designed to work with, not repeat or replicate, NHS processes and procedures that staff use every day to report what is happening in local areas. These processes and procedures are called 'business as usual' in the Standards.

People may report or mention issues through business as usual processes which could meet the whistleblowing definition. To avoid duplication and confusion, the procedure set out in the Standards should normally only be used if:

- no other procedure or processes are being used
- an existing procedure or process has been used but has not resulted in the outcome the person raising the concern expected, or
- the person asks for the whistleblowing procedure to be used.

People should raise concerns within six months of first becoming aware of the issue the concern relates to.

2.3 Assessment

2.3.1 Roles and Responsibilities

Everyone in the organisation has a responsibility under the Standards, however, there are some specific roles which are particularly important.

NHS Highland Board

The Board plays a critical role in ensuring the standards are adhered to.

Leadership – Setting the tone to encourage speaking up and ensuring concerns are addressed appropriately

Monitoring – through ensuring quarterly reporting is presented and robust challenge and interrogation of this

Overseeing access – ensuring HSCP, third party and independent contractors who provide services are able to raise concerns, as well as students and volunteers.

Support – providing support the Whistleblowing champion and to those who raise concerns.

Board Non-Executive Whistleblowing Champion

This role is taken on by **Albert Donald**, who has been in place since February 2020.

The role monitors and supports the effective delivery of the organisation's whistleblowing policy and is predominantly an assurance role which helps NHS boards comply with their responsibilities in relation to whistleblowing. The whistleblowing champion is also expected to raise any issues of concern with the board as appropriate, either in relation to the implementation of the Standards, patterns in reporting of concerns or in relation to specific cases.

INWO Liaison Officer

This role is taken on by **Fiona Hogg**, Director of HR and OD, as a result of her executive lead role in Culture and Communications. This is the main point of contact between the INWO and the organisation, particularly in relation to any concerns that are raised with the INWO. They have overall responsibility for providing the INWO with whistleblowing concern information in an orderly, structured way within requested timescales. They may also provide comments on factual accuracy on behalf of the organisation in response to INWO investigation reports. They are also expected to confirm and provide evidence that INWO recommendations have been implemented.

HR Lead

This role is taken on by Gaye Boyd, Deputy Director of HR and is responsible for ensuring all staff have access to this procedure, as well as the support they need if they raise a concern. They are also responsible for ensuring that anything raised within HR procedures which could amount to a whistleblowing concern is appropriately signposted to this procedure for full consideration, ensuring that all staff are made aware of the Standards and how to access them, including the channels available to them for raising concerns. They must also ensure that managers have the training they need to identify concerns that might be appropriate for the Standards and to manage them appropriately.

However, it is important to note that Whistleblowing is not a process overseen by the HR team and as set out above, it is separate to our main people processes, reflecting the different scope and nature of Whistleblowing complaints .

Confidential Contacts

This "confidential contact" role which is set out in the Standards, is carried out in NHS Highland by our independent Speak Up **Guardian Service**. All organisations that deliver services for NHS Scotland must ensure that they provide staff with at least one point of contact who is independent of normal management structures and who has the capacity and capability to be an initial point of contact for staff who want to raise concerns. They

support staff by providing a safe space to discuss the concern and assist the staff member in raising their concern with an appropriate manager.

Our Guardian Service will provide this role across all areas that the standards cover, including independent contractors and primary care. They also work with the organisation to promote the standards and ensure they are being applied correctly.

There are lots of other contacts and routes for colleagues to chose to discuss a concern and to raise this,

Chief Executive / Executive Directors / Senior Management

Overall responsibility and accountability for the management of whistleblowing concerns lies with the organisation's chief executive, executive directors and appropriate senior management

Managers

Any manager in the organisation may receive a whistleblowing concern. Therefore all managers must be aware of the whistleblowing procedure and how to handle and record concerns that are raised with them, with their colleagues and also with any third party or independent contractors who deliver services on our behalf.

Union representatives

Union representatives play a key role in supporting members to raise concerns and providing insight into the effectiveness of our systems and processes.

All colleagues

Anyone who delivers an NHS service should feel able and empowered to raise concerns about harm or wrong-doing. They should be trained so they are aware of the channels available to them for raising concerns, and what access to the Standards means.

Integrated Joint Boards (IJB) and Health and Social Care Partnerships (HSCP)

IJBs and other monitoring arrangements must ensure that all HSCP staff, across both the local authority and the NHS, as well as any students, trainees, agency staff or volunteers, are be able to raise a concern through this procedure. It is therefore, more important than ever that senior managers in HSCPs and the integration joint board (IJB) itself promote a culture that encourages staff to raise issues or concerns at the earliest opportunity.

Primary Care

All primary care providers and contracted services are required to have a procedure that meets with the requirements of these Standards. This means that any organisation delivering NHS services, whether it is a private company, a third sector organisation or a primary care provider, has the same requirement to ensure access to a procedure in line

with these Standards. NHS Highland colleagues who manage the contracts and relationships with Primary Care will be critical in promoting awareness of the Standards.

Managers and Supervisors of Students and Trainees

Those who supervise students and trainees who are working in our organisation, but aren't usually employed by us, have a specific responsibility to ensure that they are aware of the Standards and how they can raise a concern.

Volunteer Coordinator

The Standards also apply to Volunteers, who are working in our services. It is important that they are made aware of the Standards and how to raise a concern and access support.

2.3.2 Training

Training in the Standards and how to make or receive a concern is critical. To help with this, the INWO team have created two learning programmes. One is for staff needing an overview of the Standards and the other is for managers. The managers' programme is for any person working in the NHS who is likely to receive concerns. It covers in-depth what a manager needs to know to be able to respond to a concern. NHS Highland would expect all Executives and Senior Managers to complete the manager training and to identify anyone in their wider teams who they would expect to carry this out, recognising that due to the serious nature of whistleblowing concerns, these should be escalated to and dealt with at an appropriate level.

These are available on the TURAS Learn site to which all NHS colleagues have access and is being promoted now. National Whistleblowing Standards training | Turas | Learn (nhs.scot) . Non NHS colleagues can also get access to this by signing up for a free account. We will be actively promoting this via leadership cascades and our communications channels.

There is also an excellent website, https://inwo.spso.org.uk/ again publicly available, which is easy to navigate and has lots of helpful information and resources.

Through the Turas Learn portal, managers can see who in their team has completed the learning and this will go down several levels in the structure. We will also be able to provide customised reporting which will give us an organisational picture of how many people have completed the training.

We will be setting up "Ask Me Anything" sessions on the Standards, where we can further promote the training and encourage people to discuss and ask questions they have.

There is a requirement for us to ensure any investigations are carried out by managers who are appropriately trained and skilled, and this skill is part of our ongoing Once for

Scotland policy training and our People Processes workstream. Initially, we will rely on our most senior and experienced leaders to support any requirements, whilst we complete further training, These individuals wouldn't just be trained to investigate Whistleblowing concerns, they would form part of a highly skilled resource to support a range of investigations which the organisation undertakes.

2.3.3 Investigating and Recording Concerns

A key part of the standards is ensuring that concerns are recorded, tracked and investigated appropriately and in a timely manner. This is why NHS Highland is using the Speak up Guardian service to support this, as it has been in place since August 2020 and is well known across the organisation as an independent channel to raise concerns and has two dedicated full time staff, an established reporting process and agreed channels and escalation routes into all areas of the organisation.

The role of the Guardian service is not to determine if the concern is or isn't a whistleblowing concern or investigate the concerns, but to ensure that the appropriate person within the organisation is made aware of the concern, a decision made and recorded by an appropriate person about the status and how it is handled, and to track and monitor the progress with the concern, escalating as required, if it is not being addressed in line with agreed policy and / or the standards. This has been in place for all concerns since August 2020 and has taken on over 100 cases to date, which is why we are confident the process is well established and robust.

NHS Highland have agreed a number of specific contact points for the Guardian Service, to make the decision on whether something is a whistleblowing complaint. This includes senior Professional Leadership, Clinical Governance Leads, senior Finance and HR professionals, the Fraud Liaison Officer, Deputy Chief Execuive and the Head of Occupational Health & Safety.

Where a concern is raised to another person, they will make contact with the Guardian Service to register the concern and for progress to be tracked and recorded by the Guardian service, to ensure this is in line with our processes and the standards.

An additional benefit of this approach is that where a concern is deemed not to be a Whistleblowing concern, the Guardian service can still provide advice and support to colleagues and it would still be reported under our usual processes so we can learn from this.

NHS Highland will not be using the Datix system in recording or reporting Whistleblowing concerns, although clearly an incident or concern recorded in the system could end up being a source of a whistleblowing concern. However, we will not have to rely on this for our tracking and reporting and we believe the Guardian Service will provide us with much more robust and accurate data, given their expertise and their role in the wider process.

2.3.4 Route for logging Whistleblowing concerns

The Guardian Service have set up a dedicated Whistleblowing Line for NHS Highland, which will operate Monday – Friday 9am to 5pm on 0333 733 8448 and an email route via contact@theguardianservice.co.uk . This will ensure that any potential whistleblowing concern, whether from an NHS Highland employee or a third party, can be picked up and addressed. This can be contacted by the individual or someone else on their behalf who they have discussed this with, to register the concern, such as a manager, colleague or union rep.

This will be promoted as part of our campaign to promote understanding of the Whistleblowing Standards and encouraging Speaking Up.

There is also the ability to contact the **INWO** by phone 0800 008 6112 or email INWO@spso.gov.scot , who can provide information and advice about how a concern should be handled, and can provide support through the process. However, it is the responsibility of NHS Highland to manage the complaint through the 2 stage process.

There are lots of other channels for support, including managers, colleagues, trade unions and professional bodies, as well as our Occupational Health service, Employee Assistance Programme and Chaplaincy service.

2.3.5 Oversight of Implementation

An Implementation Group has been established and has been meeting fortnightly, and currently is meeting weekly over the launch period. This is chaired by the Director / Deputy Director of HR and attended by the Whistleblowing Non Executive, alongside representative from across the organisation and professional groups, as well as third parties, including primary care, adult social care and Argyll & Bute and Highland Council.

They have been reviewing plans, commenting on proposals and tracking progress and providing feedback about their respective areas and will continue to meet for the coming weeks until we are confident that initial phase of implementation is complete, with meetings then less frequent, but still checking in to ensure ongoing promotion, awareness and highlighting of any issues.

They will also form a network out into the wider organisation and our third parties, to promote awareness and share information about the standards.

The Implementation Group will continue to meet until it is felt all elements of the Standards have been implemented and are working effectively. It will provide reporting on progress to the Staff Governance Committee and Highland Partnership Forum, as well as the Culture Oversight Group.

2.3.6 Communication

We have a communications plan which has been drafted with input from a working group, including colleagues from Communications, HR, Culture, Staffside and Clinical leadership.

Our approach to communications and awareness raising is to build this into a wider multi-channel campaign entitled “Speak Up, Listen Up” which will run from late March to late May. It’s important that we don’t overload people with lots of communication in early April, especially given the proximity to Easter holidays, the ongoing pressures on delivering services and remobilising as there is a risk this would be missed.

Our “Speak Up, Listen Up” campaign will have several distinct aims:

- Promote the launch of the standards and our response to this
- Build understanding of what whistleblowing is and what it isn’t,
- Promote the raising of concerns and whistleblowing and the routes to do so,
- Promote the required actions we need to take when someone raises a concern,
- Promote understanding of the role of the Whistleblowing Champion.
- Promote and link to the wider cultural development work, including values and behaviours, civility saves lives,
- Encourage colleagues to engage with the organisation and each other, to give feedback not just about concerns but about suggestions and praise and thanks.

And will be delivered through the following channels

- Email
- Intranet
- Posters
- Social Media
- Ask me anything sessions
- Webinars / E Learning and Turas
- Team Briefing packs
- Virtual sessions with Guardian Service, Staffside, HR, WB champion and others
- Awareness sessions at key meetings and committees, including Board, IJB, EDG
- Videos / Podcasts / Story telling about experiences of raising concerns
- Staffside and national Trade unions / Professional bodies

We are also exploring the concept of holding a virtual conference on the subject of Speaking Up, given our experience and our access to a range of individuals and organisations who have supported this.

We’ve already initiated the communications, with an initial message in the weekly update email to all colleagues on 19 March. There will be several further communications via email in the lead up to the 1 April and afterwards. Posters are being commissioned for

display in key locations, and an Ask Me Anything session will be scheduled for early April and recorded.

We've already discussed the Standards at the Executive Directors Group on 15th and 22nd March, at the Highland Partnership Forum on 19th and 26th March and at the Argyll & Bute Clinical and Care Governance Meeting on 18th March. This paper will also be presented at the Argyll & Bute IJB meeting on 31st March. Executives and Senior Managers will add this to their leadership meeting agendas and it will also be covered at the Corporate Services Management meeting on 31st March.

We believe that our longer term "Speak Up, Listen Up" campaign running across several months, will ensure that widespread awareness and understanding is built, not just of the Standards and Whistleblowing, but encouraging colleagues to understand how to share concerns and for the organisation to know how to respond to these.

2.3.7 Readiness Assessment

The Whistleblowing Standards are extensive and place a significant responsibility on the organisation, at a time when we our capacity to deliver and absorb change is limited. We will not be fully compliant with every aspect of the standards on the 1st April however, as set out in a recent letter from the INWO, it is understood that this will be a work in progress and the important thing is that Boards have a plan to address this effectively, which we have set out here.

I am confident that we have put systems and processes in place that mean that on or after 1 April 2021, concerns raised will be able to be appropriately dealt with in line with the Standards, through a dedicated phone line open to all, including 3rd parties, and that an appropriate tracking and escalation system is already in place to ensure we address and record in line with the standards.

Initial awareness raising activity will have been delivered through internal and external channels, as set out above, and so as many people as possible will have been made aware of the Standards and what they mean and encouraged to access the training and more information. Management will be actively promoting this with their teams and key contacts will share the information with third parties.

Most important to us is that we will spend significant time and effort over an extended time period, to both establish the standards, but also their place in our wider system of raising and addressing concerns and improving trust and developing ourselves as a listening and learning organisation. This will ensure that everyone hears about and understands the standards and their place in our organisation.

The Board will not be fully compliant with the Standards on 1 April 2021, with ongoing work to fully document investigation processes and to roll out investigation training a key

area for us to continue to progress. Awareness with third parties who deliver services on our behalf will also not be fully covered off on 1 April, but again, plans are in place to do so, through a range of channels and contacts. Training will be available, but attention will be needed to ensure that this is promoted effectively, especially given the pressure the organisation continues to be under. We would expect these elements to be fully in place by 31 July.

2.3.7 Risks and Mitigation

The main risk is that a concern is raised, on or after 1 April, inside our organisation or with a service provider, which is a whistleblowing concern, and it is not handled correctly.

We will mitigate that risk by ensuring all those who may be involved in a concern, understand the requirements and the process, including managers, staff side, HR, our clinical governance and complaints teams, and those who deal with primary care, HSCPs third parties and contracts. This is part of our communication and engagement approach.

Our Guardian Service is also a key mitigation, in already being established as the mechanism for raising concerns and who will be able to direct any concerns raised into the correct process, if they believe they may be in scope.

There is also a risk as not all of the Standards will be fully in place on 1 April 2021, as set out above. However, as noted in the INWO letter of 26 February, the important thing is that we have an action plan in place to address this, which we do have. The Implementation Group will continue to meet fortnightly to oversee progress until it is felt that all areas have been established and are running effectively.

For NHS Highland, the establishment of the Standards and our response to these has ensured that we do now have a effective process and policy for Whistleblowing, which has been a previous challenge for the Board in being able to identify and track concerns which may be whistleblowing.

2.3.1 Quality/ Patient Care

The Whistleblowing Standards are designed to support timely and appropriate reporting of concerns in relation to Quality and Patient Care and ensure we take action to address and resolve these.

2.3.2 Workforce

The Whistleblowing Standards will require some additional resource including to lead investigations, but this is being covered as part of the wider people processes work under the Culture programme and a resource request will be confirmed in the next few weeks. Our workforce will have additional protection in place under these standards.

2.3.3 Financial

The Whistleblowing Standards also offer another route for addressing allegations of a financial nature. There are no immediate cost implications of implementing the standards as the Guardian Service is already in place, although there may be some small costs for promotion, however, ensuring there is a robust mechanism for addressing concerns could lead to significant future cost avoidance due to litigation or other claims.

2.3.4 Risk Assessment/Management

The risks of the implementation have been assessed and included. Consideration is being given to where this would sit on our operational and board level risks.

2.3.5 Equality and Diversity, including health inequalities

No specific impacts

2.3.6 Other impacts

None

2.3.7 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

- INWO
- Councils and key third party stakeholders who deliver services

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Highland Partnership Forum, Friday 19 March 2021
- Whistleblowing Standards Implementation Group, Monday 22 March 2021
- Executive Directors Group, Monday 22 March 2021
- Culture Oversight Group, Monday 22 March 2021

Confirmation received from EDG on 22 March 2021

2.4 Recommendation

- **Discussion** – Examine and consider progress and the proposed approach to implementation and any associated risks and issues.

Agenda Item 10

A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item:**

Date of Meeting: **31st March 2021**

Title of Report **COVID19 Public Health update**

Presented by: **Dr. Nicola Schinaia, Associate Director of Public Health**

The Integrated Joint Board is asked to:

Consider the COVID19 current status update, in terms of:

- ◊ distribution of infection rates in A&B community;
- ◊ COVID-19 testing in A&B community;
- ◊ COVID-19 vaccination in A&B community;
- ◊ support to A&B community during the peak of COVID-19 pandemic and its adaptation to the new response phases

1. EXECUTIVE SUMMARY

This paper reviews the work of Public Health in Argyll and Bute relating to COVID-19 and focuses on four main areas:

- Understanding the epidemiology of COVID-19 in Argyll and Bute – following a considerable spike in number of infections earlier this year, with symptomatic people with varying degrees of severity, incidence rates have considerably dropped recently.
- Testing for SARS-CoV-2 in Argyll and Bute – alongside established processes, new sites have been established. New programmes have started, such as the testing of all patient facing health and social care staff, and it is about to start the testing of asymptomatic people.
- The follow up programme of reported cases has kept up to increased demand, and has contributed to identifying reasons for acquiring this virus.
- Vaccination program for COVID-19 – following sound planning, almost have of adult population have already been injected.
- Caring for people work stream supporting our communities is adapting to changing situation.

2. INTRODUCTION

This paper builds on accounts provided in the earlier reports, and will present the most timely update as possible of how the pandemic is unfolding in A&B, as well as the improved response, in terms to timely access to testing and clinical management.

3. DETAIL OF REPORT

A. Epidemiology of COVID-19 in Argyll and Bute

Epidemiology Briefing

The report in Appendix 1 is prepared centrally by the Public Health Intelligence team within the main Public Health Department of NHS Highland. It offers snapshots of information through tables and graphs.

Number of confirmed cases in Argyll and Bute has decreased since a peak near the beginning of February.

Methodological Notes

- The graphics presented are based upon the date that tests are undertaken (specimen date) and include data to the 21st March 2021.
- The fixed tables within the report show the position to 19th March 2021, the most complete week for which data are available. This is due to the 2-to-3-day time delay in processing tests and submitting records for inclusion.
- Data in the Epidemiology Briefing may differ slightly from that published by Public Health Scotland.
- Data on confirmed cases in the Epidemiology Breifing is sourced from the Test and Protect Data Virtualisation.
- Please also note that data are dynamic and may be different depending on the day the data are accessed.

Local Area Data

The following shows number of cases by Intermediate Geography area for week ending 20th March and week ending 13th March.

- Data are suppressed in many neighbourhood areas.
- Note that cases can occur in any area.

The data source is Public Health Scotland. Please note that the names of these areas can be misleading. A map showing neighbourhood areas is available here: COVID-19 Daily Dashboard - PHS COVID-19 | Tableau Public

Local Area	Notes	7 days until:	
		20-Mar-21	13-Mar-21
Bute	Does not include all of the area of Bute. There is a separate area for Rothesay	*	*
Rothesay Town		*	*
Cowal North	Includes part of H&L area e.g. Arrochar	*	*
Cowal South		*	*
Dunoon		*	*
Hunter's Quay		*	*
Garelochhead	Includes Faslane	*	*
Helensburgh Centre		*	*
Helensburgh East		*	*
Helensburgh North		4	*
Helensburgh West and Rhu		*	*
Lomond Shore		*	*
Whisky Isles	Includes Islay, Jura and Colonsay	*	*
Campbeltown		*	*
Kintyre Trail	Not including Campbeltown	*	*
Greater Lochgilphead	Includes Lochgilphead and Ardrishaig	*	*
Knapdale	Includes Tarbert as well as Kilberry, Inverneil, Tayvallich and Achnamara	*	*
Mid Argyll	Includes Inveraray and Ardfern. Does not include Lochgilphead or Tarbert	*	*
Mull, Iona, Coll and Tiree		*	*
Benderloch Trail	Relatively large geographical area including Benderloch, Apin and Lismore	*	*
Loch Awe	Relatively large geographical area.	*	*
Oban North		*	*
Oban South		*	*

Source: Public Health Scotland * suppressed data. Accessed 23rd March

Modelling

As reported by the Scottish Government on 18th March, with estimates dated 17th March:

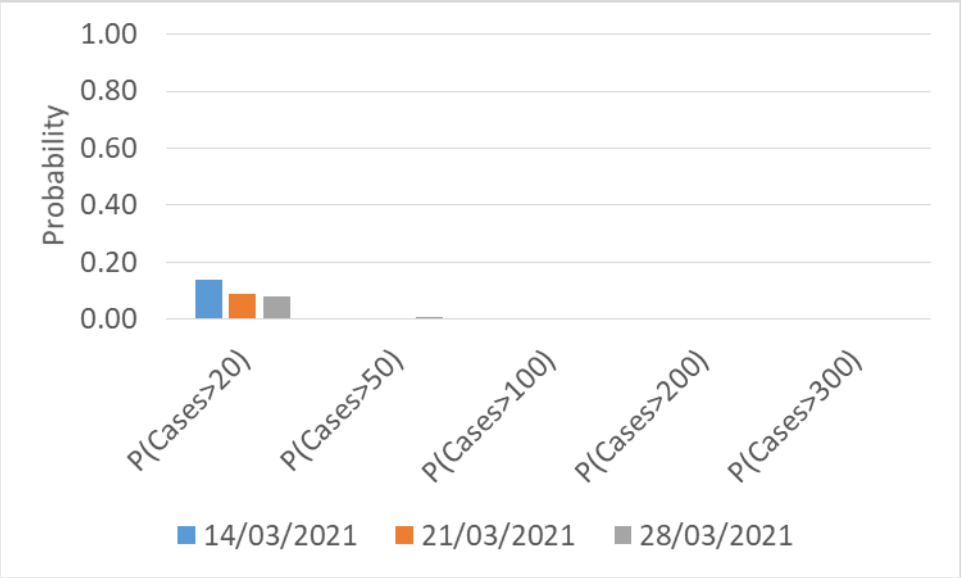
- The reproduction rate R in Scotland is currently estimated as being between 0.7 and 1.0.
- The number of new daily infections for Scotland is estimated as being between 1 and 18, per 100,000 people.
- The growth rate for Scotland is currently estimated as being between -6% and -2%.
- Hospital bed and ICU occupancy are projected to fall over the next few weeks, but with the potential to plateau, or increase, as a result of schools reopening.

Coronavirus (COVID-19): modelling the epidemic - gov.scot (www.gov.scot)

Imperial College London estimate the R number for Argyll and Bute, at 17th March, to be 0.76 (90% confidence interval between 0.62 and 0.86). The

probability of > 20 cases per 100,000 population is now estimated to be <0.75 for w/c 14th March to 28th March (Figure 1).

Figure 1. Modelled probability of case rates per 100,000 for Argyll and Bute for weeks commencing 14th March, 21st March and 28th March



Source: COVID-19 UK (imperialcollegelondon.github.io) Data updated 23rd March

Test and Protect

How this service works has been explained in detail in our previous Public Health update. It is managed by the Health Protection team within the Public Health Directorate, and is operated by Department staff as well as additional staff purposely recruited and trained, working h8:00 am – 8:00 pm, 7 days per week. Positive cases are electronically fed into the Health Protection Team and are phoned individually. Information is collected on a standard national web-based database, aimed primarily at identifying:

- People that have been in close contact with case
- Risk exposure for cases, or settings where transmission may have occurred or infection could be spread further.

The HPT works in close contact with the AB Council Environmental Health (EH) Department. Namely, EH receive notifications from HPT team in respect of businesses linked to positive cases or close contacts. These business require to be assessed.

School linked cases continue with effective arrangements in place between NHS and Council Education, although are no longer an issue of major concern in the last few weeks.

Information from contract tracing carried out has been used by NHS Highland to appeal to the public to follow COVID-19 guidance and “stay at home”. Pre-Christmas socialising combined with people mixing indoors over the festive period has been described by the Health Protection Team as having thought to be the cause of increased infections in Highland and Argyll and Bute Council areas. When the number of cases of Covid-19 rises in our communities, we inevitably also see an increase in positive cases in health care workers and care home staff. So strong reminders were issued not to mix with others outside

own household, despite awareness of how challenging this has been for many people.

B. Testing for COVID-19 in Argyll and Bute

This section will include:

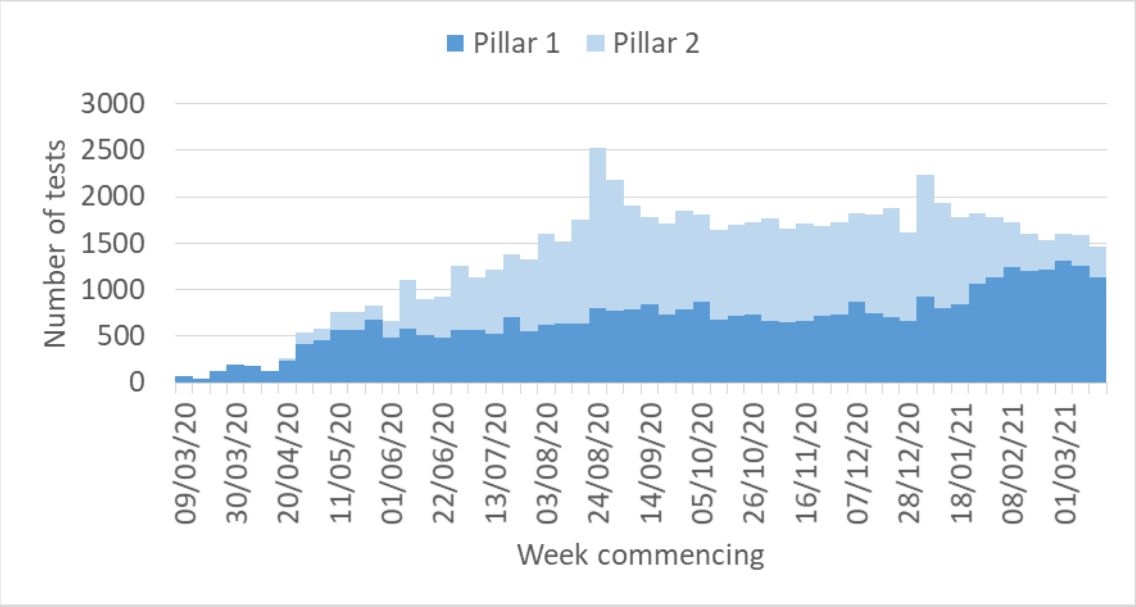
- An update on testing volumes, including some recent developments aimed at increasing efficiency and effectiveness of the programme;
- A detailed outline of the newly introduced testing programmes, namely the Lateral Flow Device (LFD).

B1 PCR Testing volume

Testing for COVID-19 in Argyll and Bute is accessible through different pathways for the public, hospital patients, symptomatic health and social care staff or household contacts, care home staff and residents and non-health and social care keyworkers. The total volume of testing, as published by Public Health Scotland, is shown in Figure 2.

Pillar 1 relates to NHS testing whereas pillar 2 relates to UK Government laboratory test including those conducted at UK Government sites including mobile testing units, and home tests. Note that some routine testing of care home staff has moved from UK Government to NHS laboratories in recent weeks.

Figure 2. Weekly number of tests of Argyll and Bute residents, as published by Public Health Scotland.



Source: Public Health Scotland. Accessed on 23rd March 2021
https://www.opendata.nhs.scot/dataset/COVID-19-in-scotland

Use of Mobile Testing Units in Lochgilphead, Campbeltown, Rothesay and Dunoon have ceased with the roll out of home tests provided through Scottish Fire and Rescue Service (SFRS). From 2nd March, these were available in:

- Arrochar
- Campbeltown
- Cove (Loch Long)
- Dunoon
- Lochgilphead
- Tarbert
- Rothesay

The number of days that testing is available in Helesburgh has increased to 7-days a week since 15th February, leading to an increase in testing volume at this site in that week (and a decrease observed in Argyll and Bute residents acessing the Glasgow Airport test site). Use of home delivery of tests has increased in January with the availability of the Fire Station sites. Large numbers of PCR tests each week continue to occur for Argyll and Bute Care home staff.

Referrals continue for NHS testing from Argyll and Bute Council via or Social work admin with the volume of referrals having reduced from 46 in the 4 weeks from 4th January to 20 in the proceeding 4 weeks, commencing 1st February.

B2 Lateral Flow Device (LFD) testing

Key Messages

- The Covid Testing Portal has been improved allowing staff to create a personal account and record their result quickly and easily and in addition, a bulk upload facility allowing multiple results to be added simultaneously.
- Test kits are for staff member use only and should not be used by family members, including in the event of a positive test. Staff with a positive LFD test will undertake confirmatory PCR using their organisations pathway.
- Staff must continue to undertake the twice weekly testing during periods of annual leave and record all test results (positive, negative or invalid) on the covid testing portal within 24 hours of taking the test.
- 1350 kits have been ordered from NSS for the resupply of Healthcare staff. Localities will receive their allocation in the coming weeks for distribution to staff who will require their next set of kit. Staff must complete the electronic form prior to collecting their next test kit.
- The Scottish Government announced on the 17th March the inclusion of testing for all remaining healthcare workers including those in non-patient facing roles – further guidance is awaited with the implementation expected to take place in April.

Overview

Lateral Flow Device (LFD) testing for asymptomatic staff is currently being rolled out to all frontline Health and Social Care workers across the country, including Primary Care. This programme is based on Guidance from Scottish Government to Boards and HSCPs.

The programme is not mandatory however we encourage all eligible staff to consider taking part and aim for 80% participation rate. Staff wishing to participate must complete a registration form prior to collecting their test kit. This procedure confirms that staff agree to follow the instructions for use, are competent to undertake the test and will register the result of every test (positive, negative or invalid) on the Covid Testing Portal within 24 hours of taking each test - contact tracing will be initiated by registering the test result on the covid portal. Staff undertake testing twice weekly. If they return a positive test result, they (and their household), must immediately self-isolate. The staff member must contact their Line Manager and arrange a confirmatory PCR test using their organisations' pathway.

This programme is managed across NHS Highland, with 4 main workstreams: Raigmore, New Craigs, North Highland Community Services, and Argyll and Bute.

LFD testing has been extended to social care where up to two designated visitors a week can test prior to visiting care home residents.

We await guidance from the Scottish Government regarding the inclusion of Children and Families social work staff, however this programme is currently being implemented. Data regarding the number of kits allocated will be included in this report going forward.

LFD testing of staff and senior Secondary School students programme has started and Community Asymptomatic Testing and Screening (ATS) is in development and will be in place in the coming weeks.

Progress in Argyll and Bute

There are three workstreams: Healthcare Workers, Adult Social Care, and Primary Care (GP practices).

Figures for Kits Issued to Staff in Argyll and Bute.

Number of test kits issued to staff by workstream as of 19/3/2021.

Workstream	Kits issued to staff
Healthcare workers	1392
Social Care staff	1518
Total	**2910**

All three workstreams have been initiated but are at different stages of implementation. Independent Primary Care now receive push delivery of kits and therefore are no longer included in this report. The total number of kits

issued across the three work streams above has increased by 65 from previous week.

An electronic system for NHS Healthcare staff to register when they have collected test kits was launched on 23rd February and can be accessed here. A link is also available on the Intranet, however you do not need access to the intranet to use the form. The link can also be accessed on tablet and mobile devices by emailing or texting the link. Paper registration forms will not be used for reissue of kit.

Data on all of the LFD programmes has become available on the Public Health Scotland Dashboard and will improve in the coming weeks and months.

Healthcare Workstream

This week approximately ten additional kits have been allocated to staff, all localities are at the stage of identifying the last remaining eligible staff. Sites with a small surplus of kits are advised to keep this for issuing to people such as: eligible staff who have yet to be identified, students, bank workers and newly recruited staff.

Re-allocation of kits will begin in the coming weeks and will require staff to register using the electronic kit registration form.

Number of test kits supplied and allocated to Healthcare Staff up to 19/3/21

Location	Kits Delivered to sites	Kits supplied to staff	Unallocated
Oban	450	441	9
Lochgilphead	325	325	0
Kintyre	130	122	8
Islay	100	84	16
Mull, Tiree, Colonsay & Coll	36	36	0
Cowal	182	170	12
Bute	115	110	5
Helensburgh	128	104	24
Total	**1466**	**1392**	**74**

Social Care Workstream

There has been an increase of 54 kits distributed to care providers, the total number of kits issued to social care workers to date is 1518.

Table shows kits issued the week of 15th to the 19th March from Hubs.

Allocation Detail	Bute	Cowal	Helensburgh and Lomond	Islay	Kintyre	Mid Argyll	Oban Lorn	Totals
Adult Social Work, Mental Health and Children and Families	0	0	0	0	0	0	0	**0**
Day Services	1	0	0	0	0	0	0	**1**
Self-Directed Support, Personal Assistants	0	0	0	0	0	3	0	**3**
Internal Homecare	0	0	0	0	0	0	50	**50**
External Care at Home Housing Support	0	0	0	0	0	0	0	**0**
Child Residential, Hostel	0	0	0	0	0	0	0	**0**
TOTALS	**1**	**0**	**0**	**0**	**0**	**3**	**50**	**54**

Recording of Test Results by Staff on the Covid Testing Portal

Up to Friday the 19th of March 84,450 tests have been registered from NHS Highland area across all staff groups on the Covid Testing Portal. 9690 tests were registered between the 12th and 18th of March, an increase of 135 on the previous week. It is not currently possible to extricate Argyll and Bute Healthcare/Social Care/Primary Care staff figures from the data provided by the portal.

The Scottish Government are aware of the limitations of the Covid Testing Portal however there have been significant improvements to the portal. Improvements include the creation of user accounts so personal information will only have to be input once.

It is important that staff do not share their LFD test kits with family members and that record their results, (positive, negative and invalid) after each test on the Covid Testing Portal even during annual leave periods.

Positive Lateral Flow Device Tests

NHS Highland Occupational Health have reported 15 positive LFD Test results from Healthcare staff in NHS Highland to date, and 4 of those returned positive PCR results. This has remained the same since 24th February 2021.

Internal Social Care have reported no positive tests and 1 invalid result to date.

B3 Asymptomatic Community Testing section

NHS boards in Scotland have been tasked by the Scottish Government to develop plans to implement asymptomatic Covid-19 testing. This will complement other areas of Covid-19 testing. The purpose of this asymptomatic testing is to identify people who are unknowingly infected with the Covid-19 virus and who may subsequently transmit the virus to other people. Boards have been directed to customise their own asymptomatic testing plans based on local needs, for example, current and previous known incidence rates, demographic factors, and other variables such as waste water sampling. Asymptomatic community testing is being delivered in partnership with The Highland Council and Argyll and Bute Council. A hub and spoke model is being utilised with testing hubs in Inverness and Helensburgh where the majority of recent infections have occurred, albeit these cases have significantly reduced in recent weeks. The importance of having the ability to deliver testing at short notice to any area of NHS Highland is the spoke element of the plan and pop up testing centres can be deployed at short notice to emerging outbreaks. Testing centres have been operating in Inverness and Helensburgh since 22 March with the support of a military MACA arrangement (Military Assistance for Civilian Authorities). The MACA will end in April with a transition to local furloughed staff delivering this service.
Asymptomatic community testing is done with Lateral Flow Device (LFD) tests which provide results in 30 minutes. People receiving positive results with this form of testing are referred for a PCR test to confirm the result is positive or negative. There are known barriers to people accessing testing and a comprehensive wrap around support service is being developed to meet a range of needs such as loneliness, mental health problems, money worries or access to food while self-isolating. The implementation plan also recognises the importance of clear communication messages for the public.

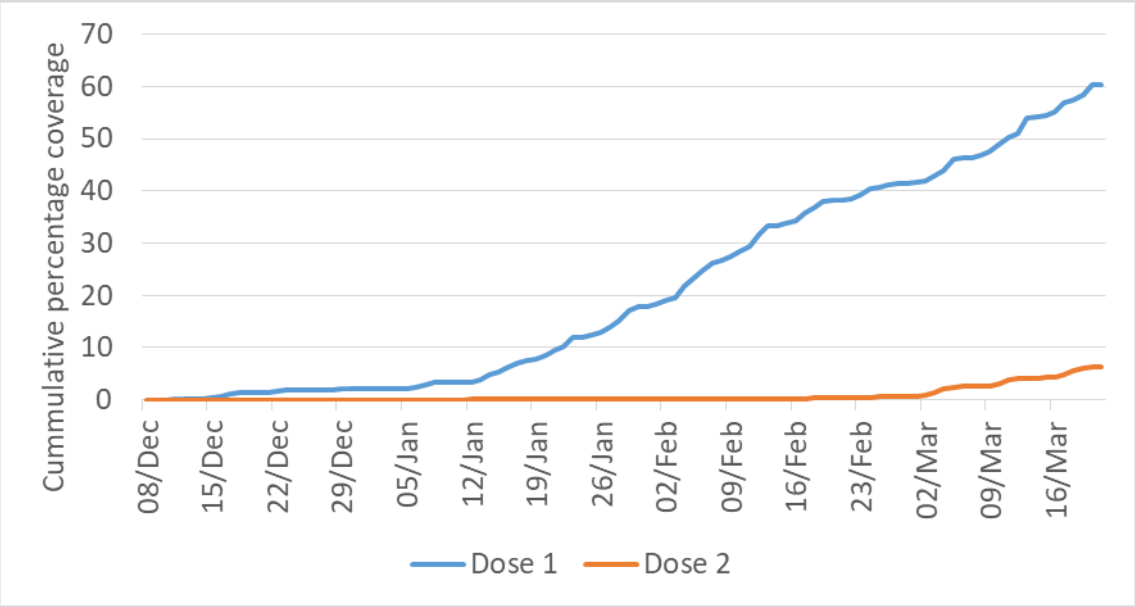
C. COVID-19 Vaccinations

Vaccinations across Argyll and Bute commenced in December with all care home staff and residents vaccinated. Front line Health and Social care staff as well as care at home staff are currently being vaccinated. GP practices are now receiving vaccine for the over 80s group and progress is being made. The delivery of such an extensive vaccination programme should not be underrated.

Public Health Scotland (PHS) reporting on vaccination uptake is now available via the daily PHS dashboard. COVID-19 Daily Dashboard - PHS COVID-19 | Tableau Public

- It is reported that 44,069 people in Argyll and Bute (an estimated 60% of the population) have had a first dose (up to 22nd March, updated 23rd March.)
- Uptake is be expected to be relatively high in Argyll and Bute due to the high proportion of the population in older age groups, which have been prioritised for vaccination.

Figure 6. Estimated percentage coverage for Argyll and Bute residents for dose 1 and dose 2



Source: NHS open data. [COVID-19 Vaccination in Scotland - Datasets - Scottish Health and Social Care Open Data (nhs.scot)] Accessed 23rd March 2021

Vaccination programmes in Argyll & Bute are following the Joint Committee on Vaccination and immunisations (JCVI) priority framework for vaccinations.

See table below.

Priority group	Risk group
1	Residents in a care home for older adults Staff working in care homes for older adults
2	All those 80 years of age and over Frontline Health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over Clinically extremely vulnerable individuals (not including pregnant women and those under 16 years of age)
5	All those 65 years of age and over
6	Adults aged 16 to 65 years in an at-risk group (Table 3)
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over

Vaccinations continue to progress well led by GPs for the public. Currently age groups 55 to 59 and 50 to 54 are receiving first doses. Most of our practices plan to continue with the 18 to 49s due to commence at end of April. Contingency plans in place or planned for any practices who withdraw
All dependant on vaccine supply.
Care home clients, staff and frontline HSCP staff are currently receiving their 2nd doses.

D. Caring for People

The Caring for People partnership continues to meet monthly as a collaborative group:

- A statement of intent for the group has developed which defines the purpose as information sharing.
- The group will at any time be able to step the response back up if required.
- The evaluation of Caring for People will continues as planned. This evaluation will shape how future humanitarian responses will be carried out and has already helped to shape how Caring for People partnership moves forward into its next phase.

A sub group was developed to set up a volunteering support for vaccination clinics if required. A partnership with Red Cross, TSI, A and B council and our Public Health team has developed a volunteer support model ready to respond for larger vaccination clinics if required.

E. Recovery

Throughout the emergency response, partners have been sighted on the recovery phase and this continues to be a focus, alongside the emergency response. To date activity includes:

- Continued collaborative working with Argyll and Bute Council's Building Back Better workstream. Building Back Better is being considered as a Community Planning Partnership cross-cutting theme, alongside community wealth building, child poverty, climate change and digital inclusion. Public Health sit as one of the Community Planning Partners.
- NHS Highland continues to develop their strategic response to recovery entitled Social Mitigation Strategy. The corporate lead for this will be the Public Health Department, however the purpose of the strategy is to review how the whole organisation and services must transform to meet changing needs. Examples of these needs include social factors such as economy and employment and health factors such as mental health impacts. This work is ongoing and will inform the Public Health workplan over the coming year.
- The Living Well Strategy for Argyll and Bute has ongoing engagement via our third sector partners and this is overseen by the Steering Group which

continues to meet bi-monthly. Living Well is currently particularly focussed on healthy weight and mental/emotional wellbeing, physical activity and access to information. Work is being commissioned via the third sector on the impact of COVID-19 on people with mental health conditions. This will inform service transformation. Physical activity continues to be a key priority for people at risk of increasing frailty.

4. RELEVANT DATA AND INDICATORS

Data have been reported in the above section and in the Appendices. In summary, we have presented trends on: confirmed cases of COVID-19 infection, overall and COVID-19-specific mortality.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

This work supports/underpins the HSCPs strategic and operational response to this emergency pandemic.

6. GOVERNANCE IMPLICATIONS

Financial Impact

These activities - responding to the pandemic and following on from it - have employed a larger number of resources, primarily in terms of person-time, than budgeted for the year. Such increased spending has been tagged to dedicated COVID-19 funding and will be accounted under this budget line.

Staff Governance

The workforce consequences and staff and TU fantastic response to the crisis has epitomised the adoption and strengthening of good communication and formal engagement processes and partnership working.

Clinical Governance

Clinical governance response has been fundamental to the shaping and management of the public health projections and demand modelling and our response to ensure patient, client and staff safety.

7. PROFESSIONAL ADVISORY

Inputs from professionals across stakeholders remain instrumental in the response to the COVID19 pandemic. There has been a close collaborative working between the Departments of Public Health in Argyll and Bute and North Highland. We expect this to be a long-lasting positive outcome of this major incident.

8. EQUALITY & DIVERSITY IMPLICATIONS

Equality and diversity will need to be reviewed and considered as we progress through this pandemic cycle and emergency operating arrangements. Experience from other countries shows that marginalised communities fair worst in relation to both infection rates and health outcomes. An impact assessment will be developed for the response in due course, but in the meantime principles of equality have informed specific programmes of activity. Examples of this include targeted activity with gypsy/traveller communities and developing communications materials for different audiences eg learning disability friendly and subtitles for people with hearing impairment.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Compliance with GDPR remains critical and is being considered within the various pieces of work supporting the sharing of information and data to protect health and wellbeing of staff and the public and patients.

10. RISK ASSESSMENT

Not required for this report.

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

A comprehensive communications strategy exists to provide accurate information on the COVID-19 response to staff, partners and the wider population. The Third Sector Interface contributes to the Caring for People Tactical Partnership and provides a link to local community resilience activity, third sector organisations and community members.

12. CONCLUSION

Following the declaration of major incident in NHS Highland to respond to the COVID-19 pandemic, the Department of Public Health identified a number of key activities to contribute to the overall HSCP response. Human resources have been focused to the response. Our overriding working principles of cooperative working within the HSCP have strengthened and it is expected that may be helpful in the management of the subsequent phases of the pandemic and the post-COVID-19 work.

DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

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COVID-19 Epidemiology Report
22nd March 2021

Note:

The data in this report are extracted from NSS Test and Protect Data Virtualisation tables that record case management information and data collected by NHS Scotland laboratories and UK Government Testing.

Lateral Flow Tests (LFT) are not included.

Cases are assigned to geographies using the postcode recorded at the time of testing or, if that is not available, by the postcode of usual residence derived from the Community Health Index database.

The time necessary to process and submit testing data means that tests carried out in the most recent two to three days will be incomplete. Public Health Scotland estimate that 90% of tests carried out are reported within two days. Positive results can be subject to retest and numbers may therefore change for this reason. The seven-day figures in the report are presented with a lag to try and ensure that a complete period of data are provided.

Summary overview of positive cases

22/03/2021

Week ending **19/03/2021**

Confirmed new positive case rate per 100,000 population of COVID-19 over 7 days

	Current week		Change from previous week	
	Number of cases	7 day rate per 100,000	Number of cases	7 day rate per 100,000
NHS Highland	75	23.3	-35	-10.9
Argyll & Bute	8	9.3	1	1.2
Highland	67	28.4	-36	-15.3

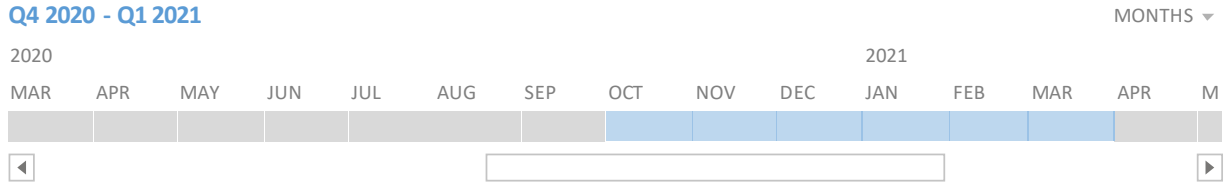
Testing rates vary across the week and data for the most recent three days will be partially complete.

Recent positive results may be subject to change as a result of re-testing

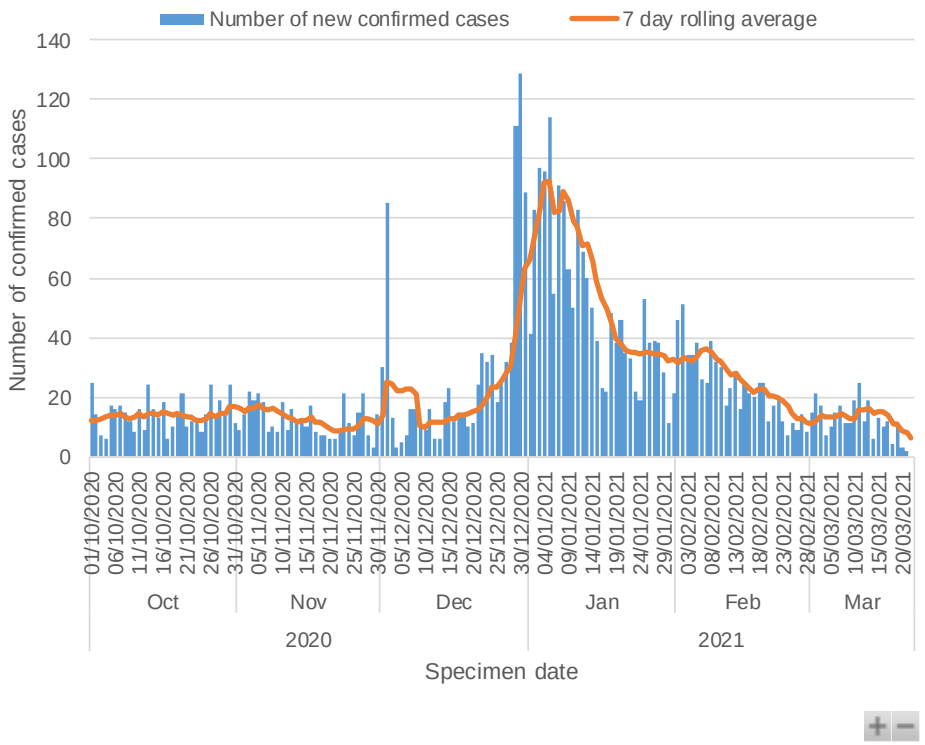
Includes testing undertaken in NHS Scotland laboratories and UK Government Regional Testing Centre laboratories (including Drive Through Centres and Mobile Units, and Home Testing).

NHS Highland Public Health Intelligence Team

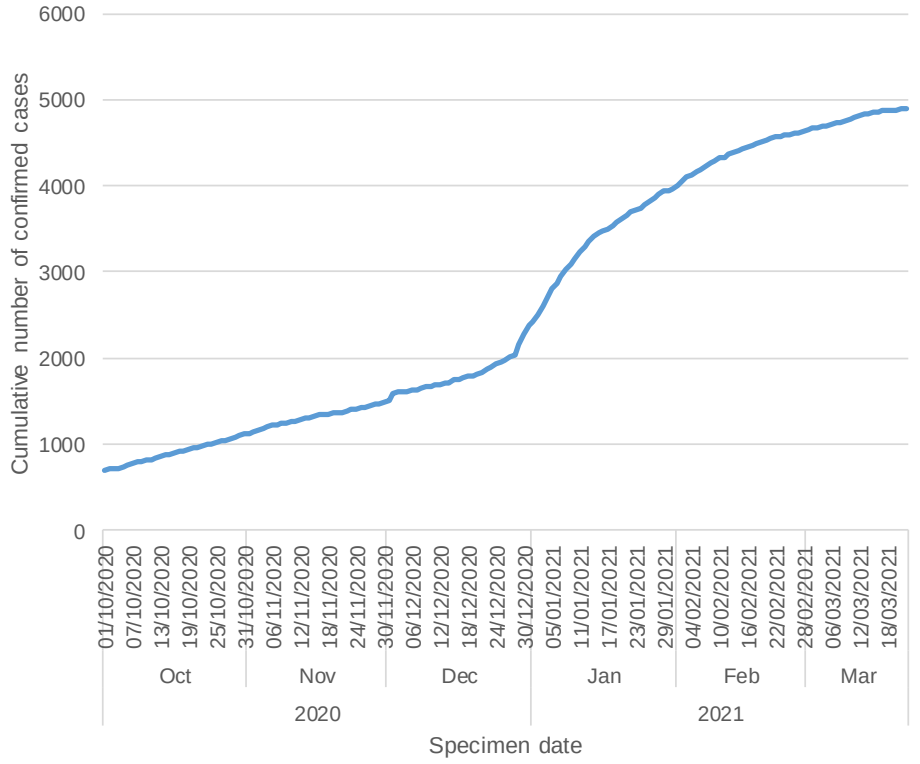
NHS Highland
Number of new positive cases of COVID-19



Number of confirmed cases

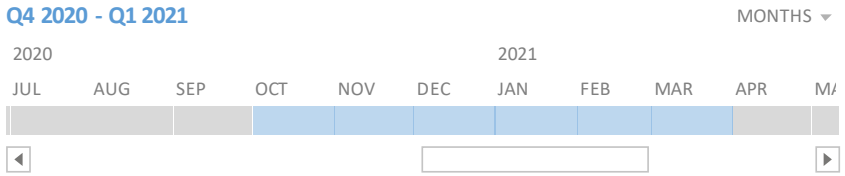


Cumulative number of confirmed cases



Testing rates vary across the week and data for the most recent three days will be partially complete

NHS Highland
Number and rates of new cases of COVID-19 over 7 days

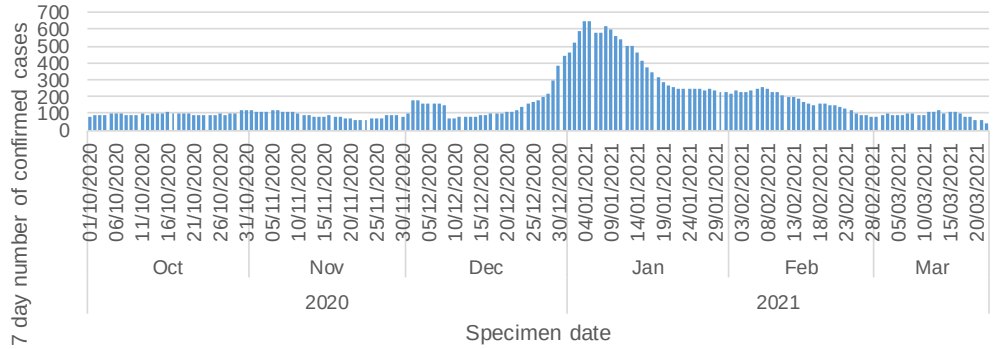


Select week ending date

Date

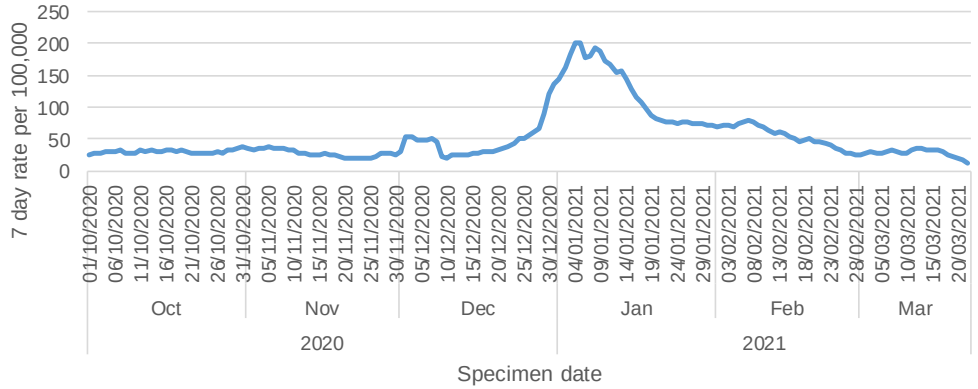
22/03/2021	21/03/2021	20/03/2021
19/03/2021	18/03/2021	17/03/2021

Number of cases



	Week beginning	Week ending	Number of cases	7 day rate per 100,000
Selected	13/03/2021	19/03/2021	75	23.3
Previous	06/03/2021	12/03/2021	110	34.2

Rates per 100,000 population



Testing rates vary across the week and data for the most recent three days will be partially complete

Data source: NSS Test and Protect Data Virtualisation Layer, NHS Highland BI Data Warehouse

NHS Highland Public Health Intelligence Team

Number and rates of new cases of COVID-19 over seven days

NHS Highland Local Authority Areas

All ages

Date

Q4 2020 - Q1 2021

MONTHS

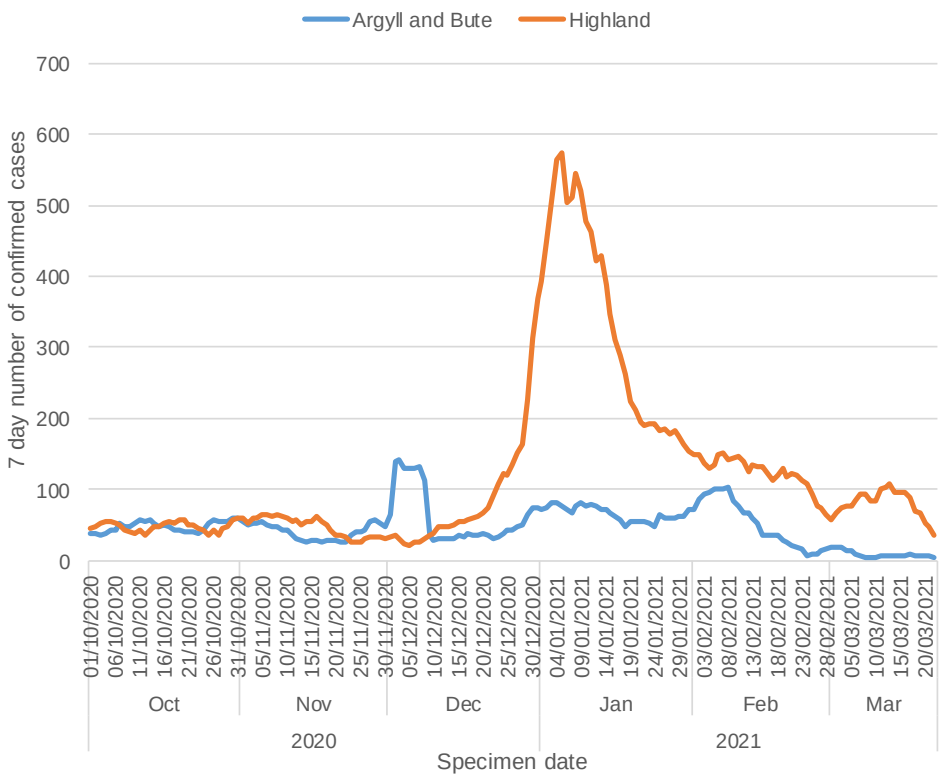
2020 2021

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MA

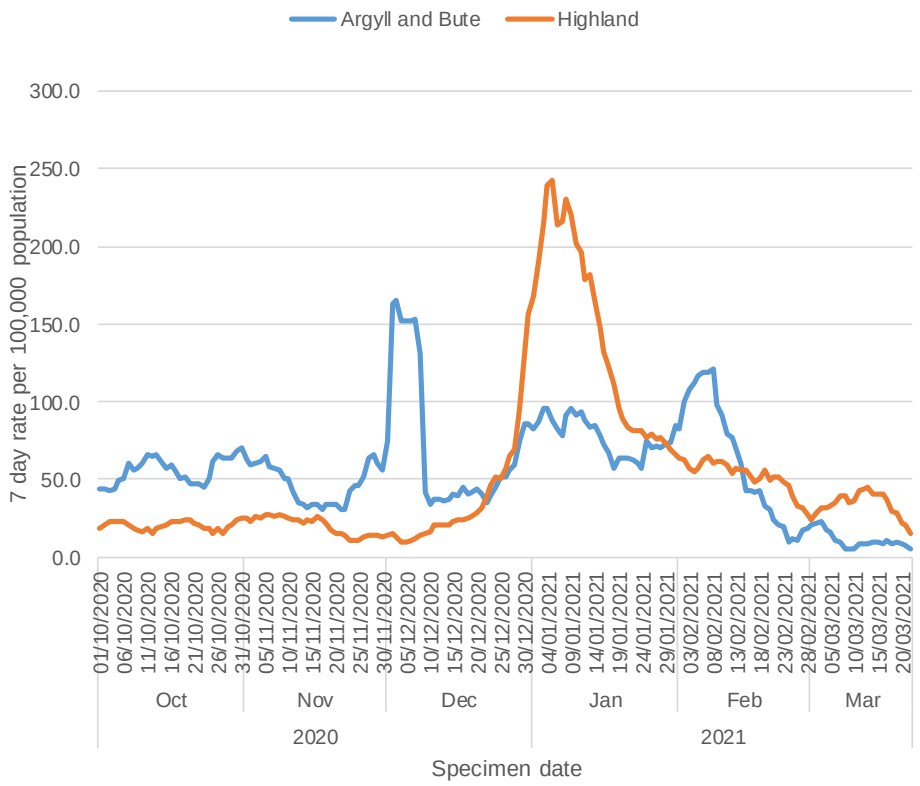
Argyll and Bute

Highland

Number of cases



Rates per 100,000 population



Testing rates vary across the week and data for the most recent three days will be partially complete

Data source: NSS Test and Protect Data Virtualisation Layer, NHS Highland BI Data Warehouse

Estimated Dissemination Ratio (EDR) of COVID-19

NHS Highland Local Authority Areas

Date

Q4 2020 - Q1 2021

MONTHS

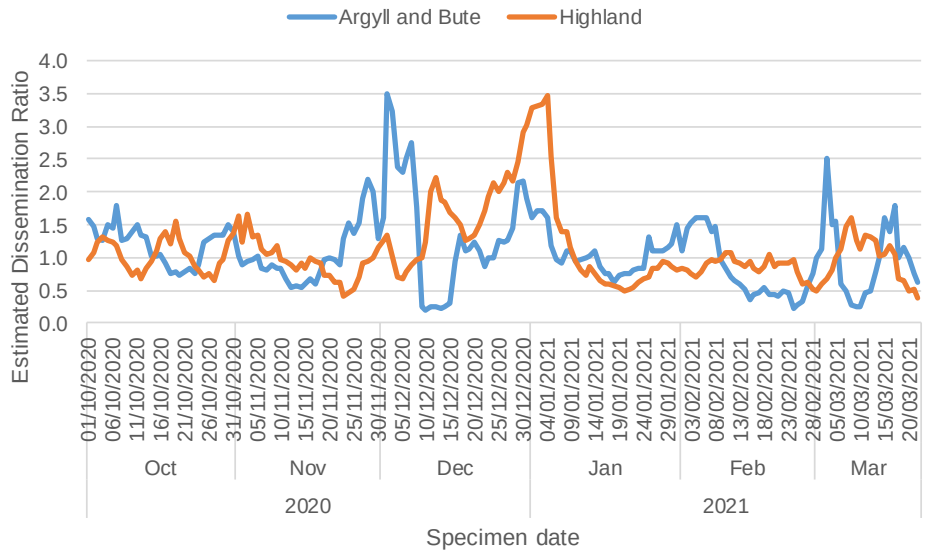
2020 2021

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MA

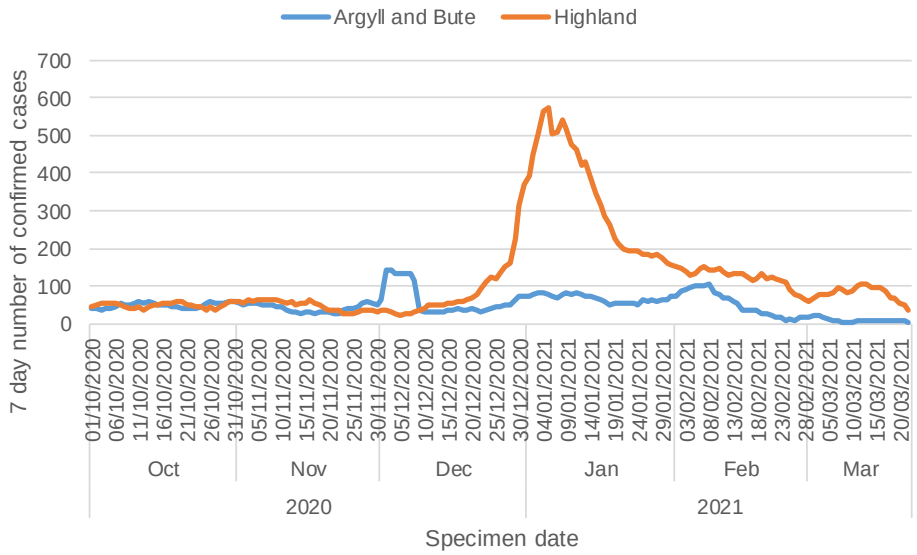
Argyll and Bute

Highland

Estimated Dissemination Ratio



7-day number of confirmed cases



The Estimated Dissemination Ratio is shown as a 7 day rolling ratio of the total number of new cases in the last 7 days divided by the total number of cases in the previous 7 day period.

An EDR of > 1 indicates that the epidemic is accelerating

An EDR of 1 indicates that the epidemic is neither accelerating or slowing

An EDR of < 1indicates that the epidemic is slowing

Testing rates vary across the week and data for the most recent three days will be partially complete

Data source: NSS Test and Protect Data Virtualisation Layer, NHS Highland BI Data Warehouse

NHS Highland Public Health Intelligence Team

Number and rates of new cases of COVID-19 over seven days

NHS Highland

Broad age category

Date

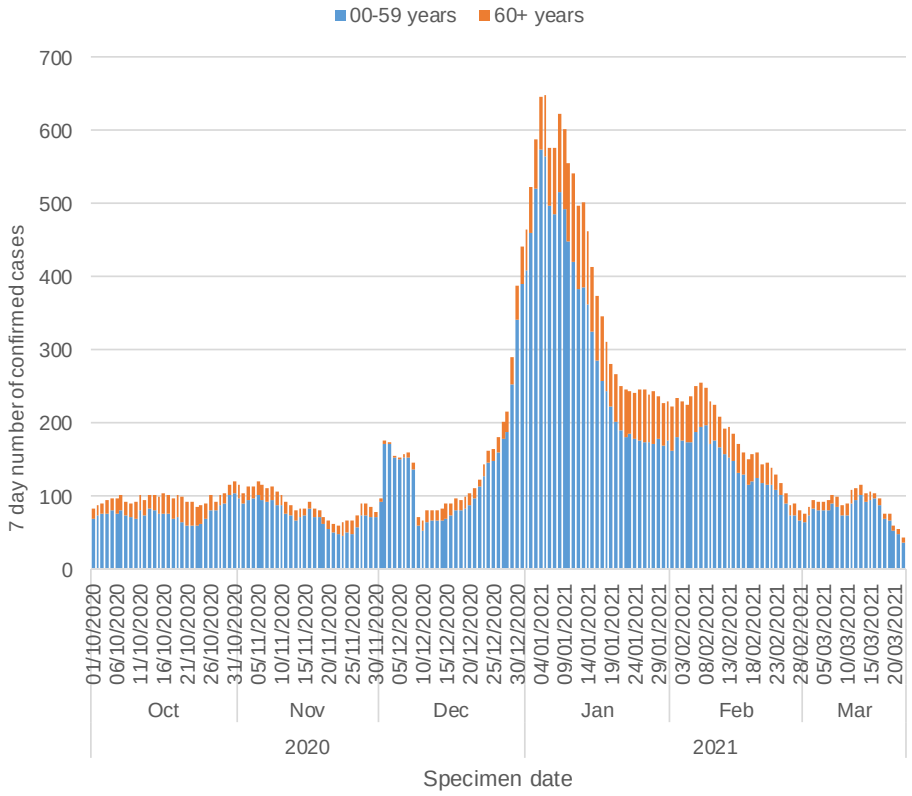
Q4 2020 - Q1 2021

MONTHS

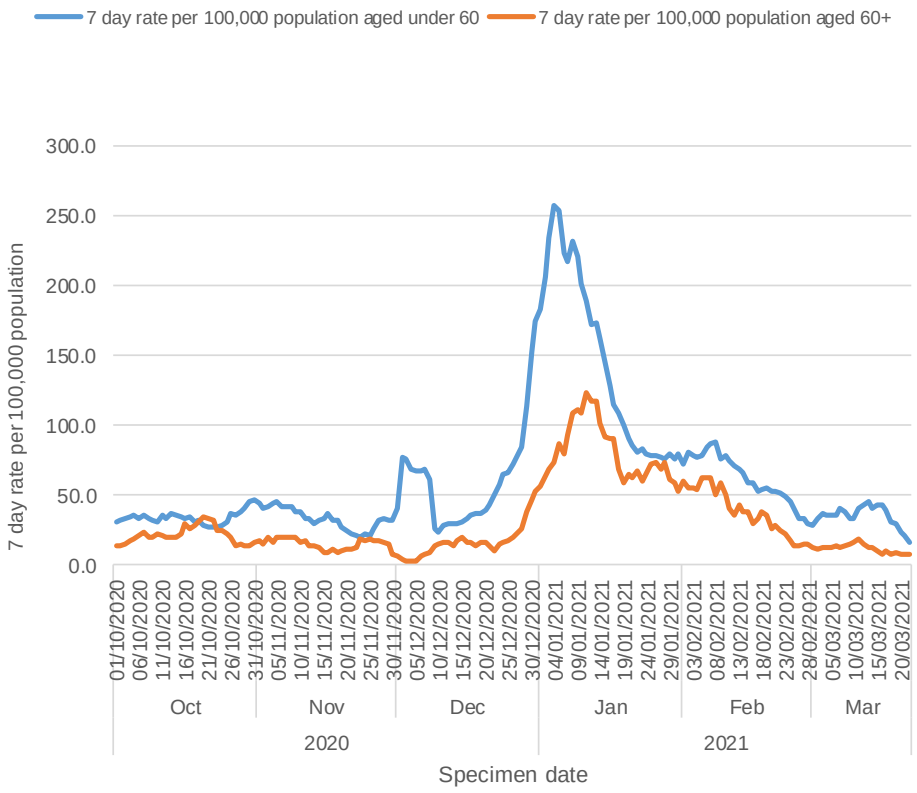
2020 2021

MAR APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY

Number of cases



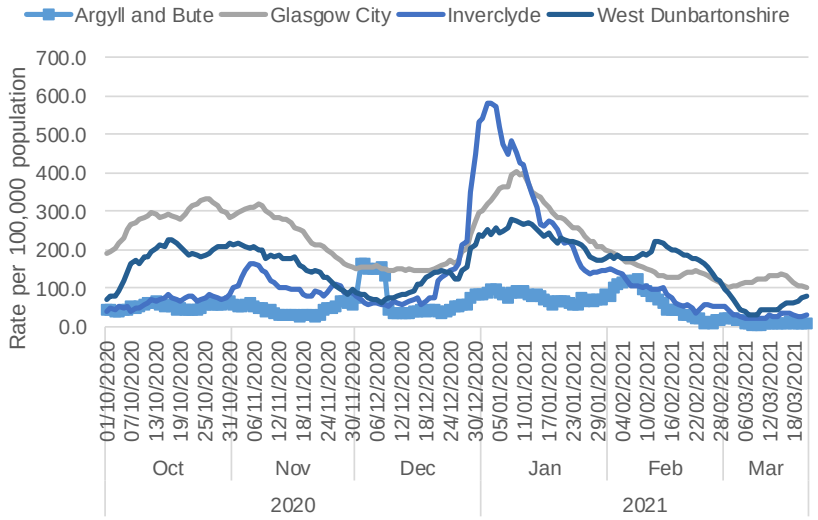
Rates per 100,000 population

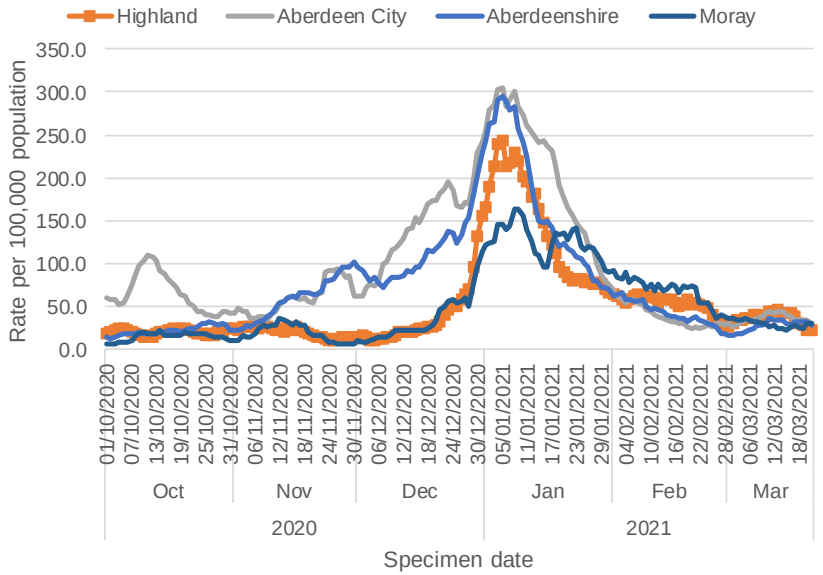


Testing rates vary across the week and data for the most recent three days will be partially complete

Confirmed new case rate per 100,000 population over 7 days

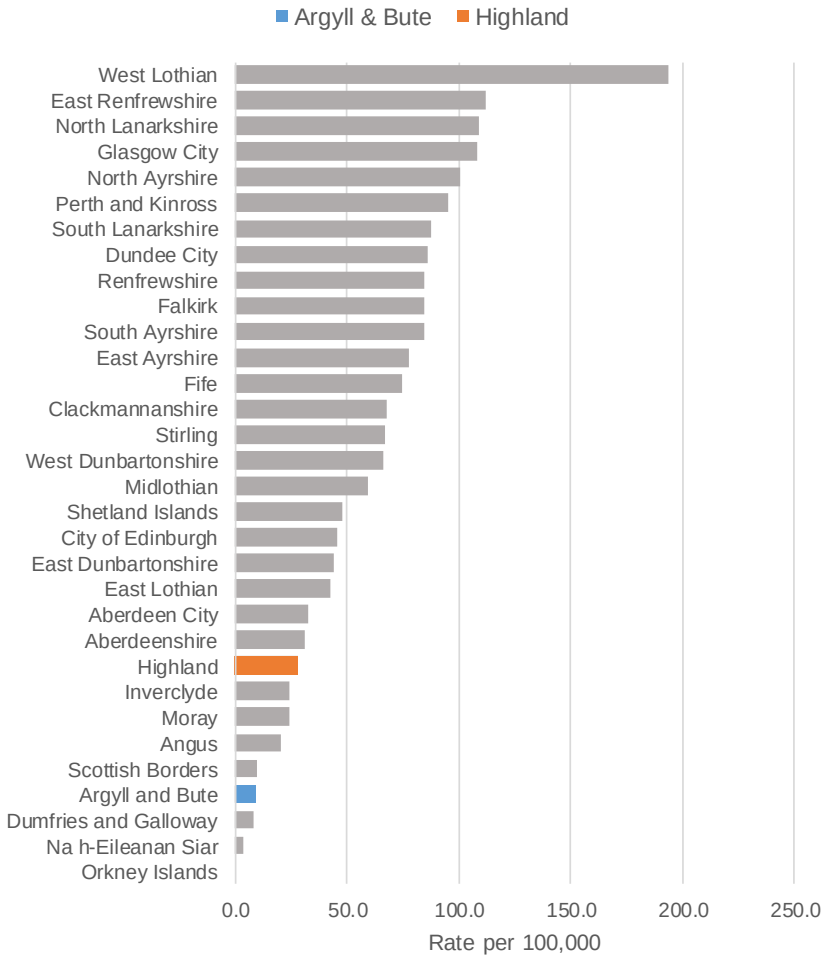
Local Authority Areas (selected)





21/03/2021 | 20/03/2021 | 19/03/2021

7 day rate per 100,000 population for the week ending 19 Mar 2021



Testing rates vary across the week and data for the most recent three days will be partially complete

NHS Highland Community Partnerships

Number and rates of new cases over seven days

Select week ending date

21/03/2021
20/03/2021
19/03/2021
18/03/2021

Testing rates vary across the week and data for the most recent three days will be partially complete.

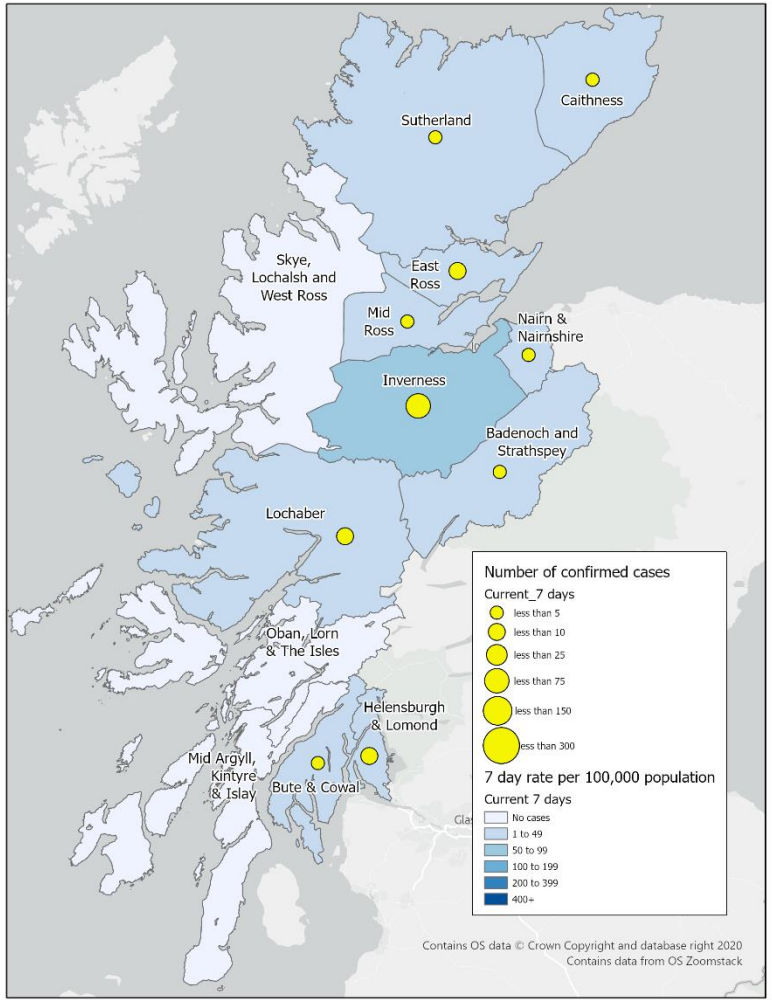
	Total number of confirmed cases over the 7 days (13/03/21 to 19/03/21)	Total number of confirmed cases over the previous 7 days (06/03/21 to 12/03/21)	Change in number of cases	Incidence rate per 100,000 population (13/03/21 to 19/03/21)
NHS Highland	**75**	**110**	**-**	**23**
Badenoch and Strathspey	1 to 4	1 to 4	-	Less than 20
Caithness	1 to 4	1 to 4	-	Less than 20
East Ross	7	19	-	31
Inverness	44	64	-	54
Lochaber	7	1 to 4	+	35
Mid Ross	1 to 4	10	-	Less than 20
Nairn & Nairnshire	1 to 4	0	+	Less than 20
Skye, Lochalsh and West Ross	0	0	nc	0
Sutherland	1 to 4	1 to 4	nc	Less than 20
Highland	**67**	**103**	**-**	**28**
Cowal & Bute	1 to 4	1 to 4	-	Less than 20
Helensburgh & Lomond	7	1 to 4	+	27
Mid-Argyll, Kintyre & Islay	0	1 to 4	-	0
Oban, Lorn & The Isles	0	0	nc	0
Argyll & Bute	**8**	**7**	**+**	**9**

nc = no change

NHS Highland Community Partnerships

Number and rates of new cases over seven days

Current Week



Confirmed cases of COVID-19 in the seven day period 13th March 2021 to 19th March 2021 by NHS Highland Community Partnership

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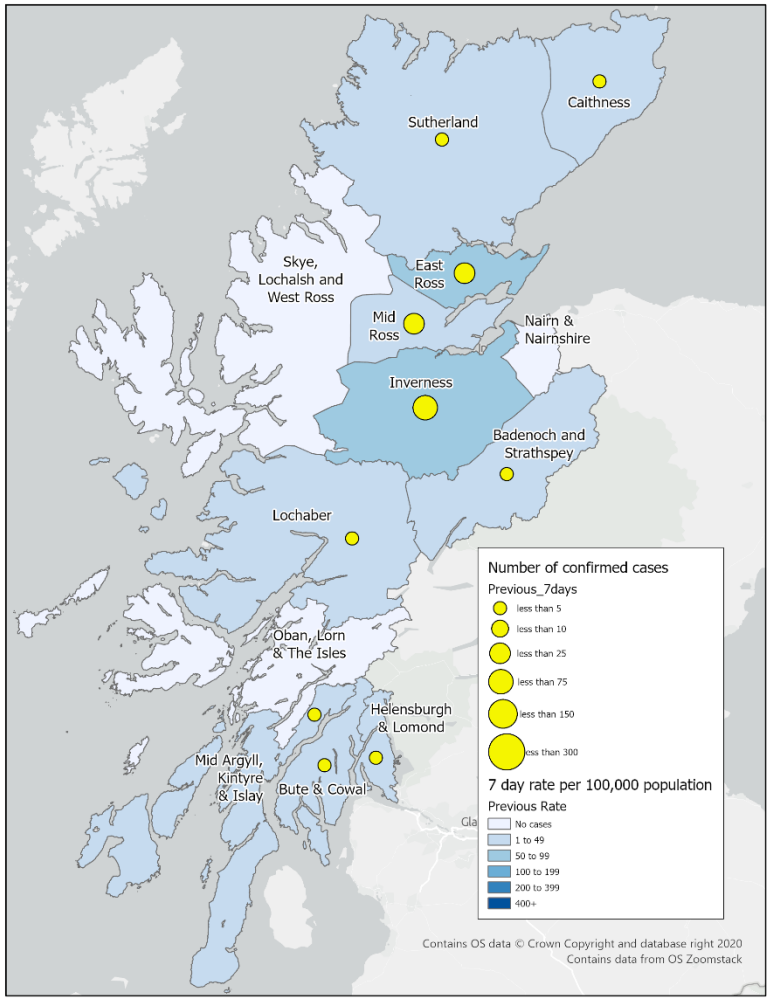
Directorate of Public Health
Public Health Intelligence Team
Larch House, Inverness

Date: March 2021

Previous Week



Confirmed cases of COVID-19 in the seven day period 6th March 2021 to 12th March 2021 by NHS Highland Community Partnership

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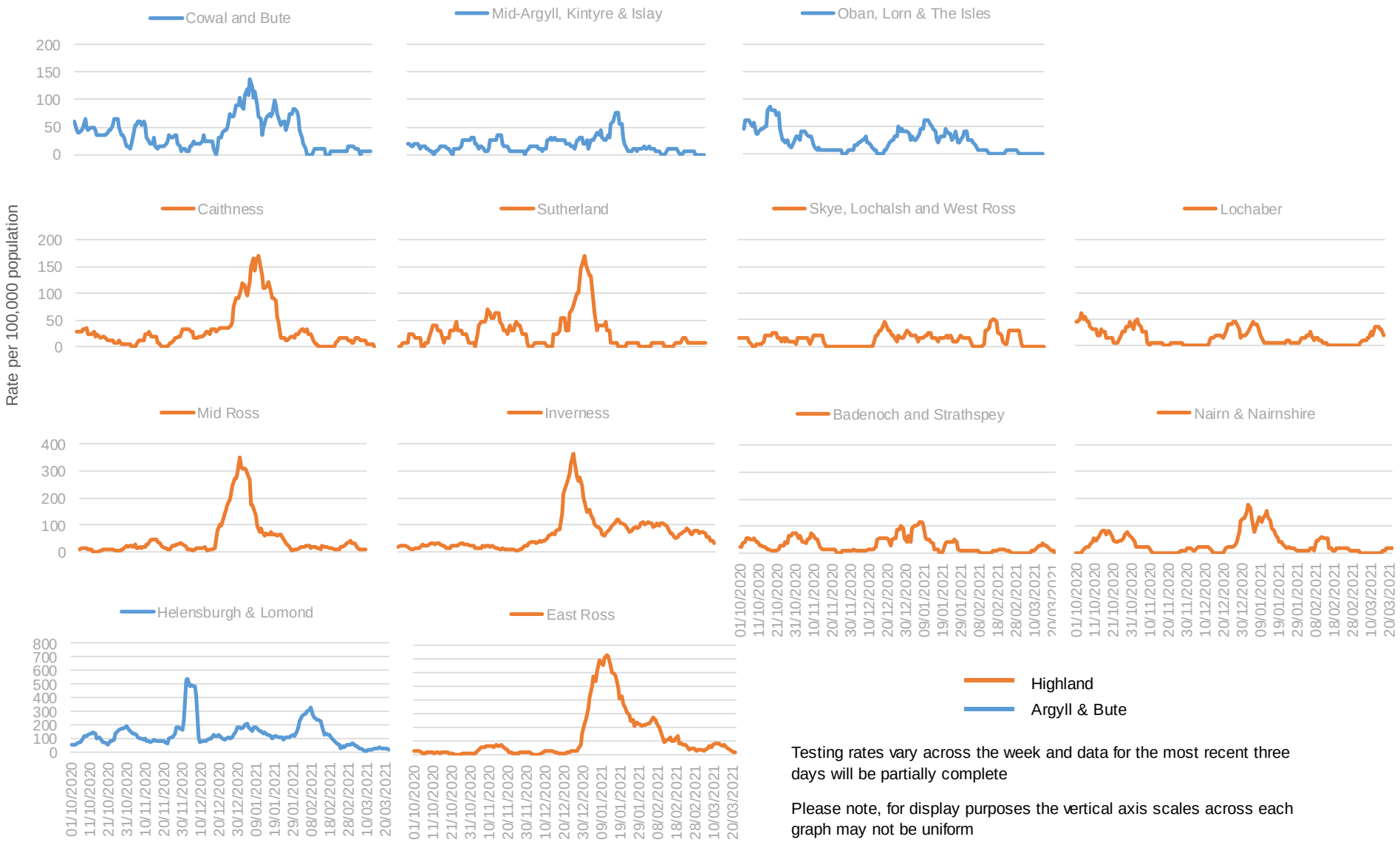
Directorate of Public Health
Public Health Intelligence Team
Larch House, Inverness

Date: March 2021

NHS Highland Community Partnerships

Confirmed case rate per 100,000 population over seven days



Testing rates vary across the week and data for the most recent three days will be partially complete

Please note, for display purposes the vertical axis scales across each graph may not be uniform

Data source: NSS Test and Protect Data Virtualisation Layer, NHS Highland BI Data Warehouse

NHS Highland Public Health Intelligence Team

NHS Highland Community Partnerships

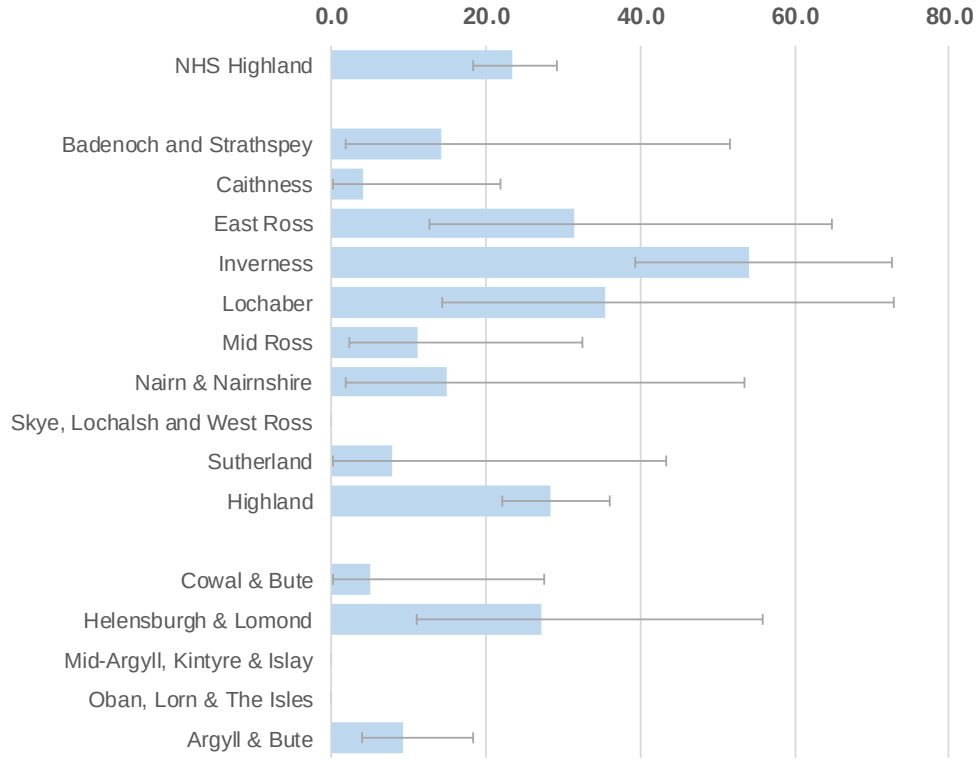
Rates of new cases over seven days: 13/03/2021 to 19/03/2021

Select week ending date

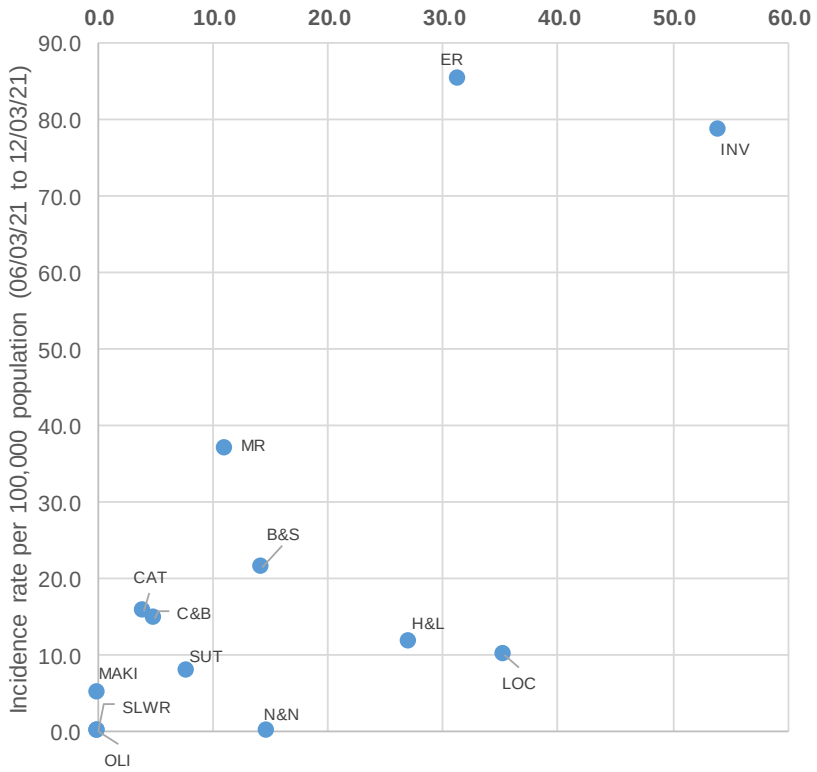
22/03/2021 | 21/03/2021 | 20/03/2021 | 19/03/2021

Testing rates vary across the week and data for the most recent three days will be partially complete.

Incidence rate per 100,000 population (13/03/21 to 19/03/21)



Incidence rate per 100,000 population (13/03/21 to 19/03/21)

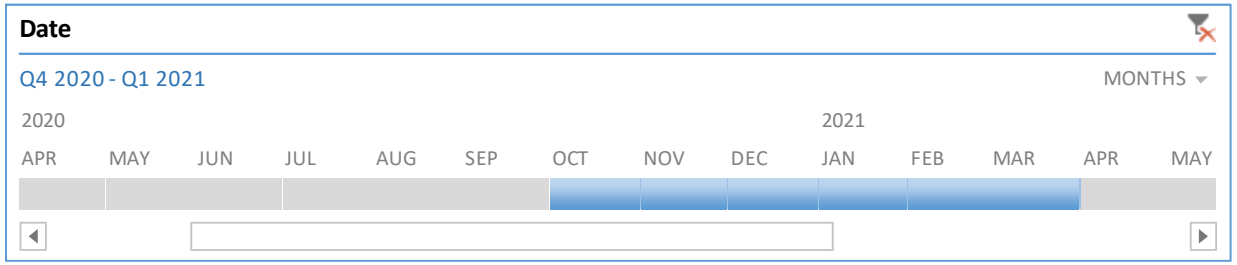


Data source: NSS Test and Protect Data Virtualisation Layer, NHS Highland BI Data Warehouse

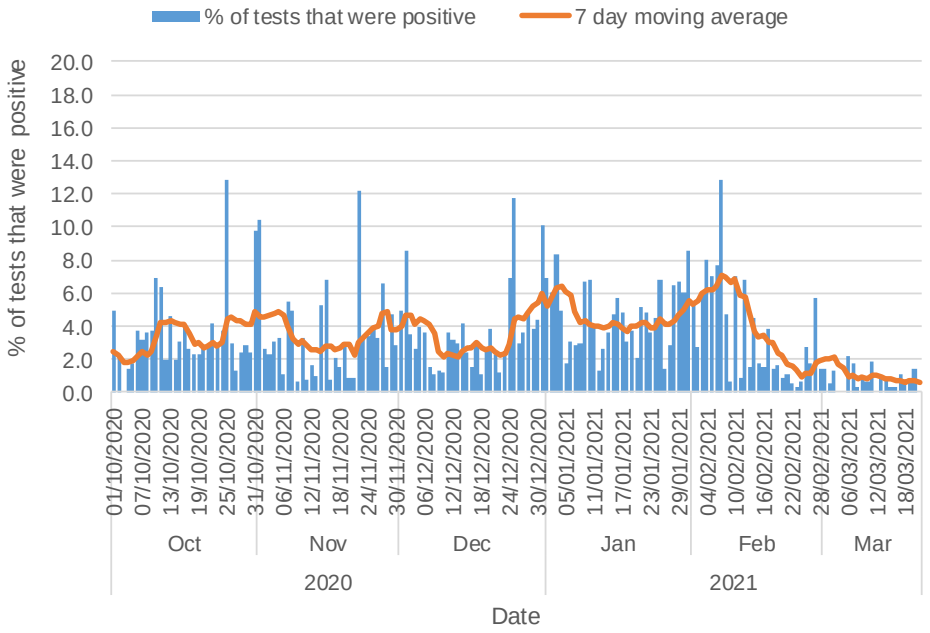
NHS Highland Public Health Intelligence Team

Test positivity rate

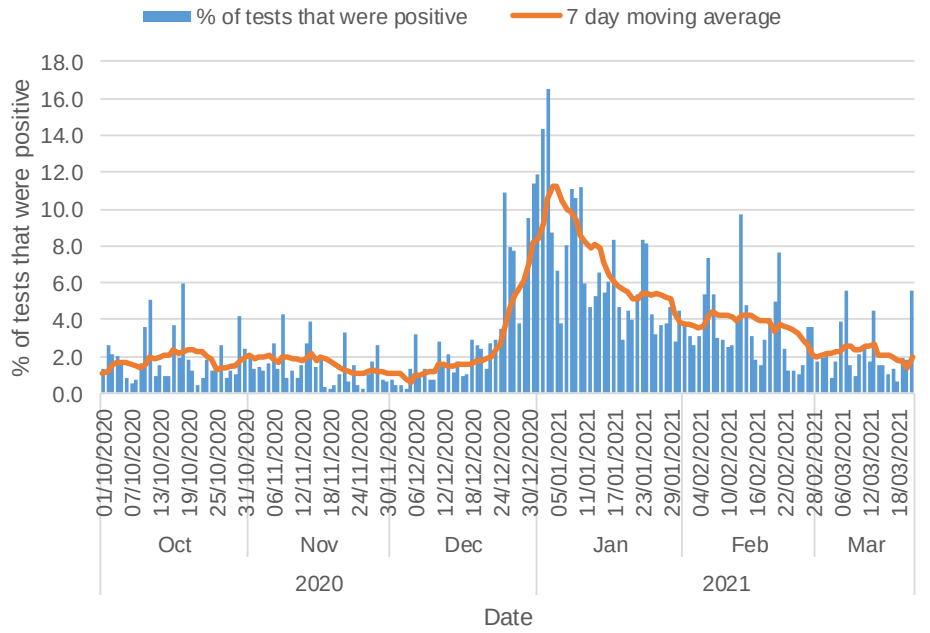
NHS Highland Local Authority Areas



Argyll & Bute



Highland

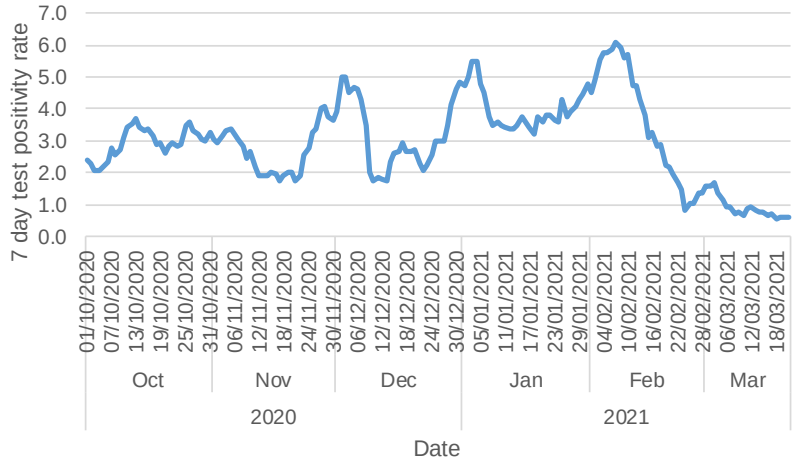


Test positivity rate is the number of newly reported positive tests divided by the total number of newly reported tests, in the specified time period, multiplied by 100.

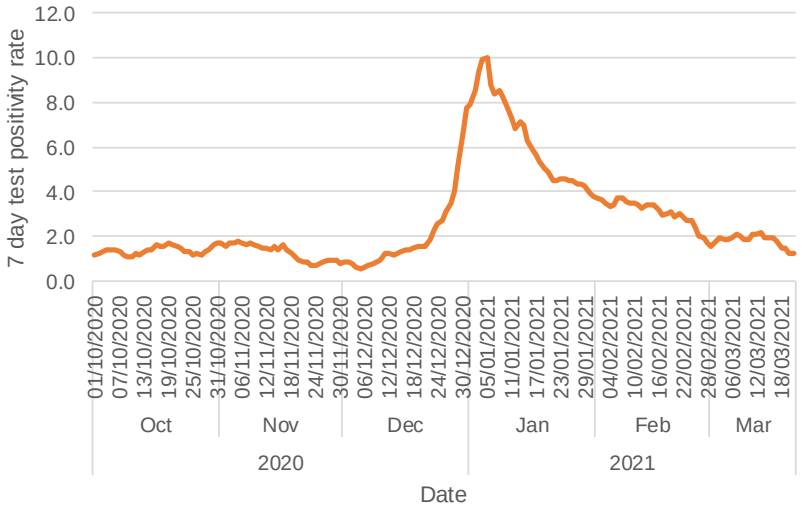
Seven day test positivity rate

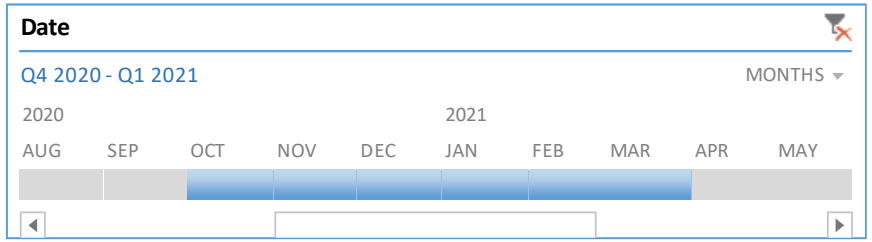
NHS Highland Local Authority Areas

Argyll and Bute



Highland





Select week ending date

21/03/2021	20/03/2021	19/03/2021
18/03/2021	17/03/2021	16/03/2021

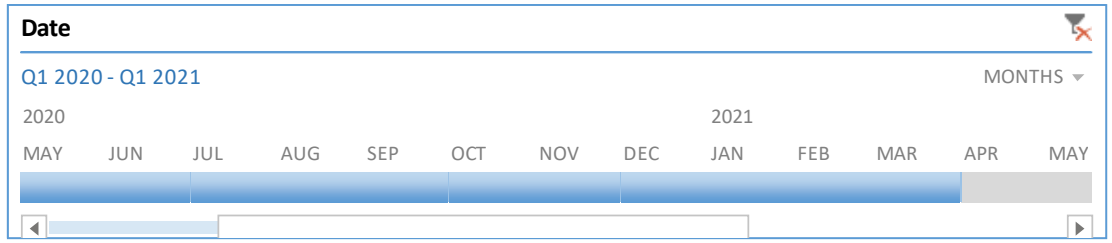
Week: 13/03/2021 to 19/03/2021

	Number of positive tests	Total number of tests	Test positivity rate (%)
Argyll and Bute	9	1511	**0.6**
Highland	80	5372	**1.5**

Test positivity rate is the number of newly reported positive tests divided by the total number of newly reported tests, in the specified time period, multiplied by 100.

Confirmed deaths from COVID-19

NHS Highland Local Authority Areas

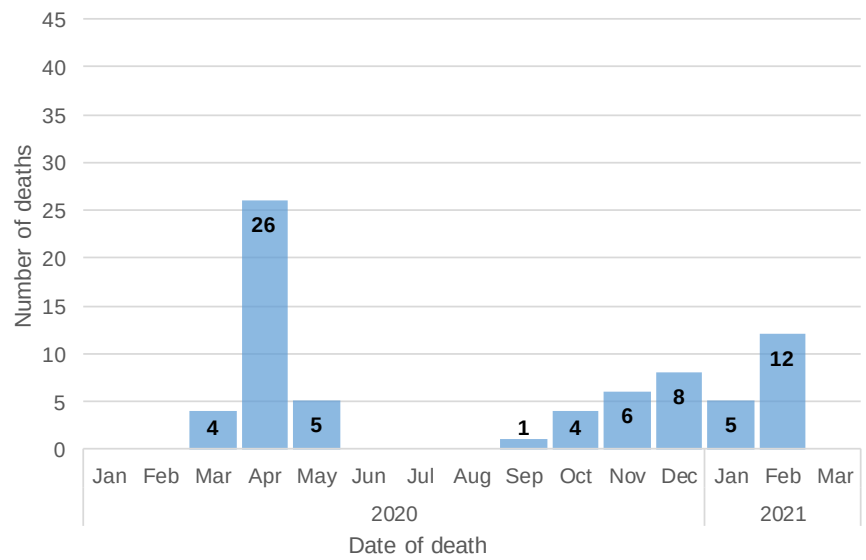


Argyll and Bute	Total number to date	71
	Total in selected period	71

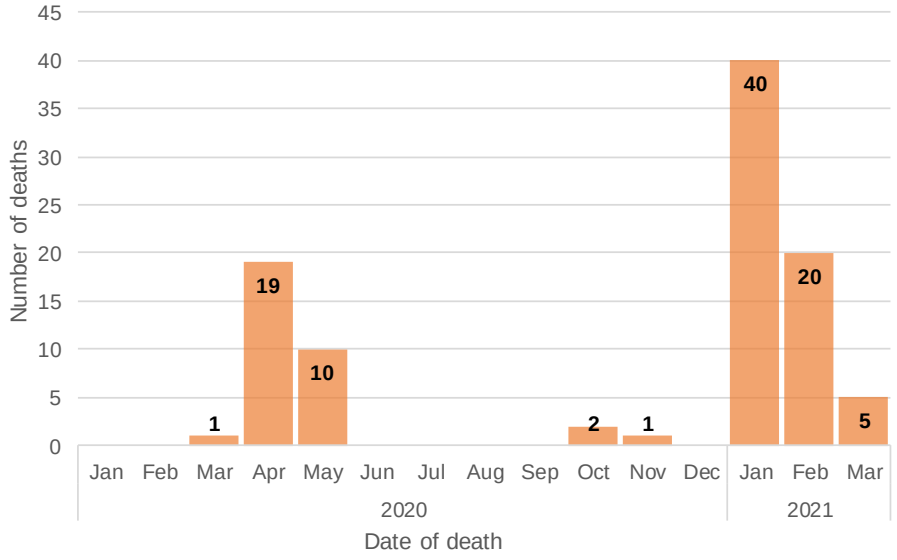
Highland	Total number to date	98
	Total in selected period	98

Deaths (COVID-19 confirmed) by date of death

Argyll and Bute



Highland

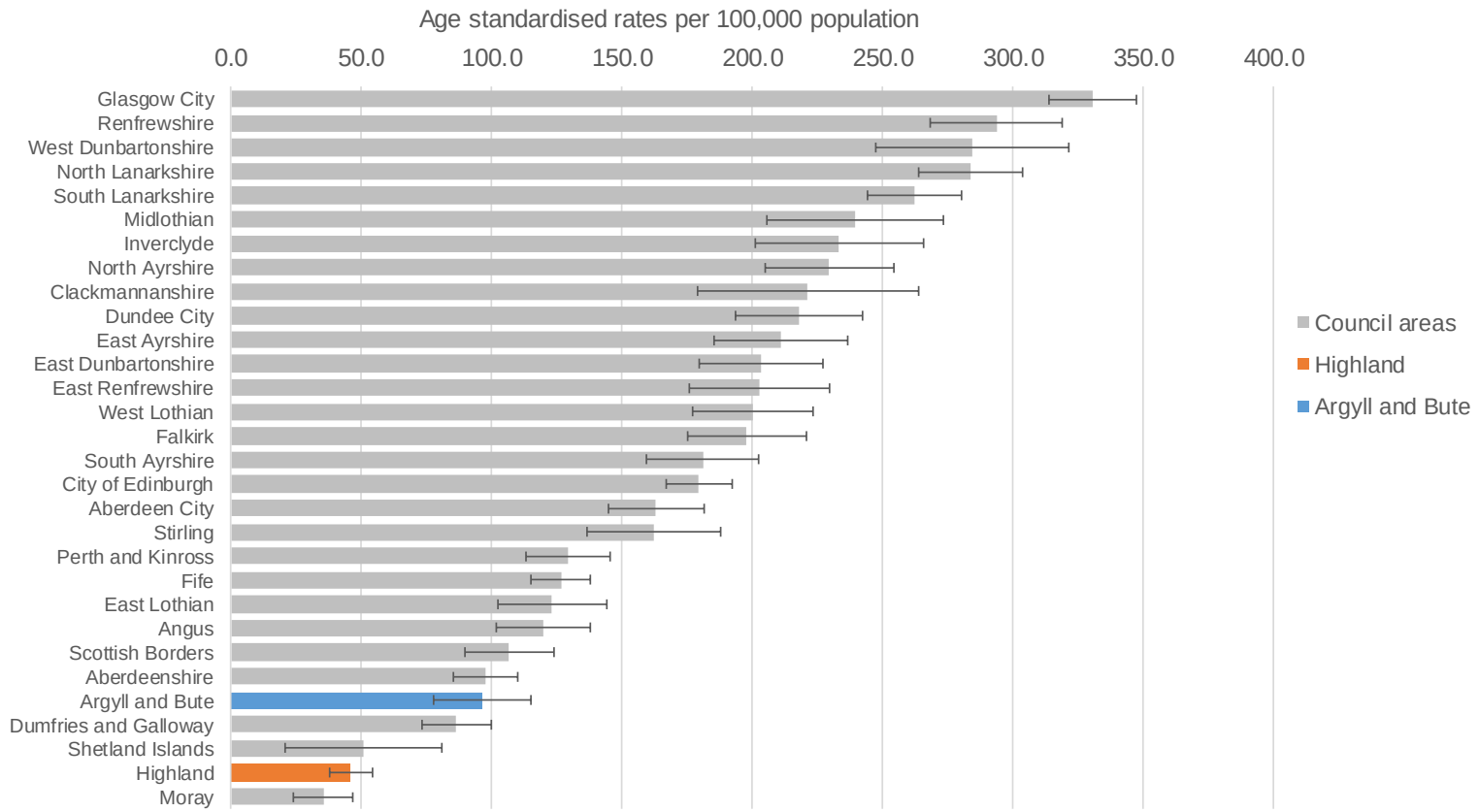


National Records of Scotland (NRS) deaths data linked to ECOSS testing data

Deaths refer to the total number of individuals who died within 28 days of their first laboratory confirmed report of COVID-19 infection and whose death was registered with NRS.

Age standardised rates for deaths involving COVID-19 in Council areas

1st March 2020 to 28th February 2021



Age-standardised mortality rates are presented per 100,000 people and standardised to the 2013 European Standard Population. Age-standardised mortality rates allow for differences in the age structure of populations and therefore allow valid comparisons to be made between geographical areas, the sexes and over time.

The lower and upper 95% confidence limits have been provided. These form a confidence interval, which is a measure of the statistical precision of an estimate and shows the range of uncertainty around the estimated figure. Calculations based on small numbers of events are often subject to random fluctuations. As a general rule, if the confidence interval around one figure overlaps with the interval around another, we cannot say with certainty that there is more than a chance difference between the two figures.

Cause of death was defined using the International Classification of Diseases, Tenth Revision (ICD-10) codes U07.1 and U07.2. Rates include deaths where coronavirus (COVID-19) was the underlying cause or was mentioned on the death certificate as a contributory factor.

Figures are for deaths occurring between 1 March 2020 and 28 February 2021 and only include deaths that were registered by 10 March 2021.

Data Source: National Records Scotland

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item:**

Date of Meeting: **31 March 2021**

Title of Report: **Budget Monitoring as at 28 February 2021**

Presented by: **Judy Orr, Head of Finance and Transformation**

The Integration Joint Board is asked to:

- Note the forecast outturn position for 2020-21 is a forecast underspend of £2.016m as at 28 February 2021 and that there is a year to date underspend of £4.055m as at the same date.
- Note the above position includes provision for Scottish Government assistance with non-delivery of savings due to Covid-19.
- Note that £2.65m is included in Social Work annual budget and forecasted expenditure which relates to funding from Scottish Government and is intended to be carried forward into next year. Also there is £0.8m in Health reserves similarly expected to be carried forward in relation to Covid funding, as well as £1.6m new allocations received this month for Primary Care Improvement Fund (PCIF - £1.418m) and Action 15 of the Mental Health Strategy (£217k).

1. EXECUTIVE SUMMARY

1.1 This report provides a summary of the financial position of the Health and Social Care Partnership as at 28 February 2021. It should be noted that this now includes the Covid-19 funding announced on 5 February for both Health and Social Work.

1.2 There is a year to date underspend of £4.055m as at 28 February 2021 (an improvement of £2.539m in the month). This consists of an underspend of £1.592m within Social Work delivered services (mainly improved due additional Covid funding for undelivered savings) and a year to date underspend of £2.463m within Health. The underspends are mainly where there has been reduced activity and spend due to suspension of some services, along with vacancies in Community & Hospital Services, Mental Health & Learning Disability, and Dental. The Social Work figures are presented on a cash basis, showing the value of actual transactions processed to date, rather than on an accruals basis, which include adjustments for costs incurred but not yet paid for, and therefore do not reflect the full cost of activity to the end of February.

There has been reductions in care home placements and care at home packages due to Covid-19, and whilst providers are encouraged to invoice for additional costs and loss of income through under occupancy, these were still in progress at end of February as these schemes have been extended. Overall the year to date position is still fluid as Covid-19 funding allocations will continue to be revised later in the year. Any excess funding received has to be earmarked for use against Covid costs in next financial year.

1.3 The forecast outturn position for 2020-21 is a forecast underspend of £2.016m (an improvement of £1.560m in the month). This consists of an underspend of £295k within Social Work delivered services (improved by £1.329m since last month) and an underspend of £1.721m within Health (improved by £231k since last month). The forecast outturn for social work takes into account the planned early repayment of £1m to the Council which will reduce the amount due to be paid back next financial year.

1.4 The forecast outturn is significantly impacted by the Covid-19 pandemic. All work on delivery of savings was halted for 2 months at end of March as resource was put onto mobilising for the pandemic. Additional costs are being incurred for staffing (to cover for people off with symptoms or in households with symptoms, or shielding or with child care issues), and for PPE, additional cleaning, additional provider costs, and running Covid Assessment Centres (CACs) and vaccination clinics across our area.

1.5 We have received approval in principle for these additional costs and 12 tranches of funding have been announced for social work costs – totalling £7.656m. £7.635m is reflected in the year to date position and forecast outturn where we have assumed that all funding is matched by expenditure in full. Health has received funding of £7.377m (including a GP allocation of £409k, and for elective / planned care of £479k) all of which is reflected in the revised year to date and forecast positions – unchanged since last month. £2.65m of this funding for Social Care is intended for next year, but has not yet been created as an earmarked reserve. Currently the forecast outturn budget and expenditure are both “inflated” by this amount.

1.6 The changes in the forecast outturn and year to date positions are mainly due to Covid funding.

2. INTRODUCTION

2.1 This report provides a summary of the financial position of the Health and Social Care Partnership as at 28 February 2021. Information is provided on both the year to date position and the forecast outturn position and is summarised at a service/activity level.

3. DETAIL OF REPORT

3.1 Year to Date Position as at 28 February 2021 – Social Work

3.1.1 As previously advised, accrual accounting is not in place for Social Work and self-billing, although planned, is not in place yet. We have however implemented a new interface between CareFirst and payables for non-residential care payments to speed up the processing of these which supplements the previous interface for residential care invoices.

3.1.2 There is a year to date underspend of £1.592m (2.5%) as at 28 February 2021 which is improved by £2.205m in the month – mainly by the Covid funding for undelivered savings. Further information is provided within Appendix 1.

3.1.3 The largest overspend is £1.141m on Learning Disability due to service demand in supported living and residential care and due to non-delivery of savings where work paused due to Covid (£682k) and reduced income from paused services. The next biggest overspend is Physical Disability £700k mainly due to supported living. The third biggest area of overspend is on Looked after children - £366k driven by an increased demand for residential placements. The overspend on Older People of £71k is due to non-delivery of savings where work paused due to Covid (£1m), which is offset by reduced spend on care home placements, care at Home packages and transport, and over recovery of income.

3.1.4 The main area of underspend is under Chief Officer (£3.232m) where we are capturing vacancy savings which are well above budget. Vacancy savings increased by £169k in the month to £1.129m. This cost centre is also used for Covid costs and related income, including for loss of income £160k and undelivered savings £2.228m.

3.1.5 We are catching up in processing supplier relief claims. We have recruited a temporary staff member to concentrate on these claims. We have now processed 96 contract variations to 11 March totalling £1.080m.

3.1.6 Unlike last year, we are now showing gross Social Work expenditure before the funds flow of £12m from NHS Highland, which is in line with annual accounts presentation. This explains why the social work year to date and full year budget appears to have jumped significantly from the comparable period last year.

3.2 Year to Date Position as at 28 February 2021 – Health

3.2.1 Within Health, there is a year to date underspend reported of £2.463m which is an increase of £334k in the month. The biggest change has been prescribing where the position has improved by £222k in the month as we are seeing lower volumes due to Covid offsetting non-delivery of savings.

3.2.2 The underspend is primarily caused by Covid-19 related funding exceeding Covid related expenditure along with underspends due to suspension of services which has caused a noticeable drop in routine service delivery costs, and the prior year rates rebate reported last month. This is offset in part by shortfalls against savings targets of £500k forecast (net of non-recurring underspends). There is also a shortfall in income from charges to other health boards, again largely due to the Covid-19 pandemic, and a small number of budget overspends arising from cost pressures.

3.2.3 The most prominent budget overspends are:

- unfunded costs for long stay in-patients in New Craigs and Fife
- locum costs for medical staffing in Dunoon
- sickness absence medical locum cover at Lorn & Islands Hospital
- agency staffing in Lorn & Islands Hospital surgical services
- unfunded pay costs for three displaced staff

- TAVI procedures at the Golden Jubilee (transcatheter aortic valve implantation)
- additional overnight nurse staffing in Mull PCC
- locum radiography costs at MACHICC
- a high cost admission to the Priory
- locum GP costs in Kintyre Medical Group
- out of hours costs on Jura
- growth in oncology drug use in Lorn & Islands Hospital Day Bed Unit
- increased charges from NHS GG&C for cystic fibrosis and oncology drugs
- loss of income arising from fewer out of area admissions to A&B hospitals

3.2.4 With Covid-19 causing interruption to delivery of a range of services, unsurprisingly a number of short-term underspends have emerged in budgets for services which have been affected. These include:

- salaried dental services
- chargeable cost per case services provided by NHS Greater Glasgow & Clyde
- patients travel costs
- staff travel costs
- Lorn & Islands Hospital theatre supplies
- delay in the opening of Bute dialysis service

3.2.5 The main areas of overspend are in Income and Planning & Performance all caused by savings not achieved due to Covid, and in the areas described above. More detail is given at Appendix 1.

3.3 Forecast Outturn Position as at 28 February 2021 – Social Work

3.3.1 The forecast outturn position for Social Work for 2020-21 is a forecast underspend of £295k (1.4%), improved by £1.329m from last month's forecast. This is after allowing for early repayment of £1m to the Council re previous years' overspends. The main change is from the funding from Scottish Government for undelivered savings of £2.228m. The main driver is overspends in the following areas due to <u>demand</u> pressures (totalling £2.649m):

- Homecare £442k (increased by £171k in month)
- Physical Disability supported living £702k (largely unchanged)
- Learning Disability supported living £270k (increased by £10k in month)
- Learning Disability Joint Residential £417k (reduced by £60k in month)
- External residential placements for children £818k (largely unchanged)

3.3.2 The above figures show the impact of higher demand and do not include the impact of non-delivery of savings which are now funded. Further information is provided within Appendix 2.

3.3.3 Children and Families overall has a forecast outturn underspend of £172k, reduced by £72k in the month, driven mainly by an overspend on Looked After Children in residential placements of £841k offset by underspends of fostering and adoption £357k, Child protection £201k (staffing and contact & welfare payments) and criminal justice £234k (staffing and travel).

3.3.4 Chief Officer forecast positive variance is £2.373m reflecting funding for undelivered savings £2.228m and income £380k along with forecast over-recovery of vacancy savings of £188k (net of early repayment of £1m to the Council). This cost centre budget includes £7.522m Covid funding received to date from Scottish Government. This is shown as fully matched by expected expenditure with a zero variance. At least £2.65m of this is to be carried forward to next year.

3.3.5 Adult Services overall is forecast to be overspent by £2.261m which is reduced in the month by £84k. The biggest single area of Social Work overspend continues to be on Learning Disability (£1.330m) where there has been a failure to deliver all anticipated savings so far (although this is now improving), along with higher than budgeted demand.

3.3.6 The next largest area of forecast overspend is Physical Disability £808kk - nearly all on supported living - mainly additional demand, but also some on the Integrated Equipment Store where planned savings have not been delivered. The overspend on Older People is now well reduced to £95k driven by Older People Other £910k (undelivered savings) offset by underspends on care home placements and on our own residential units and on homecare. Care home admissions have not yet returned to more normal pre-Covid levels and this may not now happen in the near future.

3.3.7 In terms of the forecast outturn, this is now improved due to the funding for undelivered savings which was announced on 5 February 2021, offset by early repayment of £1m to the Council.

3.4 Forecast Outturn Position as at 28 February 2021 – Health

3.4.1 Within Health delivered services the forecast underspend is £1.721m improved by £231k from last month. The assumption is now that Covid costs, loss of income and undelivered savings will be fully reimbursed by Scottish Government in line with the funding announced on 5 February and included in January allocations. The outturn forecast is therefore largely driven by undelivered savings (reduced now to £500k due to offsetting non-recurring underspends) and significant vacancies and reduced non-pay costs due to suspension of services. More detail is given at Appendix 2.

3.4.2 Health has received funding of £7.377m (including a GP allocation of £409k, and for elective / planned care of £479k) all of which is reflected in the revised year to date and forecast positions at the end of February.

3.5 Savings Delivery

3.5.1 As at end of February, £6.254m of the target £10.386m savings have been delivered, 60% of the total and this includes £615k delivered on a non-recurring basis. This has increased by £434k in the month. We are now forecasting to deliver £7.662m of the savings in total by the year end, 74% of the total, an increase of £69k in the month. Further information is provided at Appendix 3a. The highlighted lines show where savings have been declared in the month and forecasts updated.

3.5.2 The forecast outturn shortfall for Social Work is £2.224m which is improved by £27k in the month. This is after non-recurring savings of £115k.

3.5.3 The forecast outturn shortfall for Health is £500k after non-recurring savings and this is unchanged in the month. There is a 4 weekly cycle of regular meetings to review both Health & Social Work savings by Head of Service. Current progress on the unachieved savings is set out in the action tracker included at Appendix 3c.

3.5.4 The failure to deliver on all savings (overall shortfall of £2.724m predicted) is now offset by Scottish Government funding support of £2.728m included in January allocations. It has been recognised that efforts were hampered by the need to prioritise responses to Covid-19 pandemic in March through to June, and subsequent work on re-mobilising services where these were suspended.

3.6 Progress against Financial Recovery Plan

3.6.1 On 16 September 2020 the IJB agreed a financial recovery plan as required by the integration scheme when an overspend is predicted. The plan totalling £2.988m is summarised below:

Increased confidence in delivering already agreed savings	£1.000m
Additional non-recurring savings	£0.650m
Covid loss of income and undelivered savings claim	£1.338m

3.6.2 The above position was based on the financial forecast as at end of July. The forecast as at end of February is now improved such that an underspend is predicted. The revised claim for undelivered savings of £2.728m delivers all the requirement, along with loss of income claim of £807k. Any excess funding provided is required to be set up as an earmarked fund at the year end and carried into the new year to offset Covid pressures next year.

3.6.3 In summary, the financial recovery plan has been achieved and will now be covered through the Covid claims for undelivered savings, as well as through further improvements in savings delivery and additional offsetting underspends.

3.7 Earmarked reserves

3.7.1 At 1 April 2020 earmarked reserves of £605,018 were carried forward to the new year. As previously reported £374,551 have been utilised and the carried forward balance remains unchanged at £230,447. Additional earmarkings are expected to carry forward surplus Covid funds into next year, as well as for Primary Care Improvement Fund and Action 15 of the Mental Health Strategy where we received £1.6m new allocations this month.

3.8 Virements over £100,000

3.8.1 The IJB is requested to authorise the virements completed during the 2020/21 financial year listed below. The transfers did not create any new commitments for the IJB and were completed to either allocate new funding or to allocate the contingency balances held centrally.

Nbr	Period Occurred	Amount £m	Adjustment Description
1	May 20-21	0.359	Allocation of 2020/21 increase in Resource Release and Funds Flow income from NHS Highland to front line service budgets.
2	June 20-21	0.300	Transfer of £0.300m saving in Helensburgh and Lomond Home Care budget to the central contingency fund for allocation to cost pressures in the Social Work budget.
3	Aug 20-21	0.227	Declaration of saving 1920-42 Step up/down of care funded from the central contingency fund.
4	Aug 20-21	0.198	Transfer of LD Supported Living cost pressure for sleepovers to contingency fund for reallocation to cost pressures in the Social Work budget.
5	Nov 20-21	0.405	Declaration of saving 2021-31 & partial declaration of saving 1819-25 using funding from the contingency fund.
6	Jan 20-21	0.851	Allocation of contingency funding to cost pressures in the front line services.
	Total	**2.340**	

3.8.2 The opening contingency balance was £1.175m and the balance is now reduced to £14k as follows:

Nbr	Description	Funds Added / (Funds Removed) £m	Running Balance £m
	2020/21 Opening Balance		1.175
2	Transfer of £0.300m saving in Helensburgh and Lomond Home Care budget to the central contingency fund for allocation to cost pressures in the Social Work budget.	0.300	1.475
3	Declaration of saving 1920-42 Step up/down of care funded from the central contingency fund.	(0.227)	1.248
4	Transfer of LD Supported Living cost pressure for sleepovers to contingency fund for reallocation to cost pressures in the Social Work budget.	0.198	1.446
5	Declaration of saving 2021-31 & partial declaration of saving 1819-25 using funding from the contingency fund.	(0.405)	1.040
6	Allocation of contingency funding to cost pressures in the front line services.	(0.851)	0.189
Other	Total of virements processed with an individual value of less than £0.100m.	(0.175)	0.014

	2020/21 Current Balance (as at 10 March 2021)		0.014

Members should note that the first virement shown in the virement list for £0.359m did not impact on the contingency fund balance.

3.9 Debt Repayment to Argyll and Bute Council

3.9.1 As at April 2020, the IJB owed Argyll and Bute Council £5.348m towards the deficits which accrued for financial years 2017/18, 2018/19 and 2019/20. A repayment of £0.500m has already been made in 2020/21, reducing the balance to £4.848m. Under section 8 of the IJB Scheme of Integration, the IJB is required to repay any underspends at the end of a year to reduce this debt. The forecast being presented to the Board assumes a repayment of £1.0m which is consistent with the Council agreement to reduce next year's repayment from £1.2m to £200k. Should the year end outturn have a greater underspend, then the repayment with be increased in accordance with the scheme of integration.

4. RELEVANT DATA AND INDICATORS

4.1 Information is derived from the financial systems of Argyll and Bute Council and NHS Highland.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery. This needs to be considered when options are developed to balance the budget.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact – The forecast outturn position for 2020-21 is a forecast underspend of £2.016m as at 28 February 2021.

6.2 Staff Governance – None directly from this report but there is a strong link between HR and delivering financial balance.

6.3 Clinical Governance - None

7. PROFESSIONAL ADVISORY

7.1 Professional Leads have been consulted on implications of all savings.

8. EQUALITY AND DIVERSITY IMPLICATIONS

8.1 None directly from this report but any proposals to address the estimated budget gap will need to consider equalities.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

9.1 No issues arising directly from this report.

10. RISK ASSESSMENT

10.1 There are a number of financial risks which may affect the outturn. These are reviewed at 2 monthly intervals by the IJB.

11. PUBLIC AND USER INVOLVEMENT AND ENGAGEMENT

11.1 None directly from this report but any proposals to address the estimated budget gap will need to take into consideration local stakeholder and community engagement.

12. CONCLUSIONS

12.1 This report provides a summary of the financial position as at 28 February 2021. The forecast outturn position for 2020-21 is a forecast underspend of £2.016m. This allows for repayment of £1m to Argyll and Bute Council.

13. DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	√
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

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APPENDICES:

Appendix 1 – Year to Date Position as at 28 February 2021
Appendix 2 – Forecast Outturn for 2020-21 as at 28 February 2021
Appendix 3a – Savings achieved and forecast as at 28 February 2021
Appendix 3b – Unachieved savings only as at 28 February 2021
Appendix 3c – Savings action tracker as at 28 February 2021 (to follow)

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ARGYLL AND BUTE HEALTH AND SOCIAL CARE PARTNERSHIP **APPENDIX 1**

REVENUE BUDGET MONITORING SUMMARY - YEAR TO DATE POSITION AS AT 28 FEB 2021

Reporting Criteria: +/- £50k or +/- 10%

For information:
The Council don't do monthly based accrual accounting, whereas Health do.
On the Council side, there may be a mismatch between year to date actual and budgets, due to timing differences as to when invoices are paid.
Health do monthly based accrual accounting, therefore, you should see a correlation in the year to date position and the year end outturn position.

Service	Actual £000	Budget £000	Variance £000	% Variance	Explanation
COUNCIL SERVICES:					
Chief Officer	2,137	5,369	3,232	60.2%	The YTD variance is due to the over-recovery of agreed vacancy savings (£1.129m) as well as over-recovery of charges to clients (£347k) and efficiency savings (£1.834m) which are both impacted by Covid-19 adjustments from Scottish Government funding to offset income loss and unachieved efficiency savings elsewhere in the service. This is partially offset by overspends on payments to other bodies and software licences.
Service Development	332	338	6	1.8%	The YTD variance is outwith reporting criteria.
Looked After Children	6,435	6,069	(366)	(6.0%)	The YTD overspend is as a result of demand for residential placements (£683k) combined with slippage on savings (£21k) and staffing overspends in the childrens houses partially offset by YTD underspends on fostering (£139k) and catering purchases in the hostels, as well as additional in year income for external adoption placements (£32k) and from the Home Office for Unaccompanied Asylum Seeking Children (£60k).
Child Protection	2,170	2,428	258	10.6%	The YTD underspend reflects lower than expected demand for contact and welfare services (£106k) as well as underspends on staffing costs (salaries and travel) in area teams (£153k).
Children with a Disability	628	697	69	9.9%	The YTD underspend reflects underspends on payments to other bodies due to changes to service provision as a result of Covid-19 as well as travel underspends partially offset by YTD overspends on direct payments.
Criminal Justice	(24)	200	224	112.0%	The YTD underspend reflects underspends on staffing (£128k) as well as underspends on payments to other bodies, combined with small underspends in printing & stationery, rent and staff travel costs.
Children and Families Central Management Costs	2,206	2,236	30	1.3%	The YTD variance is outwith reporting criteria.
Older People	30,620	30,549	(71)	(0.2%)	The YTD overspend is mainly due to slippage on the delivery of agreed savings (£1m) offset by the YTD underspend at Homecare HQ (£414k), YTD underspend on CHP budgets (£324k), YTD over recovery of client income in the HSCP care homes (£156k) and various underspends across transport related expenditure (£36k).
Physical Disability	2,837	2,137	(700)	(32.8%)	The YTD overspend is mainly due to demand driven overspends on third party payments in supported living, YTD overspend on equipment purchase in the integrated equipment store and lower than expected income from fees and charges.
Learning Disability	13,340	12,199	(1,141)	(9.4%)	The YTD overspend is due to service demand in supported living and residential care as well as slippage on agreed savings (£682k) and YTD slippage on income from clients partially offset by YTD underspends on respite.

Service	Actual £000	Budget £000	Variance £000	% Variance	Explanation
Mental Health	2,149	2,208	59	2.7%	The YTD underspend is mainly due to the YTD underspend on employee costs within the integrated addiction team and underspends across the service on transport relating expenditure.
Adult Services Central Management Costs	456	448	(8)	(1.8%)	The YTD variance is outwith reporting criteria.
COUNCIL SERVICES TOTAL	**63,286**	**64,878**	**1,592**	**2.5%**	
HEALTH SERVICES:					**Explanation**
Community & Hospital Services	52,797	53,437	640	1.2%	Vacancies and reduced non-pay spend due to suspension of services
Mental Health and Learning Disability	12,998	13,531	533	3.9%	Vacancies and reduced non-pay spend due to suspension of services
Children & Families Services	7,240	7,354	114	1.6%	Vacancies and reduced non-pay spend due to suspension of services
Commissioned Services - NHS GG&C - main SLA	60,120	60,204	83	0.1%	High cost drug therapies & procedures for a small number of patients
Commissioned Services - Other Cmmty & Hosp Srvcs	3,489	3,500	11	0.3%	Outwith reporting criteria.
General Medical Services	17,558	17,742	184	1.0%	Reduced spend due to Covid
Community and Salaried Dental Services	3,154	3,637	483	13.3%	Vacancies and reduced non-pay spend due to suspension of services
Other Primary Care Services	10,088	10,088	0	0.0%	Outwith reporting criteria.
Prescribing	17,897	18,048	151	0.8%	Reduced spend due to Covid
Public Health	1,402	1,506	104	6.9%	Vacancies
Lead Nurse	1,964	1,993	29	1.5%	Vacancies and reduced non-pay spend due to suspension of services
Management Service	2,555	2,798	243	8.7%	Vacancies and reduced non-pay spend due to suspension of services
Planning & Performance	1,906	1,777	(129)	(7.3%)	Savings targets not being achieved
Budget Reserves	0	0	0		Outwith reporting criteria.
Income	(1,292)	(1,466)	(174)	(11.9%)	Non achievement of savings target due to impact of covid on out of area treatments
Estates	7,150	7,340	190	2.6%	Prior Year Rates Rebates
HEALTH SERVICES TOTAL	**199,026**	**201,489**	**2,463**	**1.2%**	
GRAND TOTAL	**262,312**	**266,367**	**4,055**	**1.5%**	

ARGYLL AND BUTE HEALTH AND SOCIAL CARE PARTNERSHIP **APPENDIX 2**

REVENUE BUDGET MONITORING FORECAST OUTTURN - AS AT 28 FEB 2021

Reporting Criteria: +/- £50k or +/- 10%

Service	Annual Budget £000	Forecast Outturn £000	Variance £000	% Variance	Explanation
COUNCIL SERVICES:					
Chief Officer	9,127	6,754	2,373	26.0%	The forecast underspend reflects additional Covid-19 funding to adjust for slippage on savings achievement (£2.223m) as well as lost income from clients as a result of changes to services during the on-going pandemic (£380k) (offsetting under-recovery of savings and income can be seen across other services). The forecast also includes the over-recovery of vacancy savings (£188k) which has reduced this month in order to reflect the acceleration of repaying accumulated historic overspends back to the council. This is partially offset by provision for bad debts (£80k) and estimated slippage on the delivery of agreed savings in this service (£222k). The budget has moved significantly this month due to a combination of increased vacancy savings, Covid-19 additional funding and efficiency savings achievement partially offset by a reduction in funding from the Council of £100k to correct historic overspend repayments.
Service Development	394	383	11	2.8%	The forecast variance is outwith reporting criteria.
Looked After Children	6,933	7,332	(399)	(5.8%)	The forecast overspend arises due to demand for external residential placements (£818k) and slippage on agreed savings (£22k) partially offset by underspends in fostering and supporting young people leaving care arising due to lower than budgeted service demand as well as adoption from in year additional income for external placements (£86k).
Child Protection	2,975	2,774	201	6.8%	The forecast underspend arises mainly due to lower than anticipated service demand for contact and welfare services as well as staffing and travel underspends in the area teams.
Children with a Disability	825	781	44	5.3%	The forecast variance is outwith reporting criteria.
Criminal Justice	166	(67)	233	140.4%	The forecast underspend arises due to staff vacancies (£130k) and related reduced staff travel expenses as well as underspends on payments to other bodies, computer software, rent and utilities.
Children and Families Central Management Costs	2,663	2,571	92	3.5%	The forecast underspend arises due to underspends on payments to other bodies within service strategy and regulation as well as underspends across supplies and services in the integrated care area teams.
Older People	35,737	35,832	(95)	(0.3%)	The forecast overspend arises due to slippage on agreed savings (£1.148m). This is offset by higher than expected income from fees and charges in the HSCP care homes, underspends across the external residential care budgets due to the impact from Covid, and underspends on payments to other bodies within Telecare.

Service	Annual Budget £000	Forecast Outturn £000	Variance £000	% Variance	Explanation
Physical Disability	2,508	3,316	(808)	(32.2%)	The forecast overspend reflects higher than budgeted demand for supported living (£702k) and higher than budgeted purchasing in the integrated equipment service (£117k). This is offset slightly by a forecast underspend (£9k) in the residential care budget, underspend in the sensory impairment service (£5k) and other minor underspends across the service.
Learning Disability	15,314	16,644	(1,330)	(8.7%)	The forecast overspend reflects higher than budgeted demand for services in supported living (£245k) and residential placements (£551k) as well as slippage on agreed savings (£744k) and
Mental Health	2,735	2,709	26	1.0%	The forecast variance is outwith reporting criteria.
Adult Services Central Management Costs	564	617	(53)	(9.4%)	The forecast overspend arises due to slippage on agreed savings (£88k) offset by a forecast
COUNCIL SERVICES TOTAL	**79,941**	**79,646**	**295**	0.4%	
HEALTH SERVICES:					**Explanation**
Community & Hospital Services	58,180	57,410	770	1.3%	Vacancies and reduced non-pay spend due to suspension of services
Mental Health and Learning Disability	14,759	14,122	637	4.3%	Vacancies and reduced non-pay spend due to suspension of services
Children & Families Services	8,016	7,901	115	1.4%	Vacancies and reduced non-pay spend due to suspension of services
Commissioned Services - NHS GG&C	65,586	65,836	(250)	(0.4%)	High cost drug therapies & procedures for a small number of patients
Commissioned Services - Other Cmmty & Hosp Srvcs	3,817	3,867	(50)	(1.3%)	Higher than predicted activity for TAVI cardiac procedure at Golden Jubilee
General Medical Services	19,444	19,300	144	0.7%	Reduced spend due to Covid
Community and Salaried Dental Services	3,953	3,440	513	13.0%	Vacancies and reduced non-pay spend due to suspension of services
Other Primary Care Services	11,356	11,356	0	0.0%	Outwith reporting criteria.
Prescribing	19,687	19,593	94	0.5%	Reduced spend due to Covid
Public Health	1,642	1,532	110	6.7%	Vacancies and reduced non-pay spend due to suspension of services
Lead Nurse	2,123	2,095	28	1.3%	Vacancies and reduced non-pay spend due to suspension of services
Management Service	3,047	2,797	250	8.2%	Vacancies and reduced non-pay spend due to suspension of services
Planning & Performance	2,088	2,540	(452)	(21.6%)	Savings targets not being achieved
Budget Reserves	5,048	5,048	0	0.0%	Outwith reporting criteria.
Income	(1,612)	(1,412)	(200)	12.4%	Savings targets not being achieved due to impact of covid
Estates	8,093	8,081	12	0.1%	Outwith reporting criteria.
HEALTH SERVICES TOTAL	**225,227**	**223,506**	**1,721**	0.8%	
GRAND TOTAL	**305,168**	**303,152**	**2,016**	0.7%	

ARGYLL & BUTE SOCIAL WORK SAVINGS PLAN 2020/21

Ref.	Savings Description	Manager	Target £' 000	Year to 28 Feb 2021 Achieved £' 000	Unachieved £' 000	% Achieved	Full Year Forecast Achievement £' 000	Shortfall £' 000	% Achieved		
1819-7	Thomson Court	Jane Williams	10	0	10	0%	0	10	0%	Declared on N/R basis M7	adult/MH
1819-8	Assessment and Care Management	Caroline Cherry	42	0	42	0%	0	42	0%		Adult
1819-14	Redesign of Internal and External Childrens Residential Placements	Patricia Renfrew	200	178	22	89%	178	22	89%		C&F
1819-15	Children and Families Management Structure	Patricia Renfrew	150	150	0	100%	150	0	100%		C&F
1819-18	Review provision of HSCP care homes	Caroline Cherry	99	0	99	0%	0	99	0%		Adult
1819-19	Review and Redesign of Physical Disability Services	Jim Littlejohn	28	28	0	100%	28	0	100%		MH&LD
1819-19	Review and Redesign of Learning Disability Services - Sleepovers and Technology Argyll Wide	Jim Littlejohn	299	145	154	48%	145	154	48%	£51k declared M11	MH&LD
1819-19	Review and Redesign of Learning Disability Services - Packages of Care Mid Argyll	Jim Littlejohn	40	6	34	16%	6	34	15%		MH&LD
1819-19	Review and Redesign of Learning Disability Services - Packages of Care Kintyre	Jim Littlejohn	29	3	26	10%	3	26	10%	£3k declared M11, nothing further expected in year so full year forecast reduced	MH&LD
1819-19	Review and Redesign of Learning Disability Services - Packages of Care Lorn	Jim Littlejohn	69	23	46	33%	23	46	33%	£6k declared M11	MH&LD
1819-19	Review and Redesign of Learning Disability Services - Packages of Care Bute	Jim Littlejohn	9	9	0	100%	9	0	100%		MH&LD
1819-19	Review and Redesign of Learning Disability Services - Packages of Care Cowal	Jim Littlejohn	60	49	11	81%	49	11	81%	£11k shifted from 1819-19 ext res LD placements; £8k declared M11	MH&LD
1819-19	Review and Redesign of Learning Disability Services - Packages of Care Helensburgh	Jim Littlejohn	69	58	11	84%	58	11	84%	£4.7k declared M11	MH&LD
1819-19	Review and Redesign of Learning Disability Rothesay Resource Centre	Jane Williams	14	0	14	0%	0	14	0%		adult/MH
1819-19	Review and Redesign of Learning Disability Assist Cowal Resource Centre	Jane Williams	30	0	30	0%	0	30	0%		adult/MH
1819-19	Review of Ext Residential Learning Disability Placements	Jim Littlejohn	194	0	194	0%	0	194	0%	Declared and forecast reduced to 0 M11 £11k shifted to 1819-19 packages of care Cowal	MH&LD
1819-22	Adult Care West - Restructure of Neighbourhood Teams (SW & Health)	Caroline Cherry	250	0	250	0%	0	250	0%		Adult
1819-25	Older People Day/Resource Centre - Address high levels of management - consolidate opening hours - shared resource	Caroline Cherry	212	155	57	73%	155	57	73%		adult/MH
1819-31	Integrate HSCP Admin, digital Tech and Central Appoint System	Patricia Renfrew/ Kirsteen Larkin	104	0	104	0%	0	104	0%		corp
1819-33	Catering, Cleaning and other Ancillary Services	Tricia / Jayne Jones / Caroline Cherry	70	0	70	0%	0	70	0%		Adult
1819-40	SLA and Grants operate within allocation	Patricia Renfrew	23	23	0	100%	23	0	100%		C&F
1819-42	Contract Management reducing payments to Commissioned External providers	Stephen Whiston	33	0	33	0%	0	33	0%		corp
1819-46	Adopt a Single Community Team Approach to undertaking Assessment and Care Management	Caroline Cherry	120	0	120	0%	0	120	0%		Adult
1920-33	Review of management structure	Joanna Macdonald / Charlotte Craig	102	55	48	53%	55	48	53%	£54.5 declared M11	corp
1920-40	Implement best practice approaches for care at home and re-ablement across all areas following Bute pilot	Caroline Cherry/ G McCready	300	0	300	0%	0	300	0%	Forecast reduced to £0 M10	Adult
1920-41	Extend use of external home care transferring hours as gaps occur	Donald Watt	33	0	33	0%	0	33	0%		Adult
1920-42	Step up/step down of care to be suspended except for exceptional cases	Judy Orr	227	227	0	100%	227	0	100%		Adult
1920-43	Cap on overtime	Donald Watt	87	0	87	0%	0	87	0%		Adult
1920-44	Reduction on adult services social work travel	Jim Littlejohn/ Donald Watt	25	25	0	100%	25	0	100%		Adult
1920-45	Planned changes in staffing for Bowman Court in line with Lorne Campbell Court structure	Donald Watt	28	0	28	0%	0	28	0%		Adult
2021-5	Bring staffing within ECCT teams and Mull Progressive Care Centre into line with best practice elsewhere	Caroline Cherry/ Donald Watt	85	0	85	0%	0	85	0%		Adult
2021-7	Review of provisioning of day services and remodel considering options of greater third sector involvement aiming for 10% reduction in cost (currently underspending by c £70k)	Caroline Cherry/ Julie Lusk	200	0	200	0%	0	200	0%		adult/MH
2021-30	Provide sleepovers on exceptional basis or as part of core and cluster, and increase technology provision as alternative - savings on top of £299k for earlier years b/fwd and not yet delivered	Jim Littlejohn	50	0	50	0%	0	50	0%	Forecast reduced to 0 M11	MH&LD
2021-31	Reduce double up care activity for care at home visits through more effective use of equipment, technology and staff training	Caroline Cherry	250	250	0	100%	250	0	100%		Adult
2021-32	Review housing support services and remove where not required for LD and PD clients	Julie Lusk	181	6	175	3%	6	175	3%	Forecast reduced by £23k M11	MH&LD
2021-33	Reduce travel and increased grip and control of expenditure	All Managers	60	60	0	100%	60	0	100%		adult/MH
2021-34	Additional recovery of direct payments (S30110...) (running above budget)	Caroline Cherry/David Forshaw	25	25	0	100%	25	0	100%		Adult
2021-35	Carers support (S30091..)	Caroline Cherry/David Forshaw	150	150	0	100%	150	0	100%		Adult
2021-36	Respite Care (HQ) (S30090...) - align budget to current levels of expenditure, review all expenditure and ensure in line with policy	Caroline Cherry	80	80	0	100%	80	0	100%		Adult
2021-37	Day Care - additional client charge income (running above budget) (S300500..)	Julie Lusk/David Forshaw	25	25	0	100%	25	0	100%		MH&LD
2021-38	Development & flex budgets not currently utilised (MAKI / B&C) (S300930..)	Caroline Cherry	10	10	0	100%	10	0	100%		Adult
2021-39	Progressive Care Mull additional income (S3008002..)	Caroline Cherry/David Forshaw	10	10	0	100%	10	0	100%		Adult
2021-40	Resource Release - budget not use (S300351..)	Caroline Cherry/David Forshaw	6	6	0	100%	6	0	100%		Adult
2021-41	Telecare - additional income above budget (S300330)	Stephen Whiston/David Forshaw	80	80	0	100%	80	0	100%		corp
2021-42a	integrated equipment store - increased consistency in prescribing	Julie Lusk/Jim Littlejohn	80	80	0	100%	80	0	100%		MH&LD
2021-42b	integrated equipment store - restriction in range of catalogue items to aid re-use and improved procurement; remove items supported priority 3 and 4 needs (bathing assessments/equipmnet)	Julie Lusk/Jim Littlejohn	20	20	0	100%	20	0	100%		MH&LD

Ref.	Savings Description	Manager	Target £' 000	Year to 28 Feb 2021 Achieved £' 000	Unachieved £' 000	% Achieved	Full Year Forecast Achievement £' 000	Shortfall £' 000	% Achieved		
2021-43	Sensory impairment -See/Hear monies underspent	Julie Lusk	10	10	0	100%	10	0	100%		MH&LD
2021-44	Resource Centres/Day Centres - additional income £35k; Travel underspent £10k; Savings on Enable day service £25k	Julie Lusk/David Forshaw	70	70	0	100%	70	0	100%		MH&LD
2021-45	Community Support Teams Dunoon Link Club £12k ended previously and underspend on travel £10k	Julie Lusk/David Forshaw	22	22	0	100%	22	0	100%		MH&LD
2021-10	Transformation of Social Work admin increasing use of technology and integration with NHS admin services - savings not yet quantified	Patricia Renfrew/Kirsteen Larkin	93	0	93	0%	93	0	100%		C&F
2021-12	Staffing review to include workload analysis and risk assessment (possible saving of 3 social worker posts (H&L/B&C/OLI) 2 para professional (T&AC))	Patricia Renfrew	246	246	0	100%	246	0	100%		C&F
2021-46	Improved rostering of staff for school hostels	Patricia Renfrew	50	44	6	88%	44	6	88%		C&F
2021-47	Review of catering arrangements at Dunclutha and East King Street	Patricia Renfrew	23	23	0	100%	23	0	100%		C&F
2021-48	Redesign Emergency Social Work service - shift to contracted hours	Patricia Renfrew/Brian Reid	100	100	0	100%	100	0	100%		C&F
2021-49	Reduce external contracted hours for childrens support workers	Patricia Renfrew	8	8	0	100%	8	0	100%		C&F
2021-50	Dunoon hostel - income from nursery meals	Patricia Renfrew/David Forshaw	20	20	0	100%	20	0	100%		C&F
2021-51	contact & welfare £10k per locality	Patricia Renfrew	40	40	0	100%	40	0	100%		C&F
2021-52	CABD, physio & OT NHS hire of facility	Patricia Renfrew	15	15	0	100%	15	0	100%		C&F
2021-11	SLA with GG&C for CAMHS service (Fusions)	Patricia Renfrew/David Forshaw	23	23	0	100%	23	0	100%		C&F
2021-55	Technology Enabled Care - improve re-use of equipment through better asset utilisation, cap Telecare equipment cost, reduce travel budget	Stephen Whiston	34	34	0	100%	34	0	100%		corp
2021-60b	Additional vacancy savings (above £600k already budgeted)	Joanna Macdonald/David Forshaw	250	250	0	100%	250	0	100%		corp
2021-62	Unused central funds cost centre S0000000000.40300	Joanna Macdonald/David Forshaw	180	180	0	100%	180	0	100%		corp
	Totals		**5,453**	**3,021**	**2,432**	**55%**	**3,113**	**2,339**	**57%**		

ARGYLL & BUTE HEALTH SAVINGS PLAN 2020/21

Ref.	Savings Description	Manager	Target £' 000	Year to 28 Feb 2021 Achieved £' 000	Unachieved £' 000	% Achieved	Full Year Forecast Achievement £' 000	Shortfall £' 000	% Achieved		
1819-4	Closure of West House / Argyll & Bute Hospital site	David Ross	20	20	0	100%	20	0	100%		corp
1819-5	Closure of Aros (running costs)	David Ross/ Charlotte Craig	60	60	0	100%	60	0	100%		corp
1819-16	Children & Families services staffing	Patricia Renfrew	50	50	0	100%	50	0	100%		C&F
1819-32	Catering & cleaning review	Caroline Cherry	20	0	20	0%	0	20	0%	Forecast reduced m11	Adult
1819-44	Advanced Nurse Practitioners - Oban	Caroline Henderson	14	0	14	0%	0	14	0%		Adult
1819-53	Vehicle Fleet Services (see also 2021-57)	Stephen Whiston	18	0	18	0%	0	18	0%	Forecast reduced m11	corp
1920-3	Health Promotion Discretionary Budgets	Alison McGrory	54	0	54	0%	0	54	0%		corp
1920-4	Review of Service Contracts	Judy Orr	86	22	64	26%	22	64	26%	£18.4k declared and forecast reduced £14k M11	corp
1920-8	GP Prescribing	Fiona Thomson	500	96	404	19%	96	404	19%	£20k declared and forecast increased m11	corp
1920-22	Dunoon Medical Services (see also 2021-16)	Rebecca Heliwell	100	0	100	0%	0	100	0%		corp
1920-31	Review of SLAs with GGC	Stephen Whiston	290	290	0	100%	290	0	100%		corp
1920-32	Review of management structure	Joanna Macdonald / Charlotte Craig	200	160	40	80%	160	40	80%	£160k declared m11 and forecast increased by £10k	corp
1920-35	Bed reduction savings : Dunoon	Jane Williams	150	0	150	0%	0	150	0%		Adult
1920-38a	LIH Theatre nurse staffing - HAK112	Caroline Henderson	38	8	30	21%	8	30	21%		Adult
1920-38b	Lorn & Islands Hospital staffing	Caroline Henderson	124	97	28	78%	97	28	78%	£27.5k declared m11	Adult
2021-1	Mental Health redesign of dementia services (excludes commissioned services)	Caroline Cherry	200	0	200	0%	0	200	0%	Declared non-recurring instead	Adult
2021-2	Standardise procurement of food across all sites and expansion in conjunction with Council for early years	Caroline Cherry	69	0	69	0%	0	69	0%		Adult
2021-3	AHP - carry out workforce planning and establishment setting to find efficiencies in posts and realign services provided to match	Linda Currie	140	54	86	38%	54	86	38%		Adult
2021-4a	Admin & clerical general productivity / efficiency enhancement via shift to digital working in 2020/21 and 2021/22	Stephen Whiston	100	0	100	0%	0	100	0%		corp
2021-4b	Right size admin budgets Mid Argyll and LIH	Caroline Cherry	45	0	45	0%	0	45	0%		Adult
2021-8	Review maternity arrangements for out of hours and bring within contracted hours	Patricia Renfrew	100	100	0	100%	100	0	100%		C&F
2021-9	Review health visitor and school nurse staffing	Patricia Renfrew	100	100	0	100%	100	0	100%		C&F
2021-13	Right size budget for services delivered under SLA by NHS GG&C for those charges on cost by case basis	Stephen Whiston	100	100	0	100%	100	0	100%		corp
2021-14	Removal of health & wellbeing small grant fund	Nicola Schinaia	50	50	0	100%	50	0	100%		corp
2021-15	Investment fund savings - reduce spend on Care & repair by £60k originally funded as short term investment	C Cherry / J Littlejohn	60	0	60	0%	0	60	0%		Adult
2021-16	Rationalisation of medical services for Dunoon (adds to 1920-22)	Rebecca Heliwell	20	0	20	0%	0	20	0%		corp
2021-17	Ongoing grip and control of all non-essential expenditure	Caroline Cherry/Julie Lusk	340	84	256	25%	84	256	25%		adult/MH
2021-18	Savings in time & travel through further roll out of Near Me (Attend Anywhere)	John Dreghorn/Kristin Gillies	50	50	0	100%	50	0	100%	£50k declared m11	corp
2021-19	Redesign of hotel services to reflect reduction in inpatient numbers	Caroline Cherry	99	0	99	0%	0	99	0%		Adult
2021-20	Centralised booking of medical records - reduction in admin costs	Stephen Whiston	97	0	97	0%	0	97	0%		corp

Ref.	Savings Description	Manager	Target £' 000	Year to 28 Feb 2021 Achieved £' 000	Unachieved £' 000	% Achieved	Full Year Forecast Achievement £' 000	Shortfall £' 000	% Achieved		
2021-21	Alternative local provision for patients placed with high cost providers - 10% saving on £2.2m budget predominantly mental health clients	Julie Lusk	200	200	0	100%	200	0	100%		MH&LD
2021-22	Patient Travel costs - spending below budgets	Caroline Cherry	100	100	0	100%	100	0	100%		Adult
2021-23	Catering & domestic - spending below budgets	Caroline Cherry	80	50	30	63%	50	30	63%	£25k declared m11	Adult
2021-24	Oban medical services - underspending areas of admin and non-pay	Caroline Cherry/Caroline Henderson	100	100	0	100%	100	0	100%		Adult
2021-25	Near Me Mental Health project - savings on travel	John Dreghorn/Kristin Gillies	10	10	0	100%	10	0	100%		MH&LD
2021-26	Admin pays - removal of budget for 2 half posts saved in Lochgilphead in 2019/20	Caroline Cherry	29	29	0	100%	29	0	100%		Adult
2021-27	Cowal general transport - underspend	Caroline Cherry	15	15	0	100%	15	0	100%		Adult
2021-29	Dunoon Gum clinic - underspend	Caroline Cherry	20	0	20	0%	0	20	0%	Declared Non-recurring instead	Adult
2021-53	Reduction of health improvement team budget by one third	Nicola Schinaia	6	6	0	100%	6	0	100%		corp
2021-54	Printer rationalisation and centralisation of GP servers	Stephen Whiston	17	17	0	100%	17	0	100%	£7k declared m11 and forecast increased	corp
2021-57	Fleet management - electric vehicles, improved accuracy of mileage claims using postcodes; fuel savings through use of telematic data (see also 1819-53)	Stephen Whiston	40	0	40	0%	0	40	0%	Forecast reduced m11	corp
2021-58	Additional income from other health boards (being achieved in 19/20)	George Morrison	200	0	200	0%	0	200	0%		corp
2021-59	Review of continence nursing practice and related use of supplies (Lead Nurse)	Elizabeth Higgins	20	20	0	100%	20	0	100%		Adult
2021-60a	Additional vacancy savings - achieving £2.85m in 2019/20	Joanna MacDonald	500	500	0	100%	500	0	100%		corp
2021-61	Investment fund savings - reduction in funds to support colocation and vacant posts	Joanna MacDonald	72	72	0	100%	72	0	100%		corp
2021-63	Estate Rationalisation (£50k provision in Investment Fund to be used only on a spend to save basis)	Kevin Willan	50	49	1	98%	49	1	98%		corp
2021-68	Forensic billing review of utilities - water	David Ross	30	30	0	100%	30	0	100%		corp
2021-64	Review of Forensic Medical Examiner Costs - particularly Bute & Cowal and Out of hours costs (full year saving may only be available in 2021/22)	Rebecca Heliwell	50	0	50	0%	0	50	0%		corp
2021-66	Community dental practices	Donald MacFarlane	25	5	20	20%	5	20	20%	Declared Non-recurring instead	corp
2021-67	Homecare pharmacy services - right size budget	George Morrison	75	75	0	100%	75	0	100%		corp
	Totals		**4,933**	**2,618**	**2,315**	**53%**	**2,618**	**2,315**	**53%**		
	Non Recurring Savings - Social Work										
1819-7	Thomson Court	Jane Williams	0	10	(10)		10	(10)		£10k declared M7	
1819-18	Review provision of HSCP care homes	Caroline Cherry	0	99	(99)		99	(99)		£99k declared M7	
2021-46	Improved rostering of staff for school hostels	Patricia Renfrew	0	6	(6)		6	(6)		£6k declared M8	
	sub-total		0	115	(115)		115	(115)			
	Non Recurring Savings - Health										
2021-1	Mental Health redesign of dementia services	Caroline Cherry	0	200	(200)		200	(200)		£200k declared M2	Adult
1920-3	Health Promotion Discretionary Budgets	Alison McGrory	0	54	(54)		54	(54)		£27k declared M2 £13k declared M7, £14k M8	corp
2021-29	Dunoon Gum Clinic	Caroline Cherry / Jane Williams	0	20	(20)		20	(20)		£20k declared M4	Adult
2021-66	Community dental practices	Donald MacFarlane	0	20	(20)		20	(20)		£20k declared M6	corp
1920-35	Bed reduction savings : Dunoon	Jane Williams	0	120	(120)		120	(120)		£120k declared M7	
2021-3	AHP - carry out workforce planning and establishment setting to find efficiencies in posts and realign services provided to match	Linda Currie	0	86	(86)		86	(86)		£86.4k declared M10	
1920-4	Review of Service Contracts	Judy Orr	0	64	(64)		64	(64)		£63.6k declared m11, balance of recurring target	
	Sundry budget underspends badged as non-recurring savings		0	0	0		1,251	(1,251)		Reduced by £61k M11 as new N/R saving added	
	sub-total		0	564	(564)		1,815	(1,815)			
	Totals		**0**	**679**	**(679)**		**1,930**	**(1,930)**			
	ARGYLL & BUTE HSCP TOTAL SAVINGS PLAN 2020/21		**10,386**	**6,318**	**4,068**	**61%**	**7,661**	**2,724**	**74%**		

Funding announced 3 Feb 2021

SG funding support for undelivered savings: Health	500
SG funding support for undelivered savings: Social Work	2,228
	2,728
Overall shortfall	-4

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Appendix 3 (b)

ARGYLL & BUTE SOCIAL WORK SAVINGS PLAN 2020/21

			Year to 28 Feb 2021				Full Year Forecast		
Ref.	Savings Description	Manager	Target £' 000	Achieved £' 000	Unachieved £' 000	% Achieved	Achievement £' 000	Shortfall £' 000	% Achieved
1819-7	Thomson Court	Jane Williams	10	0	10	0%	0	10	0%
1819-8	Assessment and Care Management	Caroline Cherry	42	0	42	0%	0	42	0%
1819-14	Redesign of Internal and External Childrens Residential Placements	Patricia Renfrew	200	178	22	89%	178	22	89%
1819-18	Review provision of HSCP care homes	Caroline Cherry	99	0	99	0%	0	99	0%
1819-19	Review and Redesign of Learning Disability Services - Sleepovers and Technology Argyll Wide	Jim Littlejohn	299	145	154	48%	145	154	48%
1819-19	Review and Redesign of Learning Disability Services - Packages of Care Mid Argyll	Jim Littlejohn	40	6	34	16%	6	34	15%
1819-19	Review and Redesign of Learning Disability Services - Packages of Care Kintyre	Jim Littlejohn	29	3	26	10%	3	26	10%
1819-19	Review and Redesign of Learning Disability Services - Packages of Care Lorn	Jim Littlejohn	69	23	46	33%	23	46	33%
1819-19	Review and Redesign of Learning Disability Services - Packages of Care Cowal	Jim Littlejohn	60	49	11	82%	49	11	82%
1819-19	Review and Redesign of Learning Disability Services - Packages of Care Helensburgh	Jim Littlejohn	69	58	11	84%	58	11	84%
1819-19	Review and Redesign of Learning Disability Rothesay Resource Centre	Jane Williams	14	0	14	0%	0	14	0%
1819-19	Review and Redesign of Learning Disability Assist Cowal Resource Centre	Jane Williams	30	0	30	0%	0	30	0%
1819-19	Review of Ext Residential Learning Disability Placements	Jim Littlejohn	194	0	194	0%	0	194	0%
1819-22	Adult Care West - Restructure of Neighbourhood Teams (SW & Health)	Caroline Cherry	250	0	250	0%	0	250	0%
1819-25	Older People Day/Resource Centre - Address high levels of management - consolidate opening hours - shared resource	Caroline Cherry	212	155	57	73%	155	57	73%
1819-31	Integrate HSCP Admin, digital Tech and Central Appoint System	Patricia Renfrew/ Kirsteen Larkin	104	0	104	0%	0	104	0%
1819-33	Catering, Cleaning and other Ancillary Services	Tricia / Jayne Jones / Caroline Cherry	70	0	70	0%	0	70	0%
1819-42	Contract Management reducing payments to Commissioned External providers	Stephen Whiston	33	0	33	0%	0	33	0%
1819-46	Adopt a Single Community Team Approach to undertaking Assessment and Care Management	Caroline Cherry/ G McCready	120	0	120	0%	0	120	0%
1920-33	Review of management structure	Joanna Macdonald / Charlotte Craig	102	55	47	54%	55	47	54%
1920-40	Implement best practice approaches for care at home and re-ablement across all areas following Bute pilot	Caroline Cherry/ G McCready	300	0	300	0%	0	300	0%
1920-41	Extend use of external home care transferring hours as gaps occur	Donald Watt	33	0	33	0%	0	33	0%
1920-43	Cap on overtime	Donald Watt	87	0	87	0%	0	87	0%
1920-45	Planned changes in staffing for Bowman Court in line with Lorne Campbell Court structure	Caroline Cherry / Donald Watt	28	0	28	0%	0	28	0%
2021-5	Bring staffing within ECCT teams and Mull Progressive Care Centre into line with best practice elsewhere	Caroline Cherry / Donald Watt	85	0	85	0%	0	85	0%
2021-7	Review of provisioning of day services and remodel considering options of greater third sector involvement aiming for 10% reduction in cost (currently underspending by c £70k)	Caroline Cherry/ Julie Lusk	200	0	200	0%	0	200	0%
2021-30	Provide sleepovers on exceptional basis or as part of core and cluster, and increase technology provision as alternative - savings on top of £299k for earlier years b/fwd and not yet delivered	Jim Littlejohn	50	0	50	0%	0	50	0%
2021-32	Review housing support services and remove where not required for LD and PD clients	Julie Lusk	181	6	175	3%	6	175	3%

Ref.	Savings Description	Manager	Year to 28 Feb 2021 Target £' 000	Achieved £' 000	Unachieved £' 000	% Achieved	Full Year Forecast Achievement £' 000	Shortfall £' 000	% Achieved
2021-10	Transformation of Social Work admin increasing use of technology and integration with NHS admin services - savings not yet quantified	Patricia Renfrew/Kirsteen Larkin	93	0	93	0%	93	0	100%
2021-46	Improved rostering of staff for school hostels	Patricia Renfrew	50	44	6	88%	44	6	88%
	Totals		**3,154**	**722**	**2,431**	**23%**	**815**	**2,339**	**26%**

ARGYLL & BUTE HEALTH SAVINGS PLAN 2020/21

Ref.	Savings Description	Manager	Year to 28 Feb 2021 Target £' 000	Achieved £' 000	Unachieved £' 000	% Achieved	Full Year Forecast Achievement £' 000	Shortfall £' 000	% Achieved	
1819-32	Catering & cleaning review	Caroline Cherry	20	0	20	0%	0	20	0%	
1819-44	Advanced Nurse Practitioners - Oban	Caroline Henderson	14	0	14	0%	0	14	0%	
1819-53	Vehicle Fleet Services	Stephen Whiston	18	0	18	0%	0	18	0%	
1920-3	Health Promotion Discretionary Budgets	Alison McGrory	54	0	54	0%	0	54	0%	
1920-4	Review of Service Contracts	Judy Orr	86	22	64	26%	22	64	26%	
1920-8	GP Prescribing	Fiona Thomson	500	96	404	19%	96	404	19%	
1920-22	Dunoon Medical Services	Rebecca Heliwell	100	0	100	0%	0	100	0%	
1920-32	Review of management structure	Joanna Macdonald / Charlotte Craig	200	160	40	80%	160	40	80%	
1920-35	Bed reduction savings : Dunoon	Jane Williams	150	0	150	0%	0	150	0%	
1920-38a	LIH Theatre nurse staffing - HAK112	Caroline Henderson	38	8	30	21%	8	30	21%	
1920-38b	Lorn & Islands Hospital staffing	Caroline Henderson	124	97	28	78%	97	28	78%	
2021-1	Mental Health redesign of dementia services (excludes commissioned services)	Caroline Cherry	200	0	200	0%	0	200	0%	
2021-2	Standardise procurement of food across all sites and expansion in conjunction with Council for early years	Caroline Cherry	69	0	69	0%	0	69	0%	
2021-3	AHP - carry out workforce planning and establishment setting to find efficiencies in posts and realign services provided to match	Linda Currie	140	54	86	38%	54	86	38%	
2021-4a	Admin & clerical general productivity / effriciency enhancement via shift to digital working in 2020/21 and 2021/22	Stephen Whiston	100	0	100	0%	0	100	0%	
2021-4b	Right size admin budgets Mid Argyll and LIH	Caroline Cherry	45	0	45	0%	0	45	0%	
2021-15	Investment fund savings - reduce spend on Care & repair by £60k originally funded as short term investment	C Cherry / J Littlejohn	60	0	60	0%	0	60	0%	
2021-16	Rationalisation of medical services for Dunoon	Rebecca Heliwell	20	0	20	0%	0	20	0%	
2021-17	Ongoing grip and control of all non-essential expenditure	Caroline Cherry/Julie Lusk	340	84	256	25%	84	256	25%	
2021-19	Redesign of hotel services to reflect reduction in inpatient numbers	Caroline Cherry	99	0	99	0%	0	99	0%	
2021-20	Centralised booking of medical records - reduction in admin costs	Stephen Whiston	97	0	97	0%	0	97	0%	
2021-23	Catering & domestic - spending below budgets	Caroline Cherry	80	50	30	63%	50	30	63%	
2021-29	Dunoon Gum clinic - underspend	Caroline Cherry	20	0	20	0%	0	20	0%	
2021-57	Fleet management - electric vehicles, improved accuracy of mileage claims using postcodes; fuel savings through use of telematic data	Stephen Whiston	40	0	40	0%	0	40	0%	
2021-58	Additional income from other health boards (being achieved in 19/20)	George Morrison	200	0	200	0%	0	200	0%	£100 declared to PMO in 2019/20

Ref.	Savings Description	Manager	Year to 28 Feb 2021 Target £' 000	Achieved £' 000	Unachieved £' 000	% Achieved	Full Year Forecast Achievement £' 000	Shortfall £' 000	% Achieved
2021-63	Estate Rationalisation (£50k provision in Investment Fund to be used only on a spend to save basis)	Kevin Willan	50	49	1	98%	49	1	98%
2021-64	Review of Forensic Medical Examiner Costs - particularly Bute & Cowal and Out of hours costs (full year saving may only be available in 2021/22)	Rebecca Heliwell	50	0	50	0%	0	50	0%
2021-66	Community dental practices	Donald MacFarlane	25	5	20	20%	5	20	20%
	Totals		**2,939**	**624**	**2,315**	**21%**	**624**	**2,315**	**21%**
ARGYLL & BUTE HSCP TOTAL SAVINGS PLAN 2020/21			**6,093**	**1,347**	**4,746**	**22%**	**1,439**	**4,653**	**24%**

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ARGYLL & BUTE SOCIAL WORK SAVINGS PLAN 2020/21

Ref.	Unachieved Savings Description	Manager	Target £' 000	Achieved £' 000	Forecast £' 000	Actions completed to 28 February 2021	Actions planned for next 4 weeks	What planned actions will achieve	Why there is a forecast shortfall in the saving?	What are we doing to recover from forecast shortfall
1819-19/ 2021-30	Development of Core & Cluster Models and Repatriation of Out of Area Placements	Jim Littlejohn	543	145	145	SIO now appointed. Service Manager with a focus on this portfolio appointed. Fyne View planning as 3 person site progressing with target to have 3 tenants by end of financial year (first mid Feb). 3 persons now planned for Campbell St facility, and 4th still to be identified as earlier SU has refused. £27k saving achieved following move of 4th tenant to waterfront in June 2020 Just Checking licences extended f.o.c.	Waterfront - MM due to move before Xmas but still delayed Campbell St - proposed 4th tenant identified Fyneview - 3 proposed service users identified - expect end of year before 3 people move in. Dealing with fire requirements Dunbeg Development – 2 su's identified for share. Property due to be completed Dec/Jan but much delayed. Continuing discussions with contractor for Helensburgh Golf course new build - 2 @ 2 bed plus 1@3 bed bungalows. Now likely to be much delayed.	Not yet quantified	Currently at a plateau until new models of accommodation and support are completed and implemented	New policies / procedures needed re out of area placements
1819-25/7 & 2021/7 &1819-19	Older People Day/Resource Centre - Address high levels of management - consolidate opening hours - shared resource Review of provisioning of day services and remodel considering options of greater third sector involvement aiming for 10% reduction in cost (currently underspending by c £70k) Review and Redesign of Learning Disability Assist Cowal Resource Centre Review and Redesign of Learning Disability Rothesay Resource Centre	Caroline Cherry/ Julie Lusk	466	155	155	Now agreed to split savings target for day services between Older Adults and MH,LD and PD. Recently completed works at Lynnside / Lorn Resource Centre (external walkway between the 2 buildings and one shared manager) were done specifically to enable shared management across LD and OP day services, and this has been the pattern in a number of localities. Pamela is to declare the saving for vacant driver and caretaker posts. No vacancies being filled on permanent basis as services paused - £64k vacancy savings ytd and savings from bank/sessional staff of c £74k not yet declared Successful application with ihub Collab for Review of LD Day Services - project team formed and first session end of Oct	Overall plan for day services to be developed. 3 vacant posts to be declared this month - £83k Ongoing discussions about implementing pilot of transport model to and from day service being removed and being replaced by service user's own mobility component of their benefits or their own mobility vehicle. Progress with ihub collaborative re future delivery of LD Day Services The savings split agreed is as follows: 1819-25 – opening savings £212,000, less contingency transfer of £155,269, leaving an opening balance for next year of £56,731 all Older Adults 1819-7 £10k and 1819-19 £44k all LD. Re OP: Savings required for next year £105,244. CC to meet with LC to start to progress the community supports work and develop community alternatives to traditional day care for older adults.	Re- assess feasability of having shared managers	Changes in management has meant lack of clear direction so now being re-scoped	Not yet identified
1819-19 / 2021-32	Review of LD Care Packages A&B wide (overall target split equally across 4 localities)	Jim Littlejohn	449	145	145	1 waking night has now been removed on Bute (full year £57k), 2nd waking night £40k (FYE £130k) with agreement on phased removal of sleepovers for su in Oban starting in January (£38k). Just checking is also in place for 2 further service users in Bute and Oban and awaiting outcome of review. CRG process now agreed including for MH/LD - to be approved by SLT in Jan - will assist with equity and budgetary control	Review of Care Packages ongoing by Care Managers, with some smaller care packages still to be declared. Still awaiting confirmation of dates for 2 service users at Daldorch moving from residential to supported living - variation now approved by Care Inspectorate	maximise savings	Impact of covid has reduced review frequency alongside provider sustainability payments	
1819-8/22/46	Adult Care West - Restructure of Community Teams (SW & Health) and adopt a single community team approach to undertaking assesment and care management	Caroline Cherry / G Mc Cready	412	0	0	SIO appointed. Info on all teams in scope collated. Terms of reference for SLWG drafted and members identified. CRG process has been established and rolled out to Area Managers. This should ensure standardisation of care packages, ensuring budget monitoring through the CRG process and that reviews start to be undertaken within timescales set. First Community Teams sub group has taken place. Information on staffing has been collated.	Working towards single vision for all teams working with Older People. Working with chair (Finola Owen) and co-chair to clarify priorities. Report drafted and to be reworked for next meeting. The scope is to be significantly broadened to include district nurses, ECCT, assessment & care management such that the balance of care can be shifted and hospital beds reduced along with reductions in footfall to hospitals. Once scoped properly, can then clarify the potential for delivering this scale of savings	Re-focus onto deliverable actions supported by project plan	Paused due to Covid. Previous plans no longer clear.	to be re-visited in 2020/21

Ref.	Unachieved Savings Description	Manager	Target £' 000	Achieved £' 000	Forecast £' 000	Actions completed to 28 February 2021	Actions planned for next 4 weeks	What planned actions will achieve	Why there is a forecast shortfall in the saving?	What are we doing to recover from forecast shortfall
1920-40	Implement best practice approaches for care at home	G McCready / Caroline Cherry	300	0	0	SIO appointed. Scrutiny of block contracts has been started to identify areas of down time. Final agreement for the Tighnabruaich run has enabled the block to be reduced from 82.5 hours per week to 50 hours per week. This should result in a saving of approx. £7k this year and a full year saving of around £33k.Savings identified in Strachur route £118k FYE by removal of travelling expenses and introduction of rural rate. Progressing savings on 3 Oban blocks but delayed due to provider staff shortages. Templates for all meetings with providers have been developed and shared with Resources Team Leaders and Procurement staff. Meetings have been held with Bute and Cowal staff to discuss the	A pilot in Oban for assessors to complete assessment to identify needs and then to pass to care at home for commissioning of service starts next week. Meetings with HCOs and HCPOs being arranged to share this and the CRG process and the progress with monitoring visits. Block contracts have not progressed due to a number of operational priorities for the service. More focus needs to be put on this work and a more radical reshuffle required in Oban where the provider has threatened to withdraw service of the changes are implemented.	Standardisation of processes. Reduction in duplication. Enablement approach. Clarity of responsibilities around invoices, identification of downtime, communication with providers and monitoring of service delivery. All local services will have to work together to ensure priority services are provided and best use is made of all resources across the services.	Pause due to Covid. Additional staff required due to shielding. Expect higher demand as users less keen on going into care homes	Monthly meetings to hold local team leads accountable, close monitoring of activity and focus of work within this project by Head of Service. But progress is expected to be impacted by priority response to Covid-19
1819-14	Redesign of Internal and External Childrens Residential Placements	Tricia Renfrew	200	178	178	The Core & Cluster property in Helensburgh is now operational and has recently been intensively used. A project closure report has been completed. The roll out to Oban has been put on hold as the initial review of the Helensburgh implementation confirms it has not delivered the anticipated savings due in part to the ages of the young people (<16) and the associated additional costs. No vacancies in childrens houses. All external placements are reviewed monthly on a multi agency basis. Savings of £178k declared from children moved back from placements. 3 month scoping of longer term transformational work approved by SLT in Dec.	Continue scoping for transformational work to shift from high levels of residential care to more fostering and early support.	The Core and Cluster Model has a role in providing a step down provison for care experienced young people on their path to independence.	Because Core and Cluster is addressing under capacity in the wider system.	The need for both external and internal placements has grown over the past six months and is projected to grow further. All appropriate measure are being taken to care for and support our young people in Argyll and Bute. These developments should be taken as cautionary because the equilibrium of the wider system is presently out of balance.
2021-5 & 1920-45	Bring staffing within ECCT teams and Mull Progressive Care Centre into line with best practice elsewhere	Caroline Cherry / Louise Beattie/ Donald Watt/Piers Massey	113	0	0	MG made presentation to SLT on 18 December and direction agreed. Paused due to Covid, and now staff sickness. LB has drafted proposal including options appraisal and with DW for review. To include option from Piers for covering hospital at night. Working group established and Terms of Reference drafted. Initial meeting with elected	Mull and LCC are two different models and both need to be assessed. This work will be taken forward by the newly appointed Area Manager with support from LB and DW with a model of care to be identified. This work will also link into the care at home strategy being developed	Focus onto deliverable actions supported by project plan	Paused due to Covid.	Not yet identified
1819-31	Integrate HSCP Admin, digital Tech and Central Appoint System	Tricia Renfrew/ Kirsteen Larkin/ Stephen Whiston	104	0	0	Work re-started in October. SW has established a programme board covering admin and related savings with support from LB & JD. Meeting every 4 weeks and project plan agreed. The ELT paper from March 2020 outlined the 9 areas of work that will be covered by the programme board.	Review what further work can be done and realign to Corporate savings workstream. Amalgamate with Health savings 2021-4a /20 and pursue integrated admin support across HSCP. No saving to be delivered in 2020/21 but expected to deliver in full in 21/22	Development of proposals	No further admin savings can be realised under new model until other automation work is completed	Other areas of support service budget will be examined to find shortfall in savings
1920-33	Review of management structure	Joanna Macdonald	102	55	55	Matchings carried out with staff affected. New structure went live at end of September. Remaining vacancies advertised - 1 area manager post still to be recruited to. Saving now declared.	Shortfall expected and IJB to be requested to write off unachieved balance	Implementation now to be 30 September	Delay in progressing restructuring due to extended consultation process	Indicated vacancy savings as recruitment to vacant posts over the course of the year has been put on hold.
1819-18	Review for efficiencies within HSCP care homes	Caroline Cherry	99	0	0	The original plan was not progressed. Now focussing on an efficiency review. Currently under spend on these budgets and saving declared on non-recurring basis due to extra income.	To consider recurring options. AMcA is doing some work to look at income recovery over the past few years to see if savings can be realistically identified through this source on a recurring basis	expected to deliver savings in full	Paused due to Covid.	Now starting project with allocated resource
2021-10	Transformation of Social Work admin increasing use of technology and integration with NHS admin services - savings not yet quantified	Tricia Renfrew/Kirsteen Larkin	93	0	93	Identified full £93k of saving from vacant posts and expect to be able to deliver in full. Revised structure presented to SLT 2 March and approved	saving now to be declared and changes implemented as agreed	expected to deliver savings in full	Forecast not yet updated	expected to deliver savings in full

Ref.	Unachieved Savings Description	Manager	Target £' 000	Achieved £' 000	Forecast £' 000	Actions completed to 28 February 2021	Actions planned for next 4 weeks	What planned actions will achieve	Why there is a forecast shortfall in the saving?	What are we doing to recover from forecast shortfall
1920-43	Cap on overtime CAH internal service	Donald Watt	87	0	0	Savings made from staffing at Mid Argyll Home Care and Home Care on Mull and Tiree. Some scope to keep going with cost reduction and aim for further savings. Additional bank staff recruited in Mid Argyll. Whilst overtime is lower than last year, it is still above budget, so no saving. DW meeting fortnightly with Resources TL to monitor the situation.	Local Area Managers continue to approve all exceptional overtime in advance of hours being worked. Looking at increase use of bank staff to avoid overtime. To review Islay where overtime slightly up due to shielding.	Reduce forecast overspend and deliver saving. Recruited additional bank staff.	Forecast shortfall based on impact to date.	Continue efforts to reduce overtime wherever possible.
1819-33	Catering, Cleaning and other Ancillary Services	Jayne Jones / Caroline Cherry	70	0	0	Catering review on shared services basis is continuing with Council. Jane Williams nominated as key contact for HSCP. The catering mapping exercise is now complete and has been approved through HSCP SLT on 6 November 2019 and SMT on 11 November 2019. Approval given at Dec SLT l to appoint a programme manager	Tender drafted for contract for programme manager and closes on 5th March, so we can have the successful contractor in place from 6th April (immediately after Easter weekend). This appointment will be for a 12 month period. Expressions of interest being sought internally for someone to work closely with the programme manager.	Possible savings from rationalisation of catering services across the Council and the HSCP.	Progress on shared services has been slower than anticipated.	Confident that these savings will be delivered longer term.
2021-46	Improved rostering of staff for school hostels	Tricia Renfrew	50	44	44	£44k declared M7. £6k declared on non-recurring basis.	Further recurrent saving from a temporary domestic post now identified. To be progressed.	Improved assessment of likely saving	Paused due to Covid	Confident that these savings will be delivered longer term.
1819-42	Contract Management reducing payments to Commissioned External providers	Stephen Whiston	33	0	0	Contract & Demand Management Officer started on 30 November. list of contracts for review collated. Audit Services contract tendered and awarded but saving not declared as may be needed for adhoc reviews.	Ewan concentrating on reviewing health contracts.	SLAs review completed and cost profile for2020/21 agreed	Delays in reviewing SLA, and difficulties anticipated in reducing costs due to notice periods etc.	Full year effect will be received in 2021/22.
1920-41	Extend use of external home care transferring hours as gaps occur	Donald Watt	33	0	0	Both Kintyre and Mid Argyll have this direction to externalise where possible any new packages. However increases made to contracted hours by HR which now removes this flexibility to change. All new contracts now require HoS approval.	To continue with this as circumstances allow	Ongoing monitoring at local level and liaison with procurement to identify and transfer hours where possible.	Issues with external providers in some areas not having the capacity to increase their hours.	No plans
	Totals		**3,154**	**722**	**815**					

ARGYLL & BUTE HEALTH SAVINGS PLAN 2020/21

Ref.	Unachieved Savings Description	Manager	Target £' 000	Achieved £' 000	Forecast £' 000	Actions completed to 28 February 2021	Actions planned for next 4 weeks	What planned actions will achieve	Why there is a forecast shortfall in the saving?	What are we doing to recover from forecast shortfall
1920-8	GP Prescribing	Fiona Thomson	500	96	96	3 months pause due to Covid. No drugs coming off patent. Introduction of Pharmacy First may see increase in costs. Split into 8 schemes all in delivery. Fewer alternative medecines being approved so less opportunities this year.	Continue to work closely with North Highland workstream. Significant shortfall now expected.	maximise savings	Covid-19 and reduction in capacity	Not yet identified
2021-17	Ongoing grip and control of all non-essential expenditure	Caroline Cherry/Julie Lusk	340	84	84	Grip and control relaxed due to Covid mobilisation and speed of response required. JMD has issued statement to LMs & LAMs regarding PECOS scrutiny/authorisation. Mobile SIM contracts ended where unused but saving not yet calculated	Continue with ongoing grip and control. There should also be savings from reductions in printing. Mobile SIM contracts saving will not be declared till start of new year	maximise savings	Covid-19 and reduction in capacity	Not yet identified
2021-2/19/23; 1819-32	Redesign of hotel services to reflect reduction in inpatient numbers; Catering & domestic - spending below budgets; Standardise procurement of food across all sites and expansion in conjunction with Council for early years	Caroline Cherry	268	50	50	Catering review on shared services basis is continuing with Council. Jane Williams nominated as key contact for HSCP. The catering mapping exercise is now complete and has been approved through HSCP SLT on 6 November 2019 and SMT on 11 November 2019. Approval given at Dec SLT to appoint a programme manager	Tender drafted for contract for programme manager and closes on 5th March, so we can have the successful contractor in place from 6th April (immediately after Easter weekend). This appointment will be for a 12 month period. Expressions of interest being sought internally for someone to work closely with the programme manager.	Possible savings from rationalisation of catering services across the Council and the HSCP.	Progress on shared services has been slower than anticipated.	Confident that these savings will be delivered longer term.
1920-32	Review of management structure	Joanna MacDonald	200	160	160	Matchings carried out with staff affected. New structure went live at end of September. Remaining vacancies advertised - 1 area manager post still to be recruited to. Saving now declared.	Shortfall expected and IJB to be requested to write off unachieved balance	Implementation now to be 30 September	Delay in progressing restructuring due to extended consultation process	Indicated vacancy savings as recruitment to vacant posts over the course of the year has been put on hold.

Ref.	Unachieved Savings Description	Manager	Target £' 000	Achieved £' 000	Forecast £' 000	Actions completed to 28 February 2021	Actions planned for next 4 weeks	What planned actions will achieve	Why there is a forecast shortfall in the saving?	What are we doing to recover from forecast shortfall
2021-1	Mental Health redesign of dementia services (excludes commissioned services)	Caroline Cherry	200	0	0	Temporary close of Knapdale and use of Fyne View - all patients now moved on. Noted that savings were being made due to operating under establishment. Closure of Knapdale as part of service redesign was approved by the IJB in March. Working on staff redeployment - can't declare saving until all staff redeployed.	Declared as non-recurrent saving in 2020/21. Meeting on 8 Feb to review redeployment register. Consultant post being recruited (closes 16 Feb) which will reduce locum costs, and the new SW posts were approved for advert at recent meeting. CCh also noted that there remains a need for an additional management post but the funding for this has still to be identified.	Expect to deliver in full as non-recurrent saving in 2020/21	Paused due to Covid	Expect to deliver as non-recurrent saving in 2020/21
2021-58	Additional income from other health boards (being achieved in 19/20)	George Morrison	200	0	0	Unlikely to achieve due to Covid-19 as fewer visitors in our area and number of RTAs reduced. Normally two thirds of income achieved in first 6 months of year.	Continue to assess, but not achievable based on first quarter. Will keep on plan for next year delivery	Updated forecast	Covid-19	Shortfall included in Covid claim
2021-4a/20	Admin & clerical general productivity / efficiency enhancement via shift to digital working in 2020/21 and 2021/22 Centralised booking of medical records - reduction in admin costs	Stephen Whiston	197	0	0	Rapid move to digital working, use of MS Teams and less travel due to Covid 19 . Working with North Highland on use of Netcall system for appointment booking. Looking at Active Clinical & Referral Triage. Workshops taken place to scope. Work re-started in October. SW has established a programme board covering admin and related savings with support from LB & JD. The 1st meeting held on 19 Nov and every 4 weeks thereafter. The ELT paper from March 2020 outlined the 9 areas of work that will be covered by the programme board.	To take forward with 1819-31 review of social work admin. Do not expect to deliver any saving for 20/21 but should deliver in full next year	Updated forecast	Covid-19	Not yet identified
1920-38a/b & 1819-44	Lorn & Islands Hospital staffing	Caroline Henderson / George Morrison	176	105	105	Now includes Theatre saving of £60k and ANP saving of £14k to allow this saving to be delivered differently. ANP role was funded from reduction in Junior Doc hours, essential role to support clinical care & Jnr Doc rota. £113k identified Recent meeting to discuss Urology work being undertaken in Oban for North Highland patients to increase utilisation. Inpatient beds in Ward A reconfigured, closed 4 in-patient and converted to day case. Review of Oban Lab staffing and Lab redesign has taken place. £100k saving made but needed to offset increased microbiology costs. Recruited microchemist and haemotology posts Nursing establishments reviewed. All budget lines reviewed	A paper is going to SLG on re-design of the medical unit. £14k from cardio-physiology post will not now be achieved due to increased workload as a result of new guidelines	Increase in savings	Theatre utilistation group across 4 acute Hospitals being led By D Jones. This may increase activity. Unlikely this financial year to declare any further staffing cuts. Not yet been able to identify sufficient staffing savings to meet target. HDU staffing review and audit of dependency levels. Establishment not agreed as yet for ward B.	A review of ECG service to be carried out to identify potential savings. Ward establishment settings to be confirmed and report completed. This has been slightly delayed due to Covid 19.
1920-35	Bed reduction savings : Dunoon	Finola Owen	150	0	0	Bed modelling ongoing with planning. £120k non-recurring saving declared last year and this year. Currently operating from one ward but need to maintain 2nd ward in case of Covid resurgence.	Workforce planning taking place with Lead Nurse. Jayne Lawrence-Winch has drafted a report. Changes have been paused due to Covid. Currently only able to have 3 beds in 4 bedded side wards for social distancing and consider how to meet mixed sex standards.	Updated forecast	Covid-19	Non-recurrent savings declared of £120k last year and expect to make it recurrent this year
2021-3	AHP - carry out workforce planning and establishment setting to find efficiencies in posts and realign services provided to match	Linda Curry	140	54	54	Target fully met for 2020/21 with balance from non-recurring. A review of the workforce will be completed later in the year.	Workforce reviews won't now complete till April with review in October so pays savings are non-recurring for 20/21 LC confirmed that work was starting on radiography and orthotics reviews in the autumn so may contribute to 21/22 savings plans.	Updated forecast	Covid-19	Not yet identified
1920-22/ 2021-16	Dunoon Medical Services	Rebecca Heliwell	120	0	0	Had recruited 3 but 1 decided not to join and start dates for 2 are delayed due to personal considerations. New practitioner rota implemented. Capital works approved at Asset Management Board for reconfiguration of space in hospital to allow 2 GP practices to move in. Business Case completed and funding now being sought	Discuss with local GP practices alternative ways of filling gaps in rota. 2 local GP practices keen to move into hospital. GP accommodation in hospital could make more attractive jobs blending casualty, out of hours and GP work. Will feed into Dunoon place based review commissioned. Also to link into Medical Workforce Productivity workstream	Clinically more stable team Encourage positive collaborative learning culture and better governance within team	The timescale is more medium to long term- eventually aim is to have no locum spend and all substantive posts in self sustaining rota but this is likely to take years. Positive recruitment and initial progress should make easier as team establishes- ie should build speed with time	Have looked at locum costs and prioritised use of cheapest ones. Working with PMO workstream medical workforce to standardise payments to updated Medacs contracts ie no travel and accommodation to be paid as routine

Ref.	Unachieved Savings Description	Manager	Target £' 000	Achieved £' 000	Forecast £' 000	Actions completed to 28 February 2021	Actions planned for next 4 weeks	What planned actions will achieve	Why there is a forecast shortfall in the saving?	What are we doing to recover from forecast shortfall
1920-4	Review of Service Contracts	Judy Orr	86	22	22	Contract & Demand Management Officer started on 30 November. List of contracts for review produced	Working on GP OOH contracts, FME contracts, and radiology equipment maintenance EMG to work with management accountants to identify underspends against service contracts and declare recurrently	SLAs review completed and cost profile for 2020/21 agreed	Delays in reviewing SLA, and difficulties anticipated in reducing costs due to notice periods etc.	Full year effect will be received in 2021/22.
2021-15	Investment fund savings - reduce spend on Care & repair by £60k originally funded as short term investment	J Littlejohn/C Cherry	60	0	0	Paused due to Covid-19. Initial notice given in Jan 2020. Formal feedback received from supplier concerned about adverse impacts and meeting held to discuss. Little or no non-recurrent saving due to Covid.	LB reported that saving cannot be delivered at this time as it needs whole system change. Still to give formal 12 weeks notice of saving. JLu & JLi has asked that a manager be identified within adult services to manage this contract. LB further reported that an end to end process mapping exercise had been completed which highlighted the need for a transformational process and she had prepared a report for SLT outlining options and identifying the preferred option of moving this service in-house.	Update forecast	Covid-19	N/A
2021-57 / 1819-53	Fleet management - electric vehicles, improved accuracy of mileage claims using postcodes; fuel savings through use of telematic data	Stephen Whiston	58	0	0	Reduction in fuel costs due to Covid 19 . Going forward envisage less use of vehicles and rationalising of fleet. There should be at least 16 EVs in the fleet by the end of the year. New charging points in process of being installed	financial analysis to be completed and assess how much is recurrent / non-recurrent	Paused due to Covid	Covid-19	Not yet identified
1920-3	Health Promotion Discretionary Budgets	Alison McGrory	54	0	0	SLA ended September. This is currently a non recurrent saving as based on staff member's secondment to GG&C. NR saving resulting from a post holder being temporarily redeployed	assess alternative savings for next year	Update forecast	Expected staff member to be made permanent	Not yet identified
2021-63	Estate Rationalisation (£50k provision in Investment Fund to be used only on a spend to save basis)	Kevin Willan	50	49	49	Just £1k outstanding	no plans	expect to deliver in full	Covid-19	N/A
2021-64	Review of Forensic Medical Examiner Costs - particularly Bute & Cowal and Out of hours costs (full year saving may only be available in 2021/22)	Rebecca Heliwell & George Morrison	50	0	0	Contracts costs and end dates collated showing wide variation in costs and low usage. SW has indicated to practices that he expects contracts to be rolled forward to 31 March 2022 which would mean any savings from changed practices would be deferred for further year.	Review possibility of using NearMe to deliver service from a possible new pan Highland remote service delivered in-house following changes in requirements for taking of bloods by doctors. JD to follow this up through PMO with A Ennis & G Barron	Paused due to Covid	Covid-19	Not yet identified
2021-4b	Right size admin budgets Mid Argyll and LIH	Caroline Cherry	45	0	0	Underspends being made in 2019-20	assess savings for next meeting	Paused due to Covid	Covid-19	Not yet identified
2021-66	Community dental practices	Donald MacFarlane	25	5	5	£5k declared in m3. £20k non-recurrent savings due to vacancy declared in M6 but this needs filled in future to provide essential services	Proposed plan to fill at Dental officer level rather than Senior Dental Officer giving some recurring saving. Potential savings from the maintenance of dental decontamination units being brought in house. Also from ending of car lease c £5.5k. GM to review budgets with new Head of Primary Care	expect to deliver in full	Covid-19	N/A
2021-29	Dunoon Gum clinic - underspend	Caroline Cherry	20	0	0	Declared on non-recurring basis	JLW has submitted a paper which indicated that £40k saving could be achieved - the additional £20k to be scored against the Cowal 1% efficiency target for next year.	To assess future for this clinic	N/A	N/A
	Totals		**2,939**	**624**	**624**					
ARGYLL & BUTE HSCP TOTAL SAVINGS PLAN 2020/21			**6,093**	**1,346**	**1,439**					

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item:**

Date of Meeting: **31 March 2021**

Title of Report: **Covid-19 financial implications**

Presented by: **Judy Orr, Head of Finance and Transformation**

The Integration Joint Board is asked to:

- Note the details provided in relation to Covid-19 response and associated mobilisation plan costing for 2020-21 and subsequent years
- Acknowledge the uncertainties in the cost elements submitted
- Note that the Scottish Government has in principle approved all mobilisation plans, but that approval for individual cost lines has not yet been received
- Note that any excess funding received must be carried forward as an earmarked reserve at the year end to be used against Covid costs next year

1. EXECUTIVE SUMMARY

1.1 This report provides an overview of the HSCP's Covid-19 mobilisation costs and its future cost planning for living and operating with Covid-19. It provides a snapshot of the financial estimates of the costs of dealing with the Covid-19 response. These cost estimates are updated on a regular basis, and are still subject to considerable uncertainties.

1.2 The Scottish Government has in principle approved all mobilisation plans. However all expenditure items over £500k require formal approval and this is still awaited for all lines submitted. All funding is being routed via NHS Highland and announcements to date total £14.995m. This now includes £2.6m for adult social care winter plan tranche 2 (£600k), community living change fund (£300k) and further integration authority support (£1.7m) announced on 5 February for which fuller details are awaited and which are wholly additional to the Covid-19 cost claims. A small amount (£57.5k) re Chief Social Work Officer funding has still to be distributed. Two other amounts of funding (GP allocation and Scottish Living Wage) are being excluded from our Covid-19 cost returns – in total £598k – and so are not reflected in the analysis below. Looking solely at the allocations from our regular Covid-19 returns, based on the latest return as at 15 January 2021, we have claimed £11.284m and this has now been paid over in full to NHS Highland.

1.3 This report is based on the return for end of January as at 16 February with details of actuals for first 10 months. Scottish Government are reviewing

returns on a quarterly basis. They have indicated that any excess funding should be carried forward at the yearend as earmarked reserves and not returned. This should then be used for any Covid-19 costs in next year before seeking any further support from them.

1.4 In addition the return provides projections for future years' costs as recently submitted to the Scottish Government. These costs have all been excluded from the Budget Outlook reports and the Budget Proposals as the expectation is that all Covid-19 related costs will continue to be funded. One significant change to be noted that there is no expectation of any funding for undelivered savings in future years as a result of Covid-19 activity.

2. INTRODUCTION

2.1 This report provides information on the Health and Social Care Partnership's response to Covid-19 pandemic and associated estimated costs.

3. DETAIL OF REPORT

3.1 Summary of Covid-19 status update and look forward

3.1.1 Re-mobilisation plans have slowed as a result of higher levels of Covid-19 and it is now expected that it may take till quarter 2 or 3 next year before we see a return to fully normal pre-Covid-19 levels of activity.

3.1.2 No additional Covid-19 beds have been required to date. This is a significant reduction from early estimates as a result of the effective social distancing now in place. So far, few people have required hospitalisation and there have been few new deaths in our area.

3.1.3 We expect our Community Assessment Centres (CACs) to have a role for some considerable time, and we have recruited additional staff to man these. The Mobile Testing Units have reduced with fire stations now offering home testing kits in most of our towns, and anew asumptomatic test site planned for late March / early April in Helensburgh along with pop up testing capability. There is now a weekly regimen of lateral flow tests for testing staff and residents in care homes and care at home workers, day centres and personal assistants. It is also offered to all front facing clinical staff through our hospitals and GP practices. Testing is now also being offered to teachers in schools. Where there is a positive case identified, then additional PCR testing needs to be carried out.

3.1.6 We are continuing to provide financial sustainability support to care homes for vacant places (as agreed nationally) and have so far agreed payments totalling £710k. Financial support is also being provided for additional staffing costs, and other direct costs, and we have agreed payments for these of a further £431k. These claims are being processed as fast as possible. We have employed an additional temporary member of staff to concentrate on processing these claims. Financial support is continuing from December to March on a changed, less generous, basis.

3.1.7 Social care providers have been provided with personal protective equipment (PPE) free of charge from our community PPE hubs since the

start of May. These hubs are now expected to be in operation at least until end of June, and an updated Memorandum of Understanding governing this has recently been received. After June there will be monthly reviews.

3.1.8 Hospital PPE was also provided free of charge on a push basis from the national distribution centre for a period of time, but this has reverted to a normal chargeable basis since mid-May with the exception of FFP3 masks which are being issued on a push basis due to low supplies, and supplies to support flu and Covid-19 vaccination programmes. There are continuing direct deliveries to GP practices, dental practices and optometrists which are not chargeable. If addition, there are push deliveries of PPE to support vaccination clinics. If they run out in between, further supplies are obtainable through Health Boards. GP practices and dental practices are currently transitioning to direct delivery with online ordering for PPE.

3.1.9 It is clear that the length of time we will have to deal with the implications of this pandemic is extending into the next financial year as well as this year. This disease burden is part of the new activity "norm" and we will have to focus on simultaneously managing Covid-19 whilst resuming routine, comprehensive health and social care. This has financial implications and regular cost returns are submitted of the levels of estimated costs as explained below. We have recently returned a template for estimating Covid-19 costs for 2021/22 to 2025/26. This is attached at Appendix 3. The estimates are summarised below:

Financial Year	**Estimated cost £m**
2021/22	6.9
2022/23	3.4
2023/24	2.3
2024/25	2.0
2025/26	2.0

3.1.10 This shows that costs are expected to be roughly 60% of current year's level for the next year, and then halving again the following year to c 30%. There is an expectation of a small loss of income in Q1 of next year, thereafter it is expected to recover to normal levels. No support for undelivered savings is included in these estimates.

3.2 Covid-19 Mobilisation costing

3.2.1 Since the start of April, the HSCP has been required to contribute to a local mobilisation plan cost return on a regular basis, submitted to Scottish Government through NHS Highland. The most recent return was drafted on 16 February and has been referenced for this report.

3.2.2 The format of the return has changed regularly in this period. The initial return of 2 April provided certain parameters for expected staff absence and a predetermined phasing for costs associated with additional beds. The most recent return to Scottish Government reflects actual costs for the first 9 months and revised assumptions to end of the year. These returns will now be submitted only on a quarterly basis going forward, but locally we will continue to update our data on a monthly basis. The return now requires

data to be split between health and social work as funding arrangements differ for each.

3.2.3 A small amount of expenditure was incurred in 2019/20 of £41,000 which is matched by a specific funding allocation. In addition the additional FHS Prescribing cost accrual of £324,000 (reflecting people ordering prescriptions earlier than usual in March because of the impending lockdown) was funded through NHS Highland directly in 2019/20, and then clawed back in 2020/21 where there is an offsetting reduction in costs expected.

3.2.4 Actual costs are being carefully tracked. Social care providers have been asked to invoice additional Covid-19 related costs separately and detailed guidance has been given to them on what type of additional costs (such as PPE, equipment and additional staffing) is expected. Care Homes are receiving funding of vacant beds due to under-occupancy at 80% of the agreed national care home contract rates to end of August. These payments are now being tapered over a three-month transition period with 75% of claims for voids caused by Covid-19 paid for the month of September, 50% for the month of October and 25% for the month of November. Further support beyond December is on a different basis again. Additional support for extended sick pay for social care providers has also been extended. Claims for other additional costs from end of September are restricted to those for infection prevention control, PPE and additional staffing costs.

3.2.5 Direct costs for supplies and equipment are being charged to Covid-19 cost centres. Where additional staff are being employed in-house, and for additional hours over normal working, this is also being tracked through codes on time sheets and specific Covid-19 approvals through workforce monitoring.

3.2.6 The Scottish Government has in principle approved all mobilisation plans. Two meetings have been held with Scottish Government officials on our plan submissions but no individual lines have been formally approved. The health and social care system will continue to operate on an emergency footing until the end of March 2021.

3.2.7 Separate funding has been received through NHS Highland for the national agreement to implement the Scottish Living Wage which came in 3 weeks earlier than we would normally have implemented it, and at a slightly higher rate. We have received £189k which covers our extra costs, and these are now removed from the mobilisation cost tracker. There was also direct funding of £409k for additional GP practices and pharmacies predominantly for opening on the bank holidays which is not included in the tracker.

3.2.8 A summary of all the funding announced and distributed is attached at Appendix 1. All funding is being routed via NHS Highland and announcements to date total £14.995m. This includes an additional £2.6m not included without our covid-19 cost claim. A small amount (£57.5k) re Chief Social Work Officer funding has still to be distributed. Looking solely at the allocations from our regular Covid-19 returns, based on the latest return as at 15 January 2021, we have claimed £11.284m and NHS Highland has received this in full.

3.2.9 Our estimated costs on the claim as at 16 February 2021 total £11.283m prior to receipt of any funding. This has decreased by £1k from the £11.284m previously reported as of 15 January to Scottish Government. The current submission covers the following key areas:

Cost area	£000s	comment
Additional hospital beds	126	Bed purchases
Reduction in delayed discharges (17)	290	Now tracked actual costs for 17 clients, 10 for care at home packages, 7 care home placements. Increased by £11k due to changes in care
PPE	228	Reduced by £8k - community PPE hubs in place till end of year providing f.o.c. to social care and more being pushed f.o.c. to Health also
Estates & facilities	684	Includes hospital deep cleans. Additional costs of remobilisation anticipated. Increase of £11k
Additional staff overtime	523	Decreased by £7k
Additional temporary staff	1,496	Decreased by £164k as Jan costs lower
Additional costs for externally provided services	99	+ £11k
Social care sustainability payments	1,530	Increased by £134k due to new scheme for non-res providers but offset in part by new underspends
Mental Health services	58	Counselling services -£3k
GP practices + Opticians	82	Decreased by £12k – mostly all reversed in December
Additional prescribing (1%)	420	unchanged
Community hubs (CACs) and screening / testing	713	Decreased by £88k re CACs in January
Staff accomm, travel, IT & telephony costs	270	Supporting home working – increased by £5k
Revenue equipment	243	Increased by £17k
Loss of income	822	Reduced charges to patients of other boards and social work client contributions reflecting lack of activity +£15k
CSWO, infection control, Public health capacity, vaccination program	870	Increased by £156k – additional vaccination costs expected March
Winter planning	169	Unchanged
Managing backlog of planned care and unmet demand	13	Unchanged
Underachievement of savings	2,728	In line with latest forecasts – unchanged

Offsetting savings – Soc Work	(80)	New - Offsets sustainability payments for non-res providers in part
Total	**11,283**	

3.2.10 The key changes are in claim for additional temporary staff (decreased by £164k); community hubs decrease of £88k; vaccination program costs increased by £156k; and sustainability for social care providers increased by £134k which is partially offset by savings on non-residential providers of £80k.

3.2.11 Since then, we have seen substantial increases in our estimates for financial sustainability claims from our care homes – the latest expectation is that these could be as much as £2m. This increase is likely to be fully offset by decreases in the costs on the health side as actual costs have been relatively low in February. Overall our expectation is that we will be slightly overfunded at the year end, and this will require to be earmarked to be carried forward to meet next year's costs

4. RELEVANT DATA AND INDICATORS

4.1 Information is derived from the financial systems of Argyll and Bute Council and NHS Highland.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 This work supports/underpins the HSCPs strategic and operational response to this emergency pandemic.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact – The additional funding and costs for responding to Covid-19 are estimated and set out in the appendices. There are considerable uncertainties surrounding these estimates and in the funding that will be made available from Scottish Government.

6.2 Staff Governance – The workforce deserves significant credit for their flexibility and proactive response.

6.3 Clinical Governance - Clinical governance response has been fundamental to the shaping and management of the public health projections and demand modelling and our response to ensure patient, client and staff safety.

7. PROFESSIONAL ADVISORY

7.1 Input from professionals across the stakeholders remain instrumental in the response to the Covid-19 pandemic.

8. EQUALITY AND DIVERSITY IMPLICATIONS

8.1 These will need to be reviewed and considered as we progress through this pandemic cycle and emergency operating arrangements

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

9.1 Compliance with GDPR remains critical and is being considered within the various pieces of work supporting the sharing of information and data to protect health and wellbeing of staff and the public and patients.

10. RISK ASSESSMENT

10.1 There is still some uncertainty around the final funding that will be made available from the Scottish Government for Covid-19 mobilisation plans. However funding has been received in full based on the return submitted on 15 January. We expect there will be a small degree of over funding and this will be required to be carried forward as an earmarked reserve towards next year's Covid-19 costs Approval has been received in principle but we do not yet have approval for any specific expenditure lines for 2020/21. Funding for the 2019/20 costs of £41,000 has been confirmed.

11. PUBLIC AND USER INVOLVEMENT AND ENGAGEMENT

11.1 None directly from this report.

12. CONCLUSIONS

12.1 This report provides an overview of the HSCP response to address the Covid-19 pandemic. This has been achieved through fantastic commitment and support of our staff and all our partners and stakeholders and the wider Argyll and Bute community as well as the SAS and NHS GG&C.

12.2 Our scale of mobilisation has flexed and adapted over the last 12 months. We are however, now moving towards a new phase of this pandemic "Covid-19 normal" which is certainly going to extend into the next 12 months and probably longer. This requires the HSCP and partners to cement new ways of working and operating in our new Covid-19 world and to continue to flex activity for new waves of infection.

12.3 The appendix provides a snapshot of the costing for the Covid-19 mobilisation as per the return of 16 February 2021 which is only £1k different in total for the mid-January return. This will continue to be updated regularly as assumptions are refined and actual costs are incurred. There is also an estimate of future years' Cov-19 costs which are expected to be funded.

13. DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	√
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

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APPENDICES:

Appendix 1 – Covid-19 funding summary as at 5 February 2021
Appendix 2 – Covid-19 local mobilisation tracker weekly return as at 16 February 2021
Appendix 3 – Covid-19 future years cost estimates as at 21 February 2021

Summary of Covid funding

	Argyll & Bute HSCP	Distributed by SG to Health Board	Relates to LMP claim	Health	Soc Work	Invoiced from Council to Health Board	comments
Social care sustainabilty tranche 1	£903,000	£903,000	£903,000		£903,000	£903,000	share of £75m
GP Covid allocation	£409,480	£409,480		£409,480			Not on LMP
Scottish Living Wage	£188,712	£188,712			£188,712	£188,712	Not on LMP
Social care sustainabilty tranche 2	£452,000	£452,000	£452,000		£452,000	£452,000	share of £75m now totalling £1.355m
Social care sustainabilty tranche 3	£400,000	£400,000	£400,000		£400,000	£400,000	share of £8m
September allocation from '£1.1 billion allocation'	£5,553,000	£5,553,000	£5,553,000	£5,721,000	-£168,000	-£168,000	mix of actuals and NRAC shares so overallocated
November top up allocation for sustainability payments	£122,814	£122,814	£122,814		£122,814	£122,814	
December allocation for winter plan funding	£1,070,000	£1,070,000	£1,070,000		£1,070,000	£1,070,000	£560k for sustainability; £400k for staff restriction; £100k for admin
CSWO funding - 6 months to end Dec							£25k max Used for training - Dec invoices £19k in Covid return
CSWO funding - 3 months to end Mar 21	£12,500		£0	£12,500			To fund additional nursing post through Health - not yet claimed
CSWO enhanced care home support	£20,000		£0		£20,000		targeted at recruiting or backfilling two qualified social workers to support rapid response teams, where outbreak or significant care deficiencies have been identified and resultant ASP/LSI work.
Elective/Planned Care	479,460	479,460		479,460			share of £7.019m shown against Health Board - in September allocation
Q1-4 Covid allocation	2,784,186	£2,784,186	2,784,186	767,000	2,017,186	£2,017,186	announced 5 Feb £3.4m
Adult social care winter plan tranche 2 share of £40m	650,000	£650,000			650,000	£650,000	
Community Living Change fund share of £20m	300,000	£300,000			300,000	£300,000	
Further Integration Authority support share of £100m	1,700,000	£1,700,000			1,700,000	£1,700,000	
TOTAL	**£15,045,152**	**£15,012,652**	**£11,285,000**	**£7,389,440**	**£7,655,712**	**£7,635,712**	

Invoiced early Feb	£1,024,814
Invoiced late Feb	2,017,186
Invoiced late Feb	2,650,000

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Argyll and Bute

Health Board information	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Additional Bed Capacity (Bed numbers)												
Staff absence rates actual/assumption (%)	4%	4%	4%	4%	5%							

	Revenue												Revenue	Capital	
H&SCP Costs (NHS delegated Costs)	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020/21	2020/21	Supporting Narrative
Additional Hospital Bed Capacity/Costs - Maintaining Surge Capacity	91	31	0	2	0	0	2	0	0	0	0	0	126		Bed Equipment Purchases
Delayed Discharge Reduction- Additional Care Home Beds	0	0	0	0	0	0	0	0	0	0	0	0	-		
Delayed Discharge Reduction- Additional Care at Home Packages	0	0	0	0	0	0	0	0	0	0	0	0	-		
Delayed Discharge Reduction- Other measures	0	0	0	0	0	0	0	0	0	0	0	0	-		
Personal protective equipment	6	8	(1)	2	1	0	1	1	1	1	1	1	22		
Deep cleans	0	0	0	0	0	0	0	0	0	0	0	0	-		Cost in Estates & facilities as can't separate from domestic costs, pays in additional staff costs
COVID-19 screening and testing for virus	6	5	6	3	12	21	38	21	14	18	30	30	203		Testing being undertaken in Oban lab includes additional lab staffing and supplies, transport costs for lab samples to both Oban & GG
Estates & Facilities cost including impact of physical distancing measures	73	90	44	49	40	46	59	68	47	26	60	75	678		Includes deep clean costs as not identified from other cleaning costs. June adjustment for staff costs in April & May per the revised gu
Additional staff Overtime and Enhancements	71	88	100	20	20	8	33	2	(3)	17	30	30	415		Additional hours contracts coming to an end Sept/Oct
Additional temporary staff spend - Student Nurses & AHP	4	3	3	8	5	5	9	4	3	7	25	25	101		AHP costs, shielding staff jan-March
Additional temporary staff spend - Health and Support Care Workers	100	240	273	196	173	58	64	23	3	7	50	50	1,236		Shielding staff Jan - March
Additional temporary staff spend - All Other	1	17	1	41	6	3	5	0	8	9	10	10	110		Dec Jan higher due to IT contractors
Social Care Provider Sustainability Payments	0	0	0	0	0	0	0	0	0	0	0	0	-		
Social Care Support Fund- Costs for Children & Families Services (where delegated to HSCP)	0	0	0	0	0	0	0	0	0	0	0	0	-		
Other external provider costs	7	10	4	0	0	0	0	0	0	0	0	0	21		
Additional costs to support carers	0	0	0	0	0	0	0	0	0	0	0	0	-		
Mental Health Services	3	5	9	8	0	3	0	5	3	2	10	10	58		Mental Health Assessment Units
Additional payments to FHS contractors	47	460	83	83	109	33	30	22	(808)	0	11	11	82		Dec remove Gos April to Nov & FHS funding, £503k total of GP covid, £409k funding received
Additional FHS Prescribing	41	64	32	0	0	0	0	0	212	24	24	24	420		Public Holiday cover & staffing April to June, Dec-March Seratridine & Paracetamol Costs
Community Hubs	56	58	15	15	12	57	126	125	(73)	39	40	40	510		Revised forecast based on actual service being provided Jan-March, Dec value correction to Oct & Nov
Other community care costs	0	0	0	0	0	0	0	0	0	0	0	0	-		
Loss of income	50	61	74	39	4	11	9	24	15	54	50	50	442		Patient Treatment Income, Catering Income, Dental Treatment Income
Staff Accommodation Costs	7	11	4	5	1	1	0	0	0	(0)	2	2	33		
Additional Travel Costs	0	1	2	1	2	1	1	0	0	0	1	1	10		
Digital, IT & Telephony Costs	5	27	2	39	9	62	17	17	5	4	10	10	207		
Communications	0	5	1	1	0	0	0	2	0	0	0	0	9		
Equipment & Sundries	42	41	26	9	13	10	5	10	13	28	10	10	217		Excludes any equipment required for Covid Vaccination Programme
Homelessness and Criminal Justice Services	0	0	0	0	0	0	0	0	0	0	0	0	-		
Children and Family Services	0	0	0	0	0	0	0	0	0	0	0	0	-		
Prison Healthcare Costs	0	0	0	0	0	0	0	0	0	0	0	0	-		
Hospice - Loss of income	0	0	0	0	0	0	0	0	0	0	0	0	-		
Staffing support, including training & staff wellbeing	2	2	0	1	0	0	0	0	0	0	0	0	4		Staff catering costs, rest room equipment
Resumption & redesign of primary care/contractor services to support access to urgent care in hours and OOH	0	0	0	0	0	0	0	0	0	0	0	0	-		
Costs associated with new ways of working- collaborative	0	0	0	0	0	0	0	0	0	0	0	0	-		
Winter Planning	0	0	0	0	0	0	0	0	12	46	58	54	169		This is in addition to the costs being covered by the £180k allocation for winter planning received from SG which is fully committe
Additional FHS - GPS	0	0	0	0	0	0	0	0	0	0	0	0	-		
Chief Social Work Officer Support	0	0	0	0	0	0	0	0	0	0	0	0	-		
Contract Rate Uplift	0	0	0	0	0	0	0	0	0	0	0	0	-		
Legal Fees	0	0	0	0	0	0	0	0	0	0	0	0	-		
Managing Backlog of Planned Care	0	0	0	0	0	2	11	0	0	0	0	0	13		
Management of Unmet Demand	0	0	0	0	0	0	0	0	0	0	0	0	-		Funding received by NHS H for unscheduled care flow centres
Infection Prevention and Control Measures	0	0	2	3	3	3	1	1	3	3	3	3	23		Professional Nurse supporting care homes
Public Health Capacity	0	0	0	0	0	0	200	200	0	0	0	0	400		Estimated additional cost of programme £159k GP DES, £135 Vaccine, £66k nurse staffing, £30k venues , £10k equipment
Covid Vaccination Programme	0	0	0	0	0	0	0	0	16	42	70	300	428		Per SG Return 22/01/2021, estimated costs as programme is still fluid & dependent on vaccine deliveries
Other - Please update narrative	0	0	0	0	0	0	0	0	0	0	0	0	-		
Offsetting cost reductions - HSCP	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)	200	200	200	200	-		Non-recurring offsets being used to reduce unachieved savings
Total	**511**	**1,126**	**582**	**425**	**310**	**222**	**510**	**425**	**(328)**	**525**	**695**	**935**	**5,938**	**-**	
												Subtotal		**5,938**	
Expected underachievement of savings (HSCP)	150	150	150	150	150	150	157	157	(179)	(179)	(179)	(179)	500		Non-recurring offsets being used to reduce unachieved savings
Total	**661**	**1,276**	**732**	**575**	**460**	**372**	**667**	**582**	**(507)**	**347**	**516**	**757**	**6,438**	**-**	
												Total		**6,438**	

	Revenue												Revenue	Capital	
H&SCP Costs (Local Authority delegated Costs)	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	2020/21	2020/21	Supporting Narrative
Additional Hospital Bed Capacity/Costs - Maintaining Surge Capacity	0	0	0	0	0	0	0	0	0	0	0	0	-		
Delayed Discharge Reduction- Additional Care Home Beds	20	18	13	14	17	11	36	(18)	11	19	14	12	166		
Delayed Discharge Reduction- Additional Care at Home Packages	5	9	8	10	11	11	14	18	10	10	9	9	124		Updated 12/02/21
Delayed Discharge Reduction- Other measures	0	0	0	0	0	0	0	0	0	0	0	0	-		
Personal protective equipment	69	12	59	18	10	6	1	2	7	2	10	10	206		Updated 12/02/21
Deep cleans	0	0	0	0	0	0	0	0	0	0	0	0	-		Updated 12/02/21
COVID-19 screening and testing for virus	0	0	0	0	0	0	0	0	0	0	0	0	-		
Estates & Facilities cost including impact of physical distancing measures	0	0	0	0	0	0	0	6	0	0	0	0	6		
Additional staff Overtime and Enhancements	0	0	9	9	7	1	60	(5)	0	6	10	10	107		Updated 12/02/21
Additional temporary staff spend - Student Nurses & AHP	0	0	0	0	0	0	0	0	0	0	0	0	-		
Additional temporary staff spend - Health and Support Care Workers	0	3	5	3	8	6	7	2	2	2	2	8	48		Updated 12/02/21
Additional temporary staff spend - All Other	0	0	0	0	0	0	0	0	0	0	0	0	-		
Social Care Provider Sustainability Payments	0	51	42	34	99	309	139	38	25	513	100	180	1,530		/2021. January includes an accrual for £426k and an estimate of the impact of the change in guidance for support for non-res providers income
Social Care Support Fund- Costs for Children & Families Services (where delegated to HSCP)	0	0	0	0	0	0	0	0	0	0	0	0	-		
Other external provider costs	0	0	63	1	0	0	3	0	0	11	0	0	78		
Additional costs to support carers	0	0	0	0	0	0	0	0	0	0	0	0	-		
Mental Health Services	0	0	0	0	0	0	0	0	0	0	0	0	-		
Additional payments to FHS contractors	0	0	0	0	0	0	0	0	0	0	0	0	-		
Additional FHS Prescribing	0	0	0	0	0	0	0	0	0	0	0	0	-		
Community Hubs	0	0	0	0	0	0	0	0	0	0	0	0	-		
Other community care costs	0	0	0	0	0	0	0	0	0	0	0	0	-		
Loss of income	5	24	24	(1)	104	26	46	35	30	29	29	29	380		Updated 12/02/21
Staff Accommodation Costs	0	0	0	0	0	0	0	0	0	0	0	0	-		
Additional Travel Costs	0	0	0	0	0	0	0	0	0	0	0	0	-		
Digital, IT & Telephony Costs	0	0	2	0	0	1	0	4	0	0	0	0	7		Updated 12/02/21
Communications	0	0	0	0	0	0	0	0	0	0	0	0	-		
Equipment & Sundries	0	0	26	0	0	0	0	0	0	0	0	0	26		Updated 12/02/21
Homelessness and Criminal Justice Services	0	0	0	0	0	0	0	0	0	0	0	0	-		
Children and Family Services	0	0	0	0	0	0	0	0	0	0	0	0	-		
Prison Healthcare Costs	0	0	0	0	0	0	0	0	0	0	0	0	-		
Hospice - Loss of income	0	0	0	0	0	0	0	0	0	0	0	0	-		
Staffing support, including training & staff wellbeing	0	0	0	0	0	0	0	0	0	0	0	0	-		
Resumption & redesign of primary care/contractor services to support access to urgent care in hours and OOH	0	0	0	0	0	0	0	0	0	0	0	0	-		

	Revenue												Revenue	Capital	
H&SCP Costs (NHS delegated Costs)	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**2020/21**	**2020/21**	**Supporting Narrative**
Costs associated with new ways of working- collaborative	0	0	0	0	0	0	0	0	0	0	0	0	-		
Winter Planning	0	0	0	0	0	0	0	0	0	0	0	0	-		
Additional FHS - GPS	0	0	0	0	0	0	0	0	0	0	0	0	-		
Chief Social Work Officer Support	0	0	0	0	0	0	0	0	19	0	0	0	19		
Contract Rate Uplift	0	0	0	0	0	0	0	0	0	0	0	0	-		
Legal Fees	0	0	0	0	0	0	0	0	0	0	0	0	-		
Managing Backlog of Planned Care	0	0	0	0	0	0	0	0	0	0	0	0	-		
Management of Unmet Demand	0	0	0	0	0	0	0	0	0	0	0	0	-		
Infection Prevention and Control Measures	0	0	0	0	0	0	0	0	0	0	0	0	-		
Public Health Capacity	0	0	0	0	0	0	0	0	0	0	0	0	-		
Covid Vaccination Programme	0	0	0	0	0	0	0	0	0	0	0	0	-		
Other - Please update narrative	0	0	0	0	0	0	0	0	0	0	0	0	-		
Offsetting cost reductions - HSCP	0	0	0	0	0	0	0	0	0	0	0	(80)	(80)		Offset for paying to below plan for non-res services suspended due to COVID from December to March
Total	**100**	**117**	**251**	**89**	**255**	**371**	**306**	**82**	**103**	**592**	**174**	**178**	**2,617**	**-**	
												Subtotal		**2,617**	
Expected underachievement of savings (HSCP)	233	233	233	233	210	210	187	162	132	132	132	132	2,228		Updated 12/02/21
Total	**332**	**349**	**483**	**321**	**465**	**581**	**493**	**244**	**235**	**724**	**306**	**310**	**4,845**	**-**	
												Total		**4,845**	

	Revenue												Revenue	Capital	
Consolidated HSCP costs	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**2020/21**	**2020/21**	**Supporting Narrative**
Additional Hospital Bed Capacity/Costs - Maintaining Surge Capacity	91	31	0	2	-	-	2	-	-	-	-	-	126	-	
Delayed Discharge Reduction- Additional Care Home Beds	20	18	13	14	17	11	36	(18)	11	19	14	12	166	-	
Delayed Discharge Reduction- Additional Care at Home Packages	5	9	8	10	11	11	14	18	10	10	9	9	124	-	
Delayed Discharge Reduction- Other measures	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Personal protective equipment	75	20	58	20	11	6	2	3	7	3	11	11	228	-	
Deep cleans	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
COVID-19 screening and testing for virus	6	5	6	3	12	21	38	21	14	18	30	30	203	-	
Estates & Facilities cost including impact of physical distancing measures	73	90	44	49	40	46	59	74	47	26	60	75	684	-	
Additional staff Overtime and Enhancements	71	88	109	30	27	9	93	(3)	(3)	23	40	40	523	-	
Additional temporary staff spend - Student Nurses & AHP	4	3	3	8	5	5	9	4	3	7	25	25	101	-	
Additional temporary staff spend - Health and Support Care Workers	100	243	278	199	181	64	70	25	5	9	52	58	1,285	-	
Additional temporary staff spend - All Other	1	17	1	41	6	3	5	-	8	9	10	10	110	-	
Social Care Provider Sustainability Payments	-	51	42	34	99	309	139	38	25	513	100	180	1,530	-	
Social Care Support Fund- Costs for Children & Families Services (where delegated to HSCP)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Other external provider costs	7	10	67	1	-	-	3	-	-	11	-	-	99	-	
Additional costs to support carers	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Mental Health Services	3	5	9	8	-	3	-	5	3	2	10	10	58	-	
Additional payments to FHS contractors	47	460	83	83	109	33	30	22	(808)	-	11	11	82	-	
Additional FHS Prescribing	41	64	32	-	-	-	-	0	212	24	24	24	420	-	
Community Hubs	56	58	15	15	12	57	126	125	(73)	39	40	40	510	-	
Other community care costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Loss of income	55	85	98	38	108	38	55	59	46	83	79	79	822	-	
Staff Accommodation Costs	7	11	4	5	1	1	-	-	-	(0)	2	2	33	-	
Additional Travel Costs	0	1	2	1	2	1	1	0	0	0	1	1	10	-	
Digital, IT & Telephony Costs	5	27	5	39	9	63	17	21	5	4	10	10	214	-	
Communications	0	5	1	1	-	-	-	2	-	-	-	-	9	-	
Equipment & Sundries	42	41	51	9	13	10	5	10	13	28	10	10	242	-	
Homelessness and Criminal Justice Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Children and Family Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Prison Healthcare Costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Hospice - Loss of income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Staffing support, including training & staff wellbeing	2	2	-	1	-	-	-	-	-	-	-	-	4	-	
Resumption & redesign of primary care/contractor services to support access to urgent care in hours and OOH	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Costs associated with new ways of working- collaborative	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Winter Planning	-	-	-	-	-	-	-	-	12	46	58	54	169	-	
Additional FHS - GPS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Chief Social Work Officer Support	-	-	-	-	-	-	-	-	19	-	-	-	19	-	
Contract Rate Uplift	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Legal Fees	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Managing Backlog of Planned Care	-	-	-	-	-	2	11	-	-	-	-	-	13	-	
Management of Unmet Demand	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Infection Prevention and Control Measures	-	-	2	3	3	3	1	1	3	3	3	3	23	-	
Public Health Capacity	-	-	-	-	-	-	200	200	-	-	-	-	400	-	
Covid Vaccination Programme	-	-	-	-	-	-	-	-	16	42	70	300	428	-	
Other - Please update narrative	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Offsetting cost reductions - HSCP	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)	200	200	200	120	(80)	-	
Total	**611**	**1,242**	**832**	**514**	**565**	**594**	**816**	**507**	**(225)**	**1,117**	**869**	**1,113**	**8,555**	**-**	
												Subtotal		**8,555**	
Expected underachievement of savings (HSCP)	383	383	383	383	360	360	344	319	(47)	(47)	(47)	(47)	2,728	-	
Total	**994**	**1,625**	**1,215**	**897**	**925**	**953**	**1,160**	**826**	**(272)**	**1,071**	**822**	**1,067**	**11,283**	**-**	
												Total		**11,283**	

TITLE **Form 7b - Covid - HSCP1**

Use this template for a Health and Social Care Partnerships (HSCP)
If more than one HSCP is required, please UNHIDE as many of the prepared HSCP tabs as needed

To UNHIDE right click on the tab below and select UNHIDE from the popup menu and then the next tab e.g. **Form7b - Covid HSP2**

Guidance

Please fill in any yellow cells with data where appropriate
You can change the percentages to update the estimated values for 2021/22 (If you want to update the number manually in column P then please also feel free)

#	Cost Category	FY estimate (£m) Q3 position	2021/22 %	2021/22 £m	2022/23 %	2022/23 £m	2023/24 %	2023/24 £m	2024/25 %	2024/25 £m	2025/26 %	2025/26 £m	Notes
001	Additional staff costs HSCPs	2.2	25%	£0.55	10%	£0.22	0%	£0.00	0%	£0.00	0%	£0.00	This should decrease significantly in 21/22 and the amounts rolling forward in future years should stop.
002	Digital transformation	0.2	120%	£0.25	120%	£0.25	120%	£0.25	120%	£0.25	120%	£0.25	It would be useful to verify the high level assumption on licence costs which would be the recurring element
003	Equipment and Maintenance costs	0.9	70%	£0.63	40%	£0.36	20%	£0.18	20%	£0.18	20%	£0.18	Likely to be ongoing need for extra space to support social distancing new ways of working, deep cleans
004	Hospital scale up - Staffing and beds (non-recurring)	0.1	45%	£0.06	25%	£0.03	25%	£0.03	25%	£0.03	25%	£0.03	May need some additional beds and staffing into next year but would expect this to decrease significantly
005	Loss of income	0.8	40%	£0.32	0%	£0.00	0%	£0.00	0%	£0.00	0%	£0.00	May be small carry over into the next financial year but this positon should recover.
006	Louisa Jordan	0.0	40%	£0.00	0%	£0.00	0%	£0.00	0%	£0.00	0%	£0.00	There are likely still to be Louisa Jordan costs next year. We are unsure when arrangement ends but it is unlikely that venue will be open for normal usage anytime soon and there will still be a large backlog of activity.
007	Other	0.1	25%	£0.02	0%	£0.00	0%	£0.00	0%	£0.00	0%	£0.00	This is a mix of types of funding so giving small amount of cover for next year
008	Planned Care	0.5	100%	£0.48	100%	£0.48	100%	£0.48	100%	£0.48	100%	£0.48	If this category reflects the normal allocation of Access funding(i.e. the waiting time funding which HBs receive every year, there is an argument that it should be 100% across the board as most HBs spend this funding on recurring costs to meet waiting times, will review.
009	PPE	0.2	50%	£0.12	30%	£0.07	30%	£0.07	30%	£0.07	30%	£0.07	Assuming there will be less need for PPE in future years, but still increased usage from pre Covid times. Depending on timing of vaccination 2021/22 could move significantly but assuming this will remain at a high level for now. These costs may be impacted by high purchase costs early on hence going to 50%
010	Primary care	1.1	60%	£0.68	30%	£0.34	30%	£0.34	30%	£0.34	30%	£0.34	Assume some of the ways of working will remain
011	Public Health Measures (including flu)	0.4	150%	£0.60	100%	£0.40	30%	£0.12	30%	£0.12	30%	£0.12	Public health measures are likely to continue to be a focus in future years.
012	Remobilisation	0.2	150%	£0.25	70%	£0.12	0%	£0.00	0%	£0.00	0%	£0.00	This is fluctuating regularly so difficult to estimate. Assume there will be continued costs in 21/22 to recover from winter pressures. It looks likely that there will be a backwards shunt in remobilisation costs this year as boards won't have got the staff in yet and there will be additional activity from late diagnosis and delays to elective care.
013	Social Care (payments to third parties, DD reduction)	1.5	50%	£0.74	0%	£0.00	0%	£0.00	0%	£0.00	0%	£0.00	Will depend on policy decisions. Outputs from "Review of Social Care" will be key to this.
014	Test and Protect	0.0	70%	£0.00	20%	£0.00	20%	£0.00	20%	£0.00	20%	£0.00	Assuming set up costs will have been greatest in 2020/21 (although only part year) with recurring staff costs in 21/22. Assume there will be some level of continuation of this programme for resilience for future pandemics.
015	Unscheduled care	0.0	100%	£0.00	100%	£0.00	100%	£0.00	100%	£0.00	100%	£0.00	Most of this is expected to be recurring through staff costs and IT
016	Mental Health	0.1	100%	£0.25	100%	£0.35	100%	£0.40	100%	£0.50	100%	£0.50	We expect there to continue to be a significant impact on mental health as a result of the pandemic both in terms of activity and how this is delivered.
017	Offset Savings	2.7	0%	£0.00	0%	£0.00	0%	£0.00	0%	£0.00	0%	£0.00	Would expect offsetting savings to reduce if not end due to remobilisation of services in future years
018	Covid Vaccinations	0.3		£2.00		£0.75		£0.40					Costs are likely to increase for next financial year especially given it will be vaccination costs (NSS have stressed from a purchasing/staffing perspective how demanding this will be as there will be a need to run Flu and COVID-19 jabs solidly for the next few months – and remobilisation plans are likely to slip (especially with the increases in covid-19 now). These costs are likely to tail off in 2022/23.
019	**Total**	**11.3**		**£6.9**		**£3.4**		**£2.3**		**£2.0**		**£2.0**	

PLEASE NOTE THAT #15-18 HAVE CHANGED SINCE THE NOVEMBER SUBMISSION - Underachievement of Savings has been removed and Mental Health has been added

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: **31 March 2021**

Title of Report: **Budget Outlook 2021-22 to 2023-24**

Presented by: **Judy Orr, Head of Finance and Transformation**

The Integration Joint Board is asked to:

- Consider the current estimated budget outlook report for the period 2021-22 to 2023-24
- Note that there is a separate report on the agenda detailing savings options to deliver a balanced budget in 2021-22.

1. EXECUTIVE SUMMARY

1.1 This report summarises the budget outlook covering the period 2021-22 to 2023-24. The budget outlook presented to the IJB on 27 January has been updated.

1.2 The main change has been to update the funding for health and social care following Scottish Government budget announcements, pay inflation following the public sector pay policy announcement, consequential impacts on uplifts for other NHS boards and Carers Act expenditure, updated dated estimates for workforce establishment reviews, cystic fibrosis, some funding for Knapdale works, CAMHS staffing pressures and potential investment in transformation which is subject to budget approval. There have been a number of other small adjustments to estimates.

1.3 The funding from the Council has now been approved. The main changes from the previous outlook are that there is a 0.39% increase (previously assumed a flat cash position) for 2020/21 along with a share of national additional funding which amounts to £1.398m. This includes Carer's Act extension, further funding for free personal care Scottish Living Wage uplift and Criminal Justice funding. The Council has also agreed to reduce repayment of previous year's overspend by £1m but this is dependent on outturn for the current year. The intention is to repay this in the current financial year.

1.4 The funding from NHS Highland is still under negotiation. This paper reflects the interim funding offer detailed at 3.1.1. This includes 50% of the share of NHS Highland's NRAC uplift of £16.4m in the Scottish Government

settlement, which is worth £2.9m. This is the main reason for the improvement in the outlook since this last one presented to the Board.

1.5 A single scenario is now presented for 2021/22 with a budget gap before new savings of £4.134m. The usual best, mid-range and worst case scenarios are presented for the next two years. In the mid-range scenario, the Health and Social Care Partnership budget gap estimated over the three year period 2021-22 to 2023-24 is £9.446m with a gap of £4.134m in 2021-22.

1.6 The budget gap in the best case scenario over the three years is £5.514m and in the worst case scenario, the budget gap over the three years is £30.571. A summary of all three scenarios is included within Appendix 1.

1.7 The budget gap over 2020-21 to 2022-23 across each scenario is summarised in the table below:

Budget Gap	**2021-22 £000**	**2022-23 £000**	**2023-24 £000**	**Total £000**
Best Case	4,134	(8,632)	(1,116)	**(5,614)**
Mid-Range	4,134	1,576	3,736	**9,446**
Worst Case	4,134	15,574	10,863	**30,571**

2. INTRODUCTION

2.1 This report summarises the budget outlook covering the period 2021-22 to 2023-24. The outlook is based on three different scenarios, best case, worst case and mid-range. A single scenario is presented for 2021-22. The detail of all three scenarios is provided at Appendix 1.

2.2 The updates include new funding estimates following the Scottish Government budget on 28 January and reflect draft funding offers received from NHS Highland and the funding offer from the Council approved at the Council meeting on 25 February 2021. The Council has agreed a further deferral of the repayments in respect of previous years' overspends and revised details for this are presented below.

3. DETAIL OF REPORT

3.1 Funding Estimates

NHS Highland

3.1.1 The assumptions for funding from NHS Highland for 2021/22 has been amended to a 1.5% mid-range increase (the national uplift) plus an NRAC uplift of £2.9m based on their interim funding offer. This is 50% of our share of the total NRAC uplift of £16.4m. To this, we have added the expected allocations for Primary Medical Services and other recurring funding. The Other recurring funding figures are based on allocations as at month 9 which are matched by equivalent expenditure. For future years, the mid-range forecast still assumes a 2.5% uplift. We have been advised that New Medicines funding will be decreased by c £550k but this should be offset in cost reductions. Following discussion of this through the relevant networks,

we are reflecting the loss of funding in the mid-range scenario, and in worst case.

3.1.2 The table overleaf outlines the estimated funding from NHS Highland over the next three years within the mid-range scenario.

	2021-22 £000	**2022-23 £000**	**2023-24 £000**
Baseline funding	185,699	185,699	185,699
Baseline funding uplift (1.5%/2.5%)	2,707	7,286	11,979
Other Recurring Funding	35,815	35,815	35,815
Reduction in New Medicines Funding	-550	-550	-550
Resource Transfer baseline	7,057	7,057	7,057
Resource Transfer uplift (1.5%/ 2.5%)	185	372	562
NRAC uplift offered	2,900	5,821	5,967
Total Funding NHS	**233,813**	**241,500**	**246,529**

Council Funding

3.1.3 The estimates for Council funding are also changed from the previous Budget Outlook and reflect the additional funding in the Scottish Budget on 28 January and a funding uplift of 0.39% from the Council agreed in their budget setting. A total of £1.398m new funding was announced including above inflation uprating for free personal and nursing care of £253k; Scottish Living Wage uplift of £616k; Carers Act funding of £516k and £13k for Criminal justice. There are a number of consequential impacts for expenditure.

3.1.4 The Council also agreed that "With reference to the HSCP request for a deferral of £1m of the £1.2m that is due to be paid in 2021-22, agrees this in principle, subject to the proviso that the amount to be deferred be reduced by the amount of any HSCP underspend in 2020-21." The intention is to repay this early in 2020-21. Based on that assumption, the agreed repayment schedule is presented below:

3.1.5

	Repayment 2017-18 Overspend £000	Repayment 2018-19 Overspend £000	Repayment 2019-20 Estimated Overspend £000	Total Repayment £000	Status
2020-21	1,055	445	0	1,500	Indicative subject to underspend
2021-22	0	200	0	200	Agreed as above
2022-23	0	1,255	0	1,255	indicative
2023-24	0	1,227	0	1,227	Not yet agreed
2024-25	0	0	1,166	1,166	Not yet agreed
Total	**1,055**	**3,127**	**1,166**	**5,348**	

3.1.6 The table overleaf outlines the funding from Argyll and Bute Council expected over the next three years in the mid-range scenario.

	2021-22 £000	2022-23 £000	2023-24 £000
Baseline funding	62,211	62,211	62,211
Total Funding Council	**62,211**	**62,211**	**62,211**
Less 2018-19 overspend payment	(200)	(1,255)	(1,227)
Net Payment from Council	**62,011**	**60,956**	**60,984**

3.1.7 The table below summarises the total estimated funding over the next three years within the mid-range scenario.

	2020-21 £000	2021-22 £000	2022-23 £000
Funding NHS	233,813	241,500	246,529
Funding A&B Council	62,011	60,956	60,984
New SG funding for social work	0	1,000	2,000
Total Funding	**295,824**	**303,456**	**309,513**

3.2 Savings Measures Already Approved

3.2.1 A number of additional savings for 2021-22 were agreed at the IJB on 27 March 2019 as part of setting the 2019/20 budget. These new savings totalled £520k and comprise a further £500k on prescribing and £20k for criminal justice.

3.2.2 Saving 2021-65 of £50k, review of support payments to GP practices, was deferred to 2021/22 at the budget meeting on 25 March 2020. There is no change to this position from that reported in the previous budget outlook.

3.3 Base Budget

3.3.1 The base budget is the approved budget from 2020-21 and includes the second year of the agreed investment in financial sustainability for 2021/22. In view of the impact of Covid-19, a request is being made to extend this for a third year, and this is subject to approval in the budget paper. An adjustment has been made to the base budget for the uplift in other recurring funding from Health of £1.978m to reflect the Month 9 funding position. There are no changes from the base budget previously presented.

3.3.2 The table below summarises the base budget in the mid-range scenario.

	2021-22 £000	2022-23 £000	2023-24 £000
Base Budget NHS	216,267	216,267	216,267
Base Budget Council	60,077	60,077	60,077
Investment in financial sustainability – 2nd year	318	330	0
Resource Transfer	12,304	12,304	12,304
Base Budget	**288,966**	**288,978**	**288,648**

3.4 Employee Cost increases

3.4.1 For Health staff, the assumptions have been reduced downwards following the announcement of the Scottish public sector pay policy for 2021-22 of a flat rate £750 increase for those earning up to £25k, 1% for those earning between £25k and £80k and flat rate £800 increase for those earning above £80k p.a.. Modellling has indicated that this will cost an average of 2% for social care pay and 1.5% for health pay. Assurances have been received that for health, if actual pay award is greater, then there will be additional funding made available, but this does not extend to social care. For social care staff, for 2022-23 onwards, the best case scenario assumes a 1% increase p.a., the mid-range scenario assumes a 2% increase, and the worst case scenario assumes a 3.0% increase (similar to the 2018-19 offer). For health staff, I have assumed for 2022-23 onwards in the best case scenario a 2% increase p.a., the mid-range scenario assumes a 2.5% increase, and the worst case scenario assumes a 3.5% increase.

3.4.2 There are also additional costs in relation to incremental drift, and a proposed change to the Council's pay and grading structure and an estimate has been built into all three scenarios. This estimate is unchanged.

3.4.3 The increases to the employee budgets estimated over the next three years within the mid-range scenario are summarised in the table below.

	2021-22 £000	**2022-23 £000**	**2023-24 £000**
Health pay award	977	2,630	4,324
Health pay increments	185	370	555
Social Work pay award	672	1,357	2,056
Social Work pay increments	87	174	261
Social work change to pay structure	-2	-2	-2
Total Employee Cost Changes	**1,919**	**4,529**	**7,194**

3.5 Non-pay Inflation

3.5.1 A review of the non-pay inflation assumptions has been undertaken and all assumptions have been rolled forward with some recalculations for the Scottish Living Wage uplift, for increases in free personal and nursing care (previously included along with SLW uplift) and non-domestic rates freeze announced in budget, and for NHS board contracts now assumed to increase in line with the national funding uplift.

3.5.2 The table overleaf summaries the updated non-pay inflation estimated over the next three years within the mid-range scenario. Further information is included within Appendix 1.

	2021-22 £000	2022-23 £000	2023-24 £000
Health:			
Prescribing	1,000	2,000	3,000
Hospital Drugs	79	160	244
Main GG&C SLA	830	2,236	3,677
Other SLAs	447	1,233	2,008
Energy Costs, catering and Rates	161	328	496
Social Work:			
Catering Purchases	37	58	79
National Care Home Contract	530	1,082	1,655
NHS Staffing Recharges	125	180	237
Purchase and Maintenance of Equipment	11	22	33
CPI Essential increases	9	18	28
Scottish Living Wage	577	1,166	1,768
Free personal & nursing care	176	231	286
Carers Allowances	33	67	101
Utilities	26	35	45
Total Non-Pay Inflation	**4,041**	**8,816**	**13,657**

3.6 Cost and demand pressures

3.6.1 As with non-pay inflation, the cost and demand pressure assumptions have been rolled forward. The following assumptions have been updated:

- New cost pressure for CAMHS staff following review
- New cost pressure for NMAHP staffing following completion of establishment reviews
- New cost pressure for depreciation which has been growing each year
- Removed allowance for new high cost packages
- Increased allowance for new cystic fibrosis drugs
- Reduced cost pressure for Golden Jubilee Cardiac SLA
- Reduced costs for Knapdale refurbishment to take account of existing budget
- Added new cost pressure for one-off investment in transformation which is subject to budget approval
- All others have simply been rolled forward as per the previous outlook, but some calculations have been slightly updated to reflect current forecast where this is above budget.

3.6.2 The table below summaries the updated cost and demand pressures estimated over the next three years within the mid-range scenario. Further information is included within Appendix 1.

	2021-22 £000	2022-23 £000	2023-24 £000
Health:			
LIH* Laboratory	50	100	150
Additional junior doctor LIH	51	52	53

Additional NMAHP staffing	350	359	368
Day responder services	57	58	59
Golden Jubilee Cardiac SLA	60	62	64
New high cost care packages	0	0	0
Low secure service NHS Fife	190	190	190
New Craigs Mental health unit	150	150	150
Other NSD* developments	50	100	150
Oncology medicines demand	450	900	1,350
Bute Dialysis staffing	115	118	122
Microsoft Licence fees	0	0	0
Cystic fibrosis drugs	405	405	405
WoS* Sexual Assault & Rape Services	28	29	30
New clinical waste disposal contract	50	50	50
CareFirst replacement cost	30	75	78
Additional HR staffing	77	41	0
Gastro service at LIH*	60	62	64
Adaptation of Knapdale Ward	320	0	0
Contracted out laundry service	18	18	18
TAVI procedures	78	80	82
Additional medical director sessions	31	32	33
Depreciation	25	50	75
CAMHS additional staffing	413	421	430
Investment in transformation	517	0	0
Social Work:			
Older People Growth	380	766	1,158
Care Services for Younger Adults: Learning Disability & Mental Health	326	659	999
Care Services for Younger Adults: Physical Disability	455	520	586
Continuing Care demand pressure in Children & Families	350	600	850
Allowance for Unknown Cost and Demand Pressures	0	1,000	2,000
Total Cost and Demand Pressures	**5,602**	**7,413**	**10,030**

*LIH: Lorn & Isles Hospital *NSD: National Services Division
*WoS West of Scotland

3.7 Updated Budget Outlook

3.7.1 The updated budget outlook for the mid-range scenario, taking into consideration all the factors noted within this report, is summarised in the table below:

	2021-22 £000	**2022-23 £000**	**2023-24 £000**
Base Budget	288,966	288,978	288,648
Employee Cost Changes	1,919	4,529	7,194

Non-Pay Inflation	4,041	8,816	13,657
Cost and Demand Pressures	5,602	7,413	10,030
Management/Operational Savings agreed March 2019	(520)	(520)	(520)
Management/Operational Savings agreed March 2020	(50)	(50)	(50)
Total Estimated Expenditure	**299,958**	**309,166**	**318,959**
Estimated Funding	295,824	303,456	309,513
Estimated Budget Surplus /(Gap) Cumulative	**(4,134)**	**(5,710)**	**(9,446)**
Estimated Budget Surplus / (Gap) In Year	**(4,134)**	**(1,576)**	**(3,736)**

3.7.2 In the mid-range scenario, the Health and Social Care Partnership budget gap estimated over the three year period 2021-22 to 2023-24 is £9.446m with a gap of £4.134m in 2020-21.

3.7.3 In contrast, the budget gap in the best case scenario over the three years is £1.116m surplus and in the worst case scenario, the budget gap over the three years is £30.571m. A summary of all 3 scenarios is included within Appendix 1.

3.7.4 The changes from the previous anticipated outlook to 2022-23 (as noted at the IJB meeting on 27 January 2021) are summarised in the table below based on the mid-range scenario:

	2021-22 £000	**2022-23 £000**	**2023-24 £000**
Previous Reported Budget Gap (mid-range)	**(6,604)**	**(10,218)**	**(14,586)**
Funding increase	4,584	6,331	6,397
Change in base budget	(1,978)	(2,308)	(1,978)
Employee cost changes	959	1,299	1,655
Decrease in non-pay inflation	658	568	491
Increase in cost & demand pressures	(1,753)	(1,899)	(1,425)
Revised Budget Gap (mid-range)	**(4,134)**	**(5,710)**	**(9,446)**

3.7.5 The budget gap over 2021-22 to 2023-24 across each scenario is summarised in the table below:

Budget Gap	**2021-22 £000**	**2022-23 £000**	**2023-24 £000**	**Total £000**
Best Case	4,134	(8,632)	(1,116)	**(5,614)**
Mid-Range	4,134	1,576	3,736	**9,446**
Worst Case	4,134	15,574	10,863	**30,571**

4. RELEVANT DATA AND INDICATORS

4.1 The budget outlook is based on a number of assumptions, using a best, worse and mid-range scenario. These assumptions will be regularly reviewed and updated as appropriate.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery. This needs to be considered when options are developed to balance the budget.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact – There is a significant budget gap for future years that requires to be addressed.

6.2 Staff Governance – None directly from this report but there is a strong link between HR and delivering financial balance.

6.3 Clinical Governance - None

7. PROFESSIONAL ADVISORY

7.1 There are no recommendations from this report which require to be consulted on with Professional Advisory leads.

8. EQUALITY AND DIVERSITY IMPLICATIONS

8.1 None directly from this report but any proposals to address the estimated budget gap will need to consider equalities.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

9.1 None directly from this report.

10 RISK ASSESSMENT

10.1 There is a risk that sufficient proposals are not approved in order to balance the budget in future years. Any proposals will need to consider risk. In addition, the funding from NHS Highland is still under negotiation for next year. This paper reflects the interim offer including 50% of the NRAC uplift for next year, and the full uplift for the following year in the mid-range scenario.

11. PUBLIC AND USER INVOLVEMENT AND ENGAGEMENT

11.1 None directly from this report but any proposals to address the estimated budget gap will need to take into consideration local stakeholder and community engagement.

12. CONCLUSIONS

12.1 A budget outlook covering the period 2021-22 to 2023-24 has been updated following a review of cost and demand pressures. In the mid-range scenario, the Health and Social Care Partnership budget gap estimated over

the three year period is £9.446m with a gap of £4.134m in 2021-22. This has improved from the outlook previously presented by £2.470m for 2021-22 mainly due to the additional NRAC uplift funding in the interim funding offer from NHS Highland.

13. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	√
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

APPENDICES:
Appendix 1 – Budget Outlook Best, Worst and Mid-Range Scenarios

AUTHOR NAME: Judy Orr, Head of Finance and Transformation
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BUDGET OUTLOOK 2021-22 TO 2023-24 **APPENDIX 1**

INTEGRATION JOINT BOARD 31 MARCH 2021

	Draft Budget	Best case scenario		Mid-range scenario		Worst case scenario	
	2021-22 £000	2022-23 £000	2023-2024 £000	2022-23 £000	2023-2024 £000	2022-23 £000	2023-2024 £000
Base Budget:							
Base Budget	288,648	285,739	285,739	288,648	288,648	285,739	285,739
Base Budget Adjustments	318	0	0	330	0	330	0
Revised Base Budget	**288,966**	**285,739**	**285,739**	**288,978**	**288,648**	**286,069**	**285,739**
Employee Cost Changes:							
Pay Award	1,649	2,974	4,665	3,987	6,380	5,337	8,801
Pay Increments/change to employee base	270	499	727	542	814	912	1,369
Total Employee Cost Changes	**1,919**	**3,473**	**5,392**	**4,529**	**7,194**	**6,249**	**10,170**
Non-Pay Inflation:							
Health:							
Prescribing	1,000	1,800	2,700	2,000	3,000	2,200	3,300
Hospital Drugs	79	97	150	160	244	232	348
Main GG&C SLA	830	1,955	3,102	2,236	3,677	2,517	4,254
Other SLAs (GPs, GG&C, other HBs, service inputs)	447	1,082	1,699	1,233	2,008	1,384	2,319
Utilities and rates	161	327	493	328	496	338	507
Social Work:							
Catering Purchases	37	58	79	58	79	58	79
National Care Home Contract	530	807	1,229	1,082	1,655	1,359	2,089
NHS Staffing Recharges	125	180	237	180	237	180	237
Purchase and Maintenance of Equipment	11	16	25	22	33	27	42
Specific CPI Increases	9	9	14	18	28	28	42
Scottish Living Wage excluding FPNC	577	811	1,226	1,166	1,768	1,634	2,488
Free personal & nursing care uplift	176	214	253	231	286	252	330
Carers Allowances	33	50	75	67	101	84	127
Utilities	26	32	39	35	45	39	51
Total Non-Pay Inflation	**4,041**	**7,438**	**11,321**	**8,816**	**13,657**	**10,332**	**16,213**
Cost and Demand Pressures:							
Health:							
LIH Laboratory	50	100	150	100	150	200	300
Additional junior doctor LIH	51	52	53	52	53	52	53
Additional NMAHP (nursing, midwifery & Allied Health Professionals) staffing	350	359	368	359	368	463	477
Day responder services	57	58	59	58	59	58	59
Golden Jubilee Cardiac SLA	60	62	64	62	64	62	64

	Draft Budget	Best case scenario		Mid-range scenario		Worst case scenario	
	2021-22	2022-23	2023-2024	2022-23	2023-2024	2022-23	2023-2024
	£000	£000	£000	£000	£000	£000	£000
New high cost care packages	0	0	0	0	0	200	200
Low Secure Service NHS Fife	190	190	190	190	190	190	190
New Craigs Mental Health Rehab Unit	150	100	100	150	150	150	150
Other NSD developments	50	100	150	100	150	100	150
Oncology Medicines Demand	450	700	1,050	900	1,350	1,100	1,650
Bute Dialysis	115	118	122	118	122	118	122
Microsoft Licence Fees	0	0	0	0	0	200	200
Cystic Fibrosis Treatments	405	405	405	405	405	511	564
WoS Sexual Assault & Rape Services	28	29	30	29	30	29	30
New Clinical Waste Disposal Contract	50	0	0	50	50	75	75
Additional HR staffing agreed by IJB for 23 months	77	41	0	41	0	41	0
Care First replacement cost	30	75	78	75	78	75	78
Re-instate gastro service at LIH	60	62	64	62	64	62	64
MACHICC adaptation of Knapdale	320	0	0	0	0	0	0
contracted out laundry	18	18	18	18	18	18	18
Additional TAVI procedures	78	0	0	80	82	134	138
Additional Med Director sessions	31	32	33	32	33	32	33
Depreciation	25	50	75	50	75	50	75
CAMHS SBAR	413	0	0	421	430	0	0
Investment in transformation	517	0	0	0	0	1,545	2,354
Council:							
Older People Growth	380	0	0	766	1,158	1,545	2,354
Care Services for Younger Adults (< 65 years) LD, MH	326	328	494	659	999	993	1,513
Care Services for Younger Adults (< 65 years) PD	455	258	288	520	586	787	895
Extension of Carers Act services	516	250	250	516	516	516	516
Continuing care demand pressure in Children & Families	350	50	50	600	850	1,150	1,650
Allowance for Unknown Cost and Demand Pressures	0	500	1,250	1,000	2,000	1,750	3,750
Total Cost and Demand Pressures	**5,602**	**3,937**	**5,341**	**7,413**	**10,030**	**12,206**	**17,722**
Savings Previously Agreed:							
Management/Operational Savings - Agreed March 2019	(520)	(520)	(520)	(520)	(520)	(520)	(520)
Management/Operational Savings - Agreed March 2020	(50)	(50)	(50)	(50)	(50)	(50)	(50)
Total Savings	**(570)**	**(570)**	**(570)**	**(570)**	**(570)**	**(570)**	**(570)**
Total Estimated Expenditure	**299,958**	**300,016**	**307,223**	**309,166**	**318,959**	**314,286**	**329,274**
Funding:							
NHS	233,813	243,232	249,519	241,500	246,529	235,093	238,766
Council	62,011	62,220	63,748	61,956	62,984	58,878	58,013
Total Funding	**295,824**	**305,452**	**313,267**	**303,456**	**309,513**	**293,971**	**296,779**

	Draft Budget	Best case scenario		Mid-range scenario		Worst case scenario	
	2021-22	2022-23	2023-2024	2022-23	2023-2024	2022-23	2023-2024
	£000	£000	£000	£000	£000	£000	£000
Budget Surplus / (Gap) Cumulative	**(4,134)**	**5,436**	**6,044**	**(5,710)**	**(9,446)**	**(20,316)**	**(32,495)**
Budget Surplus / (Gap) In Year	**(4,134)**	**9,570**	**608**	**(1,576)**	**(3,736)**	**(16,181)**	**(12,180)**
Partner Bodies Split:							
Health	(1,647)	5,702	6,730	298	(1,279)	(7,027)	(11,917)
Social Work	(2,487)	(1,205)	(1,116)	(6,008)	(8,167)	(12,682)	(18,654)
Budget Surplus / (Gap) Cumulative	**(4,134)**	**4,498**	**5,614**	**(5,710)**	**(9,446)**	**(19,709)**	**(30,571)**
Budget Surplus / (Gap) In Year	**(4,134)**	**8,632**	**1,116**	**(1,576)**	**(3,736)**	**(15,574)**	**(10,863)**

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item:**

Date of Meeting: **31 March 2021**

Title of Report: **Financial Risks 2021-22**

Presented by: **Judy Orr, Head of Finance and Transformation**

The Integration Joint Board is asked to:

- Consider the updated financial risks identified for the Health and Social Care Partnership.
- Note there are continuing uncertainties around Covid costs and funding which are described in more detail in a separate report.
- Note that financial risks will continue to be reviewed and monitored on a two monthly basis and reported to the Board.

1. EXECUTIVE SUMMARY

1.1 The report to the IJB on 27 March 2019 introduced a process of identifying and reporting financial risks to the Board on a regular basis. This report provides an updated assessment of these risks for 2021/22. Two new risks have been added.

1.2 Each risk has been classified as to its likelihood and also has been quantified within a financial range. Each risk also notes any current mitigations in place to keep the risk from being realised.

1.3 29 risks have been identified in total, with 17 classified as possible, 5 classified as likely and 1 as almost certain. The remainder have been classed as unlikely. One has been quantified as being over £500,000 and relates to the uplift in the service level agreement (SLA) with NHS Greater Glasgow & Clyde (GG&C) which is now under negotiation. Overall these risks have been quantified as potentially amounting to £1.698m. This is increased from the £895k reported to IJB in January as we are now looking at the risks for the full financial year.

1.4 In addition, there is still considerable uncertainty around levels of Covid funding from Scottish Government for next year and there is a separate report on the agenda about that risk which is not included in this summary.

1.5 Financial risks will continue to be reviewed and monitored on a two monthly basis and will be reported to the Board as part of the pack of financial reports.

2. INTRODUCTION

2.1 This report updates the Board on the financial risks facing the organisation which have not been reflected in the budget for the next financial year.

3. DETAIL OF REPORT

3.1 For each risk, the likelihood has been assessed based on what is a relatively standard risk matrix:

	Likelihood	**Probability applied**
1	Remote	0%
2	Unlikely	10%
3	Possible	25%
4	Likely	50%
5	Almost Certain	75%

3.2 Each financial risk has been quantified into ranges as follows:

Range	**Quantified as:**
Less than £100,000	£50k
Between £100,000 and £300,000	£200k
Between £300,000 and £500,000	£400k
Between £500,000 and £1.5m	£1.0m
Over £1.5m	£2.5m

3.3 Alongside each risk identified there is a note of any current mitigations that are in place to keep the risk from being realised. There are some risks where monitoring can take place but it is difficult to mitigate some risks due to Scottish Government policy directions and the introduction of new drugs.

3.4 The UK withdrawal from the European Union has led to additional financial risks in relation to supplies even though a trade agreement has been put in place. National Procurement have taking considerable steps to increase stocks centrally but there is still risk over price increases. We will continue to monitor developments.

3.5 The individual financial risks are detailed in Appendix 1 and are summarised in the table below.

Likelihood / Range	**Remote**	**Unlikely**	**Possible**	**Likely**	**Almost certain**	**Total**
<£100k	0	4	5	1	0	**10**
£100k - £300k	0	2	12	3	1	**18**
£300k - £500k	0	0	0	0	0	**0**
£500k - £1.5m	0	0	0	1	0	**1**
>£1.5m	0	0	0	0	0	**0**
Total	**0**	**6**	**17**	**5**	**1**	**29**

3.6 There are 29 risks identified in total with 6 classed as unlikely, 17 classified as possible, 5 classified as likely and 1 as almost certain. One has been identified as over £500k. Quantifying these risks with an expected probability and financial impact gives a total potential adverse impact of £1.698m, increased from the £895k previously reported.

3.7 No risks have been removed, and three new risks have been added. The main changes have been from increasing the likelihood and value of risks as we are at a start of a new financial year. The new risks are for potential of unbudgeted uplift in the SLA with NHS GG&C where this is now under negotiation across the west of Scotland, and for an increase in rates for Social Work Emergency Standby Service where the union is threatening to lodge a petition for SJC social work rates to be paid rather than national standby rates. The third one is that pay settlements may exceed what has been budgeted for as negotiations are still continuing and there were changes to the public sector pay policy after funding announcements were made. These changes are highlighted in Yellow on the appendix.

3.8 Financial risks will be reviewed and monitored on a two monthly basis and will be reported to the Board as part of the pack of financial reports.

4. RELEVANT DATA AND INDICATORS

4.1 Financial risks have been identified based on previous and current year cost pressures and those areas of the budget where spending is more volatile. Financial risks have been classified as to their likelihood and an estimate o of the potential financial impact.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 Financial risks are identified based on delivery of service to meet the strategic priorities.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact – Each financial risks has been assessed as to its estimated financial impact.

6.2 Staff Governance – None.

6.3 Clinical Governance – None.

7. PROFESSIONAL ADVISORY

7.1 There are no recommendations from this report which require to be consulted on with Professional Advisory leads.

8. EQUALITY AND DIVERSITY IMPLICATIONS

8.1 None directly from this report.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

9.1 None directly from this report.

10. RISK ASSESSMENT

10.1 Risks are detailed within the report.

11. PUBLIC AND USER INVOLVEMENT AND ENGAGEMENT

11.1 None directly from this report.

12. CONCLUSIONS

12.1 This report summarises the key financial risks facing the Health and Social Care Partnership. There are 29 risks identified in total with a potential adverse impact of £1.698m which are not included in the financial outlook / budget for next year. The largest risk is in relation to the SLA with NHS GG&C which is quantified as in the range of £500k to £1.5m. The budget has included an uplift of 1.5% which is the nationally agreed uplift for all NHS Boards for next year and is the base point for these negotiations which have recently commenced.

13. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	√
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

APPENDICES:

Appendix 1 – Financial Risks 2021-22 (sorted by size of quantified risk)

AUTHOR NAME: Judy Orr, Head of Finance and Transformation
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ARGYLL AND BUTE HEALTH AND SOCIAL CARE PARTNERSHIP - FINANCIAL RISKS 2021/22
INTEGRATION JOINT BOARD - MARCH 2021 UPDATE

HEALTH OR SOCIAL WORK	SERVICE AREA	DESCRIPTION OF RISK	CURRENT MITIGATIONS	2021-22 LIKELIHOOD	2021-22 FINANCIAL IMPACT £000	Quantified Risk £000s	Comments on change since last update
Health	Commissioned Services - NHS GG&C	Potential for uplift in the main SLA costs based on review of activity levels.	Discussed through Corporate Finance Network. Expected to be based on overall funding uplift as for 2020-21. New activity based model is still to be progressed.	4	500-1,500	500	Activity is still depressed due to COVID
Health	Service wide	High volume of grievances received from ward based health care assistants band 2s who believe they should be re-graded to AfC band 3. Some health boards have now settled this and awarded uplifts	Short life working group being established to agree generic job descriptions for band 3 role of Health Care Support Worker	5	100-300	150	
Health	Commissioned Services - NHS GG&C	Potential for further growth in the cost of oncology drugs beyond provision in the budget	A cost pressure has been build into the 2021-22 budget. This should assist in minimising this risk, however, it is a risk that there is limited control over.	4	100-300	100	Increased risk rating due to delay in receiving drug reports from GGC (pharmacy staff working on covid frontline issues than reporting)
Health	Nursing and AHP	Workforce establishment setting still to be completed to meet Safe Staffing Act requirements and may result in needs to increase establishments. Work was delayed due to Covid	Allowance built into 2021-22 budget based on all areas completed for nursing and midwifery. AHP establishment setting delayed. Teams have been asked to be innovative and review how they are organised in order to mitigate any pressures	4	100-300	100	Adjusted risk related to outstanding review of AHP staffing
Health / Council	Service wide	Pay settlements may exceed budgeted levels. Public sector pay policy has been increased but no additional funding has been announced	Negotiations continue with Scottish Government at a national level seeking these be fully funded. CFO network has been assured that there will be funding for additional costs for NHS pay settlements but there is more uncertainty re social care	4	100-300	100	New for 2021/22 as pay settlements have ended
Health	Adult Services	Overspending on GP prescribing budgets for several potential reasons causing short supply of drugs resulting in price increases	Prescribing advisors advise GPs on good prescribing practice to contain costs.	3	100-300	50	Ongoing impact of Covid is affecting this.
Health	Adult Services	Potential for consultant vacancies at Lorn & Islands Hospital resulting in increased use of locums	Most consultant roles are currently filled by employed staff and there would be an attempt to recruit to vacancies rather than use locums.	3	100-300	50	
Health	Commissioned Services - NHS GG&C	New cystic fibrosis drugs costs higher than budgeted for.	A cost pressure has been build into the 2021-22 budget. This should assist in minimising this risk, however, it is a risk that there is limited control over.	3	100-300	50	Triple therapy drug made available by SG, start date of 1 Sept 2020. Ending of free supply of drugs on compassionate grounds will increase costs to HSCP. Cost pressure recognise in budget, but potential for further growth
Health	Commissioned Services - Other	Potential for higher level of eating disorder patient referrals to the Priory	Development of local CAMHS service. Limited mitigations for adult services possible at present	3	100-300	50	Potential for crisis referrals following lockdown
Health	Commissioned Services - Other	Potential for growth in the number of high cost individual patient treatments (joint care packages)	This will be monitored but it is an area where there is limited control.	3	100-300	50	Likelihood reduced as more stable recently
Council	Looked After Children	Potential increase in the number of children and young people who need to be taken into care and supported/accommodated by the HSCP.	Practitioners are working hard to avoid admissions to care and the service is developing lower cost models of support for young people who become looked after. 3 month scoping project under way.	3	100-300	50	

HEALTH OR SOCIAL WORK	SERVICE AREA	DESCRIPTION OF RISK	CURRENT MITIGATIONS	LIKELIHOOD	FINANCIAL IMPACT £000	Quantified Risk £000s	Comments on change since last update
Council	Children with a Disability	Potential increase in the number of children and young people requiring support/families requiring support as well as the potential for increased levels of support required by existing service users.	The weekly Children's Resource Panel is scrutinising requests for service. Consideration is being given to how SDS and other service models could be developed to provide support in the future.	3	100-300	50	Adjusted to reflect increased demand for services
Council	All Social Work	Difficulties in recruiting and retaining qualified staff as well as increased demand/complexity in terms of the services required and/or increased sickness absence which result in the use of locum/ supplemental staffing.	Work is ongoing with HR and the Communications team to look at how we can encourage people to come and work in Argyll and Bute. Review of spend by agency staff for adults undertaken by the CSWO. Review of the effectiveness of the SW Training Board. Attendance management processes in place.	3	100-300	50	numbers of agency social workers is reducing. Close management review from CSWO. Cost reduced as additional social workers recruited recently but likelihood increased due to Covid and other pressures
Council	Social Work Emergency Standby Costs	Potential for an uplift in the rates paid to staff in line with the SJC rates for SW standby. Report presented to March SLT.	Currently undergoing review in relation to potential equalities issues which arise for the Council in other departments.	3	100-300	50	New for 2021/22
Council	Older People	Potential increase in the number of older people requiring support.	A cost pressure has been build into the 2021-22 budget. Scrutiny by local and senior management of care packages and funding requests. Short life working group on older adult services being established to mobilise services and monitor risks.	3	100-300	50	
Council	Physical Disability	Increased demand for service, both for new clients and from increases in the needs of existing service users exceeds the demand pressure built into the budget.	A cost pressure has been build into the 2021-22 budget. Regular review of services and tracking of changes in service demand. Scrutiny by local and senior management of care packages and funding requests.	3	100-300	50	
Council	Learning Disability	Increased demand for service, both for new clients and from increases in the needs of existing service users exceeds the demand pressure built into the budget.	A cost pressure has been build into the 2021-22 budget. Regular review of services and tracking of changes in service demand. Scrutiny by local and senior management of care packages and funding requests.	3	100-300	50	
Health	Commissioned Services - NHS GG&C & Other Scottish Boards	Potential for growth in the number of high cost individual patient treatments. High volume being experienced for new TAVI cardiac procedure	A cost pressure has been build into the 2021-22 budget. This should assist in minimising this risk, however, it is a risk that there is limited control over.	4	<100	25	budget for 6, already done 8 in YTD, 1 patient listed for Dec surgery, total of 9 surgeries last year. Cost is £25k per procedure
Health	Adult Services	Continued use of agency nursing staff in Lorn & Islands Hospital	Continuation of attempts to minimise the use of agency staff.	2	100-300	20	Usage low and related to covid
Health	Adult Services	Additional cleaning standards are being considered	CFN network have advised that there may be an increase in costs from a change in cleaning standards. Limited change in costs currently being experienced so risk is low.	2	100-300	20	
Health	Adult Services	Continued use of locum GPs in Kintyre Medical Group	Practice to be re-advertised in different way post Covid	3	<100	13	Stable staffing position at the moment
Health	Adult Services	Continued use of agency staff in Lorn & Islands Hospital Laboratory	Continuation of attempts to recruit permanent staff. Where this is not possible then the service will be required to contain locum costs within budget but it has to be appreciated that this might not always be possible if it affects service delivery. Raigmore considering what they could do to assist	3	<100	13	Assumes SG Covid Funding will cover the costs of all shielding staff. Impacted by delays to recruit staff and get them into post following job offers

HEALTH OR SOCIAL WORK	SERVICE AREA	DESCRIPTION OF RISK	CURRENT MITIGATIONS	LIKELIHOOD	FINANCIAL IMPACT £000	Quantified Risk £000s	Comments on change since last update
Health	General Medical Services	Potential for high cost of reimbursements to GP practices for maternity and sickness absence cover. Covid has increased risk.	This will be monitored but it is an area where there is limited control.	3	<100	13	Risk reduced as Covid related costs are currently being reimbursed
Health / Council	Commissioned Services - Other	Third sector commissioned services cannot be delivered within the current budgets	Negotiations with third sector providers seek for such costs to be covered through efficiencies year on year	3	<100	13	
Council	Chief Officer	Increased building maintenance and repairs costs arising as the buildings we use get older and their condition deteriorates.	Regular monitoring of the fabric of the buildings and assessment for asset sustainability works funded via the capital budget. Reduction in the number of buildings in use through the co-location of staff into fewer buildings.	3	<100	13	Risk reduced as result of increased levels of home working which is expected to continue
Health	Adult Services	Continued use of agency medical staff in psychiatry	Continuation of attempts to recruit permanent staff. Where this is not possible then the service will be required to contain locum costs within budget but it has to be appreciated that this might not always be possible if it affects service delivery.	2	<100	5	Costs currently contained within budget. Recruitment of Clinical Fellows and Clinical Development Fellows has assisted. Also, fewer doctors going abroad due to Covid.
Health	Adult Services	Continued reliance on locum medical staff to cover shifts on the Oban out of hours rota	As part of grip and control, regular review of workforce undertaken by the Strategic Leadership Team to minimise excess staffing and use of locums.	2	<100	5	Better management of rota has reduced risk and cost of rota compared to previous years
Health	Adult Services	Continuation of excess community nurse staffing on Mull	As part of grip and control, regular review of workforce. Nursing workforce tools being applied.	2	<100	5	Proactive budget management has reduced the risk in year
Council	Social Work - adult services	Job Evaluation of Social Work Assistants	Evaluation has to be worked through in line with Job Evaluation principles.	2	<100	5	
	Grand Total					1,698	

TOTAL		**1,698**
Split	**Health**	1,224
	Council	474

Yellow = new risk since last report to IJB
Amber = updated

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item:**

Date of Meeting: **31 March 2021**

Title of Report: **Budget Consultation Findings**

Presented by: **Judy Orr, Head of Finance and Transformation**

The Integration Joint Board is asked to:

- Note the findings from the Budget Consultation and ensure these are fed into considerations when discussing the separate report on the agenda detailing savings options to deliver a balanced budget in 2021-22.

1. EXECUTIVE SUMMARY

1.1 The Finance & Policy Committee finalised the budget consultation at its last meeting and was launched on Friday 22 January for a 4 week period closing on 19 February. It was made available online and promoted through social media, and through community councils, TSI, and the community planning partnership.

1.2 When it closed, 625 responses had been received. This report summarises the findings. It should be noted that the responses are not fully representative of our overall population and service users. However, we very much welcome the time taken by people to give us their views. These views will be taken into account when making decisions on the Budget proposals, and in guiding future service re-design.

1.3 The key findings from the consultation are as follows:

- The services most used are GP services, followed by dentists, chemists and opticians
- The other services used by over a third of respondents are Glasgow & Clyde hospitals; Argyll & Bute hospitals; and Public health services
- The top category for reductions to funding was management and corporate costs. This was followed by Justice Social Work services.
- The top 2 priority service areas were care at home and other community support and GP practices. The next 3 areas were community hospitals; Mental health services; and residential care home placements; followed by children's services
- The most acceptable service changes are individuals taking more responsibility for their own health & wellbeing, using technology more for appointments or monitoring, less support for patient travel escorts, improve utilisation of Oban theatre, more support to unpaid carers,

care home packages capped for clients who refuse a care home placement, family & friends supporting people at home more, and, more travel to specialist services, and shift from individual packages of care to group model for Mental Health support.

- There was least support for waiting times for care packages, less face to face time with specialists, fewer local nursing and care homes, fewer health visitors and school nurses, care at home packages only for those with highest level of care needs.

2. INTRODUCTION

2.1 This report summarises the 625 online budget consultation responses received.

2.2 The online consultation was hosted on Argyll and Bute Council's website in the consultation section, and this was promoted to all visitors via a banner on the website. It was also promoted via the Council's Keep in the Loop subscriber service, via community councils, TSI and the community planning partnership.

2.3 A summary of all the responses is given at Appendix 1. A commentary is provided in section 3 below.

3. DETAIL OF REPORT

3.1 Demographics of respondents

3.1.1 Respondents were asked what age group they fell into, whether they had any dependents that they looked after, and what area they lived in. The largest group responding are in the 51-65 year category.

Age group	%
18-30 years	1%
31-50 years	23%
51-65 years	43%
66-75 years	24%
76-85 years	5%
85+ years	1%
Not answered	1%

3.1.2 Respondents have been fairly evenly distributed across all our areas as shown overleaf.

Area	%
Helensburgh & Lomond	22%

Oban Lorn and the Isles	22%
Bute & Cowal	30%
Mid Argyll, Kintyre and the Islands	25%
Not answered	1%

3.1.3

Do you have dependents that you look after?	**%**
No dependents	55%
Child or children under 18	19%
Spouse or partner	14%
Older relative(s)	12%
Other adult(s)	6%

Over half of the respondents have no dependents. Conversely half look after either children, older relatives or spouse/partners.

3.2 Services used and Service Priorities

3.2.1 The most important role for the HSCP is to deliver services for the most vulnerable, closely followed by helping us all to live longer, healthier, independent, happier lives. Many commented on the difficulty of choosing just one option.

What for you is the most important role for the HSCP (Please tick one option only)	No.	%	Last year
Deliver the services I use	43	6.9%	9.1%
Deliver services for the most vulnerable people in our communities	306	49.0%	45.5%
Help us all to live longer, healthier, independent, happier lives	223	35.7%	33.2%
Support local people to help others in our communities	24	3.8%	5.5%
Other (please tell us what)	9	1.4%	5.3%
No response	20	3.2%	1.4%

3.2.1 The services most used are GP services (39.7%), followed by dentists, chemists and opticians (22.4%). However if you add in other services used, over one-third also use Glasgow & Clyde hospitals, Argyll and Bute hospital services, and public health. This is very similar to last year.

3.3 Support for reductions to funding

3.3.1 Respondents were asked for the top 3 areas where they would most support reductions to funding and to mark these as 1, 2 and 3. 248 people said that management and corporate would be their top area for reduction, with a

further 94 naming it their second area and 78 saying it was their third area. In total 420 said it was in their top 3. This was not unexpected and it is indeed an area targeted in the list of management and operational savings for approval by the IJB. The recent restructuring of Adult Services and Children & Families will deliver substantial savings next year.

3.3.2 100 people stated that justice social work services would be their top pick for reducing, with a further 72 naming it their second area and 81 saying it was their third area. Much of this area is funded by specific grants and the plan is to make this area fully self-funding from these grants.

3.3.3 Other suggested areas for reducing spend received far fewer preferences. The only areas appearing in the top 3 for over 100 respondents were acute services from NHS GG&C; acute services from Oban hospital, public health; maternity, health visitor and school nursing services.

3.4 Top service area priorities

3.4.1 Respondents were asked for the top 3 service areas which are their priorities and to mark these as 1, 2 and 3. 131 people said GP practices was their priority, with 76 saying it was their second priority and a further 69 saying it was their third priority. In total 241 said it was in their top 3.

3.4.2 122 people said care at home and other community support packages was their priority, with 98 saying it was their second priority and a further 67 saying it was their third priority. In total 287 said it was in their top 3.

3.4.3 The next 3 areas getting support (albeit at much lower levels) were mental health services, community hospitals, and residential care home placements. The clear bottom areas were management & corporate, and justice social work – consistent with the top areas for reduction.

3.5 Views on savings proposals

3.5.1 148 people gave comments about the savings proposed which were attached to the consultation. Comments were very varied, ranging from a few agreeing with the proposals, to others finding it impossible to comment without further details, others suggesting that increasing funding is required, and quite a number stating that further cuts to management were required in line with Q4 responses. Many were in favour of the saving from moving clients to individual tenancies.

3.5.2 Of objections about particular savings proposals, the two getting more objections was the proposal to end funding for clubs, although some felt that these should be self funding, and the proposal to close local authority care homes which are not fit for purpose, although again there were some respondents in favour.

3.5.3 No other savings proposal had more than 8 comments opposing it, and again these were balance in part by some respondents being in favour of these changes. Of these the main changes opposed were :

- Ending funding for the advocacy services
- Shifting urology services from Glasgow to Oban

3.5.4 202 people responded to the request to give their ideas on other ways to save money. The top 5 suggestions were:

- The need to reduce management costs
- Use technology more (V/C, Near Me, telemedicine, appointment booking systems) and reduce admin and use less paper
- Charge for prescriptions, and reduce prescriptions
- Use volunteers more, and partner with voluntary and third sectors who are more agile and less costly
- Fund healthy living projects focussed on prevention and provide more access to personalised self-help information

3.5.5 Other comments which were much less common but repeated several times included:

- Improve funding – nationally, and increase income where possible
- Change redundancy policy, reduce sickness absence and use of locums and agency staff
- Estate rationalisation – home working, fewer offices

3.5.6 A summary of all the savings ideas from the consultation is set out at Appendix 2.

3.6 Acceptability of certain service changes

3.6.1 The areas getting most support as acceptable service changes are as follows:

Description of service change	No. saying "acceptable"	Not sure	Not acceptable
You taking more responsibility for your health & wellbeing	542	40	30
More use of technology for appointments or monitoring people	465	73	55
Less support for patient travel escorts – stricter criteria to ensure we pay for escorts only when they are absolutely necessary	449	79	76
Improve utilisation of Oban hospital theatre capacity through patients travelling from North Highland or work transferred that is currently done from Glasgow hospitals (e.g. urology)	428	125	43
More support for unpaid carers	418	96	82
Family and friends doing more to support people living at home	274	157	178
Reduce discretionary (non-contractual) support to voluntary organisations encouraging these to be self-funding	274	191	134
Shift from individual packages of care for Mental Health support to enabling model of group based care providing more peer support and social interaction	268	192	132
More travel to specialist services	242	144	216
Reduce community based day services for older people or people with learning disabilities and replace with a range of community based Third Sector services	208	174	209

3.6.2 For some other proposals, there were majorities saying that they were not acceptable. This included waiting times for care at home packages; less face to face time with specialists; fewer nursing and care home facilities; care at home packages only for those with highest level of need; and fewer health visitors and school nurses.

3.6.3 There is a clear mandate for greater use of technology for improving appointments, and monitoring of clients at home, and we know that the use of Near Me video conferencing is proving very popular with clients where is saves them long journeys for short appointments (although there are restrictions on where it is be suitable). There is also clear support for stricter criteria for patient travel escorts, increasing support for carers (more funds being allocated for this from Carers Act funding), improving the utilisation of the Oban hospital theatre facilities, and for changing community day services.

4. RELEVANT DATA AND INDICATORS

4.1 The paper is informed by 625 budget consultation responses when the consultation closed.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery. This needs to be considered along with these budget consultation responses before decisions are made on how to balance the budget.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact – There is a significant budget gap which requires to be addressed and IJB may require to take most of the proposed savings.

6.2 Staff Governance – None directly from this report but individual savings may affect staff.

6.3 Clinical Governance - None

7. PROFESSIONAL ADVISORY

7.1 There are no recommendations from this report which require to be consulted on with Professional Advisory leads.

8. EQUALITY AND DIVERSITY IMPLICATIONS

8.1 None directly from this report but any proposals to address the estimated budget gap will need to consider equalities.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

9.1 None directly from this report.

10 RISK ASSESSMENT

10.1 There is a risk that sufficient proposals are not approved in order to balance the budget in future years. Any proposals will need to consider risk.

11. PUBLIC AND USER INVOLVEMENT AND ENGAGEMENT

11.1 Engagement carried out is described within the body of the report.

12. CONCLUSIONS

12.1 The IJB welcomes the engagement of many of our residents in taking the time to respond to our budget consultation. Their responses are summarised in this report with the key findings set out at 1.3 above. The attached appendices give a full summary of responses and ideas for many savings. These responses should be given due weight when the IJB makes it decisions on savings to balance its budget. This is an analysis based on interim responses. The report will be updated for all responses received once the consultation closes.

13. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	√
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

APPENDICES:

Appendix 1 – Summary of consultation responses

Appendix 2 – Ideas on making savings

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Appendix 1

CONSULTATION QUESTIONS

Section 1: The role of the Health & Social Care Partnership in Argyll and Bute

1.	What for you is the most important role for the HSCP (Please tick one option only)			Last year
	Deliver the services I use	43	6.9%	9.1%
	Deliver services for the most vulnerable people in our communities	306	49.0%	45.5%
	Help us all to live longer, healthier, independent, happier lives	223	35.7%	33.2%
	Support local people to help others in our communities	24	3.8%	5.5%
	Other (please tell us what)	9	1.4%	5.3%
	Not answered	20	3.2%	1.4%

2	Which of these general service categories do you use most (Please tick one option only)			Last year
	Children & Families	12	1.9%	3.9%
	Adult Social Care	60	9.6%	5.9%
	Mental Health, LD and PD services	41	6.6%	N/A
	Greater Glasgow & Clyde hospitals and other services outside Argyll and Bute	36	5.8%	5.3%
	GP Services	248	39.7%	47.8%
	Dentists, Chemists & Opticians	140	22.4%	23.6%
	Argyll & Bute local hospital and community services	36	5.8%	5.3%
	Public health (immunisation, health screening and other health improvement activities)	27	4.3%	3.6%
	Other (please tell us what)	8	1.3%	3.0%
	Not answered	17	2.7%	1.4%

3	What other services do you use (Please tick any that apply))			Last year
	Children & Families	37	5.9%	8.2%
	Adult Social Care	60	9.6%	9.8%
	Mental Health, LD and PD services	64	10.2%	N/A
	Greater Glasgow & Clyde Hospitals and other services outside Argyll and Bute	174	27.8%	39.6%
	GP Services	280	44.8%	51.2%
	Dentists, Chemists & Opticians	307	49.1%	59.0%
	Argyll & Bute local hospital and community services	188	30.1%	40.0%
	Public health (immunisation, health screening and other health improvement activities)	220	35.2%	35.7%
	Other (please tell us what)	2	0.3%	2.3%

Section 2: Balancing our Budget

We need to reduce our spending by £8.3m next year but the following costs are not available for savings:

- GP, dentist and pharmacy contracts – set nationally
- Contract costs for the Mid Argyll Hospital

Plus some spending is very challenging to reduce:

- Contract for acute hospital services with NHS Greater Glasgow & Clyde where we are already in dispute over their charges

4	**In which 3 categories would you most support reductions to spending? (Please label your top 3 options as 1, 2, 3): Top 3 added together below**			**Last year**
	Children Services – fostering & adoption, looked after children	89	14.2%	6.0%
	Maternity, Health Visitor and School Nursing services	112	17.9%	7.5%
	Justice Social Work services	253	40.5%	32.1%
	Care at Home and other community social care support packages	47	7.5%	2.5%
	Residential care and nursing home placements	66	10.6%	4.1%
	Mental health services	46	7.4%	N/A
	Disability support packages	75	12.0%	7.3%
	Community hospitals (Campbeltown, Dunoon, Lochgilphead, Mull and Iona, Islay and Bute)	95	15.2%	9.4%
	Community services (nursing, Occupational Therapy)	87	13.9%	4.1%
	Acute Services offered from Oban Lorn & Isles Rural General Hospital	122	19.5%	10.1%
	Acute services from NHS Greater Glasgow & Clyde	139	22.2%	13.9%
	GP practices	82	13.1%	3.4%
	Dentists, pharmacists and opticians	122	19.5%	10.7%
	Public health screening & immunisation and other health improvement programmes	113	18.1%	12.1%
	Management & corporate including patient safety and quality of care	420	67.2%	67.9%
	Other (please tell us what)	106	17.0%	11.9%

5	**Please indicate your top 3 priorities from these service areas (Please label your top 3 options as 1, 2, 3)): Top 3 added together below**			**Last year**
	Children Services – fostering & adoption, looked after children	126	20.2%	18.2%
	Maternity, Health Visitor and School Nursing services	70	11.2%	15.3%
	Justice Social Work services	48	7.7%	2.5%
	Care at Home and other community social care support packages	287	45.9%	47.8%
	Residential care and nursing home placements	173	27.7%	22.0%
	Mental health services	178	28.5%	N/A
	Disability support packages	94	15.0%	13.9%

Community hospitals (Campbeltown, Dunoon, Islay, Mid Argyll, Mull, Rothesay)	177	28.3%	30.0%
Community services (Nursing, Occupational Therapy)	85	13.6%	N/A
Services offered from Oban Lorn & Isles Rural General hospital	105	16.8%	17.9%
Acute services from NHS Greater Glasgow & Clyde	124	19.8%	18.1%
GP practices	276	44.2%	53.8%
Dentists, pharmacists and opticians	119	19.0%	16.7%
Public health screening & immunisation and other health improvement programmes	81	13.0%	11.4%
Management & corporate including patient safety and quality of care	47	7.5%	0.9%
Other (please tell us what)	20	3.2%	6.9%

6 All of the HSCP's funding comes from NHS Highland and Argyll and Bute Council. In turn, the bulk of their funding comes from the Scottish Government. We know this funding will not be enough to cover all our service costs in the coming year. We have identified a number of savings to the value of £1.6m that may affect the services you are used to accessing. These are listed in the table in Appendix 1 and we would like to hear your views on these options.

If you have comments on the £1.6m savings options, please let us know
148 people gave comments about the savings proposed which were attached to the consultation. Comments were very varied, ranging from a few agreeing with the proposals, to others finding it impossible to comment without further details, others suggesting that increasing funding is required, and quite a number stating that further cuts to management were required in line with Q4 responses. Many were in favour of the saving from moving clients to individual tenancies Of objections about particular savings proposals, the two getting more objections was the proposal to end funding for clubs, although some felt that these should be self funding, and the proposal to close local authority care homes which are not fit for purpose, although again there were some respondents in favour. No other savings proposal had more than 8 comments opposing it, and again these were balance in part by some respondents being in favour of these changes. Of these the main changes opposed were : • Ending funding for the advocacy services • Shifting urology services from Glasgow to Oban

7	We need to identify more ways to bridge our estimated funding gap. If you have any other ideas about where we could save money please let us know here:
202 people responded to the request to give their ideas on other ways to save money. The top 5 suggestions were: • The need to reduce management costs	

- Use technology more (V/C, Near Me, telemedicine, appointment booking systems) and reduce admin and use less paper
- Charge for prescriptions,
- Use volunteers more, and partner with voluntary and third sectors who are more agile and less costly
- Fund healthy living projects focussed on prevention and provide more access to personalised self-help information

Other comments which were much less common but repeated several times included:

- Improve funding – nationally, and increase income where possible
- Change redundancy policy, reduce sickness absence and use of locums and agency staff
- Estate rationalisation – home working, fewer offices

A summary of all the savings ideas from the consultation is set out at Appendix 2.

8 We understand that people worry about changes to services and how this might affect them and their families, however the need for change is imperative due to our financial situation. We are interested in what changes might be acceptable to you. Please let us know your views on the following service changes:

Option	**Acceptable**	**Not sure**	**Not acceptable**
More use of technology e.g. video facilities for appointments or electronic monitoring systems for people looked after at home – already used much more due to Covid social distancing requirements	465	73	55
Reduce housing support services for learning disability clients ensuring this is based on level of need	196	203	185
Shift from individual packages of care for Mental Health support to enabling model of group based care providing more peer support and social interaction	268	192	132
Fewer local nursing home and care home facilities for older people in order to sustain and concentrate services in the remaining homes (occupancy levels are dropping)	178	150	272
Fewer health visitors and school nurses	166	186	237
Reduce community based day services for older people or people with learning disabilities and replace with a range of community based Third Sector services	208	174	209
For clients who refuse a care home placement, Care at Home packages capped at £30k p.a. (equivalent to cost of residential care) with option for clients to cover costs above this level themselves	397	101	104

More support for unpaid carers (family and friends) including short breaks / respite	418	96	82
Improve utilisation of Oban hospital theatre capacity through patients travelling from North Highland or work transferred that is currently done from Glasgow hospitals (e.g. urology)	428	125	43
Remove support for lunch clubs	214	213	170
Reduce discretionary (non-contractual) support to voluntary organisations encouraging these to be self-funding	274	191	134
Less support for patient travel escorts – stricter criteria to ensure we pay for escorts only when they are absolutely necessary	449	79	76

9 Please let us know if the impacts of these changes are acceptable or not:

Impacts	**Acceptable**	**Not sure**	**Not acceptable**
More travel to specialist services	242	144	216
Less face to face time with specialists	163	123	322
Waiting times for care at home packages	55	176	372
Care at home packages only for those with the highest level of care needs	195	152	263
Family and friends doing more to support people living at home	274	157	178
You taking more responsibility for your health and wellbeing and making healthy lifestyle choices to prevent health problems	542	40	30

Section 3: About You

10	Age Group			Last year
	Under 18	1	0.2%	
	18-30	20	3.2%	4.4%
	31-50	141	22.6%	26.6%
	51-65	268	42.9%	43.2%
	66-75	149	23.8%	18.1%
	76-85	34	5.4%	6.4%
	Over 85	4	0.6%	0.4%
	Not answered	8	1.3%	0.9%

11	What is your gender		
	Male	226	36.1%
	Female	378	60.5%
	Transgender	1	0.2%
	Non-binary	1	0.2%
	Prefer not to say	10	1.6%
	Not answered	9	1.4%

12	Which area do you live in?			Last year
	Helensburgh and Lomond	136	21.8%	14.6%
	Oban, Lorn, and the Isles	138	22.1%	40.7%
	Bute and Cowal	187	29.9%	16.3%
	Mid Argyll, Kintyre, and the Islands	158	25.3%	25.0%
	Not answered	6	1.0%	3.4%

13	Do you have dependents that you look after?			Last year
	No dependents	345	55.2%	45.6%
	Child or children under 18	118	18.9%	27.2%
	Spouse or partner	85	13.6%	22.0%
	Older relative(s)	75	12.0%	14.9%
	Other adult(s)	36	5.8%	4.1%

14	Are you a young carer, or a person being cared for by others, or disabled?		
	I am a Young Carer	12	1.9%
	I am cared for by others	17	2.7%
	I have a disability	58	9.3%

Ideas on making savings **Appendix 2**

Comments given on making savings include:

- Review of senior management staffing and reduction of senior salaries
- Reducing travelling to meetings, more use of VC or NHS Near Me, use of telemedicine, provide more services locally or use technology to access services in Glasgow remotely
- Reducing temporary and agency staffing, and high paid locums
- Greater involvement of third sector and local charities and volunteers
- Phase out letters – go paperless. Email / text appointments
- Close some of the community hospitals / provide services in fewer locations
- Turn lights off and heating down, energy efficiency measures
- Reduce bureaucracy and level of admin staff
- Change redundancy and sick pay policies and address staff on redeployment and protected salaries
- Charge for prescription of medicines. Reduce number of prescriptions. GP practices to use SG formulary
- Close Kintyre Medical Group and merge with Campbeltown and Tarbert medical practices
- Redesign GP services
- Improve procurement
- More emphasis on prevention
- Better use of spare theatre capacity at Oban hospital. Reduce costs to Glasgow
- More reviews of care packages and reduce disparity between packages. Cap packages at £25k p.a.
- Reduce/remodel very expensive GP out of hours services
- Close Eader Glinn care home as not fit for purpose
- Remove Link workers
- Improve contract with NHS GG&C
- Increase day services for older people to prevent need growing
- Progress dementia services re-design
- Reward departments who spend below budget
- Stop vanity projects
- Externalise internal care at home, care homes and day services
- Invest in better community care with targeted programmes for mental health, obesity and type 2 diabetes
- Invest in forensic accounting
- More home working, and reduce buildings used
- Close outdated and underused leaning disability day centres
- Children to bring own toothbrushes to school for tooth brushing rather than being supplied with these
- Invest in quick local testing facilities rather than send to Glasgow labs
- Re-use equipment e.g. walkers
- Have clear strategic plan and objectives
- Stop using hire vehicles from Arnold Clark
- Improve sharing of patient records
- Remove hostel place for school children
- Increase home care
- Re-instate dementia ward in Mid Argyll

- Have more sheltered housing and homely care homes rather than providing care in clients own homes which dilutes staff/increases travel
- Reduce staff levels in staff canteens
- Charge of missed appointments

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: **31 March 2021**

Title of Report: **Budget Savings 2021/22: Assessing Equality and Socio-Economic Impact**

Presented by: **Judy Orr, Head of Finance and Transformation**

The Integration Joint Board is asked to:

- Note the findings from the summary Equality and Social-Economic Impact Assessment (EQIA) and ensure these are considered when discussing the savings options to deliver a balanced budget in 2021-22.

- Note that the EQIA relating to transfer of clients from in house run care home which is no longer fit for purpose to private sector care home within same locality is reported on separately in the Care Homes and Housing policy paper.

1. EXECUTIVE SUMMARY

1.1 As a public authority, the IJB has duties under the Equality Act 2010, the Public Sector Equality Duty 2011, the Fairer Scotland Duty (Part one of the Equality Act), and the Island (Scotland) Act 2018 to give due regard to their aims when making strategic financial decisions. We assess the potential impact of the decisions using the HSCP's Equality and Socio-Economic Impact Assessment (EQIA) process.

1.2 This report outlines the work undertaken to ensure that due regard is given to equalities, islands and the Fairer Scotland Duty in the decision-making process relating to budget savings, and it presents a strategic EQIA for the savings programme to advise on overall impact.

1.3 There are no impacts identified through the EQIA process that show actual or potential unlawful discrimination. However, there are some potential negative impacts that have been identified which have not yet been fully mitigated. The IJB should take these into account when making its decisions on how to set a balanced budget for 2021/22.

2. INTRODUCTION

2.1 As a public authority, the IJB has duties under the Equality Act 2010, the Public Sector Equality Duty 2011, the Fairer Scotland Duty (Part one of the

Equality Act), and the Island (Scotland) Act 2018 to give due regard to their aims when making strategic financial decisions. We assess the potential impact of the decisions using the HSCP's Equality and Socio-Economic Impact Assessment (EQIA) process. The full guidance can be found here: https://www.argyll-bute.gov.uk/equality-legislation-and-reporting. New unified procedures were developed by the HSCP in summer 2019 which cover both parent bodies' requirements.

2.2 This report outlines the work undertaken to ensure that due regard is given to equalities, islands and the Fairer Scotland Duty in the decision-making process relating to budget savings, and it presents a strategic EQIA for the savings programme to advise on overall impact. This report should be read alongside the report on the findings from the budget consultation on the savings proposals, and be taken into account when finalising budget savings proposals.

2.3 A summary of all the EQIAs is given at Appendix 1. A commentary is provided in section 3 below.

3. DETAIL OF REPORT

3.1 The protected characteristics covered by the Equality Act (2010) are:

- Age.
- Disability.
- Gender reassignment.
- Marriage and civil partnership.
- Race.
- Religion or belief.
- Sex.
- Pregnancy and maternity.
- Sexual orientation.

3.2 The areas to be considered as a result of the Fairer Scotland Duty and the Islands Act are as follows:

- Mainland rural population.
- Island populations.
- Low income.
- Low wealth.
- Material deprivation.
- Area deprivation.
- Socio-economic background.
- Communities of place.
- Communities of interest.

3.3 The HSCP discharges its duties under the above acts through its use of Equality and Socio-economic Impact Assessments (EQIAs). EQIAs have been carried out for those individual budget savings proposals that relate to policy decisions and/or affect people. Where EQIAs have been required, these have been developed by relevant managers and Heads of Service in parallel with the budget savings templates. The EQIAs have been updated as the development of the proposals has progressed to take into account information gathered through consultation and engagement. EQIAs consider the impact on service users as well as on the workforce and other

service deliverers. The individual EQIAs are all published on the Council and NHS Highland websites.

3.4 Informed by the individual EQIAs and savings proposals, this report presents a combined EQIA, designed to assess the overall, strategic impact of the savings options on equality and socio-economic groups as well as on the workforce. This assessment is attached as Appendix 1. Tables 1 and 2 of the EQIA show impacts on service users and services deliverers respectively.

3.5 The summary EQIA identifies that there are no cumulative impacts of the savings proposals that impact disproportionately on any specific group. There are no impacts identified through the EQIA process that show actual or potential unlawful discrimination.

3.6 IJB Members are advised that the Equality Act 2010, the Public Sector Equality Duty 2011, the Fairer Scotland Duty (Part one of the Equality Act) and the Island (Scotland) Act 2018 requires the IJB to pay due regard to the legislation and use the impact assessments to inform their decision making. The duties enable the IJB to demonstrate that it is making financial decisions in a fair, transparent and accountable way, considering the needs and rights of different members of the community. These duties have been discharged by the IJB for the budget setting process through the EQIA.

3.7 Members are asked to note that EQIAs have been completed for all savings which are identified as “Policy” ones which means they have some impact on service users and/or service deliverers. Three of the savings originally classed as policy ones have now been reclassed as operational as the changes have already happened, or require only minor operational changes. Savings reference 2122-6 and 2122-7 have been removed from the tables as these are covered by a joint EQIA reported on in a separate paper on the agenda entitled Care Homes and Housing. Savings reference 2122-13 is also not reported on as this saving has been deferred till 2022-23 as it requires further work before it can proceed. One saving classed previously as operational (2122-26 – remove advanced nurse vulnerable groups post) has now been reclassed as policy as the post is not vacant as had been incorrectly thought earlier. A further saving 2122-18 re Oral Health has been re-worked to achieve this in a different way with fewer impacts. It should be noted that the plans for saving 2122-10 re Oban Integrated Care Fund saving are incomplete in respect of £31k of this saving.

3.8 The saving with the most potential for negative impacts is 2122-13 - End externally contracted day services for learning disability and replace with alternative provision due to the scale of this saving. The EQIA requires to 5 options but the one being considered is option 5 termination of the existing contract. As yet details of the alternatives have not been fully worked up by the Head of Service.

4. RELEVANT DATA AND INDICATORS

4.1 The paper is informed by the detailed EQIAs prepared in respect of each policy related savings proposal.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities, equality duties and promote quality service delivery. This needs to be considered along with the budget consultation responses before decisions are made on how to balance the budget.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact – There is a significant budget gap which requires to be addressed and IJB may require to take most of the proposed savings.

6.2 Staff Governance – Individual savings may affect staff and this has been summarised at Appendix 1.

6.3 Clinical Governance – None directly from this report.

7. PROFESSIONAL ADVISORY

7.1 Individual savings proposals have been consulted on with Professional Advisory leads.

8. EQUALITY AND DIVERSITY IMPLICATIONS

8.1 Protected characteristics, socio–economic impacts and island impacts are all summarised at Appendix 1.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

9.1 None directly from this report.

10 RISK ASSESSMENT

10.1 Risk has been mitigated by carrying out the individual EQIAs and this summary EQIA on the savings proposals.

11. PUBLIC AND USER INVOLVEMENT AND ENGAGEMENT

11.1 Engagement carried out as described in the separate report on the budget consultation and within the individual EQIAs.

12. CONCLUSIONS

12.1 The IJB, as a public authority, has a duty under the Equality Act 2010, the Public Sector Equality Duty 2011, the Fairer Scotland Duty, and the Islands Act to have due regard to the aims of those duties when making financial decisions. This is done through assessing the potential impact of the decision on equality using the HSCP's Equality and Socio-economic Impact Assessment (EQIA) process, and identifying any mitigating measures. This has been informed by the wider budget consultation (see separate report on

agenda) and by the consultation undertaken in respect of the individual savings proposals (see individual EQIAs).

12.2 This report and the accompanying combined EQIA attached at Appendix 1, which has been informed by the impact assessments carried out for individual savings proposals, demonstrate compliance with those duties.

13. DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	√
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

APPENDICES:

Appendix 1a – Summary EQIA

Appendix 1b – Summary EQIA tables

Appendix 2 – Individual EQIAs have been published and can be access here:

https://www.argyll-bute.gov.uk/equality-and-socio-economic-impact-assessments

https://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Pages/ArgyllButeHSCPEqualityImpactAssessments.aspx

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APPENDIX1: SUMMARY EQIA

A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

Equality Impact Assessment (EQIA)

Section 1: About the proposal

Title of Proposal
Budget savings proposals 2021/22: combined Equality and Socio Economic Impact Assessment

Intended outcome of proposal
To inform IJB's decisions on the HSCP budget for 2021/22

Description of proposal
The overall budget proposal contains a series of savings which have been developed by the HSCP's Senior Leadership Team in order to deliver a balanced budget for 2021/22. Individual EQIAs have been prepared for each of the "Policy" related savings proposals. These are the proposals which have been assessed as impacting service users and / or service deliverers in some way. Following completion of the individual EQIAs, this combined impact assessment brings together their conclusions so that the cumulative impact of the budget savings proposals can be assessed before decisions are made by the IJB. In total, these proposals would impact on up to 35.4 FTE next year. Wherever possible, savings will be taken through turnover in order to avoid redundancy and / or redeployment being required.

HSCP Strategic Priorities to which the proposal contributes

Lead officer details: The lead officer of each savings proposal is the third tier manager or Head of Service for the relevant business area. The lead officer for the overall EQIA is the Head of Finance & Transformation.	
Name of lead officer	**Judy Orr**
Job title	**Head of Finance & Transformation**
Appropriate officer details	
Name of appropriate officer	Caroline Cherry, Head of Adult Services Julie Lusk, Head of Adult Services Brian Reid Interim Head of Children & Families Patricia Renfrew, Interim Head of Children & Families Donald Macfarlane, Asst Clinical Dental Director

Sign-off of EIA	Judy Orr, Head of Finance & Transformation
Date of sign-off	18 February 2021

Who will deliver the proposal?
The proposals will be delivered by the HSCP's Senior Leadership Team (SLT)

Section 2: Evidence used in the course of carrying out EIA

Consultation / engagement

The Heads of Service have consulted with staff groups affected. They have also identified information from the wider budget consultation, and other engagement with stakeholder groups pertaining to their proposals.

This impact assessment should be read in conjunction with the findings of the budget consultation which is the subject of a full report to the IJB as part of the agenda for 31 March 2021. The interim findings were presented to the IJB development session on 24 February to ensure findings could influence the EQIAs.

Data

Data has been gathered by the SLT members from a range of sources as set out in the individual EQIAs.

The net number of posts identified as being at risk of redundancy or otherwise affected as a result of the budget savings proposals is 2 FTE. The details for each saving where staff are potentially affected are set out in the table below:

Savings ref	Description	FTE affected
2122-18	Reduce Senior Dental Officer post by 0.4 WTE following retirement	1.0
2122-26	Remove advanced nurse vulnerable groups post	1.0

Where there is no entry in the table above, this confirms that the savings proposal does not affect any staff currently in post. Where savings relate to vacant posts, these posts are also not included above.

The employees in post are a mix of male and female staff with more female staff being affected, and predominantly affected in the location of the in house run care homes. This is a reflection of the workforce employed in these roles and is not an indication of females being targeted over males.

Other information

N/A

Gaps in evidence

The profile of employees affected will be monitored as the redundancy process progresses.

Section 3: Impact of proposal

Impact on service users:
See table 2 attached

If you have identified any negative impacts on service users, give more detail here:

Proposal 2122-9 on capping 24 hour care package at £30k, allowing the service user to fund the additional hours of care if they chose to remain at home has identified some negative impacts on service users on low income or low wealth, and impacts on area deprivation and socio-economic background. This is because low income service users would have less choice.

Proposal 2122-18 Reduce senior dental officer by 0.4 WTE has identified negative impacts

based on a reduced capacity of the service to provide clinical support to dental officers.

Proposal 2122-26 Remove advanced nurse vulnerable groups has identified negative impacts potentially affecting socio-economic factors based on a reduced capacity of the service.

If any 'don't knows' have been identified, when will impacts on these groups be clear?

Proposal 2122-11: remove funding for lunch clubs – the "don't knows" will be clarified as detailed proposals are drawn up for lunch clubs to become self funding.

Proposal 2122-12: Reduce payments to voluntary organisations for non-contracted services– the "don't knows" will be clarified as detailed proposals are drawn up for these to become self funding.

Proposal 2122-14: End Service Level Agreement for commissioned advocacy service and replace with signposting to other services – the "don't knows" will be clarified as detailed proposals are drawn up for alternative sign posting.

Proposal 2122-12: End grants paid to link clubs - the "don't knows" will be clarified as detailed proposals are drawn up for these to become self funding.

How has 'due regard' been given to any negative impacts that have been identified?

Yes. Resources will be utilised in a way that ensures that highest needs are always met. Impacts will be subject to close monitoring.

Impact on service deliverers:
See table 3 attached

If you have identified any negative impacts on service deliverers, give more detail here:

Proposal 2122-26 Remove advanced nurse vulnerable groups has identified negative impacts potentially affecting socio-economic factors based on a reduced capacity of the service. It should be noted that only 1 post is affected and this is likely to be subject to a redeployment.

If any 'don't knows' have been identified, when will impacts on these groups be clear?

If proposals are approved by the IJB, work will be carried out during their planning and implementation phases to understand the impacts on groups where impacts are currently unknown. Mitigation to these impacts will be implemented as required.

How has 'due regard' been given to any negative impacts that have been identified?

Negative impacts as described above are mitigated through minimising the impact on staff, and on front line service delivery affecting service users, treating all staff equally, noting that technology enables jobs to be done remotely, and staff will be provided with advice and support throughout the process.

Section 4: Interdependencies

Is this proposal likely to have any knock-on effects for any other activities carried out by or on behalf of the HSCP?	The need for development of a reablement approach to care is required to ensure people develop as much independence as possible. The impact of this will require the hospital discharge process and assessment process to change, with reablement becoming an integral part of preparation for discharge. Work is already underway to develop processes that ensure this approach is developed. Care at Home staff have been working towards this type of service delivery for a number of years, with more success in some areas than others. The learning from this is being shared across the service. The Resource Allocation process will begin to scrutinise all service costs, but it will also provide a forum for different disciplines to contribute to the care packages at appropriate points and also to ensure that all community resources are identified and known to all staff disciplines. Intend to maintain a focus on prevention and early intervention through scoping this short life working group.

Details of knock-on effects identified
2122-8/9: Contractual arrangements with private sector care homes, and any cap on funding for 24 hour care at home packages will be linked with a longer term review of care at home and the aspiration that we support people at home for as long as possible. These changes need to be linked to housing models within Argyll and Bute. They will also be linked to place based reviews and day service redesign. 2122-14: There are current interdependencies between Advocacy Contract, Carers Group contracts and this contract. Any changes may have an impact of referrals levels for Advocacy and Carers Groups across Argyll and Bute. Forums and mental health third sector/service user/carer groups may be impacted due to no oversight and coordination or support.

Section 5: Monitoring and review

Monitoring and review
Progress with the implementation of the individual proposals will be monitored by the relevant Heads of Service. This will include the implementation and monitoring of any identified mitigating measures. HR and Organisational Development will monitor redundancies and other changes in staffing.

EQIA SUMMARY

TABLE 1: Impacts on service users

		Protected characteristics									Socio-economic duty								
Ref	**Proposal**	Age	Disability	Ethnicity	Sex	Gender Reassignment	Marriage & Civil Partnership	Pregnancy & maternity	Religion	Sexual Orientation	Mainland Rural Population	Island populations	Low income	Low wealth	Material deprivation	Area deprivation	Socio-economic background	Communities of place	Communities of interest
2122-1	Align business model for staffing for the 3 children's homes	now classed as management / operational - no EQIA required																	
2122-2	Carry out hostel review to achieve best value in admin and catering	now classed as management / operational - no EQIA required																	
2122-3	Do not replace independent chair of panel	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
2122-4	Bring back urology services from NHS Greater Glasgow & Clyde and offer from Oban Hospital instead	Pos	Pos	No	No	No	No	No	No	No	Pos	Pos	Pos	Pos	No	Pos	Pos	No	No
2122-5	Only pay for escort travel where it is essential	No	Pos	No	No	No	No	No	No	No	N/A	No	No	No	No	No	No	No	No
2122-6	Transfer current clients from in house run care home which is no longer fit for purpose to private sector home within same locality	Savings removed and replaced by Care Homes and Housing policy paper which contains related EQIA																	No
2122-7	Transfer current clients from in house run care home which is no longer fit for purpose to private sector home within same locality																		No
2122-8	Pay for care home placements for older people in line with national contract with no added enhancements	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
2122-9	When a new client is assessed as requiring 24 hour care offer to fund a package of care at home up to £30k, allowing the service user to fund the additional hours of care if they chose to remain at home	DK	Pos	No	No	No	No	No	No	No	DK	DK	Neg	Neg	No	Neg	Neg	No	No
2122-10	Redirect Oban Integrated Care Funding to pay for day responder service as in other areas	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
2122-11	Remove funding for all lunch clubs	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK
2122-12	Reduce payments to voluntary organisations for non-contracted services	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK
2122-13	End externally contracted day services for learning disability and replace with alternative provision	Saving deferred to 2022/23 to alow more time to work up details ofhow this saving will be delivered																	
2122-14	End Service Level Agreement for commissioned advocacy service and replace with signposting to other services	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	No	No	No	No	No	No	No
2122-15	End grants paid to link clubs, some of which are no longer providing services	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK	DK
2122-16	Reduce befriender service following review of clients	now classed as management / operational - no EQIA required																	
2122-17	Encourage clients to have individual tenancies with housing association encouraging fuller independence for clients	Pos	Pos	No	Pos	No	No	No	No	No	No	No	No	No	No	No	No	No	No
2122-18	Reduce Senior Dental Officer post by 0.4 WTE	Neg	Neg	No	No	No	No	No	No	No	DK	DK	DK	DK	DK	DK	DK		
2122-26	Remove advanced nurse vulnerable groups post	No	No	No	No	No	No	No	No	No	No	Neg	Neg	Neg	Neg	Neg	No	No	No

Yellow = still to complete

Legend	
Neg	Negative Impact
No	No Impact
Pos	Positive Impact
DK	Unknown Impact

TABLE 2: Impacts on service deliverers

		Protected characteristics									Socio-economic duty								
Ref	**Proposal**	Age	Disability	Ethnicity	Sex	Gender Reassignment	Marriage & Civil Partnership	Pregnancy & maternity	Religion	Sexual Orientation	Mainland Rural Population	Island populations	Low income	Low wealth	Material deprivation	Area deprivation	Socio-economic background	Communities of place	Communities of interest
2122-1	Align business model for staffing for the 3 children's homes	now classed as management / operational - no EQIA required																	
2122-2	Carry out hostel review to achieve best value in admin and catering	now classed as management / operational - no EQIA required																	
2122-3	Do not replace independent chair of panel	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
2122-4	Bring back urology services from NHS Greater Glasgow & Clyde and offer from Oban Hospital instead	No	No	No	No	No	No	No	No	No	Pos	Pos	No	No	No	No	No	No	Pos
2122-5	Only pay for escort travel where it is essential	No	Pos	No	No	No	No	No	No	No	N/A	No	No	No	No	No	No	No	No
2122-6	Transfer current clients from in house run care home which is no longer fit for purpose to private sector home within same locality	Savings removed and replaced by Care Homes and Housing policy paper which contains related EQIA																	DK
2122-7	Transfer current clients from in house run care home which is no longer fit for purpose to private sector home within same locality																		Pos
2122-8	Pay for care home placements for older people in line with national contract with no added enhancements	No	No	No	No	No	No	No	No	No	DK	DK	No	No	No	No	No	DK	DK
2122-9	When a new client is assessed as requiring 24 hour care offer to fund a package of care at home up to £30k, allowing the service user to fund the additional hours of care if they chose to remain at home	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
2122-10	Redirect Oban Integrated Care Funding to pay for day responder service as in other areas	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
2122-11	Remove funding for all lunch clubs	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
2122-12	Reduce payments to voluntary organisations for non-contracted services	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
2122-13	End externally contracted day services for learning disability and replace with alternative provision	Saving deferred to 2022/23 to alow more time to work up details ofhow this saving will be delivered																	
2122-14	End Service Level Agreement for commissioned advocacy service and replace with signposting to other services	DK	DK	DK	DK	DK	DK	DK	DK	DK	No	No	No	No	No	No	No	No	No
2122-15	End grants paid to link clubs, some of which are no longer providing services	DK	DK	DK	DK	DK	DK	DK	DK	DK	No	No	DK	DK	No	DK	No	No	No
2122-16	Reduce befriender service following review of clients	now classed as management / operational - no EQIA required																	
2122-17	Encourage clients to have individual tenancies with housing association encouraging fuller independence for clients	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
2122-18	Reduce Senior Dental Officer post by 0.4 WTE	No	No	No	Pos	No	No	No	No	No	No	No	No	No	No	No	No	No	No
2122-26	Remove advanced nurse vulnerable groups post	No	No	No	No	No	No	No	No	No	No	Neg	Neg	Neg	Neg	No	No	No	No

Yellow = still to complete

Legend	
Neg	Negative Impact
No	No Impact
Pos	Positive Impact
DK	Unknown Impact

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: **31 March 2021**

Title of Report: **Budget Proposals 2021-22**

Presented by: **Judy Orr, Head of Finance & Transformation**

The Integration Joint Board is asked to:

- Approve the management/operational savings at Appendix 1 amounting to £3.658m in 2021-22 and £2.688m in 2022-23.
- Approve the policy savings at Appendix 2 amounting to £561k in 2021-22 and £1.263m in 2022-23.
- Approve the removal of £85k previously agreed savings – reference 1920-32 £44.5k and 1920-33 £40.7k both relating to the management restructure as set out at 3.2.6
- Approve the proposed investment in financial sustainability totalling £517k in 2021/22 and 2022/23 set at 3.3.6 and the proposed extension of the existing investment of £330k for a further year in 2022-23 as set out at 3.3.7
- Note that in approving the above savings and financial investment this will deliver a balanced budget in 2021-22.
- Note the financial consequences of the actions set out at paragraph 3.14 in the Care Homes and Housing paper for 2022-23 and beyond.
- Instruct the Chief Officer to accept the funding from NHS Highland and Argyll and Bute Council and issue formal Directions (see drafts at Appendix 3) delegating resources back to the Partners.
- Note the high level timetable for the budget preparation 2022-23 set out at 3.5.1.

1. EXECUTIVE SUMMARY

1.1 This report presents savings proposals identified by the Strategic Leadership Team in order to deliver a balanced budget in 2021-22.

1.2 There is a separate report on the agenda that details the budget outlook over the period 2021-22 to 2023-24. The budget gap in 2021-22 amounts to £4.134m.

1.3 Savings proposals have been classified into management/operational savings and policy savings. These have previously been discussed at the IJB development sessions and at Finance & Policy Committee meetings. The revised total of £4.219m for 2021-22 is presented of which £657k is classed as policy savings and £3.562m is classed as management/operational.

1.4 It should be noted that a budget consultation has been carried out in respect of Policy savings proposals and there is a separate report on the agenda with the results of this consultation. The results of this consultation should be taken into account when making decisions on the policy savings. Equality Impact assessments (EQIAs) have been carried out for all the policy savings and there is a summary of these presented in a separate report on the agenda. Wherever possible, negative impacts have been mitigated but there are still some negative impacts which need to be considered when making decisions on these savings proposals.

1.5 In addition a proposal is made for an investment in financial sustainability totalling £517k in 2021/22 and 2022/23, and to continue the existing investment of £318k for a further year into 2022/23, uplifted to £330k.

1.6 There is a significant estimated budget gap over the next two years in the mid-range scenario and work will need to commence shortly on identifying savings proposals to balance the budget in 2022-23. A high level timetable for the budget process 2022-23 is noted in the report.

2. INTRODUCTION

2.1 This report presents savings proposals identified by the Strategic Leadership Team in order to deliver a balanced budget in 2021-22.

3. DETAIL OF REPORT

3.1 Budget Outlook 2021-22 to 2023-24

3.1.1 There is a separate report on the agenda that details the budget outlook over the period 2021-22 to 2023-24. The budget gap in 2021-22 amounts to £4.134m.

3.1.2 The budget outlook for future years, has been prepared using three different scenarios, best case, worst case and mid-range. The budget gap over 2021-22 and 2022-23 across each scenario is summarised in the table below.

Budget Gap	**2022-23 £000**	**2023-24 £000**	**Total £000**
Best Case	(8,632)	(1,116)	**(9,748)**
Mid-Range	2,093	3,219	**5,312**
Worst Case	15,574	10,863	**26,437**

3.2 Savings Proposals

3.2.1 The Senior Leadership Team have been working over the last few months to identify savings to deliver a balanced budget in 2021-22.

Management / operational savings

3.2.3 Savings proposals have been classified into management/operational savings (where there are no policy implications and will not result in any redundancies) and policy savings, where there are either policy or staffing implications. Many of the actions required to achieve the management and operational savings have already been completed. More details about each saving is given at Appendix 1 in the column “Risk and impact on service”. These savings have been reviewed at the IJB development sessions and at Finance and Policy Committee.

3.2.4 Since the budget consultation was launched, 3 savings totalling £156k have been re-categorised as management & operational following further review as follows (highlighted in Amber at Appendix 1):

- 2021-1 £100k Align business model for staffing for the 3 children's homes - this involves reducing use of bank staff and having a similar operational model in all homes
- 2021-2 £44k Carry out hostel review to achieve best value in admin and catering – utilising already identified underspends
- 2021-16 £12k Reduce befriender service following review of clients – which has already been completed.

3.2.5 Saving 2122-26 £60K Remove advanced nurse vulnerable groups post has been reclassed as Policy as this post is not currently vacant.

3.2.6 In addition, it is proposed to remove part of the previously agreed saving reference 1920-32 of £45k and 1920-33 of £41k. These are the balance of the outstanding savings following the management restructure completed last year for adult services. This has been reviewed as all bar one post has been filled and the final savings have now been calculated

3.2.7 Saving reference 2122-68 of £5.5k re car lease costs has been used to meet current year shortfall for dental services and so is removed from the future savings list.

3.2.8 A summary of the savings identified are noted in the table below with further high level detail contained within Appendix 1.

	2021-22 £000	**2022-23 £000**	**2023-24 £000**
Management/Operational Savings proposed on 27 Jan 2021	3,568	2,598	2,598
Savings accelerated into current year (2122-68)	-6	-6	-6
Savings re-categorised from Policy	156	156	156
Saving now classed as Policy	-60	-60	-60
Revised Management/operational savings (Appendix 1)	**3,658**	**2,688**	**2,688**

Policy Savings

3.2.9 It should be noted that a budget consultation has been carried out in respect of Policy savings proposals and there is a separate report on the agenda with the results of this consultation. The results of this consultation should be taken into account when making decisions on the policy savings.

3.2.10 Officers have carried out Equality Impact Assessments (EQIAs) on the policy savings and have mitigated the negative impacts wherever possible. A summary of these is presented in a separate report on the agenda. Staffing impacts have also been identified and these are included in the summary EQIA. Wherever possible, negative impacts have been mitigated but there are still some negative impacts which need to be considered when making decisions on these savings proposals.

3.2.11 Since the budget consultation was carried out, 3 savings were re-categorised as operational – see 3.2.4 above. In addition 2 savings have been removed from the budget proposals as they are now considered separately on the agenda in the Care Homes and Housing paper. A further saving, ref 2122-13, to review learning disability day services and replace with alternative provision, has been deferred fully into 2122/23 as it needs a longer period to work up and prepare for implementation.

3.2.12 A summary of the savings identified are noted in the table below with further high level detail contained within Appendix 1.

	2021-22 £000	**2022-23 £000**	**2023-24 £000**
Policy Savings proposed on 27 Jan 2021	1,059	2,111	2,111
Saving ref 2122-13 deferred to 2022/23	-220	0	0
Dental savings ref 2122-18 amended	8	8	8
Care Home Savings removed and being considered separately	-190	-760	-760
Savings re-categorised as operational	-156	-156	-156
Saving re-categorised as policy	60	60	60
Revised Policy savings (Appendix 1)	**561**	**1,263**	**1,263**

Savings summary

3.2.13 A summary of all savings is presented below:

	2020-21 £000	**2021-22 £000**	**2022-23 £000**
Revised Management/operational savings (Appendix 1)	3,658	2,688	2,688
Management restructure savings now removed	-85	-85	-85
Policy Savings (Appendix 2)	561	1,263	1,263
Total Savings	**4,134**	**3,866**	**3,866**

3.2.14 The Board is asked to now approve the management/operational savings at Appendix 1 and the policy savings at Appendix 2. The Board is asked to note that whilst there will be some service impact in delivering the policy savings proposals as well as a reduction of a small number of posts, the Board has a responsibility to balance the budget.

3.3 Financial sustainability – proposed investment

3.3.1 The IJB has failed to deliver a balanced budget for some time. In 2018/19 it overspent by £6.681m. In 2019/20 it overspent by £2.446m, which was a big improvement. In 2020/21 we are currently projecting an underspend but that is mainly due to Scottish Government support for Covid-19 which has included £2.728m for undelivered savings.

3.3.2 Significant improvements have been made throughout 2019/20 and 2020/21 including a regime of ongoing grip and control of all expenditure and close review of all vacancies since February 2019.

3.3.3 In addition, since early summer 2019 we instigated a Project Management Office approach to the delivery of all Health savings in conjunction with NHS Highland. The IJB approved an additional investment in March 2020 which allowed us to extend this to social work. Despite the difficulty of having to onboard people remotely, we have successfully employed 3 additional service improvement officers (one on older people, one for learning disability and mental health, and for corporate/ children's services) and a contract & demand management officer for health contracts, in addition to homecare procurement officer resource. We have not yet filled the transformation programme manager post as all transformation work was paused as a result of the pandemic. The transformation board restarted on 9 February and it is now intended to move to recruitment.

3.3.4 Going forward, it would support our ability to deliver future transformation to have 2 additional Service Improvement Officers (SIO) employed by Health, and a business analyst to support them based in the Planning & Performance Team. One SIO would support the Community Hospitals transformation theme (as yet not started due to lack of resource) and one would support Children's Service transformation work to shift the balance of care from residential to fostering and adoption.

3.3.5 Recruiting to the previously agreed programme manager post is required also in order to progress and embed transformational change across the HSCP. Whilst a transformation programme has been in place for some time, the pace of change is slow and limited savings can be directly attributed to this work at present. The key problem is that no resource has been allocated to the programme and people have struggled to make progress on top of the day jobs. A programme manager will bring much needed focus to this activity.

3.3.6 It is therefore proposed that investment is made in achieving financial sustainability as follows for a 2 year period covering 2021/22 and 2022/23. The effectiveness of this investment will be monitored by the Finance & Policy Committee through reviewing quarterly reports from the SIO team. In addition a sum is requested to be set aside to support transformation, with

use of this to be approved as required by the Finance & Policy Committee. This creates a total one-off investment in 2021/22 of £517k, part of which will need to be carried forward for this purpose into 2022/23. It is then envisaged that the ongoing resource required to support transformation and operational delivery of savings could be reduced.

	£000s
1 FTE business analyst	50
2 FTE service improvement officers	120
Sub-total	170
Cost for 2 years	340
Additional unallocated resource to support transformation	178
Total	**517**

3.3.7 In addition, as much of this year's SIO activity was diverted to supporting Covid-19 pandemic, the IJB is requested to extend the earlier investment of £318k in transformation activity for a further year into 2022/23. Recognising the impact of pay awards, a sum of £330k is requested for that year.

3.4 Revised Budget Gap

3.4.1 If all the savings included within this report are accepted along with the investment proposed above, the estimated budget gap in future years, within the mid-range scenario, is summarised in the table below.

	2020-21 £000	**2021-22 £000**	**2022-23 £000**
Initial Budget Gap	**3,617**	**5,380**	**9,446**
New Investment proposals	517	0	0
Extension of existing investment	0	330	0
Estimated Budget Gap prior to savings	**4,134**	**5,710**	**9,446**
Savings Proposals	(4,134)	(3,866)	(3,866)
Revised Budget Gap / (Cumulative)	**0**	**1,843**	**5,579**
Revised Budget Gap (In-Year)	**0**	**1,843**	**3,736**

3.5 Budget Timetable for 2021-22 and Future Savings

3.5.1 The proposed high level timetable for the budget process in 2021-22 is noted below.

Date	**Event**	**Purpose/Agenda**
16 June 2021	IJB	Updated Budget Outlook report extended to 2024-25.
6 August 2021	Finance & Policy Committee	Early identification of possible future savings proposals for discussion.
15 September 2021	IJB	Updated Budget Outlook report.

24 September 2021	Finance & Policy Committee	Consideration of saving proposals for 2022-23 budget.
27 October 2021	IJB Development Session	Consideration of saving proposals for 2022-23 budget.
24 November 2021	IJB	Updated Budget Outlook report. Report on savings proposals being considered as part of 2022-22 budget. Budget Consultation approach agreed.
December/January	Budget Consultation	Seek views from the public on budget proposals.
w/c 14 December 2021 (estimated)	Scottish Budget Draft Announcement – NHS and Local Government Funding	Will inform budget outlook (but funding won't be confirmed until Feb/March)
26 January 2022	IJB	Updated Budget Outlook report (reflecting most up to date settlement positions)
25 February 2022	Finance & Policy Committee	Feedback on Budget Consultation Consideration of further savings proposals (if necessary) following latest budget outlook report and budget gap position.
24 February 2022	Argyll and Bute Council budget meeting	Will set the Council's contribution to the HSCP for 2022-23.
30 March 2022	IJB	Set Budget for 2022-23.

4. RELEVANT DATA AND INDICATORS

4.1 As noted within Section 3 and Appendices 1 and 2.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact – The Board should seek to agree a balance budget and the proposals presented within this report balance the budget for 2020-21.

There remains significant estimated budget gaps in future years that will require to be addressed.

6.2 Staff Governance – The appropriate HR processes of NHS Highland and Argyll and Bute Council will require to be followed where staff are impacted by any savings proposals.

6.3 Clinical Governance - None

7. PROFESSIONAL ADVISORY

7.1 Professional Advisory leads have been consulted in the development of the savings proposals.

8. EQUALITY AND DIVERSITY IMPLICATIONS

8.1 A summary of the Equality Impact Assessments is presented in a separate report on the agenda. Detailed EQIAs for each of the policy savings proposals are also available on Council and NHS Highland websites.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

9.1 None directly from this report.

10. RISK ASSESSMENT

10.1 There is a risk that sufficient proposals are not approved in order to balance the budget in 2020-21. There is a separate report on the agenda in relation to financial risks.

11. PUBLIC AND USER INVOLVEMENT AND ENGAGEMENT

11.1 An extension consultation has been carried out on the budget savings proposals. A separate report is presented on the findings from the Budget Consultation.

10. CONCLUSIONS

10.1 The budget gap in 2021-22 amounts to £4.134m for the Health and Social Care Partnership. The Senior Leadership Team have identified savings to deliver a balanced budget. There are new management/operational savings of £3.658m and policy savings of £561k and a recommendation to cancel existing savings of £85k. A one-off investment to achieve financial sustainability of £517k is set out for approval.

10.2 There is still a significant estimated budget gap over the next two years and work will need to commence shortly on identifying savings proposals to balance the budget in 2022-23. A high level timetable for the budget process in 2021/22 is noted in the report.

11. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	√

APPENDICES:

Appendix 1 – Management/ Operational Savings Proposals

Appendix 2 – Policy Savings Proposals

Appendix 3 – Draft Directions to Argyll and Bute Council and NHS Highland to be issued by Chief Officer (NHS Highland figures for other recurring funding are still to be finalised – these are matched by expenditure and do not affect the budget gap)

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Appendix 1: 2021/22 Operational Savings summary

Ref	2021/22 £k	2022/23 £k	Savings descriptions	Risk and Impact on service (after planned mitigations)
Children & Families & Justice				
2122-01	100	100	Align business model for staffing for the 2 children's homes	Some initial change to the current staffing capacity to one of the care homes. This is to align the homes operationally as the same staffing model. This risk will be mitigated by close control and monitoring to ensure that there is no impact on current capacity levels
2122-02	44	44	Carry out hostel review to achieve best value in admin and catering	These are already identified underspends in current budget and will be removed without impact on current service.
2122-19	50	50	remove existing underspends in contact & welfare budget	No risk - spending reduced over two previous Financial years through close monitoring by CRP
2122-20	20	20	reduction in staff travel	Risk of post-covid increase in travel to previous levels offset by reduction in lease car payments.
2122-21	24	24	align budgets with spending levels in sundry Social work Childrens budgets	No risk - consolidation of small budgets.
2122-22	70	70	remove underspend in fostering budget	No risk in the immediate short term as these are identified underspends within current fostering budgets. However, in the longer term the service aims to transform the balance of care and will require additional investment in future years to ensure more fostering placements can be found and resources will be shifted at that time.
2122-23	50	50	remove vacant assessment and reviewing officer post	Minimal Risk - This post has been vacant for some time during Covid and pandemic . The service has maintained service levels and performance with min impact. RIsk has been mitigated by close monitoring of service levels. In the longer term the service is developing transformation programme and will require a new model of staffing as the service redesign develops which may require future demand pressure. Min risk in the short term , however longer term will need investment to meet new staffing resources .
2122-24	50	50	community justice to be self funding	Savings represent Justice Social Work being delivered and managed within Sec 27 grant received from Scottish Government. There is a risk that any initiatives to deliver services outwith our statutory duties to enhance outcomes for service users may be curtailed. Sec 27 grant is formulated by SG on number of orders reports etc reported on in annual return. The reduction in Court business during Covid may have a negative effect on this formula and negatively impact grant allocation in the coming years. The loss of HSCP funding may therefore impact on the service's ability to deliver statutory public protection duties in future years.

Ref	2021/22 £k	2022/23 £k	Savings descriptions	Risk and Impact on service (after planned mitigations)
2122-25	35	35	Remove 0.7 health visitor post following retirements	There is a risk that the current performance levels may not be maintained. This will be monitored closing by senior managers to ensure min effect on service and early intervention taken if needed.
2122-27	5	5	staff travel reduction	Some risk - currently travel is reduced due to COVID however this may change in the future and travel will increase.
2122-28	16	16	Reduction in Staff Nurse and Community Children's Nurse hours	Risk due to reduced capacity to deliver a community children's nursing service to children with complex health needs will impact on the Health Visitors in the team. This will be mitigated by the CHSMs and HoS child health closely monitoring, putting necessary training and early intervention measures if necessary.
2122-29	6	6	slight reduction in admin hours	Some risk as it may result in highly qualified staff members undertaking admin tasks, taking them away from their specialist role. However , the introduction of the introduction of Office 365 and automation may help mitigate any risk in the future.
Community & Hospital services				
2122-30	20	20	Introduce more re-use of walking frames and improved procurement of musculo-skeletal supplies	No risks to operational service delivery.
2122-31	21	21	Kintyre OT £13; Kintyre Physio £4k; Mid Argyll Physio £4k	No risks to operational service delivery as will be declared following workforce establishment setting.
2122-32	487	487	1% general efficiency requirement across all hospital budgets	Managers have accepted a 1% efficiency, Finance will support identifying non pay savings within budgets.
2122-33	25	25	centralise lab ordering £20k and theatre stock ordering £5 along with North Highland	Low risk for theatre stock saving even when planned activity resumes to normal levels. Lab ordering saving will be dependent on managed service contract for disposables.
2122-34	10	10	Oban hospital: outreach clinics £5k; TSSU transfer to N Highland £5k	Low risk for outreach clinic saving. Some risk re capacity at Raigmore re transfer of Theatre Sterile Supply Unit (TSSU) to North Highland.
2122-35	28	28	Mid Argyll hospital removal of surplus budgets on hotel services £20k, comms £4.3k; GMS out of hours £2k; equipment £1.5k	No risks to operational service delivery.
2122-36	30	30	Campbeltown hospital patients travel £30k	Some risk that there may be a shortfall in patient transport when NHS GG&C return to normal activity. We will mitigate this by continuing to reinforce the patient transport policy and by continuing to do direct booking with Logan air which has cut the cost of flights.
2122-37	14	14	Campbeltown hospital catering £14k;	No risks to operational service delivery.
2122-38	22	22	Campbeltown hospital sundry underspends comms £6k; portering £1; pharmacy £6k; general management discretionary £5k, transport £2k; GMS out of hours £1.5k	No risks to operational service delivery.
2122-39	10	10	Bute patient travel £10k	No risks to operational service delivery.
2122-40	10	10	Cowal Pharmacy	Risks to non delivery due to Covid-19, however detail will be scoped and efficiencies identified.

Ref	2021/22 £k	2022/23 £k	Savings descriptions	Risk and Impact on service (after planned mitigations)
2122-41	26	26	Islay: save admin on patient travel £26k	Links to policy saving 2122-05
2122-42	15	15	Islay: saving on local outreach clinics and accommodation through more remote clinics	Some challenges achieving the full amount in Year 1.No risks to operational service delivery.
2122-43	35	35	Oban Patient travel £25k; staff travel £10k	No risks to operational service delivery.
2122-44	5	5	Oban paramedical supplies £5k	No risks to operational service delivery.
2122-45	9	9	Helensburgh: Linen services £6.8k, window cleaning £2k	No risks to operational service delivery.
2122-46	22	22	Helensburgh outreach clinics £8k; casualty payments £14k,	No risks to operational service delivery.
2122-47	90	90	Reduce care home placements budgets as numbers have been falling pre Covid	No risks to operational service delivery. Occupancy will be reviewed regularly.
2122-48	12	12	terminate property lease on Jura not required	This has caused community concern as a result of lack of consultation. The flat has not been used for 3 years as respite. Discussion on respite via Gortonvogie to be discussed with the community.
2122-49	16	16	Reduce social work travel budget	No risks to operational service delivery.
2122-50	24	24	Reduction and realignment of the Development and Flexibility Budget Lines £13k and sundry other social work underspends £11k	No risks to operational service delivery.
Julie Lusk – Mental Health, LD, PD				
2122-16	12	12	Reduce befriender service following review of clients	no risk, completed
2122-51	30	30	Do not fill vacant posts in day services as service is being re-designed	redesign.
2122-52	5.5	5.5	Reduction in mental health team travel £5.5k	There may be a risk to achieving the saving where face to face interactions are reinstated or required post covid
2122-53	12.5	12.5	Removal of out of area day services no longer required	No risk
2122-54	30	60	Reduction in supported living packages through improved commissioning	Medium risk being mitigated by continued review activity of existing packages, however new demand presures are anticipated.
2122-55	2	2	Reduction in travel for Social Work Mental health & Addictions team travel	Minimal risk to achieve this saving
2122-56	3	3	Reduction in travel for Health Mental health & Addictions team travel	Reduced travel budget will directly impact the ability for teams to attend each locality base to deliver face to face patient interventions post covid
2122-57	5	5	Savings from review of Jeans Bothy SLA already completed	No risk, completed
2122-58	30	30	review of Community Mental Health SLA with NHS GG&C and improved contract management of this service	Some risk of not achieving the saving agreed for SLA, also risk if need to increase funding to cover post covid responses which might not be separately funded
Other areas				
2122-59	153	153	HSCP telephony new contract £153k;	New contract already awarded. Some risk that implementation may be delayed beyond 31 March 2021 by up to 2 months.
2122-60	13	13	Planning & Performance team - reduce budget for travel & printing £3k; Consultant Travel £10k	No risk
2122-61	7	7	re-grade of project manager post in Planning & Performance team	No risk, planned to happen following a retirement

Ref	2021/22 £k	2022/23 £k	Savings descriptions	Risk and Impact on service (after planned mitigations)
2122-62	30	30	removal of surplus from social prescribing budget	No risk
2122-63	8	8	removal of surplus from public engagement £8k	No risk
2122-64	4	4	Medical director budget - reduce Travel	No risk
2122-65	7	7	Lead Nurse budget reduce Travel £2k and Child Protection £5k	No risk re travel savings. Minimal risks regarding proposed Child Protection Committee reduction
2122-66	100	100	Savings from building rationalisation following increase in home working	Ability to deliver depends on scope to rationalise property use. Should have no impact on service delivery.
2122-67	20	20	Finance Hours reduction of 0.6 Band 4 £17k; travel and stationery £3k;	No risk. Measures to achieve saving already in place. No impact on service delivery.
2122-68			Removed	
2122-69	4	4	People & Change saving on Travel and printing £4k	The risk is minimal due to the service's ability to continue to deliver services online and paperless wherever possible
2122-70	782	782	From Social Work: unallocated growth monies for 2020/21	No risk but reduces ability of service to grow to meet future demand.
2122-71	1000	0	Non-recurring vacancy savings for one year only, reflecting continued reduction of activity into 2021/22 due to pandemic	Limited risk as vacancy savings well above target currently
Totals	**3658**	**2688**		

Appendix 2: 2021/22 Policy Savings summary

Ref	2021/22 £k	2022/23 £k	Savings descriptions	No. of staff impacted	Risk and Impact on service (after planned mitigations)
Children & Families & Justice					
2122-03	8	8	Do not replace independent chair of panel		Independent chair of Adoption & Matching Panel is not a legal requirement but was a good practice improvement. Any risk of reduced inspection grades for the fostering and adoption service should be able to be mitigated by good standards
2122-26	60	60	Remove advanced nurse vulnerable groups post	1	Risk on current levels of deliverability as specialist knowledge and support is reduced. Some risk to staffing as some tasks will require to be delegated. This will be mitigated by training, close control and monitoring.
Community & Hospital services					
2122-04	110	221	Bring back urology services from NHS Greater Glasgow & Clyde and offer from Oban Hospital instead		Will require replacement Endoscopy equipment which is on capital plan for 21/22. Robust Clinical Governance arrangements need to be in place for clinicians and clear pathways agreed. Will require good theatre utilisation and support from Acute Directorate is essential to achieve this.
2122-05	35	35	Only pay for escort travel where it is essential		Risks of patient concern mitigated by clear information which has been developed by the local team on Islay.
2122-06	0	0	Removed		
2122-07	0	0	Removed		
2122-08	70	140	Pay for care home placements for older people in line with national contract with no added enhancements		Risk of financial impact on care homes mitigated by care home assurance processes and working with Providers involving Scottish Care.
2122-09	60	100	When a new client is assessed as requiring 24 hour care and refuses care home placement, offer to fund a package of care at home up to £30k, allowing the service user to fund the additional hours of care if they chose to remain at home. The £30k threshold will be flexed to reflect the different cost of care on islands so the level of care funded is consistent.		EQIA indicates that this would require to be written up as a policy change and implemented through a staged approach over time and in the meantime savings would be pursued by review activity.
2122-10	74	74	Redirect Oban Integrated Care Funding (used to pay grants to a range of voluntary sector organisations) to pay for day responder service as in other areas		EQIA refocuses this as a gradual reduction in the frailty model so this can be embedded in practice. No financial sustainability risks identified.
2122-11	29	29	Remove funding for all lunch clubs		EQIA recognises that this is not a removal of service but review of grant funding and the role of the HSCP funding, mitigate by review carried out by the Council.
2122-12	60	60	Reduce payments to voluntary organisations for non-contracted services		Decrease in funding linked to early intervention with older people will be managed through Primary Care Work stream on link working.

Ref	2021/22 £k	2022/23 £k	Savings descriptions	No. of staff impacted	Risk and Impact on service (after planned mitigations)
Mental Health and Learning Disability and Physical Disability					
2122-13	0	440	Re-configure day services for learning disability and replace with alternative provision		Significant risk - alternatives not yet worked up.
2122-14	0	41	End Service Level Agreement for commissioned advocacy service and replace with signposting to carers groups, other advocacy services and national mental health organisations		Some risk as this is only mental health carer and service users voice in local area
2122-15	7	7	End grants paid to link clubs, some of which are no longer providing services		only Kintyre link club utilises financial support currently, others do not access grant funding
2122-17	9	9	Encourage clients to have individual tenancies with housing association - they will qualify for benefits covering housing costs - rather than HSCP paying for rents and council tax - encouraging fuller independence for clients		Positive for current residents who do not have a secure tenancy
Dental					
2122-18	40	40	Reduce Senior Dental Officer post by 0.4 WTE	0.4	The managerial and clinical support/mentoring aspects of this post will be removed, and the SDO will focus on only clinical provision. Risk of shortfall in clinical support and management which could impair service.
Totals	**561**	**1263**		**1.4**	

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Argyll and Bute Integration Joint Board (the IJB)

Written Directions to Argyll and Bute Council

This Direction is written under sections 26 and 27 of the Public Bodies (Joint Working) Scotland Act 2014.

This direction will be for the period from 1 April 2021 to 31 March 2022.

1. Functions and Services to be delivered by Argyll and Bute Council

Argyll and Bute Council will carry out the functions specified in Annex 1a of Directions dated 28 September 2016.

Argyll and Bute Council will deliver the services to which those functions relate. These services are specified in Annex 1b of Directions dated 28 September 2016.

2. Delivery of Functions and Services

Argyll and Bute Council will carry out the functions and deliver the services in a way which complies with all legal and regulatory requirements and having regard to:

a) The Integration Delivery Principles
b) The National Health & Wellbeing Outcomes
c) The Integration Scheme; and
d) The Argyll and Bute HSCP Strategic Plan 2019/20 to 2021/22

3. Finance

The opening payment that will be made to Argyll and Bute Council for the period 1 April 2021 to 31 March 2022 will be £75,132,000. This is in respect of the following:

Argyll and Bute Council Requisition £62,011,000 (net of planned repayment of £200k)

Funding transferred from Health to social care within IJB budget £632,000

Funding transfer from NHS Highland £12,489,000

The funding transfer from NHS Highland is in respect of the following:

Integration Fund (incl 1.5% uplift) £7,163,000

Resource Transfer (incl 1.5% uplift) £5,326,000

A cash payment will be made by NHS Highland to Argyll and Bute Council to the value of the funding transfer. This payment was approved by the IJB on 31 March 2021.

The budget allocation outlined above may be subject to change. The most up to date financial position will be reported to the IJB and the Council as agreed in the Integration Scheme. The Council and the IJB will observe the roles and responsibilities as set out in the Integration Scheme for the management and the development of the budget. A

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further Direction will be issued following the financial year-end to set out the final payments.

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item:**

Date of Meeting:

Title of Report: Integration Joint Board- Performance Report (March 2021)

Presented by: Stephen Whiston - Head of Strategic Planning & Performance

The Integrated Joint Board is asked to:

- Note the continued suspension of reporting against the HSCP Health & Wellbeing Outcome Indicators
- Note the current Covid19 activity within Argyll & Bute, NHS Highland and Greater Glasgow and Clyde
- Note the HSCP performance progress regarding remobilisation of activity in line with NHS Highland performance target for 2020/21 agreed with Scottish Government to 70%-80% of 2019/20 activity
- Note the extension to the reporting timescales for the Annual Performance Report and review guidance with regards to the Strategic Commissioning Plan and Integration Scheme

1. BACKGROUND

Reporting against the HSCP Health & Wellbeing Outcome Indicators continues to be affected by the recent re-escalation of Covid19 pandemic requiring health and care services remain on an "emergency" footing. Thus there continues to be a performance reporting and data lag at both a governmental and local partnership level affecting many of the HSCP Health & Wellbeing Outcome Indicators.

The remobilisation of services across both health and social care is a Scottish Government priority and frontline staff and managers are working hard to achieve this across the Health & Social Care Partnership. Our priority is on ensuring that key services and access as far as possible for people is managed and delivered locally and safely within the Covid19 pandemic operating context.

This report therefore provides the IJB with an update on the impact on service performance with regards to Covid19 pandemic and the progress made with regard to remobilising health and social care services in Argyll & Bute.

2. INTRODUCTION

NHS Highland's (NHSH) Remobilisation plan focuses on the areas agreed as priorities with the Scottish Government and includes information on 10 work streams and associated projects. Alongside this the Framework for Clinical Prioritisation has been

established to support Health Boards with prioritising service provision and framing the remobilisation of services against 6 key principles within a Covid19 operating environment:

1. ***The establishment of a clinical priority matrix*** *1P-P4 (detailed above)*
2. ***Protection of essential services*** *(including critical care capacity, maternity, emergency services, mental health provision and vital cancer services)*
3. ***Active waiting list management*** *(Consistent application of Active Clinical Referral Triage (ACRT) and key indicators for active waiting list management, including addressing demand and capacity issues for each priority level)*
4. ***Realistic medicine remaining at the core*** *(application of realistic medicine, incorporating the six key principles)*
5. ***Review of long waiting patients*** *(long waits are actively reviewed (particularly priority level four patients)*
6. ***Patient Communication*** *(patients should be communicated with effectively ensuring they have updated information around their treatment and care)*

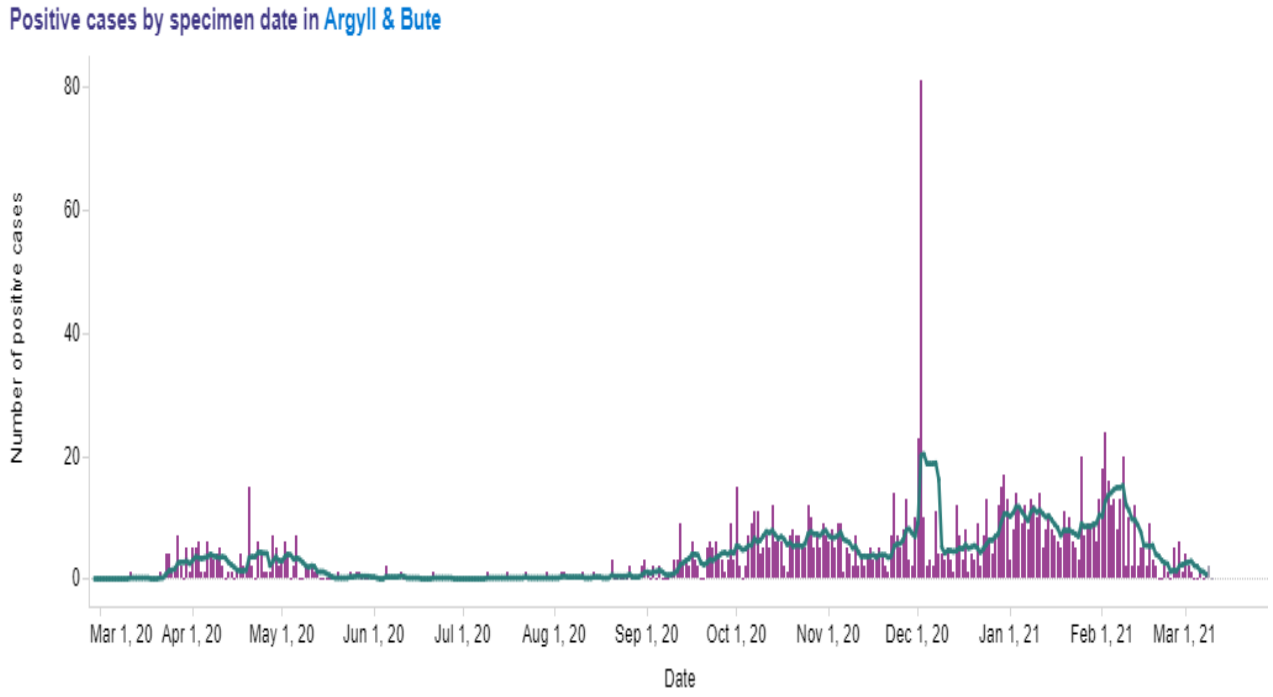
3. COVID 19 OVERVIEW

The data in the table below identifies the most recent Covid19 prevalence as at the 12th March and in particular aligns the data with testing, deaths and tier status. The data is shown by HSCP, Local Authority and Health Board areas to illustrate prevalence, the overall Scotland wide data provides the national backdrop.

National / Board / LA	Cases Daily	Cases (Last 7 Days)	Total Positive Cases	Tests Daily	Tests (Last 7 days)	Total Tests	Tests Positive % (L7d)	Deaths (Last 7 days)	Total Deaths
Scotland	591	3,524	207,747	26,761	131,308	4,771,667	3.10%	76	7,483
NHS Highland	8	100	4,793	1,334	6,874	237,712	1.70%	4	168
NHS GG&C	183	1,035	64,596	5,975	31,302	1,192,923	3.90%	19	2,151
A&B HSCP	0	5	1,410	314	1,604	70,516	0.70%	0	71
Highland Council	8	95	3,301	1001	5,175	164,165	2.00%	4	97
Glasgow City	119	727	38,261	3,168	16,521	624,333	5.00%	8	1116

(Data Source – Public Health Scotland Daily COVID 19 @ Data 12/03/2021)

The Argyll & Bute trend analysis with regards to positive COVID19 cases for March 2020 to March 2021 identifies a further reduction in the 7 day moving average in infections, and overall numbers remain low.



Figures for the most recent dates are likely to be incomplete due to the time required to process tests and submit records.

(Data Source- PHS Covid19 data as at 10th March 2021)

3.1 Covid19 Vaccination Performance

With regards to Immunisation performance the latest data up to the 14th March notes:

- **A&B dose 1** = 37,221 this equates to 51% of the total population having had their first dose
- **A&B dose 2** = 3,057 this equates to 4.2% of the total population having had their second dose

4. REMOBILISATION PERFORMANCE

The tables below summarises and illustrates the HSCP service remobilisation performance against agreed SGHD target (70-80%) across Health and Social care showing significant progress being made.

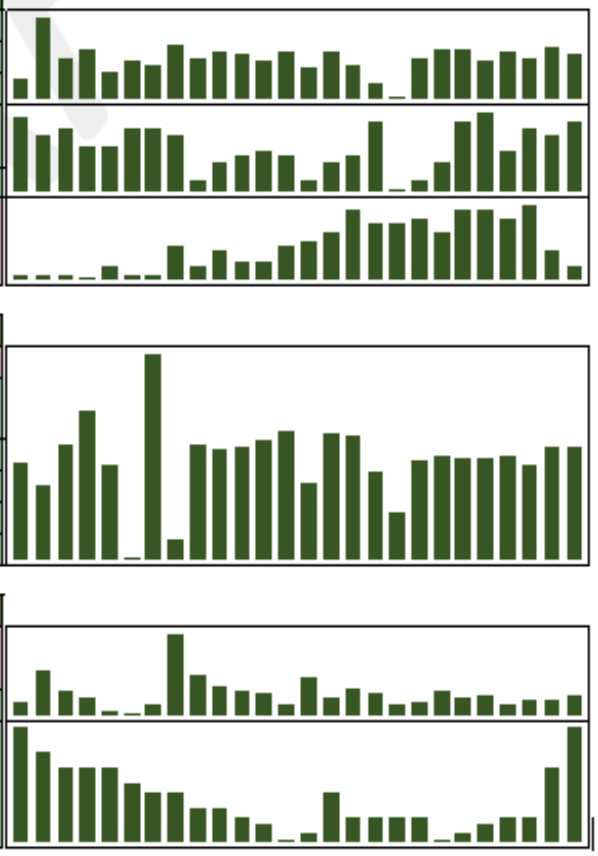
Argyll and Bute HSCP Remobilisation Cumulative Performance to 28th February 2022

	February Cumulative (to W/E 28th February)			Weekly Activity Trend (1 Sep to 28th Feb)
TTG	**Target**	**Actual**	**%Var**	
TTG Inpatient & Day Case Activity (All Elective Admissions	40	45	13%	
REFERRALS	**Target**	**Actual**	**%Var**	
Total AHP Referrals Monitoring	772	685	-11%	
Total Outpatient Referrals	764	610	-20%	
Total Urgent Suspicion of Cancer Referrals Received	20	9	-55%	
OUT PATIENTS	**Target**	**Actual**	**%Var**	
Total New OP Activity Monitoring	560	591	6%	
Total Return OP Activity Monitoring	904	1380	53%	
Total AHP New OP Activity Plan	556	613	10%	
Total AHP Return OP Activity Plan	1312	2091	59%	
DIAGNOSTICS	**Target**	**Actual**	**%Var**	
Total Endoscopy Activity Monitoring	56	67	20%	
Total Radiology Activity Monitoring	312	480	54%	
CANCER	**Target**	**Actual**	**%Var**	
Total 31 Days Cancer - First Treatment Monitoring	0	1	0%	
UNSCHEDULED CARE	**Target**	**Actual**	**%Var**	
Total A&E Attendances Monitoring (LIH)	408	364	-11%	
Total A&E Attendance (AB Community Hospitals)	1244	1281	3%	
Total % A&E 4 Hr (LIH)				
Total Emergency Admissions IP Activity Monitoring (LIH)	148	145	-2%	
Emergency Admissions IP Activity Monitoring (AB Community Hospitals)	148	172	16%	

	February Cumulative (to W/E 28th February		
ADULT SOCIAL CARE	Target	Actual	%Var
Total Number of Adult Referrals	716	954	33%
Total Number of UAA Assessments	224	273	22%
Total Adult Protection Referrals	24	36	50%
Total New People in Receipt of Homecare	36	48	33%
Total New Care Home Placements	16	19	19%
Total No of Delayed Discharges	10	12	20%

COMMUNITY HEALTH	Target	Actual	%Var
Total Mental Health – New Episodes	80	48	-40%
Total Mental Health – Patient Contact Notes	584	766	31%
Total DN – New Episodes	92	122	33%
Total DN – Patient Contact Notes	4032	4151	3%
Total AHP - New Episodes	276	325	18%
Total AHP - Patient Contact Notes	2523	2523	0%

CHILDREN & FAMILIES SOCIAL CARE	Target	Actual	%Var
Total Number of Child Request for Assistance Referrals	196	156	-20%
Total Number of NUCA Assessments	88	92	5%
Total Number of Children on CP Register	38	39	3%



(Please note that not all MH community and AHP activity is captured due to data lag and some services are not yet on automated systems)

5. WAITING TIMES PERFORMANCE

The table below identifies the length of wait associated with each of the specialities alongside the totals and booking status as at 10th February 2021

Performance against December 2020 data notes an overall 3.9% reduction in the total percentage Outpatients Waiting more than 12 weeks. Overall the data suggests a continuing slow reduction in waiting times with a slight increase in March outpatient booking activity.

		Length of Wait (weeks				Appointment Status		
Main Specialty	**Total on Waiting List**	**Over 26**	**12 to 26**	**Under 12**	**% > 12 Weeks**	**Booked**	**Unbooked**	**% Un Booked**
Consultant Outpatients Total	1095	205	187	703	35.8%	405	690	63%
Mental Health Total	745	493	135	171	77%	68	677	90.9%
AHP OTHER Total	410	72	40	298	27.3%	127	283	69.0%
Nurse Led Clinics Total	120	17	13	90	25%	72	48	40%
All OP WL Total	2931	776	461	1694	42,2%	834	2097	71.5%

New Outpatient Waiting List Summary position as at 10th February 2020

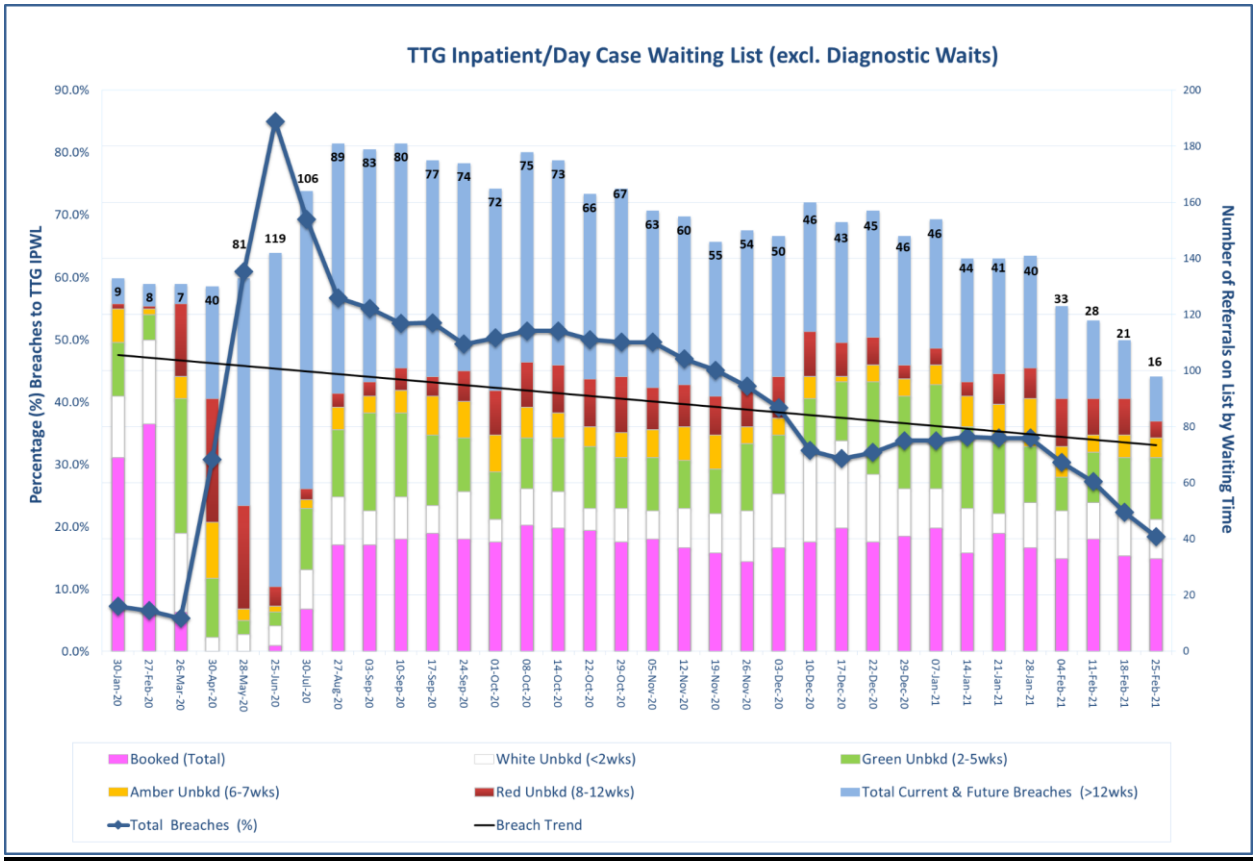
The Tables below illustrate the scale of virtual new and return consultant outpatient performance for Lorn & Islands Hospital and Community Hospitals in Argyll and Bute undertaken to the 21st February 2021:

Cumulative activity at 21st February2020 Virtual Consultant Outpatient				
Speciality	**LIH New**	**LIH Return**	**Community Hospitals New**	**Community Hospitals Return**
Cardiology	2	181	9	190
Clinical Oncology	1	10	0	0
Dermatology	4	52	0	7
ENT	97	11	17	22
Endocrinology & Diabetes	1	51	5	101
General Medicine	24	574	19	190
General Surgery	9	65	2	8
Gynaecology	28	43	28	15
Haematology	4	218	0	0
OMFS & Oral Surgery	199	12	0	0
Orthopaedics	9	60	10	8
Ophthalmology	0	0	1	9
Paediatrics	15	128	62	261
Paediatrics community	0	0	41	107
Respiratory Medicine	6	117	0	0
Urology Virtual	0	148	0	0
Total	**399**	**1670**	**194**	**918**

(Data Source- NHS Highland Remobilisation Plan We 3rd January 2021)

Virtual patient appointments data for the Lorn & Islands Hospital notes a combined 29% increase in new and returning appointments and this trend continues with a combined 28% increase for Community Hospitals against December data.

With regards to Inpatient and Day Case performance in the Lorn & Island Hospital the graph below shows continuous improvement in the percentage of people waiting longer more than 12 weeks for their Treatment Time Guarantee (TTG).



For the Boards reference Appendix 1 presents NHS Scotland Board Level KPI's including Outpatient and Percentage of Treatment Time Guarantee Waiting >12 Weeks as at February 2021. Member's attention is directed to NHS GG&C performance as our secondary care provider for the majority of our population.

6. ANNUAL PERFORMANCE & STRATEGIC COMMISSIONING PLAN UPDATE

Annual Performance Reviews

The Scottish Government has moved legislation last week to extend the Coronavirus Scotland Act (2020) through to the 30th September 2021. This means that IJBs will be able to extend the date of publication of Annual Performance Reviews through to November, using the same mechanisms as last year, which is laid out in the Coronavirus Scotland Act (2020), Schedule 6, Part 3.

7. SERVICE REMOBILISATION PLANS 2021/22

NHS Highland's (NHSH) Remobilisation plan sets out the journey in its response to Covid19 and recovering performance in the context of the NHS Scotland Covid19 Framework for Decision Making of *Re-mobilise, Recover and Re-design* and the subsequent correspondence received from the Scottish Government regarding remobilisation.

This plan takes us through 2021-2022 and focuses on the areas agreed as priorities with the Scottish Government. A significant amount of work has been completed to this effect since the last remobilisation plan was submitted to the government (31 July 2020).

The 2021/22 plan is being considered by the NHS Highland Board at its meeting on the 30th March and

Argyll & Bute HSCP's activity remobilisation performance targets have been incorporated into the NHS Highland plan for 2021/22. These have been formulated on the basis of assumed levels of capacity and demand, using financial year 2019/20 as a baseline. The HSCP has assumed demand will remain consistent with that seen in 19/20 (pre pandemic) across all specialties and settings.

For in house provisioned services i.e. the Medical, Surgical and Oral Surgery specialties delivered across Argyll & Bute and from within Lorn & Islands Hospital we anticipate 90% remobilisation capacity, this applies to planned elective inpatient/day case procedures, outpatients and endoscopy.

NHS GGC have committed to delivering 80% capacity based on 2019/20 activity targets across outpatient outreach services, throughout all four quarters.

The Radiology department in LIH has benefited from capital funding and now has a permanent second ultrasound machine, as such additional clinics can be run when necessary and 100% capacity has been assumed across non-obstetric ultrasound, CT and Barium examinations.

8 GOVERNANCE IMPLICATIONS

8.1 Financial Impact

The Covid19 pandemic and its impact has seen a national allocation of funding monies in-line with need and submitted remobilisation plans.

8.2 Staff Governance

There has been a variety of staff governance requirements throughout this pandemic which have been identified and continue to be progressed and developed include health and safety, wellbeing and new working practices within national Covid19 restrictions

8.3 Clinical Governance

Clinical Governance and patient safety remains at the core of prioritised service delivery in response to the pandemic and subsequent remobilisation.

9. EQUALITY & DIVERSITY IMPLICATIONS

Service delivery has been impacted by the Covid19 pandemic and ongoing and new EQIA will be required to be undertaken as appropriate.

10. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Data use and sharing is daily via national Scottish Government and Public Health Scotland websites meeting GDPR requirements.

11. RISK ASSESSMENT

Risk assessments are in place across he HSCP to ensure staff and service user safety within Covid19 guidance and as appropriate tier restrictions.

12. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Public and user updates are available nationally at the Scottish Government COVID 19 website alongside advice and updates on both the Council and NHS Highland Internet sites.

13. CONCLUSION

The remobilisation of services within Argyll and Bute has made good progress operating within a Covid19 compromised operating context.

The remobilisation planning for 2021/22 has taken this into account and the performance targets agreed with the SGHD and are aligned with NHSGG&C remobilisation rates and are included in NHS Highland remobilisation plan for 2021/22

The IJB are asked to note and consider this update on the impact of the Covid19 pandemic on the HSCP performance and its subsequent remobilisation of services.

14. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

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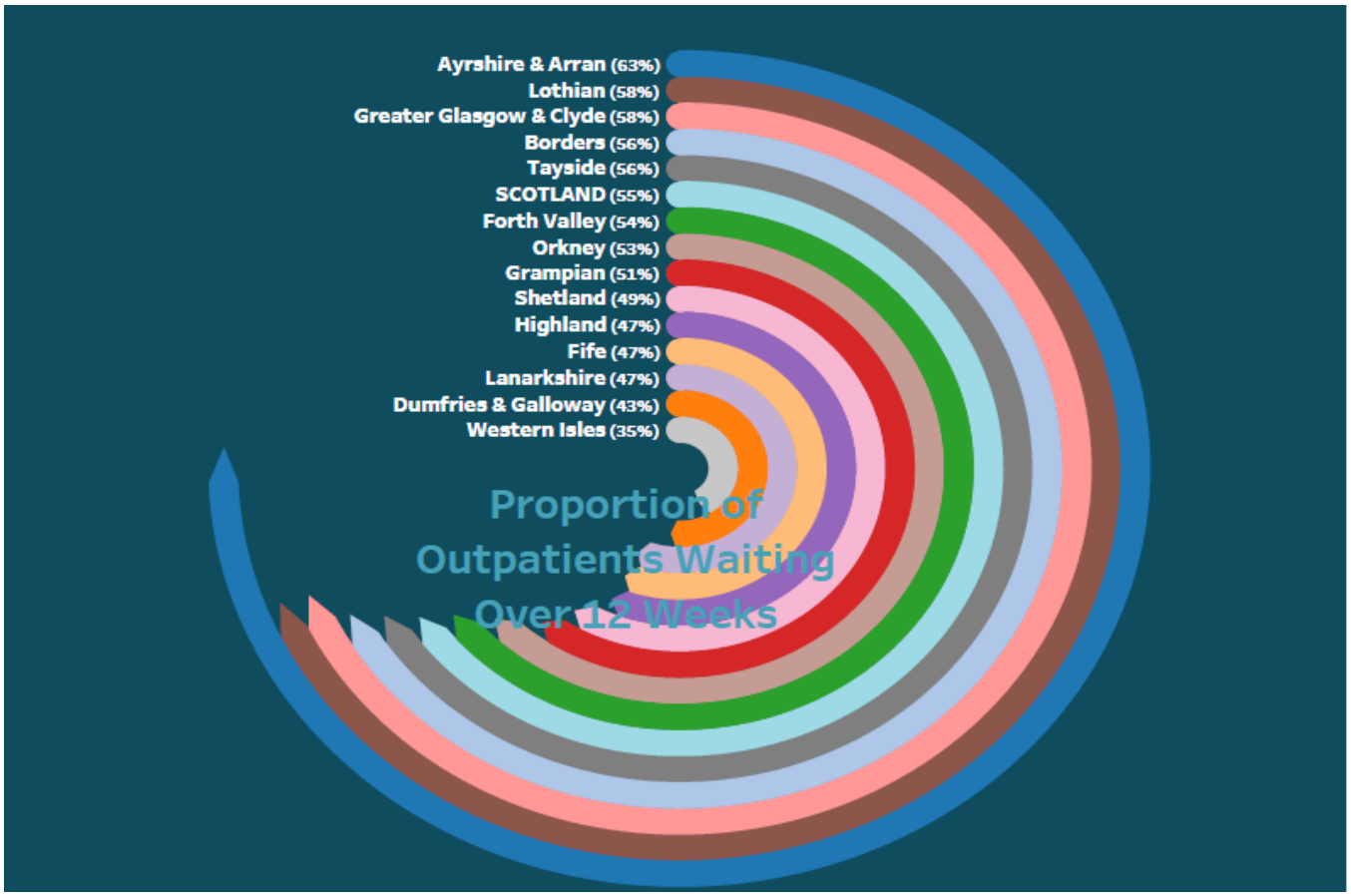
Appendix 1

Board Level KPI's & Percentage of Treatment Time Guarantee Waiting >12 Weeks as at February 2021

Current Week Performance Table

	1 February 2021								
	TTG - patients waiting over 12 weeks	TTG - patients waiting over 26 weeks	Core 4 hour ED Performance (week)	Patients Spending over 8 hours in core ED (week)	Patients Spending over 12 hours in core ED (week)	Core ED Attendances (week)	Delayed Discharges (total)	OPWL - waiting over 12 weeks	OPWL - waiting over 26 weeks
SCOTLAND	57,932	40,863	85.5%	380	99	16,503	0	186,697	98,931
Ayrshire & Arran	3,438	2,352	83.7%	84	44	1,238	0	21,139	12,354
Borders	1,064	758	71.8%	36	15	440	0	3,422	1,482
Dumfries & Galloway	556	219	91.3%	4	0	450	0	3,797	1,150
Fife	1,287	691	90.9%	2	0	759	0	8,399	3,095
Forth Valley	1,681	1,039	88.3%	14	0	812	0	8,869	3,919
Grampian	8,533	6,631	80.8%	16	2	1,133	0	15,375	8,503
Greater Glasgow & Clyde	17,230	12,752	86.5%	85	11	4,202	0	53,986	30,911
Highland	3,412	2,521	87.5%	12	3	711	0	6,564	2,749
Lanarkshire	5,803	4,287	84.8%	58	5	2,759	0	13,673	5,448
Lothian	9,210	6,133	82.2%	69	19	3,000	0	38,103	22,199
Orkney	57	36	98.4%	0	0	63	0	524	267
Shetland	98	59	100.0%	0	0	90	0	513	332
Tayside	4,770	2,985	95.3%	0	0	803	0	11,917	6,378
Western Isles	100	0	97.7%	0	0	43	0	400	132



A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item:**

Date of Meeting: **31st March 2021**

Title of Report: **Care Homes and Housing Update**

Presented by: **Caroline Cherry, Head of Older Adults and Community Hospitals**

The Integration Joint Board is asked to:

- Approve the Programme Management Approach to progressing the Care Home and Housing Transformation work.
- Approve the work stream approach and the short and longer term priorities set out at 3.3.
- Approve the options appraisal scoring framework set out at 3.10 to 3.12.
- Agree to delegate authority to the Finance & Policy Committee to approve the outcome of the options appraisal.
- Agree the approach to the financial implications set out at 3.13.
- Note the progress of the Care Home and Housing Programme Board detailed within the report.

1. EXECUTIVE SUMMARY

1.1 This report summarises the progress to date of the care home and housing programme board. It provides context in the work previously undertaken and gives details of the approach going forward.

2. INTRODUCTION

2.1 Care homes and housing is a key transformation area which is an integral part of the HSCP Strategic Plan. Care homes for older adults plays a central part of the range of services for older people. These are registered services with the Care Inspectorate but ultimately an older person's home.

2.2 The care homes and housing programme and its projects all link clearly with the HSCP strategic priorities and aims to establish future need and provide a multi-agency platform for planning how our future care homes and specialist housing requirements are met.

2.3 Significant progress towards this priority was carried out in 2018-19 through the Care Homes & Housing Steering Group.

However, it was paused due to resourcing difficulties and the planned re-start in January 2020 was put on hold due to the Covid-19 response.

2.4 The Senior Leadership Team made a decision to re-commence this work by the establishment of a new Care Home and Housing Programme Board. The focus of this board is to build on the previous work, to identify short and longer term options which includes local authority care homes in Oban and Dunoon. The new terms of reference of the board are detailed in **Appendix One.**

3. DETAIL OF REPORT

3.1 A scoping meeting was held on 12th February. This was well represented by a number of key stakeholders including the Chief Officer, Head of Service Older Adults, Scottish Care, Union Representatives, Human Resources, Commercial Services and Argyll and Bute Senior Housing Managers.

3.2 **Care Homes and Housing Programme Board**

It was agreed to progress with a new programme board approach. Where there is major change there will be complexity, risk, many interdependencies to manage and conflicting priorities to resolve. These challenges are managed through the board, its governance, themes and agreed principles. In addition, it will ensure that:

- ✓ Relevant projects (whether short term or longer term) are coordinated, and aligned with the HSCP transformational priorities.
- ✓ There is a clear structure in its framework.
- ✓ Membership allows for a multi-agency approach.
- ✓ Any failure is mitigated by a risk management approach.

3.3 **Two definite work streams were identified; one as a short term and the other as longer term:**

1. Work stream 1 : Operational Priority - Short Term (1-2 years)

   Deliver the operational priority to deliver care in a safe and comfortable environment.

2. Work stream 2 : Strategic Development - Longer Term (3-5 years)

   Deliver the strategic priority to scope and deliver a co-produced model of future care for older people with communities. The previous report along with up to date modelling and the impact of Covid-19 will be re considered.

3.4

Work stream 1: Operational Priority

1. Eadar Glinn - Oban

Eadar Glinn will be the first care home to explore alternative opportunities for care home accommodation for their residents in 2021- 22.

This is due to the condition of the fabric of the building which is in the worst state of all the care homes and is least suitable for purpose.

This timescale will be monitored closely to ensure that we engage with staff, families and carers.

2. Struan Lodge – Dunoon

Struan Lodge project will commence after the work of Eadar Glinn is well underway. This project will explore alternative accommodation in the short term for their residents. This is due to the condition of the fabric of the building and its suitability.

3.5 **Work stream 2 : Strategic Development**

The scoping of this work is planned to commence in April 21. It will be aligned with strategic developments including the outcomes of the place or assets based review of Cowal and Bute (jointly sponsored by the HSCP and Argyll and Bute Council). The aim would be to work with communities to co-produce the care outcome underpinned by the joint needs assessment which takes into consideration the impact and learning from Covid -19.

3.6 **Engagement**

The HSCP recognises the importance of engaging with all stakeholders, communities, staff, and the approach being taken forward is aligned with the HSCP Engagement framework which is based on recognised best practice.

3.7 **Early Engagement, Feb- March 21**

Early engagement sessions have been completed for families and staff at Eadar Glinn and Struan Lodge. Presentations were delivered informing on the decision to re - establish previous work, the short term options being considered and which were followed by an open questions and answers format.

Four sessions have been delivered for Eadar Glinn, two for staff and two for families. The aim of which was to inform those directly affected on the reestablishment of the previous work, the establishment of the new board, the short term options being considered and to ask those who attended to continue to work in supporting the changes going forward.

Four sessions have been delivered for the families of residents in Struan Lodge, two for families and two for staff.

Two sessions and a briefing paper was provided for local Elected Members.

3.8

Engagement Work stream 1 - Short Term 21/22 and 22/23

Engagement plans/templates were developed and were presented for approval to the Care Home and Housing Programme Board on March 12th. These plans provide details, over the next two years, on how we engage and consult with key stakeholders including staff and families at Eadar Glinn and Struan Lodge, the type of engagement and relevant timescales. The engagement findings will be presented to the programme board as part of monthly reporting.

3.9 **Work stream 2 - Longer term Strategic Development**

Engagement plans are yet to be scoped or considered. This work will commence from April 21.

3.10 **Option Appraisals for Eadar Glinn and Struan Lodge**

Option appraisals are a key management tool used to support informed and evidence based decision making within any transformation arena.
They provide a key framework which allows for a number of different options to be explored, scored and evaluated against an agreed set of success criteria. Following this rigorous process a selection for a preferred option can be made. The proposal is to complete options appraisals for Eadar Glinn and Struan Lodge.

The three options being considered for both the care homes are:

Option 1: Do nothing – continue to operate as currently in with ongoing building maintenance but no significant capital investment in the building.

Option 2: Invest and retain – carry out a major refurbishment of on a phased basis so as to minimise disturbance to existing residents. Have a pause on new admissions whilst refurbishments are underway for the same reason.

Option 3 - Transfer residents to an alternative provision and develop longer term plans – Have a pause on new admissions to offer residents and families options of alternative care homes based on availability of places in locality. Assess if TUPE applies to a transfer of undertaking based on these choices. In parallel, work up longer term requirement for care homes and extended care provision for the locality, produce options appraisal, business case for preferred option(s) and commission new facilities.

3.11

Success Criteria

The scoring and success criteria which these options will be assessed against are as follows:

	Description
1	Meets the projected local demand for care home places over the next two to three years as per the outputs from the modelling tool
2	Offers care solutions that are as close as possible to local communities
3	Offers some degree of choice to individual clients
4	Offers access to respite
5	Offers access to step up/down
6	Maintains the Care Inspectorate's average quality of care standards score
7	Supports sustainability of existing care providers

Scoring Definitions are set out below:

Score	**Description**
3	Fully - option meets all positive aspects of criterion.
2	Some - option meets some of criterion.
1	Limited – option meets only a very limited aspect.
0	Option is likely to have a neutral impact.
-1	Limited – Option would have a limited negative impact.
-2	Some - Option would have some negative impact.
-3	Fully – Option would have a strong negative impact on this criterion.

3.12

Option Appraisal Evaluations

The final part of process will be to complete options appraisal evaluation templates for Eadar Glinn and Struan Lodge. The results of the options appraisal will be presented to Finance & Policy Committee for approval. The Committee is asked to seek delegated approval from the IJB for this as the Committee meets monthly and the next meeting of the IJB after the March meeting is not till June 2021.

In addition, to the completion of the options appraisals, a full S.W.O.T (Strengths: Weaknesses: Opportunities: Threats) analysis for all of the options at each of the two care homes will be completed and presented to enhance the decision making process. Once the preferred option is selected, the Equality Impact Assessment will be completed for this option.

3.13 **Financial impact**

Depending on which option is selected, there is likely to be some financial impact on existing budgets for the IJB. Even if, 'Do Nothing' is selected, there will be consequences from the deteriorating fabric of the building. If the option is selected to, 'Invest and retain', there will need to be additional capital expenditure and there may be an impact on the capacity of the care home whilst those works are carried out. If the third option is selected, there will be a transition period as residents transfer. Costs of alternative provision will need to be factored in, along with any implementation support to assist with changeover, financial sustainability of the new provider and staff transferring. The financial consequences will be estimated into an outline business case and these financial consequences will need to be factored into the IJB's budget for 2022/23.

4. RELEVANT DATA AND INDICATORS

4.1 None

5. CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 This transformation is a key strand of the HSCP Strategic Plan.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact – If the preferred option is to transfer residents temporarily to another provider this may have some financial impact.

6.2 Staff Governance – Staff who are currently employed at Eadar Glinn and Struan Lodge may be affected depending on the outcome of the options appraisal and each preferred option. Human Resources and Staff Representation are all present at the Care Home and Housing Programme Board. Human Resources policies involving staff will be taken forward if and when appropriate. Engagement plans will confirm ongoing engagement with staff.

6.3 **Clinical Governance**

Appropriate clinical governance will be sought if needed.

7. PROFESSIONAL ADVISORY

7.1 Appropriate Professional Advisory input will be sought at all key stages of work.

8. EQUALITY AND DIVERSITY IMPLICATIONS

8.1 Protected characteristics, socio–economic impacts and island impacts are all considered in the preparation of EQIAs for areas of transformation.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

9.1 None for this report.

10 RISK ASSESSMENT

10.1 Risk will be mitigated by completion of a risk and issues logs for all areas of transformation and reporting on these to the Care Home and Housing Programme Board.

11. PUBLIC AND USER INVOLVEMENT AND ENGAGEMENT

11.1 A full engagement plan will follow after the preferred option has been approved in accordance with HSCP engagement strategy.

12. CONCLUSIONS

12.1 This report outlines the key areas for progressing work being taken forward by the Care Homes and Housing Programme Board. It sets out the direction already travelled and details the short term and longer term priorities. It also sets out the options appraisal framework and details the process being undertaken. It presents the updated terms of reference for the Care Homes and Housing Programme Board and the governance arrangements which includes reports to the wider Strategic Transformation Board. In conclusion the Care Homes and Housing Programme Board will give assurance of a multi-agency and policy approach to delivering oversight on the future care home and housing needs of older adults for the years ahead.

13. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	X
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

APPENDICES:

Appendix 1 - Updated terms of reference for Care Home and Housing Programme Board

Author: Louise Beattie, Service Improvement Officer, Argyll & Bute HSP
Louise.beattie@argyll-bute.gov.uk

Appendix 1 - Terms of Reference
Care Home and Housing Programme Board

Terms of Reference

1. INTRODUCTION

1.1 Older adult services exist in a climate of constant and increasing change. In addition, there is an increasing demand for services within an environment of consistent financial pressure. Therefore, the need to transform within and across all areas of the service is ongoing. This is balanced with maintaining our policy, legal and strategic aspirations to ensure the most vulnerable are protected and kept safe.

1.2 Services that have learned how to transform themselves through effective, collective leadership and strategic control are more likely to be successful. Programme Boards frameworks are increasingly being recognized as key to enabling services to manage their transformational agendas.

1.3 Where there is major change there will be complexity, risk, many interdependencies to manage and conflicting priorities to resolve. These challenges are managed through the programme board, its governance, themes and agreed principles. In addition, failure is mitigated further by adopting a collective leadership approach who have strategic responsibility for ensuring the changes are successful.

1.4 The Housing and Care Home change programme/projects all link clearly, with the HSCP strategic priorities and aims to establish future need and provide a multi-agency platform for planning how our future care home and specialist housing requirements are met.

1.5 Transforming Together across all areas of the partnership and across the breadth and width of Argyll and Bute is a key principle which will ensure alignment of appropriate policies, standards and processes, and that there is a clear strategic overview and understanding which will drive forward the service changes. This will be with a focus on quality and safety, ensuring services are modernised and fit for the future.

2. PURPOSE OF THE PROGRAMME BOARD

2.1 The purpose of the Programme Board is:

- To agree the principles which underpin the success of the change programme.
- To agree the governance themes which will define the approach to programme management
- To monitor and report progress on the lifecycle of the work streams/projects from there conception through to the delivery of any new capability, outcomes and benefits.
- To provide strategic direction, early decision making and intervention, authorisation, accountability and support for the delivery of change projects
- To consider and make recommendations on business cases, proposals and requests for change, presented by Short Life Working Groups, Project leaders and others as appropriate

- Promote an Argyll and Bute wide consistent approach to reviewing and implementation of service changes
- To ensure risk is managed and mitigated appropriately.
- To report progress to the Strategic Transformation Board monthly
- To provide updates to committees, members, for additional scrutiny and challenge when appropriate.
- To ensure that engagement and transparency with older adults, families and communities is at the heart of all that the board does.

2.2 **Remit and Responsibility:**

Specific areas include:

- To agree strategic direction, authorisation, accountability and support for the delivery of the programme and work streams
- To escalate any decisions needed for approval from the Strategic Transformation Board.
- To agree the goals, objectives and priorities for each work stream/project and ensure these are clearly articulated and reported for scrutiny to Strategic Transformation Board
- To enable an Argyll and Bute wide approach to re design, considering the implementation of local and national initiatives, drivers for change and improvement
- To support the development of appropriate policies, services standards and processes for the provision of services
- To ensure proposals align with duties under the Equalities Act (EQIAs)
- To monitor and manage each Programme's progress, benefits, risks, realisation and impact through the agreed programme management process
- To determine and escalate if appropriate for approval the key recommendations in business cases, proposals and cases for change from project groups
- To manage high level interdependencies and risks associated with the change process
- To approve engagement methodology and ensure appropriate communication and engagement plans are in place for each service change
- To ensure that all plans have had significant stakeholder input including staff side, members, families and older adults and other stakeholders
- To develop and monitor a risk register for the Programme Board

2.3 **Values and Behaviours**

The Care Homes and Housing Programme Board will achieve the above by building on positive relationships, demonstrating collective leadership, open and honest communication in accordance with our Argyll & Bute Culture of respect and kindness.

Membership

The Board has representation from key areas across a multi-agency partnership

Membership	
Designation	**Name**
Head of Older People and Community Hospitals (Chair)	Caroline Cherry
PA to Head of Older People and Community Hospitals	Clair McCann
Service Manager Resources (Vice Chair)	Donald Watt
Head of Finance and Transformation	Judy Orr
Council SMT representative	Ross McLaughlin/Douglas Hendry
Professional Lead Social Work	Pamela McLeod
Strategic Leads Housing	Douglas Whyte/Matt Mulderrig
Professional Lead Nursing	TBC
Care Inspectorate Representative	Simon Deveney
RSL Representative	TBC
HR Representative	Joanne McDill
Strategic Planning	Alison Ryan
Public Health	Dr Nicola Schinaia
Independent Sector	Julie Hodges
Staff side/TU Representatives	Mary Watt/Angela McMullan
Head of Estates	Kevin Willan
Programme and Project Support	John Dreghorn/ Gillian McCready/Louise Beattie
Finance	David Forshaw
Head of Commercial Services	Ross McLaughlin
Procurement	Anne McColl Smith
Professional Lead AHP	Linda Currie
Senior Information Analyst	Sally Thompson

Quoracy

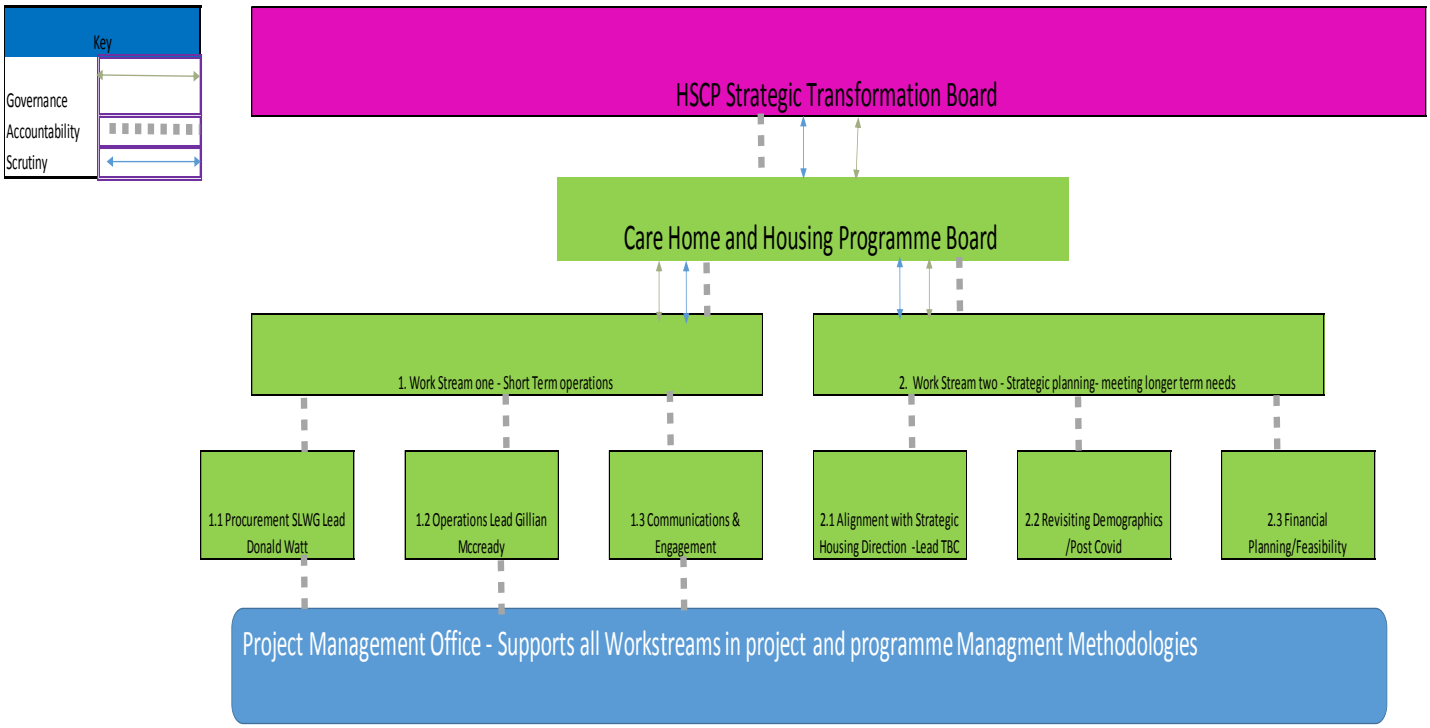
Six members of the Programme Board will constitute a quorum, with at least Chair or Vice Chair present.

Administrative arrangements

Supported by PA to the Head of Adult Services for Older People and Community Hospitals.

Governance

Image one below shows the draft structure and governance framework. Image two shows the wider governance across the wider transformational programme.


Key
Governance
Accountability
Scrutiny
HSCP Strategic Transformation Board
Care Home and Housing Programme Board
1. Work Stream one - Short Term operations
2. Work Stream two - Strategic planning- meeting longer term needs
1.1 Procurement SLWG Lead Donald Watt
1.2 Operations Lead Gillian Mccready
1.3 Communications & Engagement
2.1 Alignment with Strategic Housing Direction -Lead TBC
2.2 Revisiting Demographics /Post Covid
2.3 Financial Planning/Feasibility
Project Management Office - Supports all Workstreams in project and programme Managment Methodologies

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: 24th March 2021

Title of Report: Amendment to Civil Contingencies Act 2004 to include Integration Joint Boards as Category 1 Responders

Presented by: Douglas Hendry

The Integrated Joint Board is asked to:

- Note the content of the report of the amendment to The Civil Contingencies Act 2004 (Amendment of List of Responders) (Scotland) Order 2004
- Agree to accept responsibility for compliance with the duties as described

1. EXECUTIVE SUMMARY

1.1 This report provides the IJB with:

- information on an amendment now in force as of 17 March 2021 laid before Scottish Parliament which includes IJB's as Category 1 responders under the Civil Contingencies Act 2004
- A summary on consultation and an outline of the duties

2. INTRODUCTION

In September 2020, Jeane Freeman, Cabinet Secretary for Health and Sport wrote a letter to the chair of the Scottish Resilience Partnership to give notification of an amendment the Scottish Government intended to make to the Civil Contingencies Act 2004 (hereinafter referred to as the Act) to add IJB's as Category 1 responders in Scotland.

A further letter was sent by Jeane Freeman to NHS and Local Authority Chief Executives, and IJB Chief Officers in January 2021, outlining the next steps in the inclusion of IJB's as Category 1 responders under the Act.

Following consultation it was concluded that there were no equality, operational nor strategic planning barriers to progression and the amendment would be laid before the Scottish Parliament in January 2021 for due consideration with the aim to come into effect in the Spring of 2021. Scottish Ministers concluded that there was no reason not to legislate for IJB inclusion within the Civil Contingencies Act 2004 to ensure formal coordinated and appropriate arrangements are in place.

3. DETAIL OF REPORT

3.1 The Civil Contingencies Act (2004) makes the following requirements for those listed as Category 1 responders:

1. Assess the risk of emergencies occurring and use this to inform contingency planning.
2. Put in place emergency plans.
3. Put in place business continuity management arrangements.
4. Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
5. Share information with other local responders to enhance co-ordination.
6. Co-operate with other local responders to enhance co-ordination and efficiency.
7. Provide advice and assistance to businesses and voluntary organisations about business continuity management (Local Authorities only).

NHS Boards and Local Authorities are currently Category 1 responders under the Act.

Integration Joint Boards, Health Boards and Local Authorities share a joint responsibility and accountability for drawing up suitable plans which take account of functions managed by each individual body. Therefore, the Integration Joint Board Chief Officer and their team are expected to work alongside Health Board and Local Authority colleagues when carrying out the duties relevant to the Civil Contingencies Act 2004.

The excerpt below from the Scottish Government website highlights the rationale for extending cat 1 Responder status to IJB's and specifically the role of the Chief Officer.

Whilst Chief Officers have already been contributing to local emergency and resilience planning, they have only formally done so through their roles as directors of Health Boards and Local Authorities and without the appropriate reference to their accountable officer status within the Integration Joint Boards.

By including Integration Joint Boards as Category 1 responders, it ensures that where there is a risk of an emergency which will impact functions delegated to the Integration Joint Board, there will be formal coordinated and appropriate arrangements in place for: emergency planning; information sharing and cooperation with other responders; and joined up information sharing and advice for the public.

The Integration Joint Boards' key resource are the Chief Officers who hold multi-faceted roles as the accountable officer of the Integration Joint Board and as directors of Health Boards and Local Authorities. The Chief Officer would lead for the Integration Joint Board and can draw on resource from their integrated teams (both Health Board and Local Authority employed staff). It would be expected that the Chief

Executives of the Health Board and Local Authority be involved, or have put in place appropriate representation to ensure the views of those bodies are well covered.

The Scottish Government does not envisage that including Integration Joint Boards as Category 1 responders under the Civil Contingencies Act 2004 will cause significant additional burden to them. Although the Act sets out a number of requirements, the main addition will be the formal inclusion of Integration Joint Board Chief Officers in emergency planning, not just in their role as a director within a Health Board or Local Authority, but also in their role as the accountable officer of the Integration Joint Board.

As highlighted above, to meet their requirements, we would expect the Chief Officer to draw on resources from their integrated teams, many of whom will already be involved in this work as Health Board and Local Authority staff.[1]

3.2 The amendment is now passed it will place IJB's at the heart of, and formalises their inclusion in, planning for and responding to disruptive challenges as set out by the above duties.

3.3 The aim of the amendment is to consolidate the partnership relationship, ensuring an effective and efficient and timely response for services delegated to IJB's.

3.4 Resilience structures in Scotland for planning and response which are set out to comply with the duties require adequate representation from Health and Social Care Partnerships (HSCP's).

3.5 The amendment to the Act provides an opportunity to formalise arrangements. The duty now ensures that representation is mandatory with accountability to the IJB.

3.6 Emergency and business continuity planning is a continuous cycle that is flexible and should adapt to the internal and external environment and requires to be reviewed on an ongoing basis. The recommendation is the IJB delegate to the Audit and Risk committee to review business continuity planning and preparation in each locality and outline the representation of HSCP officers in resilience partnership activity.

4. RELEVANT DATA AND INDICATORS

[1] Civil Contingencies Act 2004 amendments - including Integration Joint Boards: consultation - gov.scot (www.gov.scot)

Argyll & Bute Health and Social Care Partnership has been an active partner through both partnerships participating in both Tactical Group in the council, Caring for People response and subsequently the newly formalised Strategic Resilience Partnership. It has also been in an active partner in the NHS Command Structure and been instrumental in delivering the clinical guidance and pathways from the NHS board operationally.

The Health and Social Care Partnership was a direct recipient of national Guidance during the pandemic response and provided accountability through the IJB and partner organisations where statutory responsibility is maintained.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The duty applies to both the planning and the response and should be a consideration within the ongoing development of the strategic plan.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

The Scottish Government has indicated that this should be a consolidation of the relationship with partners increasing resilience and without additional resource. The IJB does not employ officers to support this area of work specifically and indeed the Health and Social Care Partnership has no specific officers. On the basis the IJB's are compliant and additional duties should be minimal. It would be recommended that the Audit AND Risk committee monitor appropriate resource being provided and review whether this would require anything

6.2 Staff Governance

Review of the governance to ensure adequate participation and engagement within partner organisations and subsequent compliance with the duties of the Act.

6.3 Clinical Governance

Clinical and Care Governance Committee provides an existing forum to ensure providing accountability to clinical and care guidance and currently reports to the IJB directly.

7. PROFESSIONAL ADVISORY

No clinical and care advisory required for this paper.

8. EQUALITY & DIVERSITY IMPLICATIONS

Equality and diversity implications will be considered in response.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Compliant

10. RISK ASSESSMENT

It is requested that Audit and Risk Committee be asked to monitor the ongoing risks in compliance.

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

None directly required for this paper.

12. CONCLUSIONS

In conclusion this paper outlines the new duty which came into force on 17 March 2021 and asks the IJB to accept this duty. It further requests that the IJB request the Audit and Risk Committee to monitor compliance with the duty and any resources it may require ongoing.

13. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Date of Meeting: 31 March 2021

Title of Report: Review of the Health and Social Care Integration Scheme

Presented by: Douglas Hendry, IJB Standards Officer

The Integration Joint Board is asked to:

- Note that the Integration Scheme has been approved by the Scottish Government and that arrangements will now be put in place by the two parent bodies to publish the document.

1. EXECUTIVE SUMMARY

1.1 The NHS Highland Board and the Council, at their meetings held on 24th and 26th November 2020 respectively, approved revisions made to the Health and Social Care Integration Scheme following review and feedback from the Scottish Government (SG).

1.2 The revised Scheme was subsequently submitted to the SG for final approval. This report advises that the SG confirmed via email on 23rd March 2021 that the revised Scheme has now been signed off by the Cabinet Secretary for Health and Sport and that arrangements will now be put in place by the two parent bodies to publish the document. A copy of the approved scheme is attached at appendix 1.

2. INTRODUCTION

2.1 The legal requirement to complete a review of an Integration Scheme is set out in Section 44 of the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act). The Scheme must be reviewed each subsequent period of 5 years beginning with the day on which the Scheme was approved, in the case of Argyll and Bute, 27 June 2015. The statutory responsibility to review the Scheme sits with the Board of NHS Highland and Argyll and Bute Council.

3. DETAIL OF REPORT

3.1 Following a joint consultation exercise, which ran from 9th December 2019 to 17 January 2020, a number of revisions were made to the Scheme to take account of the feedback received and approved by NHS Highland Board and the Business Continuity Committee at their respective meetings in March and April 2020.

3.2 Thereafter, the SG undertook a review of the revised Argyll and Bute Integration Scheme and provided both verbal and written feedback on 7th and 28th October 2020. The Scheme was further updated to take account of the SG comments, and agreed by the NHS Highland Board and the Council, at their meetings held on 24th and 26th November 2020 respectively.

3.3 The SG confirmed via email on 23rd March 2021 that the revised Scheme has now been signed off by the Cabinet Secretary for Health and Sport. In line with section 8 of the Public Bodies (Joint Working) (Scotland) Act 2014, the two parent bodies will now put in place arrangements to publish the approved Scheme. The legislation is not prescriptive in regard to the specific methods that should be adopted in this regard. It is proposed that both parent bodies, and the HSCP, arrange for the document to be published on their respective websites and promoted via Social Media.

4 RELEVANT DATA AND INDICATORS

4.1 The legal requirement to undertake a quinquennial review of the Integration Scheme is set out in section 44(5) of the Public Bodies (Joint Working) (Scotland) Act 2014.

5 CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 The Scheme and Standing Orders provide the key governance documents for the IJB that support the delivery of the work of the Health and Social Care Partnership.

6 GOVERNANCE IMPLICATIONS

6.1 Financial Impact

No impact arising from this report.

6.2.1 Staff Governance

No impact arising from this report.

6.2.2 Clinical Governance

No impact arising from this report.

7 EQUALITY & DIVERSITY IMPLICATIONS

No impact arising from this report.

8 GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Activity is undertaken in line with GDPR regulations.

9 RISK ASSESSMENT

Risk of non-compliance with statutory measures under the Public Bodies (Joint Working) (Scotland) Act 2014.

10 PUBLIC & USER INVOLVEMENT & ENGAGEMENT

n/a for this report. Previous report tabled at IJB on 25 March 2020 detailed outcome of public/user consultation exercise which ran from 9th December 2019 until 17th January 2020.

10 CONCLUSIONS

10.1 Following a period of consultation and review by the SG, the Argyll and Bute Integration Scheme has been approved by the Cabinet Secretary for Health and Sport and will now be published in accordance with the Public Bodies (Joint Working) (Scotland) Act 2014.

11 DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

12 APPENDICES

Appendix 1 – Approved Scheme of Integration as at March 2021

REPORT AUTHOR AND CONTACT

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23rd March 2021

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INTEGRATION SCHEME

BETWEEN

ARGYLL AND BUTE COUNCIL

AND

NHS HIGHLAND

March 2021

Contents

Introduction

1. Vision and Values:

The vision of Argyll and Bute Council and NHS Highland is that the people in Argyll and Bute will live longer, healthier, happier, independent lives.

The core values of Argyll and Bute Council and NHS Highland are: caring; creative; committed; collaborative; teamwork; excellence; and integrity.

The core values of the Health and Social Care Partnership are: compassion; integrity; respect; continuous learning; leadership; and excellence.

2. Aims and Outcomes:

The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. The Integration Scheme is intended to achieve the National Health and Wellbeing Outcomes.

Argyll and Bute Integration Joint Board (IJB) will plan for and deliver high quality health and social care services to, and in partnership with, the communities of Argyll and Bute.

The IJB will set out within its Strategic Plan how it will effectively use allocated resources to deliver the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in regulations under section 5(1) of the Public Bodies (Joint Working) (Scotland) Act 2014, namely that:

- People are able to look after, and improve, their own health and wellbeing and live in good health for longer.
- People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.

- Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.
- People using health and social care services are safe from harm.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively and efficiently in the provision of health and social care services.
- Any other National Health and Well Being outcome prescribed in the future will also be adopted.

Argyll and Bute Council and NHS Highland have agreed that Social Care services for Children & Families and Justice Services should be included within the functions and services to be delegated to the IJB, therefore the specific national outcomes as detailed below for Children & Families and Justice are also included:

The national outcomes for Children & Families are:-

- Our children have the best start in life and are ready to succeed.
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens; and
- We have improved the life chances of children, young people and families at risk.
- Any national outcomes prescribed in the future will also be adopted.

National outcomes and standards for Social Care Services in the Justice System are:-

- Community safety and public protection.
- The reduction of re-offending.
- Social inclusion to support desistance from offending.
- Any national outcomes prescribed in the future will also be adopted

3. Scope of Integration:

Argyll and Bute Council and NHS Highland have agreed to delegate to the IJB the following functions:

- All NHS services that the legislation permits for delegation.
- All Adult social care services.
- All Children & Families social care services.
- All Justice social care services.

4. Finance arrangements:

The general principles are agreed as:

- The Council and NHS Highland recognise that they each have continuing financial governance responsibilities, and have agreed to establish the IJB as a “joint operation” as defined by IFRS 11.
- The Council and NHS Highland will work together in the spirit of partnership, openness and transparency.
- The Council and NHS Highland payments to the IJB derive from a process that recognises that both organisations have expenditure commitments that cannot be avoided in the short to medium term. The Council and NHS Highland will prepare and maintain a record of what those commitments are and provide this to the IJB.
- The IJB will monitor its financial position and make arrangements for the provision of regular, timely, reliable and relevant information on its financial position which will be shared with the Council and NHS Highland. The IJB, the Council and NHS Highland will share financial information to ensure all parties have a full understanding of their current financial information and future financial challenges and funding streams.
- The existing financial regulations of the Council and NHS Highland will apply to resources transferred to the IJB.

Integration Scheme

The Parties:

The Argyll and Bute Council, established under the Local Government (Scotland) Act 1994 and having its principal offices at, Kilmory, Lochgilphead, Argyll, PA31 8RT (herein after referred to as "the Council");

And

NHS Highland Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "Argyll and Bute CHP") and having its principal offices at Assynt House, Beechwood Park, Inverness, IV2 3BW (hereinafter referred to as "NHS Highland") (together referred to as "the Parties").

1. Definitions and Interpretation

1.1 "The Act" means the Public Bodies (Joint Working) (Scotland) Act 2014.

1.2 "Argyll and Bute Integration Joint Board" means the Integration Joint Board established by Order under section 9 of the Act.

1.3 "IJB" means Argyll and Bute Integration Joint Board.

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

1.5 "The Integration Scheme Regulations" means The Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014.

1.6 "Integration Joint Board Order" means The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

1.7 "Scheme" means this Integration Scheme.

1.8 “Strategic Plan” means the plan which the IJB is required to prepare and implement in relation to the delegated provision of health and social care services to adults and children in accordance with section 29 of the Act.

1.9 ‘’Acute Services’’ means medical and surgical treatment provided mainly in hospitals and minor injury units.

1.10 “Locality Planning Groups” mean local planning groups comprising representatives of local partners and stakeholders who are accountable to the Strategic Planning Group for the planning and partnership delivery of agreed local health and care service priorities. Their specific purpose is to develop a locality plan, influence priorities for their local area, agree mechanisms for the delivery of actions at a local level and review and report on the locality plan annually.

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

In accordance with section 1(2) of the Act, the Parties have agreed that the integration model set out in sections 1(4)(a) of the Act will be put in place for the IJB, namely the delegation of functions by the Parties to a body corporate that is to be established by Order under section 9 of the Act. This revised Scheme comes into effect on the date the Parliamentary Order comes into force.

2. Local Governance Arrangements

2.1 The role and constitution of the IJB is established through legislation, with the Parties having agreed that the voting membership will be:

2.1.1 NHS Highland: 4 members of the NHS Highland Health Board.

2.1.2 Council: 4 Elected Members of the Council nominated by the Council.

2.1.3 The Parties have agreed that the first Chair of the IJB will be the nominee of the Council. The term of office of the Chair and the Vice Chair will be a period of two years.

2.2 The IJB sets out within its Strategic Plan how it will effectively use allocated resources to deliver the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in regulations under section 5(1) of the Act, namely that:

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

2.3 The Parties have agreed that Social Care services for Children & Families social care and Justice social care should be included within the functions and services to be delegated to the IJB. Therefore, the specific national outcomes as detailed below for Children & Families and Justice are also included:

The national outcomes for Children & Families are:-

- Our children have the best start in life and are ready to succeed.
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens; and
- We have improved the life chances of children, young people and families at risk.
- Any national outcomes prescribed in the future will also be adopted.

National outcomes and standards for Social Care Services in the Justice System are:-

- Community safety and public protection.
- The reduction of re-offending.
- Social inclusion to support desistance from offending.
- Any national outcomes prescribed in the future will also be adopted

3. Delegation of Functions

3.1 The Parties agree to delegate a comprehensive range of health and social care functions for adults and children to the IJB.

3.2 The functions that are to be delegated by NHS Highland to the IJB are set out in Annex 1.

3.3 The functions that are to be delegated by the Council to the IJB are set out in Annex 2

4. Local Operational Delivery Arrangements

4.1 The local operational arrangements agreed by the Parties are:

4.1.2 The IJB has responsibility for the planning and delivery of services. This will be

achieved through the Strategic Plan.

4.1.3 The IJB is responsible for the operational oversight of Integrated Services and, through the Chief Officer, will be responsible for the operational management of Integrated Services.

4.1.4 The IJB will be responsible for the operational oversight of the planning, commissioning and contracting of delegated Acute Services and, through the Chief Officer, will be responsible for the operational management, and budget of Acute Services.

4.1.5 As the majority of Acute services are contracted from a neighbouring Health Board (NHS Greater Glasgow and Clyde), the IJB will be responsible for the operational oversight of Acute Services. A lead Director for Acute Services in NHS Greater Glasgow and Clyde (GG&C) has been identified as the contract liaison officer who is responsible for the operational management of Acute Services in NHS GG&C.

4.1.6 NHS Greater Glasgow and Clyde will provide information as part of the contract monitoring arrangements on a regular basis to the Chief Officer and the IJB on the operational delivery and performance of these services.

4.2 Support for Strategic Plan

4.2.1 The IJB is required under section 29 of the Act to prepare a strategic plan. All Health and Social Care Partnerships' primary responsibility is the achievement of the national health and wellbeing outcomes through the delivery of the principles of integration. A critical element in discharging this responsibility is the production and delivery of a Strategic Plan.

4.2.2 The NHS Board will share with the IJB necessary activity and financial data for services, facilities and resources that relate to the planned use of services by service users within Argyll and Bute for its service and for those provided by other Health Boards.

4.2.3 The Council will share with the IJB necessary activity and financial data for services, facilities and resources that relate to the planned use of services by service users within Argyll and Bute for its services and for those provided by other councils.

4.2.4 The Parties agree to use all reasonable endeavours to ensure that other

Integration Joint Boards and any other relevant Integration Authority will share the necessary activity and financial data for Services, facilities and resources that relate to the planned use by service users within the area of their Integration Authority.

4.2.5 The Parties shall ensure that their Officers acting jointly will consider the Strategic Plans of the other Integration Joint Boards or Authorities to ensure that they do not prevent the Parties and the IJB from carrying out their functions appropriately and in accordance with the Integration Planning and Delivery Principles, and to ensure they contribute to achieving the National Health and Wellbeing Outcomes. The Integration Authorities that are most likely to be affected by the Strategic Plan are:

- West Dumbarton Integration Joint Board
- Inverclyde and Renfrew and East Renfrew Integration Joint Boards share a common acute provider of services (NHS Great Glasgow and Clyde)

4.2.6 The Parties shall advise the IJB where they intend to change service provision of non- Integrated Services that will have a resultant impact on the Strategic Plan.

4.2.7 The NHS Highland Board will consult with the IJB to ensure that any overarching Strategic Plan for Acute Services and any plan setting out the capacity and resource levels required for non- delegated budgets for such Acute Services is appropriately co-ordinated with the delivery of Services across the NHS Highland area. The parties shall ensure that a group including the Chief Operating Officer, NHS Highland and Chief Officer of the IJB will meet regularly to discuss such issues.

4.3 Corporate Support Services

4.3.1 The Parties will continue to provide the corporate support required to fulfil the duties of the IJB. The Parties will:

- Identify and agree on an ongoing basis, the corporate support services required to fully discharge the IJB's duties under the Act.
- The Parties will continue to provide the IJB with the corporate support services it requires to fully discharge its duties under the Act.

.

4.4 Performance Targets, Improvement Measures and Reporting Arrangements

4.4.1 The Parties will identify a core set of indicators that relate to services, from publicly accountable and national indicators and targets against which the Parties currently report. A list of indicators and measures which relate to integration functions will be collated in a Performance Management Framework and will provide information on the data gathering and reporting requirements for performance targets and improvement measures. The Parties will share all performance information, targets and indicators from the Performance Management Framework with the IJB. The improvement measures will be a combination of existing and new measures that will allow assessment at local level. The performance targets and improvement measures will be linked to the national and local outcomes to assess the timeframe and the scope of change.

4.4.2 The Performance Management Framework will also indicate where the responsibility for each measure lies, whether in full or in part. Where there is an ongoing requirement in respect of organisational accountability for a performance target for the NHS Board or the Council, this will be taken into account by the IJB when preparing the Strategic Plan.

4.4.3 The Performance Management Framework will also be used to prepare a list of any targets, measures and arrangements which relate to functions of the Parties, which are not delegated to the IJB, but which are affected by the performance and funding of integration functions and which are to be taken account of by the IJB when preparing the Strategic Plan.

4.4.4 The Performance Management Framework will be reviewed regularly to ensure the improvement measures it contains continue to be relevant and reflective of the national and local outcomes to which they are aligned.

4.4.5 The Parties will continue to provide support to the IJB for arrangements regarding Performance Targets, Improvement Measures and Reporting, including the effective monitoring and reporting of targets and measures for

adjoining NHS Boards and Integration Joint Boards.

4.4.6 The IJB will receive performance management information for consideration, approval and agreement, and will act appropriately as necessary, in response to all relevant performance management information, including:-

4.4.6.1 Public Health and Wellbeing Status reports including analysis of Argyll and Bute population, at macro, demographic specific and locality level.

4.4.6.2 Clinical and Care Governance reports to be assured of the quality, safety, risk and effectiveness of services.

4.4.6.3 Staff Governance reports to be assured of compliance and best practice in workforce relations, workforce planning and organisational development.

4.4.6.4 Patients and Users of Care Services; Involvement and Community Engagement reports ensuring their involvement in the shaping, delivery and evaluation of service performance.

4.4.6.5 Financial Governance reports including financial management, budget setting recommendation, expenditure reporting, financial recovery plan and cost improvement plans for consideration and approval.

4.4.6.6 Performance Management Framework information, to be assured of the performance of services against targets, indicators and outcomes.

5. Clinical and Care Governance

5.1 The Parties and the IJB are accountable for ensuring appropriate clinical and care governance arrangements in respect of their duties under the Act. The Parties will have regard to the principles of the Scottish Government's Clinical and Care Governance Framework, including the focus on localities and service user and carer feedback.

5.2 The Parties recognise that the establishment and continuous review of the arrangements for Clinical and Care Governance and Professional Governance are essential in delivering their obligations and quality ambitions. The arrangements

described in this section are designed to assure the IJB of the quality and safety of services delivered in Argyll and Bute.

5.3 Explicit lines of professional and operational accountability are essential to assure the IJB and the Parties of the robustness of governance arrangements for their duties under the Act. They underpin delivery of safe, effective and person-centered care in all care settings delivered by employees of the Council, NHS Highland, the third and independent sectors, and by informal carers.

5.4 In relation to existing health and social care services, NHS Highland is accountable for health functions and services, whilst Argyll and Bute Council is responsible for social care services. Professional governance responsibilities are carried out by the professional leads through to the health and social care professional regulatory bodies.

5.5 The Chief Social Work Officer holds professional accountability for social care services. The Chief Social Work Officer reports directly to the Chief Executive and Elected Members of the Council in respect of professional social care matters. He/she is responsible for ensuring that social work and social care services are delivered in accordance with relevant legislation and that staff delivering such services do so in accordance with the requirements of the Scottish Social Services Council.

5.6 Principles of Clinical and Care Governance will be embedded at service user/clinical care/professional interface using the framework outlined below. The IJB will ensure that explicit arrangements are made for professional supervision, learning, support and continuous improvement for all staff.

5.7 The IJB will fulfil its devolved responsibility in terms of overseeing delivery of delegated functions by ensuring that there is evidence of effective performance management systems. Professional and service user networks or groups will inform the agreed Clinical and Care Governance framework directing the focus towards a quality approach and continuous improvement.

5.8 The Clinical and Care Governance and Professional Governance framework will encompass the following:

- Measure the quality of integrated service delivery by measuring delivery of

personal outcomes and seeking feedback from service users and/or carers.

- Professional regulation and workforce development.
- Information governance.
- Safety of integrated service delivery and personal outcomes and quality of registered services

5.9 Each of the four elements, listed at 5.8, will be underpinned by mechanisms to measure quality, clinical and service effectiveness and sustainability. They will be compliant with statutory, legal and policy obligations strongly underpinned by human rights values and social justice. Service delivery will be evidence-based, underpinned by robust mechanisms to integrate professional education, research and development.

5.10 The IJB is responsible for embedding mechanisms for continuous improvement of all services through application of a Clinical and Care Governance and Professional Governance Framework. The IJB will be responsible for ensuring effective mechanisms for service user and carer feedback and for complaints handling.

5.11 NHS Highland Executive Medical Director and Board Nurse Director share accountability for Clinical and Professional Governance across NHS Highland as a duty delegated by NHS Highland. This will include ensuring:

- Quality monitoring and governance arrangements that include compliance with professional codes, legislation, standards, guidance and that these are regularly open to scrutiny.
- Systems and processes to ensure a workforce with the appropriate knowledge and skills to meet the needs of the local population.
- Effective internal systems that provide and publish clear, robust, accurate and timely information on the quality of service performance.
- Systems to support the structured, systematic monitoring, assessment and management of risk.
- Co-ordinated risk management, complaints, feedback and adverse events/incident system, ensuring that this focuses on learning, assurance and improvement.
- Improvement and learning in areas of challenge or risk that are identified through local governance mechanisms and external scrutiny.
- Mechanisms that encourage effective and open engagement with staff on the

design, delivery, monitoring and improvement of the quality of care and services.

- Planned and strategic approaches to learning, improvement, innovation and development, supporting an effective organisational learning culture.

5.12 The Medical Director, or his/her depute, will be a member of the Clinical and Care Governance Committee and will provide professional advice in respect of the overview and consistency of the Clinical and Care Governance and Professional Governance Framework.

5.13 The Board Nurse Director, or his/her depute, will be a member of the Clinical and Care Governance Committee and will provide professional advice in respect of the overview and consistency of the Clinical and Care Governance and Professional Governance Framework.

5.14 The Chief Social Work Officer, through delegated authority holds professional and operational accountability for the delivery of safe and high quality social work and social care services within the Council. An annual report on these matters will be provided to the Council, NHS Highland and the IJB.

5.15 The Chief Social Work Officer will be a member of the Clinical and Care Governance Committee and will provide professional advice in respect of the delivery of social work and social care services by Council staff and commissioned care providers in Argyll and Bute.

5.16 The Parties, in support of the IJB will put in place structures and processes to support clinical and care governance, thus providing assurance on the quality of health and social care in Argyll and Bute. A Clinical and Care Governance Committee, bringing together senior professional leaders across Argyll and Bute, including the Medical Director, Board Nurse Director, Chief Social Work Officer, and the Director of Public Health, will be established. This committee, chaired by one of its members, will ensure that quality monitoring and governance arrangements are in place for safe and effective health and social care service delivery in Argyll and Bute. This will include the following:

- compliance with professional codes, legislation, standards, guidance
- systems and processes to ensure a workforce with the appropriate knowledge and skills to meet the needs of the local population.

- effective internal systems that provide and publish clear, robust, accurate and timely information on the quality of service performance.
- systems to support the structured, systematic monitoring, assessment and management of risk.
- co-ordinated risk management, complaints, feedback and adverse events/incident system, ensuring that this focuses on learning, assurance and improvement.
- improvement and learning in areas of challenge or risk that are identified through local governance mechanisms and external scrutiny.
- mechanisms that encourage effective and open engagement with staff on the design, delivery, monitoring and improvement of the quality of care and services.
- planned and strategic approaches to learning, improvement, innovation and development, supporting an effective organisational learning culture.

5.17 The Clinical and Care Governance Committee will provide advice to the IJB, the Strategic Planning Group and to locality planning groups, all of whom may seek relevant advice directly from the Clinical and Care Governance Committee, as required.

5.18 Arrangements will be put in place so that the Area Clinical Forums, Managed Care networks, other appropriate professional groups, and the Adult and Child Protection Committees are able to directly provide advice to the Clinical and Care Governance Committee.

5.19 The Clinical and Care Governance Committee will report directly to the IJB and will provide clear robust, accurate and timely information on the quality of service performance.

5.20 Information will be used to provide oversight and guidance to the Strategic Planning Group in respect of Clinical and Care Governance and Professional Governance, for the delivery of Health and Social Care Services across localities identified in the Strategic Plan.

5.21 Annex 3 provides a schematic to show the systems governance arrangements.

5.22 Annex 4 provides a schematic to show the clinical and care governance

arrangements.

6. Chief Officer

6.1 The Chief Officer has both strategic and operational responsibility for the delivery of services. The Chief Officer will be directly responsible to and line-managed by the Chief Executive Officers of both Parties, and via the Chief Executive Officers is responsible to NHS Highland and the Council. The Chief Officer is also accountable to the IJB.

6.2 The Chief Officer will be accountable directly to the IJB for the preparation, implementation of, and reporting on, the Strategic Plan. The Chief Officer will also be responsible for operational delivery of services and the appropriate management of staff and resources.

6.3 The Chief Officer will establish a senior management team, equipped to direct and oversee the structures and procedures necessary to carry out all functions in accordance with the Strategic Plan.

6.4 In the event that there is a prolonged period when the Chief Officer is unable or unavailable to fulfil his/her functions, interim arrangements will be required to temporarily replace the Chief Officer. The Parties will nominate suitably qualified and experienced senior officers to carry out the functions of the Chief Officer for the duration of the interim period, and submit the said nominations for approval by the IJB.

6.5 The Chief Officer's objectives will be set annually and performance appraised by the Chief Executive Officers of both Parties, in consultation with the Chair and Vice Chair of the IJB.

6.6 The Chief Officer will be a full member of both the Council and NHS Highland's corporate management teams, as well as a non-voting member of the IJB.

6.7 The Chief Officer will ensure the maintenance of an up to date integrated risk register in respect of all functions delegated to the IJB.

6.8 The Chief Officer will routinely liaise with appropriate officers of NHS Highland in

respect of the IJB's role in contributing to the strategic planning of acute NHS healthcare services and provision (in accordance with the Act) and delivery of agreed targets that have mutual responsibility. Operational management of Integrated Services and acute services will be the responsibility of the Chief Officer, as detailed in sections 4.1.3, 4.1.4 and 4.1.5.

6.9 The Chief Officer will routinely liaise with the appropriate Officer(s) of the Council in respect of the IJB's role in informing strategic planning for local housing and the delivery of housing support services. Housing functions, apart from equipment, adaptations and aspects that relate to personal support, are outside the scope of the IJB; however, close liaison between the Chief Officer and the appropriate Officer(s) will assist in the strategic planning process.

6.10 The Chief Officer will develop close working relationships with Elected Members of the Council and Executive and Non-Executive members of NHS Highland.

6.11 The Chief Officer will establish and maintain effective relationships with a range of key stakeholders across the Scottish Government, NHS Highland, the Council, Independent and Third sectors, service users, Trades Unions, professional organisations and informal carers.

6.12 The Chief Officer will ensure appropriate arrangements are in place in respect of information governance and the requirements of the Information Commissioner's Office.

7. Workforce

7.1 The Parties are committed to producing and maintaining a fully integrated Workforce and Organisational Development Plan, relating to the delegated functions, as prescribed in the Act. This will include engagement and learning and development for all staff, to promote the development of a robust organisational structure and healthy organisational culture. The plan will remain under annual review. Chief Officer, the IJB will be responsible for implementation and review of the plan, in conjunction with the implementation of the Strategic Plan.

7.2 The development of the plan will be remitted to the Human Resources and Workforce Development and Organisational Development work streams already in place, for completion. These workstreams are led by Human Resources and

organisational Development Leads from both Parties and include NHS staff side (Trade Unions representing NHS Highland staff) and Trades Unions representatives (representing Council staff), as well as other key stakeholders.

8. Finance

8.1 Roles and Responsibilities

8.1.1 The IJB will make arrangements for the proper administration of its financial affairs by appointing a Chief Financial Officer to discharge the responsibilities that fall within Section 95 of the Local Government (Scotland) Act 1973.

8.1.2 The Chief Financial Officer is accountable for financial management of delegated budgets and overall financial resources of the IJB.

8.1.3 The Chief Financial Officer of the IJB will be responsible for managing preparation of the annual budget of the IJB, managing the medium term financial planning process to support the strategic plan, and providing financial advice and information to support the planning and delivery of services by the IJB.

8.1.4 The Chief Financial Officer of the IJB will be responsible for producing regular finance reports to the IJB and managers, ensuring that those reports are timely, relevant and reliable.

8.1.5 The Chief Financial Officer of the IJB will be responsible for preparing the IJB's accounts and ensuring compliance with statutory reporting requirements as a body under the relevant legislation.

8.1.6 The Chief Financial Officer of the IJB will work with the Council Section 95 Officer and NHS Highland Director of Finance to ensure the Council and NHS Highland are kept informed on the financial position, performance and plans of the IJB.

8.1.7 The Chief Executive Officers of Argyll and Bute Council and NHS

Highland are responsible for the resources that are allocated by the IJB to their respective organisations for operational delivery.

8.1.8 The Chief Financial Officer will work with the Council Section 95 Officer and NHS Highland Director of Finance to ensure both organisations work together to develop systems which will allow the recording and reporting of the IJB financial transactions.

8.2 Management of Revenue Budget

8.2.1 The IJB's Strategic Plan will incorporate a medium term financial plan for its resources. On an annual basis the annual financial statement will be prepared setting out the amount the IJB intends to spend to implement its Strategic Plan. This will be known as the annual budget. The medium term financial strategy will be prepared for the IJB following discussions with the Council and NHS Highland who will provide a proposed budget based on payment for year 1, indicative payments for year 2 and 3 and outline projections for later years. The medium term financial strategy will be used in conjunction with the Strategic Plan to ensure the commissioned services by the IJB are delivered within the financial resources available.

8.2.2 The IJB is able to hold reserves. There is an expectation that it will deliver the objectives of the Strategic Plan within agreed resources. The IJB cannot approve a budget which exceeds resources available.

8.2.3 The term payment is used to maintain consistency with legislation and does not represent physical cash transfer. As the IJB does not operate a bank account, the net difference between payments into and out of the IJB will result in a balancing cash payment between the Council and NHS Highland. An initial schedule of payments will be agreed within the first 40 working days of each new financial year and may be updated taking into account any additional payments in-year.

8.2.4 The Council and NHS Highland will establish a core baseline budget for each function and service that is delegated to the IJB to form an integrated budget.

8.2.5 The budgets will be based on recurring baseline budgets plus anticipated non-recurring funding for which there is a degree of certainty for each of the functions delegated to the IJB and will take account of any applicable inflationary uplift, planned efficiency savings and any financial strategy assumptions. These budgets will form the basis of the payments to the IJB. These budgets will be reviewed against actual levels of expenditure for the previous 3 financial years. For NHS funding, the starting point will normally be the Argyll & Bute NRAC share of baseline funding.

8.2.6 For each financial year information will be provided by the Parties on the financial performance of the delegated services against budget in their respective areas to enable all parties to undertake due diligence to gain assurance that the delegated resources are sufficient to deliver the delegated functions.

8.2.7 The Parties will each prepare a schedule outlining the detail and total value of the proposed initial payment in each financial year, the underlying assumptions behind that initial payment and the financial performance against budget for the delegated services in the preceding year for their respective areas. These schedules should be prepared and concluded at least one month before the start of the financial year they relate to. The payment will include funding relating to service level agreements for hospital services provided by other Health Boards to Argyll and Bute residents. The schedules will also identify any amounts included in the payments that are subject to separate legislation or subject to restrictions stipulated by third party funders. These documents must be approved by the Director of Finance for NHS Highland and the Section 95 Officer for the Council prior to submission to the IJB.

8.2.8 The IJB Chief Financial Officer will review these documents and reach agreement with both parties on the value of the initial payment. The Chief Financial Officer will then prepare a schedule that describes the agreed value of the payments. The Council's Section 95 Officer, NHS Highland Director of Finance and the IJB Chief Officer must sign this schedule to confirm their agreement.

8.2.9 The process for agreeing the subsequent payments to the IJB will be contingent on the corporate planning and financial planning processes of the

Council and NHS Highland. The funding available to the IJB will be dependent on the funding available to the Council and NHS Highland and the corporate priorities of both. Both parties will provide indicative three year allocations to the IJB subject to annual approval through the respective budget setting processes. These indicative allocations will take account of changes in NHS funding and changes in Council funding.

8.2.10 Each year the Chief Financial Officer and Chief Officer of the IJB should prepare a draft budget for the IJB, based on the agreed funding and present this to the Council and NHS Highland for information within such timescale as may be agreed.

8.2.11 The draft annual budget should be prepared to take account of the matters set out above and uses the previous year payment as a baseline that will be adjusted to take account of:

- Activity Changes arising from the impact on resources in respect of increased demand (e.g. demographic pressures and increased prevalence of long term conditions) and for other planned activity changes.
- Cost inflation on pay and other costs.
- Efficiency savings that can be applied to budgets.
- Performance on outcomes. The potential impact of efficiencies on agreed outcomes must be clearly stated and open to challenge by the Council and NHS Highland.
- Legal requirements that result in additional and unavoidable expenditure commitments.
- Transfers to/from the budget for hospital services set out in the Strategic Plan.
- Budget savings required to ensure budgeted expenditure is in line with funding available including an assessment of the impact and risks associated with these savings.

8.2.12 The Director of Finance of NHS Highland, the Section 95 Officer of the Council and the Chief Financial Officer of the IJB will ensure a consistency of approach and application of processes in considering budget assumptions

and proposals.

8.2.13 Due diligence of the Council and NHS Highland contributions will be undertaken annually and the Chief Financial Officer of the IJB will prepare a schedule outlining the agreed value of the payments. The schedule must be approved by the IJB Chief Officer, the Council Section 95 Officer and the NHS Highland Director of Finance.

8.2.14 The allocations made from the IJB to the Council and NHS Highland for operational delivery of services will be approved by the IJB.

8.2.15 The annual direction from the IJB to the Council and NHS Highland will take the form of a letter from the Chief Officer referring to the arrangements for delivery set out in the Strategic Plan and will include information on:

- The delegated function/(s) that are being directed.
- The outcomes and activity levels to be delivered for those delegated functions.
- The amount and method of determining the payment to carry out the delegated functions.

8.2.16 Once issued, these can be amended or varied by a subsequent direction by the IJB.

8.2.17 Any potential deviation from the planned outturn should be reported to the IJB, the Council and NHS Highland at the earliest opportunity.

8.2.18 Where it is forecast that an overspend will arise, then the Chief Officer and Chief Financial Officer of the IJB will identify the cause of the forecast overspend and prepare a recovery plan setting out how they propose to address the forecast overspend and return to a breakeven position. The Chief Officer and Chief Financial Officer of the IJB should consult the Section 95 Officer of the Council and the Director of Finance of NHS Highland in preparing the recovery plan. The recovery plan should be approved by the IJB. The report setting out the explanation of the forecast overspend and the recovery plan should also be submitted to the Council and NHS Highland.

8.2.19 A recovery plan should aim to bring the forecast expenditure of the IJB

back in line with the budget within the current financial year. Where an in-year recovery cannot be achieved and a recovery plan extends beyond the current year the amount of any shortfall or deficit carried forward cannot exceed the reserves held by the IJB unless there is prior approval of the Council and NHS Highland.

8.2.20 Where recovery plans are unsuccessful and an overspend occurs at the financial year end, and there are insufficient reserves to meet the overspend, the Parties will consider making interim funds available. An analysis will be undertaken to determine the extent to which the overspends relate to either budgets delegated back to or activities managed by the Council or NHS Highland with the allocation of the interim funds being based on the outcome of this analysis. Any interim funds provided by the Council or NHS Highland will be repaid in future years based on a revised recovery plan agreed by both parent bodies, as required by either of the Parties. The NHS and Council will require to be satisfied that the recovery plan provides reasonable assurance that financial balance will be achieved. If the revised recovery plan cannot be agreed by the Parties or is not approved by the IJB, the dispute resolution mechanism in clause 14 hereof, will be followed.

8.2.21 Subject to there being no outstanding payments due to the partner bodies, the IJB may retain any underspend to build up its own reserves and the Chief Financial Officer will maintain a reserves policy for the IJB.

8.2.22 There will be arrangements in place to allow budget managers to vire budgets between different budget heads set out in the financial regulations.

8.2.23 Redeterminations to payments made by the Council and NHS Highland to the IJB would apply under the following circumstances:

- Additional one off funding is provided to Partner bodies by the Scottish Government, or some other body, for expenditure within a service area delegated to the IJB. This would include in year allocations for NHS and redeterminations as part of the local government finance settlement. The payments to the IJB should be adjusted to reflect the full amount of these as they relate to the delegated services. The Parties agree that an adjustment to the payment is required to reflect changes to demand and activity levels.

- Where either Party requires to reduce the payment to the IJB, any proposal requires a justification to be set out and then agreed by both Parties and the IJB.

8.2.24 Where payments by the Council and NHS Highland are agreed under paragraphs 8.2.3 to 8.2.23 above, they should only be varied as a result of the circumstances set out in paragraphs 8.2.16, 8.2.22 and 8.2.23. Any proposal to amend the payments outwith the above, including any proposal to reduce payments as a result of changes in the financial circumstances of either the Council or NHS Highland requires a justification to be set out and the agreement of both Parties.

8.3 Financial Systems

8.3.1 The Chief Financial Officer will work with the Section 95 Officer of the Council and Director of Finance of NHS Highland to ensure appropriate systems and processes are in place to:

- Allow execution of financial transactions.
- Ensure an effective internal control environment over such
- Maintain a record of the income, expenditure, assets and liabilities of the IJB.
- Enable reporting of the financial performance and position of the IJB.
- Maintain records of budgets, budget savings, forecast outturns, variances, variance explanations, proposed remedial actions and financial risks.

8.4 Financial reporting to the IJB:

8.4.1 The Chief Financial Officer will provide comprehensive financial monitoring reports to the IJB. These reports will set out information on actual expenditure and budget for the year to date and forecast outturn against annual budget together with explanations of significant variances and details of any action required. These reports will also set out progress with achievement of any budgetary savings required. The Chief Financial Officer will also report to the IJB as appropriate in relation to:

- Developing a medium and longer term financial strategy to

support delivery of the Strategic Plan.

- Preparation and review of the annual budget.
- Collating and reviewing budget savings proposals.
- Identifying and analysing financial risks.
- Considering the proposals in relation to reserves.

8.4.2 On a monthly basis the Parties will provide comprehensive financial monitoring reports to the Chief Financial Officer. The reports will set out information on actual expenditure and budget for the year to date and forecast outturn against annual budget together with explanations of significant variances and details of any action required. These reports will also set out progress with achievement of any budgetary savings required.

8.5 Financial reporting to management:

8.5.1 The Chief Financial Officer will work with the Section 95 Officer of the Council and Director of Finance of NHS Highland to ensure:

- Managers are consulted in preparing the budget of the IJB.
- Managers are supported in identifying budgetary savings.
- Managers are made aware of the budget they have available.
- Managers are provided with information on actual income and expenditure.
- Managers are provided with information on previous forecast outturns.
- Managers are supported to provide up to date information on forecast outturns.
- Managers are supported to provide explanations of significant variances.
- Managers are supported to identify action required.
- Managers are supported to identify and assess financial risks.
- Managers are supported to identify and assess future medium to longer term budget implications.

8.6 Financial Statements:

8.6.1 The Chief Financial Officer of the IJB will supply any information required

to support the development of the year-end financial statements and annual report for both the Council and NHS Highland.

8.6.2 The Section 95 Officer of the Council and the Director of Finance of NHS Highland will supply the Chief Financial Officer of the IJB with any information required to support the development of the year-end financial statements and annual report of the IJB.

8.6.3 Prior to 31 January each year, the Chief Financial Officer of the IJB will agree with the Section 95 Officer of the Council and the Director of Finance of NHS Highland a procedure and timetable for the coming financial year end for reconciling payments and agreeing any balances.

8.7 Capital Expenditure and Non-Current Assets

8.7.1 The IJB will not receive any capital allocations, grants or have the power to invest in capital expenditure nor will it own any property or other non-current assets. The Council and NHS Highland will:

- Continue to own any property or non-current assets used by Argyll and Bute Integration Joint Board.
- Have access to sources of funding for capital expenditure.
- Manage and deliver any capital expenditure on behalf of the IJB.

8.7.2 The Chief Financial Officer of the IJB will be required to work with the relevant officers in the Council and NHS Highland to extract details of the asset registers of property and noncurrent assets used by the IJB.

8.7.3 The Chief Officer of the IJB will work with the relevant officers in the Council and NHS Highland to prepare an asset management plan for the IJB to be approved by the IJB within a timescale to be agreed annually by the Council and NHS Highland (it is expected this would normally be 30 September). The asset management plan will set out suitability, condition, risks, performance and investment needs related to existing property and other non-current assets identifying any new or significant changes to the asset base.

8.7.4 Alongside the asset management plan, the Chief Officer of the IJB will work with the relevant officers in the Council and NHS Highland to prepare a bid for capital funding for property and other non-current assets used by the IJB. This should be approved by the IJB within a timescale to be agreed annually with the Council and NHS Highland. A business case approach should be adopted to set out the need and assess the options for any proposed capital investment. Any business case will set out how the investment will meet the strategic objectives of the IJB and set out the associated revenue costs.

8.7.5 Whilst responsibility for managing and delivery of capital expenditure remains the responsibility of the Council or NHS Highland, the relevant officers in the Council and NHS Highland will work with the Chief Officer of the IJB to report quarterly on progress with capital expenditure related to property or other non-current assets used by the IJB.

8.7.6 The IJB, the Council and NHS Highland will work together to ensure capital expenditure and property or other non- current assets are used as effectively as possible and in compliance with the relevant legislation on use of public assets.

8.7.7 Depreciation of NHS Highland owned property and other non-current assets used in the services within the scope of the IJB will be charged to the accounts of the IJB and incorporated in the budgets and payments to the IJB.

8.7.8 Revenue costs from property and other non-current assets used in the services within the scope of the IJB will be charged to the accounts of the IJB and incorporated in the budgets and payments to the IJB.

8.7.9 Any gains or losses on disposal of property and other non-current assets used in the services within scope of the IJB will be retained within the accounts of the Council or NHS Highland and not charged to the IJB.

8.7.10 Capital receipts will be retained by the Council or NHS Highland.

8.8 VAT

8.8.1 The IJB will not be required to be registered for VAT, on the basis it is not delivering any supplies that fall within the scope of VAT. The actual delivery of functions delegated to the IJB will continue to be the responsibility of the Council and NHS Highland.

8.8.2 Both the Council and NHS Highland will continue to adhere to their respective VAT arrangements which will be accounted for through respective financial ledgers and statements. The IJB will consult HMRC regarding any VAT issues arising from proposed transfer of services between the Parties (e.g. VAT leakage) taking specialist external VAT advice beforehand if necessary.

9 Participation and Engagement

9.1 A joint consultation took place on the revised Integration Scheme during December/January 2019/20. The stakeholders who were consulted in this joint consultation were:

- Local communities / general public
- Health professionals; GPs, management teams, clinical groups including Nursing Staff and Allied Health Professionals
- Social work and social care professionals
- Users of health services
- Carers of users of health care
- Commercial providers of health care
- Non-commercial providers of health care
- Argyll and Bute Council employees
- Staff side / Trades Unions
- Users of social care
- Carers of users of social care
- Commercial providers of social care
- Non-commercial providers of social care
- Non-commercial providers of social housing
- The Highland Council
- Locality Planning Groups Community / voluntary / Third Sector organisations

- Community Councils
- Argyll and Bute Council - local Councillors
- Scottish Ambulance Service
- NHS 24
- Scottish Health Council
- Local MPs / MSPs
- Dentists
- Pharmacists
- NHS Greater Glasgow & Clyde
- Police Scotland
- Scottish Fire & Rescue
- Argyll and Bute Advice Network (ABAN)
- Lomond & Argyll Advocacy Service
- Citizens Advice Bureau / Patient Advice & Support Service (PASS)
- Argyll and Bute Community Planning Partnership
- Health and Wellbeing Networks

9.2 The range of methodologies used to contact these stakeholders included both Parties' websites and intranets, e-mail and postal correspondence.

9.3 The Communication and Engagement Strategy, along with the supporting Engagement Framework and Quality standards provides a platform for stakeholders to have their voices heard, their views considered and acknowledged, as well as strengthening relationships and building capacity. The IJB has adopted the "You Said, We Did" philosophy. A wide range of engagement methods have been adopted.

9.4 The Parties will carry out Equality and Socio-Economic Impact Assessments (EQSEIAs), to ensure that services and policies do not disadvantage communities and staff.

9.5 The Parties will continue to allocate responsibility to senior managers and their teams to support local public and staff involvement and communication.

10 Information Sharing and Data Handling

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10.1 The Parties agree to be bound by the Information Sharing Protocol and to

continuance of the existing agreement to use the Scottish Information Sharing Toolkit and guidance from the Information Commissioners Office, in respect of information sharing.

10.2 The Parties have developed an Information Sharing Protocol which covers guidance and procedures for staff for sharing of information.

10.3 All staff managed within the delegated functions will be contractually required to comply and adhere to respective local information security policies and procedures including data confidentiality policies of their employing organisations and the requirements of the IJB's agreed Information Sharing Protocol.

10.4 The Data Protection Officers of NHS Highland and Argyll and Bute Council, acting on behalf of the Parties, will meet annually, or more frequently, if required, to review the Information Sharing Protocol and will provide a report detailing recommendations for amendments, for the consideration of the IJB.

10.5 With regard to individually identifiable material, data will be held in both electronic and paper formats and only be accessed by authorised staff, in order to provide the patient or service user with the appropriate service.

10.6 In order to provide fully integrated services it will be necessary to share personal information between the parties and with external agencies. Where this is the case, the IJB will apply a legal basis contained in Article 6 of the General Data Protection Regulations ('the GDPR'). Generally this will be either public task or legal obligation but, where appropriate, any of the other legal bases contained in Article 6 will be used.

10.7 Where the sharing consists of 'special category' information the legal basis for sharing will be consistent with the requirements of Article 9 of the GDPR and schedule 1 of the Data Protection Act 2018 ('the DPA').

10.8 In order to comply with the requirements of the DPA and the GDPR, the IJB will always ensure that personal data it holds will be processed in line with the Data Protection Principles contained within Article 5 of the GDPR and section 35- 40 of the DPA.

11 Complaints

The Parties agree the following arrangements in respect of complaints on behalf of, or by, service users.

11.1 Both Parties will retain separate complaints policies reflecting the distinct statutory requirements.

11.1.1 There will be a single point of contact for complainants. This will be agreed between the Parties to co-ordinate complaints specific to the delegated functions to ensure that the requirements of existing legal/prescribed elements of health and social care complaints processes are met.

11.1.2 Staff within the delegated functions will apply the complaints policy of the relevant Party, depending on the nature of the complaint made. Where a complaint could be dealt with by the policies of both Parties, the appropriate manager will determine whether both need to be applied separately or a single joint response is appropriate. Where a joint response to such a complaint is not possible or appropriate, the material issues will be separated and progressed through the respective Party's procedures.

11.2 In the first instance all complaints will be handled by front line staff. If they are unresolved, they will then be passed to a relevant senior manager and thereafter to the Chief Officer.

11.3 If the complaint remains unresolved, the complainant may refer the matter to the Scottish Public Services Ombudsman for health or for social care, as appropriate.

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

11.5 The person making the complaint will always be informed which policies are being applied to their complaint.

11.6 The Parties will produce a quarterly joint report, outlining the learning from upheld complaints. This will be provided for consideration by the IJB.

12 Claims Handling, Liability & Indemnity

The Parties agree the following arrangements in respect of claims handling, liability and indemnity:

12.1 The IJB, whilst having a legal personality in its own right has neither assumed nor replaced the rights or responsibilities of either NHS Highland or the Council as the employers of staff who are managed within the delegated functions, or for the operation of buildings or services under the operational remit of those staff.

12.2 The Parties will continue to indemnify, insure and accept responsibility for the staff that they employ; their particular capital assets that the IJB uses to deliver services with or from; and the respective services themselves, which each Party has delegated to the IJB.

12.3 Liabilities arising from decisions taken by the IJB will be shared between the Parties.

13 Risk Management

13.1 The Parties will develop a shared risk management strategy that will identify, assess and prioritise risks related to the delivery of services under integration functions, particularly any which are likely to affect the IJB's delivery of the Strategic Plan.

13.2 The risk management strategy will identify and describe processes for mitigating those risks and set out and agree the reporting standard, which will include:

- Risk Management Process
- Escalation of Risks
- Risk Register and Action Plans
- Risk Tolerance
- Training

13.3 The risk management strategy will be approved by both Parties. The risk management strategy will allow for any subsequent changes to the strategy to be

approved by the IJB.

13.4 The risk management strategy will include an agreed risk monitoring framework and arrangements for reporting risks and risk information to the relevant parties from the date of inception of the IJB.

13.5 The Parties will develop an integrated risk register that will set out the key risks for the IJB. Risk officers from each of the Parties will review respective procedures and formulate revised procedures which will allow associated risks, scoring and mitigations to be identified for inclusion in the integrated risk register.

13.6 The Integrated Risk Register will be reported to the IJB on a timescale and format agreed by the IJB, but this will not be less that once per year.

13.7 The risk integrated management strategy will set out the process for amending the integrated risk register.

13.8 The Parties will make appropriate resources available to support the IJB in its risk management.

14 Dispute Resolution Mechanism

14.1 Where either of the Parties fails to agree with the other on any issue related to this Scheme, they will follow a process which comprises:

14.1.1 A representative of NHS Highland and the Council will meet to resolve the issue, supported by appropriate Officers.

14.1.2 In the event that the issue remains unresolved, the Chief Executive Officers of NHS Highland and the Council, and the Chief Officer, will meet to resolve the issue, supported by appropriate Officers.

14.1.3 In the event that the issue remains unresolved, the Chair of NHS Highland and the Leader of the Council will meet to resolve the issue, supported by appropriate Officers.

14.1.4 In the event that the issue remains unresolved, NHS Highland and the Council will proceed to mediation with a view to resolving the issue.

14.2 With regard to the process of appointing a mediator, a representative of NHS Highland and a representative of the Council will meet with a view to appointing a

suitable independent mediator. If agreement cannot be reached, a referral will be made to the President of The Law Society of Scotland inviting the President to appoint a mediator. The Parties agree to share the cost of appointing a mediator.

14.3 Where an issue remains unresolved following the process of mediation, the Chief Executive Officers of NHS Highland and the Council will communicate in writing with Scottish Ministers, on behalf of the Parties, informing them of the issue under dispute and that agreement cannot be reached

Annex 1

Part 1

Functions delegated by NHS Highland to the IJB

Functions prescribed for the purposes of Section 1(6) of the Act

Column A	*Column B*
The National Health Service (Scotland) Act 1978	
All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of— section 2(7) (Health Boards); section 9[1] (local consultative committees); section 17A[2] (NHS contracts); section 17C[3] (personal medical or dental services); section 17J[4] (Health Boards' power to enter into general medical services contracts); section 28A[5] (remuneration for Part II services); section 48[6] (residential and practice accommodation); section 57[7] (accommodation and services for private patients); section 64[8] (permission for use of facilities in private practice); section 79[9] (purchase of land and moveable property); section 86[10] (accounts of Health Boards and the Agency); section 88[11] (payment of allowances and remuneration to members of certain bodies connected with the health services);

[1] As relevantly amended by the National Health Service and Community Care Act 1990 (c.19), section 29(5) and the Health Act 1999 (c.8), Schedule 4.
[2] Section 17A was inserted by the National Health Service and Community Care Act 1990 (c.19) and was relevantly amended by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2; the Health Act 1999 (c.8), Schedules 4 and 5; the Health and Social Care (Community Health and Standards) Act 2003 (c.43), Schedule 14; the Public Services Reform (Scotland) Act 2010 (asp 8), schedule 17; and the Health and Social Care Act 2012 (c.7), Schedule 21.
[3] Section 17C was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 21 and relevantly amended by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 2.
[4] Section 17J was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 4.
[5] Section 28A was inserted by the Health Act 1999 (c.8), section 57.
[6] The functions of the Secretary of State under section 48 are conferred on Health Boards by virtue of S.I. 1991/570.
[7] Section 57 was substituted by the Health and Medicines Act 1988 (c.49), section 7(11), and relevantly amended by the National Health Service and Community Care Act 1990 (c.19), Schedules 9 and 10. The functions of the Secretary of State under section 57 are conferred on Health Boards by virtue of S.I. 1991/570.
[8] The functions of the Secretary of State under section 64 are conferred on Health Boards by virtue of S.I. 1991/570.
[9] As relevantly amended by the Health and Social Services and Social Security Adjudications Act 1983 (c.41), Schedule 7. National Health Service and Community Care Act 1990 (c.19), Schedule 9, the Requirements of Writing (Scotland) Act 1995 (c.7), Schedule 5 and the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1. The functions of the Secretary of State under section 79 are conferred on Health Boards by virtue of S.I. 1991/570.
[10] As relevantly amended by the National Health Service and Community Care Act 1990 (c.19), section 36(6) and the Public Finance and Accountability (Scotland) Act 2000 (asp 1), schedule 4.
[11] The functions of the Secretary of State under section 88(1) (e) and (2) (d) are conferred on Health Boards by virtue of S.I. 1991/570. There are no amendments to section 88 relevant to the exercise of these functions by a Health Board.

	paragraphs 4, 5, 11A and 13 of Schedule 1[12] (Health Boards);
	and functions conferred by—
	The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000[13];
	The Health Boards (Membership and Procedure) (Scotland) Regulations 2001[14],
	The National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004[15];
	The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018[16]
	The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006[17];
	The National Health Service (Discipline Committees) (Scotland) Regulations 2006[18];
	The National Health Service (Appointment of Consultants) (Scotland) Regulations 2009[19];
	The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009[20]; and
	The National Health Service (General Dental Services) (Scotland) Regulations 2010[21].
Disabled Persons (Services, Consultation and Representation) Act 1986[22]	
Section 7 (persons discharged from hospital)	
Community Care and Health (Scotland) Act 2002	
All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	
Mental Health (Care and Treatment) (Scotland) Act 2003	
All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by section 22 (approved medical practitioners).

[12] Paragraph 4 of Schedule 4 was substituted by the Health Boards (Membership and Elections) (Scotland) Act 2009 (asp 5), schedule 1. Paragraph 5 of Schedule 1 was amended, and paragraph 11A of Schedule 1 inserted, by the Health Services Act 1980 (c.53), Schedule 6.

[13] To which there are amendments not relevant to the exercise of a Health Board's functions.

[14] To which there are amendments not relevant to the exercise of a Health Board's functions.

[15] As relevantly amended by S.S.I. 2004/216; S.S.I. 2006/136; S.S.I. 2007/207 and S.S.I. 2011/392.

[16] As relevantly amended by S.S.I. 2004/217; S.S.I. 2010/395; and S.S.I. 2011/55.

[17] As relevantly amended by S.S.I. 2007/193; S.S.I. 2010/86; S.S.I. 2010/378 and S.S.I. 2013/355.

[18] Amended by S.S.I 2009/183; S.S.I. 2009/308; S.S.I. 2010/226; S.I. 2010/231 and S.S.I. 2012/36.

[19] To which there are amendments not relevant to the exercise of a Health Board's functions.

[20] As relevantly amended by S.S.I. 2009/209; S.S.I. 2011/32; and S.S.I. 2014/148.

[21] As relevantly amended by S.S.I. 2004/292 and S.S.I 2010/378.

[22] Section 7 is relevantly amended by S.I. 2013/2341.

Education (Additional Support for Learning) (Scotland) Act 2004	Section 23 (other agencies etc. to help in exercise of functions under this Act)
Public Services Reform (Scotland) Act 2010	
All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010.	Except functions conferred by— section 31 (Public functions: duties to provide information on certain expenditure etc.); and section 32 (Public functions: duty to provide information on exercise of functions).
Patient Rights (Scotland) Act 2011	
All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011.	
Children and Young People (Scotland) Act 2014	
All functions of Health Boards conferred by, or by virtue of, Part 4 (provision of named persons) and Part 5 (child's plan) of the Children and Young People (Scotland) Act 2014.	
Carers (Scotland) Act 2016	
Section 12 (duty to prepare young carer statement)	
Section 31 (duty to prepare local carer strategy)	

Functions Prescribed for the purposes of Section 1(8) of the Act

Column A	*Column B*
The National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of— section 2(7) (Health Boards); section 2CB[23] (functions of Health Boards outside Scotland); section 9 (local consultative committees); section 17A (NHS contracts); section 17C (personal medical or dental services); section 17I[24] (use of accommodation); section 17J (Health Boards' power to enter into general medical services contracts); section 28A (remuneration for Part II services); section 38[25] (care of mothers and young children); section 38A[26] (breastfeeding); section 39[27] (medical and dental inspection, supervision

[23] Section 2CB was inserted by S.S.I. 2010/283, regulation 3(2) (as section 2CA) and re-numbered as section 2CB by S.S.I. 2013/292, regulation 8(2).

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

[25] The functions of the Secretary of State under section 38 are conferred on Health Boards by virtue of S.I. 1991/570.

[26] Section 38A was inserted by the Breastfeeding etc. (Scotland) Act 2005 (asp 1), section 4. The functions of the Scottish Ministers under section 38A are conferred on Health Boards by virtue of S.I. 1991/570 as amended by S.S.I. 2006/132.

[27] Section 39 was relevantly amended by the Self Governing Schools etc. (Scotland) Act 1989 (c.39) Schedule 11; the Health and Medicines Act 1988 (c.49) section 10 and Schedule 3, and the Standards in Scotland's Schools etc. Act 2000 (asp 6), schedule 3.

	and treatment of pupils and young persons); section 48 (residential and practice accommodation); section 55[28] (hospital accommodation on part payment); section 57 (accommodation and services for private patients); section 64 (permission for use of facilities in private practice); section 75A[29] (remission and repayment of charges and payment of travelling expenses); section 75B[30] (reimbursement of the cost of services provided in another EEA state); section 75BA[31] (reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013); section 79 (purchase of land and moveable property); section 82[32] use and administration of certain endowments and other property held by Health Boards); section 83[33] (power of Health Boards and local health councils to hold property on trust); section 84A[34] (power to raise money, etc., by appeals, collections etc.); section 86 (accounts of Health Boards and the Agency); section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services); section 98[35] (charges in respect of nonresidents); and paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards); and functions conferred by— The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989[36]; The Health Boards (Membership and Procedure) (Scotland) Regulations 2001/302; The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000; The National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004; The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018; The National Health Service (Discipline Committees) (Scotland) Regulations 2006;

[28] Section 55 was amended by the Health and Medicines Act 1988 (c.49), section 7(9) and Schedule 3 and the National Health Service and Community Care Act 1990 (c.19), Schedule 9. The functions of the Secretary of State under section 55 are conferred on Health Boards by virtue of S.I. 1991/570.

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

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

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

[32] Section 82 was amended by the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 4), section 10(2) and the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 2.

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

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

[35] Section 98 was amended by the Health and Medicines Act 1988 (c.49), section 7. The functions of the Secretary of State under section 98 in respect of the making, recovering, determination and calculation of charges in accordance with regulations made under that section is conferred on Health Boards by virtue of S.I. 1991/570.

[36] As amended by S.I. 1992/411; S.I. 1994/1770; S.S.I. 2004/369; S.S.I. 2005/445; S.S.I. 2005/572; S.S.I. 2006/141; S.S.I. 2008/290; S.S.I. 2011/25 and S.S.I. 2013/177.

	The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006; The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009; The National Health Service (General Dental Services) (Scotland) Regulations 2010; and The National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Regulations 2011[37].
Disabled Persons (Services, Consultation and Representation) Act 1986 Section 7 (persons discharged from hospital)	
Community Care and Health (Scotland) Act 2002 All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	
Mental Health (Care and Treatment) (Scotland) Act 2003 All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by— section 22 (approved medical practitioners); section 34 (inquiries under section 33: co-operation)[38]; section 38 (duties on hospital managers: examination, notification etc.)[39]; section 46 (hospital managers' duties: notification)[40]; section 124 (transfer to other hospital); section 228 (request for assessment of needs: duty on local authorities and Health Boards); section 230 (appointment of patient's responsible medical officer); section 260 (provision of information to patient); section 264 (detention in conditions of excessive security: state hospitals); section 267 (orders under sections 264 to 266: recall); section 281[41] (correspondence of certain persons detained in hospital); and functions conferred by— The Mental Health (Safety and Security) (Scotland) Regulations 2005[42]; The Mental Health (Cross border transfer: patients subject

[37] To which there are amendments not relevant to the exercise of a Health Board's functions.

[38] There are amendments to section 34 not relevant to the exercise of a Health Board's functions under that section.

[39] Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") provides a definition of "managers" relevant to the functions of Health Boards under that Act.

[40] Section 46 is amended by S.S.I. 2005/465.

[41] Section 281 is amended by S.S.I. 2011/211.

[42] To which there are amendments not relevant to the exercise of the functions of a Health Board. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

	to detention requirement or otherwise in hospital) (Scotland) Regulations 2005[43]; The Mental Health (Use of Telephones) (Scotland) Regulations 2005; and The Mental Health (England and Wales Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008.
Education (Additional Support for Learning) (Scotland) Act 2004 Section 23 (other agencies etc. to help in the exercise of functions under this Act)	
Public Services Reform (Scotland) Act 2010	
All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010.	Except functions conferred by— section 31 (public functions: duties to provide information on certain expenditure etc.); and section 32 (public functions: duty to provide information on exercise of functions).
Patient Rights (Scotland) Act 2011	
All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36[44].

[43] Section 329(1) of the 2003 Act provides a definition of “managers” relevant to the functions of Health Boards.

[44] Section 5(2) of the Patient Rights (Scotland) Act 2011 (asp 5) provides a definition of “relevant NHS body” relevant to the exercise of a Health Board's functions.

Part 2

Services currently provided by NHS Highland which are to be integrated

- Hospital inpatient (scheduled and unscheduled)
- Rural General Hospitals
- Mental Health
- Pediatrics
- Community Hospitals
- Hospital Outpatient Services
- NHS Community Services (Nursing, Allied Health Professionals, Mental Health Teams, Specialist End of Life Care, Homeless Service, Older Adult Community Psychiatric Nursing, Re-ablement, Geriatricians Community/Acute, Learning Disability Specialist, Community Midwifery, Speech and Language Therapy, Occupational Therapy, Physiotherapy, Audiology
- Community Children's Services - Child and Adolescent Mental Health Service, Primary Mental Health workers, Public Health Nursing, Health visiting, School Nursing, Learning Disability Nursing, Child Protection Advisors, Speech and Language Therapy, Occupational Therapy, Physiotherapy and Audiology, Specialist Child Health Doctors and Service Community Pediatricians
- Public Health
- GP Services
- GP Prescribing
- General Dental, Opticians and Community Pharmacy
- Support Services
- Contracts and Service Level agreements with other NHS boards covering adults and children

Annex 2

Part 1

Functions delegated by the Council to the IJB

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

Column A *Enactment conferring function*	*Column B* *Limitation*
National Assistance Act 1948([11])	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958([12])	
Section 3 (Provision of sheltered employment by local authorities)	

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

(11) 1958 c.33; section 3 was amended by the Local Government Act 1972 (c.70), section 195(6); the Local Government (Scotland) Act 1973 (c.65), Schedule 27; the National Health Service (Scotland) Act 1978 (c.70), schedule 23; the Local Government Act 1985 (c.51), Schedule 17; the Local Government (Wales) Act 1994 (c.19), Schedules 10 and 18; the Local Government etc. (Scotland) Act 1994 (c.49), Schedule 13; and the National Health Service (Consequential Provisions) Act 2006 (c.43), Schedule 1

Column A *Enactment conferring function*	*Column B* *Limitation*
The Social Work (Scotland) Act 1968([13])	
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.
Section 8 (Research.)	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.
Section 12 (General social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.

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

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 12AZA (Assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
Section 13 (Power of local authorities to assist persons in need in disposal of produce of their work.)	
Section 13ZA (Provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.
Section 13A (Residential accommodation with nursing.)	
Section 13B (Provision of care or aftercare.)	
Section 14 (Home help and laundry facilities.)	
Section 28 (Burial or cremation of the dead.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982([14])	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
Disabled Persons (Services, Consultation and Representation) Act 1986([15])	

(13) 1982 c.43; section 24(1) was amended by the Local Government etc. (Scotland) Act 1994 (c.39), schedule 13.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 2 (Rights of authorised representatives of disabled persons.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000([16])	
Section 10 (Functions of local authorities.)	
Section 12 (Investigations.)	
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (Duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
Section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions

(14) 1986 c.33. There are amendments to sections 2 and 7 which are not relevant to the exercise of a local authority's functions under those sections.
(15) 2000 asp 4; section 12 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 5(1). Section 37 was amended by S.S.I. 2005/465. Section 39 was amended by the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and by S.S.I. 2013/137. Section 41 was amended by S.S.I. 2005/465; the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and S.S.I. 2013/137. Section 45 was amended by the Regulation of Care (Scotland) Act 2001 (asp 8), Schedule 3.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions
The Housing (Scotland) Act 2001([17])	
Section 92 (Assistance to a registered for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002([18])	
Section 5 (Local authority arrangements for residential accommodation outwith Scotland.)	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	
The Mental Health (Care and Treatment) (Scotland) Act 2003([19])	
Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (Duty to inquire.)	
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	

(16) 2001 asp 10; section 92 was amended by the Housing (Scotland) Act 2006 (asp 1), schedule 7.
([18]) 2002 asp 5.
(19) 2003 asp 13; section 17 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), section 111(4), and schedules 14 and 17, and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 25 was amended by S.S.I. 2011/211. Section 34 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 259 (Advocacy.)	
The Housing (Scotland) Act 2006([20])	
Section 71(1) (b) (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Adult Support and Protection (Scotland) Act 2007([21])	
Section 4 (Council's duty to make inquiries.)	
Section 5 (Co-operation.)	
Section 6 (Duty to consider importance of providing advocacy and other.)	
Section 11 (Assessment Orders.)	
Section 14 (Removal orders.)	
Section 18 (Protection of moved persons property.)	
Section 22 (Right to apply for a banning order.)	
Section 40 (Urgent cases.)	
Section 42 (Adult Protection Committees.)	
Section 43 (Membership.)	
Social Care (Self-directed Support) (Scotland) Act 2013 ([22])	

(20) 2006 asp 1; section 71 was amended by the Housing (Scotland) Act 2010 (asp 17) section 151.
(21) 2007 asp 10; section 5 and section 42 were amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17 and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 43 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedule 14.
([22]) 2013 asp 1.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 5 (Choice of options: adults.)	
Section 6 (Choice of options under section 5: assistances.)	
Section 7 (Choice of options: adult carers.)	
Section 9 (Provision of information about self-directed support.)	
Section 11 (Local authority functions.)	
Section 12 (Eligibility for direct payment: review.)	
Section 13 (Further choice of options on material change of circumstances.)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Section 16 (Misuse of direct payment: recovery.)	
Section 19 (Promotion of options for self-directed support.)	
Carers (Scotland) Act 2016 [2324]	
Section 6 (Duty to prepare adult carer support plan)	
Section 21 (Duty to set local eligibility criteria)	
Section 24 (Duty to provide support)	

(23) section 21 was inserted into the Schedule of the Public Bodies (Joint Working) (Scotland) Act 2014 by paragraph 6 of the schedule of the Carers (Scotland) Act 2016 (asp 9)

(24)inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017/190

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 25 (Provision of support to carers: breaks from caring) Section 31 (Duty to prepare local carer strategy) Section 34 (Information and advice service for carers) Section 35 (Short breaks services statements)	

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

Column A *Enactment conferring function*	*Column B* *Limitation*
The Community Care and Health (Scotland) Act 2002 Section 4([25]) **The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002([26])**	

([25]) Section 4 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp13) schedule 4 and the Adult Support and Protection (Scotland) Act 2007 (asp 10) section 62(3)

([26]) S.S.I. 2002/265, as amended by S.S.I. 2005/445.

Additional Functions delegated by the Council to Argyll and Bute Integration Joint Board

Column A Enactment conferring function	Column B
National Assistance Act 1948	
Section 45 **(**Recovery in cases of misrepresentation or non-disclosure.)	
Matrimonial Proceedings (Children) Act 1958	
Section 11 **(**Reports as to arrangements for future care and upbringing of children.)	
The Social Work (Scotland) Act 1968	
Section 5 **(**Powers of Secretary of State.)	
Section 6B (Local authority inquiries into matters affecting children.)	
Section 27 (Supervision and care of persons put on probation or released from prisons etc.)	
Section 27ZA (Advice, guidance and assistance to persons arrested or on whom sentence deferred.)	
Section 78A (Recovery of contributions)	
Section 80 (Enforcement of duty to make contributions.)	
Section 81 (Provisions as to decrees for ailment.)	
Section 83 (Variation of trusts.)	
Section 86 (Adjustment between authority providing accommodation etc., and authority of area of residence.)	
The Children Act 1975	
Section 34 (Access and maintenance.)	
Section 39 (Reports by local authorities and probation officers.)	

Section 40
(Notice of application to be given to local authority.)

Section 50
(Payments towards maintenance of children.)

Health and Social Services and Social Security Adjudications Act 1983

Section 21
Recovery of sums due to local authority where persons in residential accommodation have disposed of assets.)

Section 22
(Arrears of contributions charged on interest in land in England and Wales)

Section 23
(Arrears of contributions secured over interest in land in Scotland)

Foster Children (Scotland) Act 1984

Section 3
(Local authorities to ensure well-being of and to visit foster children.)

Section 5
(Notification by persons maintaining or proposing to maintain foster children.)

Section 6
Notification by persons ceasing to maintain foster children.)

Section 8
(Power to inspect premises.)

Section 9
(Power to impose requirements as to the keeping of foster children.)

Section 10
(Power to prohibit the keeping of foster children.)

The Children (Scotland) Act 1995

Section 17
(Duty of local authority to child looked after by them.)

Section 20
(Publication of information about services for children)

Section 21
(Co-operation between authorities)

Section 22
(Promotion of welfare of children in need)

Section 23
(Children affected by disability)

Section 25
(Provision of accommodation for children etc.)

Section 26
(Manner of provision of accommodation to child looked after by local authority)

Section 26A
(Provision of continuing care: looked after children)

Section 27
(Daycare for pre-school and other children)

Section 29
(Aftercare)

Section 30
(Financial assistance towards expenses of education or training and removal of power to guarantee indentures etc.)

Section 31
Review of case of child looked after by local authority)

Section 32
(Removal of child from residential establishment)

Section 36
(Welfare of certain children in hospitals and nursing homes etc.)

Section 38
(Short term refuges for children at risk of harm.)

Section 76
(Exclusion orders.)

Criminal Procedure (Scotland) Act 1995

Section 51
(Remand and committal of children and young persons.)

Section 203
Reports.)

Section 234B
(Drug treatment and testing order.)

Section 245A
(Restriction of liberty orders.)

The Adults with Incapacity (Scotland) Act 2000

Section 40
(Supervisory bodies.)

The Community Care and Health (Scotland) Act 2002

Section 6
(Deferred payment of accommodation costs.)

Management of Offenders etc (Scotland) Act 2005

Sections 10
(Arrangements for assessing and managing risks posed by certain offenders)

Section 11
(Review of arrangements)

Adoption and Children (Scotland) Act 2007

Section 1
(Duty of local authority to provide adoption service.)

Section 5
(Guidance)

Section 6
(Assistance in carrying out functions under sections 1 and 4)

Section 9
(Assessment of needs for adoption support services)

Section 10
(Provision of services)

Section 11
(Urgent provision)

Section 12
(Power to provide payment to person entitled to adoption support service)

Section 19
(Notice under Section 18 local authorities duties)

Section 26
(Looked after children - adoption is not proceeding.)

Section 45
(Adoption support plans.)

Section 47
(Family member's right to require review of plan)

Section 48
(Other cases where authority under duty to review plan)

Section 49
(Re-assessment of needs for adoption support services)

Section 51
(Guidance)

Section 71
(Adoption allowance schemes.)

Section 80
(Permanence Orders.)

Section 90
(Precedence of certain other orders)

Section 99
(Duty of local authority to apply for variation or revocation.)

Section 101
(Local authority to give notice of certain matters.)

Section 105
(Notification of proposed application for order)

The Adult Support and Protection (Scotland) Act 2007

Section 7
(Visits)

Section 8
(Interviews)

Section 9
(Medical examinations)

Section 10
(Examination of records etc.)

Section 16
(Right to remove adult at risk)

Children's Hearings (Scotland) Act 2011

Section 35
(Child assessment orders.)

Section 37
(Child protection orders.)

Section 42
(Parental responsibilities and rights directions.)

Section 44
(Obligations of local authority.)

Section 48
(Application for variation or termination

Section 49
(Notice of an application for variation or termination.)

Section 60
(Local authorities duty to provide information to Principal Reporter.)

Section 131
(Duty of implementation authority to require review.)

Section 144
(Implementation of a compulsory supervision order; general duties of implementation authority.)

Section 145
(Duty where order requires child to reside in a certain place.)

Section 166
(Review of requirement imposed on local authority)

Section 167
(Appeal to Sheriff Principal: section 166)

Section 180
(Sharing of information: panel members.)

Section 183-

(Mutual Assistance)

Section 184
(Enforcement of obligations of health board under section 183)

Social Care (Self-directed Support) (Scotland) Act 2013

Section 8
(Choice of options; children and family members.)

Section 10
(Provision of information; children under 16.)

Carers (Scotland) Act 2016

Section12
(Duty to prepare a Young Carer Statement)

Column A Functions conferred by virtue of enactments	Column B
Children's Hearings (Scotland) Act 2011 Section 153 (Secure accommodation: regulations.)	

Part 2

Services currently provided by the Council which are to be integrated:

All permitted Council functions apart from housing and housing support services, other than aids and adaptations aspects of housing support.

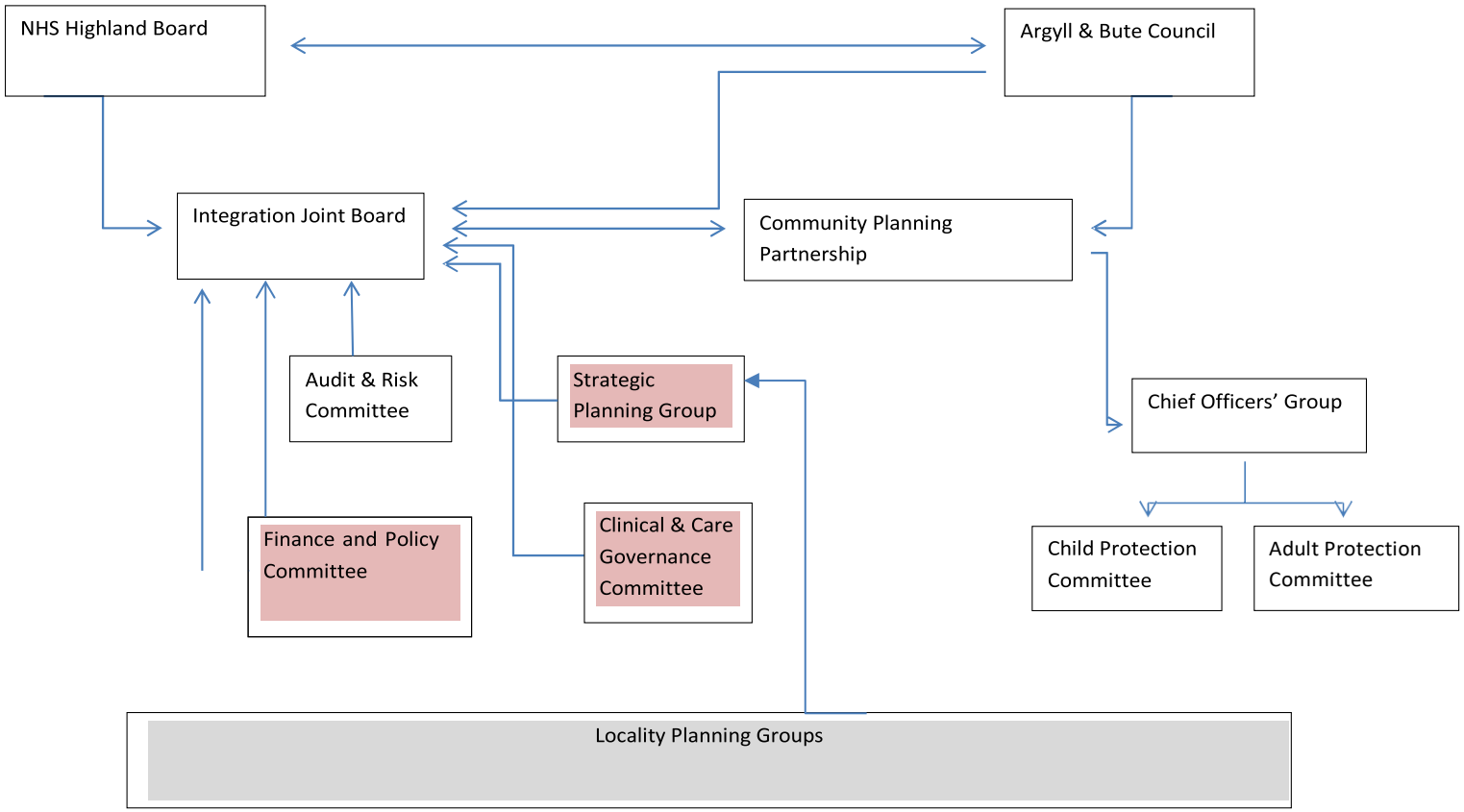
- Social care Services for Adults and Older People
    - Services and Support for Adults with Physical Disabilities and Learning Disabilities
    - Mental Health Services
    - Drug and Alcohol Services
    - Adult Protection and Domestic Abuse
    - Carers Support Services
    - Community Care Assessment Teams
    - Support Services
    - Care Home Services
    - Adult Placement Services

    - Health Improvement Services
    - Housing support including Aids and Adaptions
    - Day Services
    - Local Area Co-ordination
    - Self-Directed support
    - Respite Provision for adults and young people
    - Occupational Therapy Services
    - Re-ablement Services, Equipment and Telecare
- Social care services for children and young people
    - Child Care Assessment and Care Management
    - Looked After and accommodated Children
    - Child Protection
    - Adoption and Fostering
    - Special Needs/Additional Support
    - Early Intervention
    - Through-care Services
    - Youth Justice Services

- Social care Justice Services
    - Services to Courts and Parole Board
    - Assessment of offenders
    - Diversions from Prosecution and Fiscal Work Orders
    - Supervision of offenders subject to a community based order
    - Through care and supervision of released prisoners
    - Multi Agency Public Protection Arrangements

Annex 3: Systems Governance.

System Governance Schematic



Annex 4: Clinical and Care Governance structure.