Cunninghame House
Irvine

Thursday 18th December 2014

Shadow Integration Board

You are requested to attend a meeting of the Shadow Integration Board to be held on **Thursday 18th December 2014** at **10.00 a.m..** in the **Council Chambers, Cunninghame House, Irvine**, to consider the following business.

Business

1. **Presentation – Criminal Justice – Jim McCrae, Manager**

2. **Apologies**
   Invite intimation of apologies for absence.

3. **Declaration of Interest**

4. **Minutes / Action Note**
   Submit the minutes of the meeting of the Shadow Integration Board held on 21st November 2014 and action note (copy enclosed).

5. **Matters Arising**

6. **Strategic Plan**
   Verbal update by Stephen Brown, CSWO on progress in relation to the Strategic Plan.

REPORTS FOR APPROVAL

7. **Financial Management Report as at 30th September 2014**
   Submit report by Lesley Aird, Interim Head of Finance and Fiona Neilson, Senior Finance Manager, NHS on the budget position for the NAHSCP (copy enclosed).

8. **Strategic Planning Group Membership**
   Submit report by Jo Gibson, Principal Manager (Planning & Performance) on proposals for Strategic Planning Group membership (copy enclosed).

9. Reshaping Care for Older People
Submit report by Annie Weir, Programme Manager in relation to the above (copy enclosed).

10. Integrated Care Fund
Submit report by Annie Weir, Programme Manager in relation to the above (copy enclosed).

11. Care Opinion
Submit report by David Rowland, Head of Health & Community Care in relation to the above (copy enclosed).

12. Organisational Development Support for Shadow Integration Board.
Submit report by Lisbeth Raeside, Project Manager in relation to the above (copy enclosed).

13. Development of New Hub for Rehabilitation and Reablement.
Submit report by David Rowland, Head of Health & Community Care in relation to the above (copy enclosed).

14. Response to Scottish Government's Consultation on Wilful Neglect.
Submit report by Derek Barron on NAHSCP response to the above consultation (copy enclosed).

15. Response to Scottish Government's Consultation on Duty of Candour.
Submit report by Derek Barron, Lead Nurse on NAHSCP's response to the above consultation (copy enclosed).

REPORTS TO NOTE

16. MAPPA Annual Report
Submit report by Jim McCrae, Manager (Criminal Justice) in relation to the above (copy enclosed).

17. Director's Report
Submit report by Iona Colvin, Director, NAHSCP on development within the NAHSCP (copy enclosed).

18. Scottish Patient Safety Programme – Mental Health
Submit report by Derek Barron, Lead Nurse in relation to the above (copy enclosed).

EXEMPT INFORMATION

19. Exclusion from Public and Press

19.1 Arrangements for Delivery of Care at Home Services in the North Coast Locality.
Submit report by David Rowland, Head of Health and Community Care in relation to the above (copy enclosed).

19.2 Arrangements for Delivery of Care at Home Services in the Irvine, North Coast and Three Towns Localities.

Submit report by David Rowland, Head of Health and Community Care in relation to the above (copy enclosed).

20. Any Other Competent Business

21. Date of Next Meeting

The next meeting will be held on Thursday 22nd January 2015 at 10.00 a.m., in the Council Chambers, Cunninghame House, Irvine.

Shadow Integration Board

Sederunt

Voting Members

Mr Stephen McKenzie (Chair)	NHS Ayrshire & Arran
Councillor Anthea Dickson (Vice-Chair)	North Ayrshire Council
Dr Carol Davidson	NHS Ayrshire & Arran
Mr Bob Martin	NHS Ayrshire & Arran
Dr Janet McKay	NHS Ayrshire & Arran
Councillor Peter McNamara	North Ayrshire Council
Councillor Robert Steel	North Ayrshire Council
Councillor Ruth Maguire	North Ayrshire Council

Professional Advisors

Mr Derek Barron	Lead Nurse/Mental Health Advisor
Ms Iona Colvin	Director North Ayrshire Health & Social Care Partnership
Dr Ken Ferguson	GP Representative
Ms Laura Friel	Corporate Director - North Ayrshire Council
Mr Stephen Brown	Chief Social Work Officer- North Ayrshire Council
Ms Kerry Gilligan	Lead Allied Health Professional Advisor
Mr Derek Lindsay	Director of Finance NHS Ayrshire and Arran

Stakeholder Representatives

Mr Nigel Wanless	Independent Sector Representative
Mr David Donaghey	Staff Representative - NHS Ayrshire and Arran
Ms Louise McDaid	Staff Representative - North Ayrshire Council
Mr Martin Hunter	Service User Representative
Ms Fiona Thomson	Service User Representative
Ms Marie McWaters	Carers Representative
Ms Sally Powell	Carers Representative
Mr Jim Nichols	Third Sector Representative

For further information please contact Karen Andrews, Business Support Officer, North Ayrshire Council Social Services on (01294) 317725 or by email to **kandrews@north-ayrshire.gcsx.gov.uk**

North Ayrshire Health and Social Care Partnership
Minute of Shadow Integration Board meeting held on
Friday 21st November 2014 at 10.15 a.m., Thistle Hotel, Irvine

Present :

Stephen McKenzie (Chair), Voting Member
Councillor Anthea Dickson (Vice Chair), Voting Member
Carol Davidson, Voting Member
Bob Martin, Voting Member
Councillor Ruth Maguire, Voting Member
Dr Janet McKay, Voting Member
Iona Colvin, Director, NAHSCP
Derek Barron, Lead Nurse/Mental Health Advisor
Stephen Brown, Chief Social Work Officer, NAHSCP
Kerry Gilligan, Lead AHP
Lesley Aird, Interim Head of Finance, North Ayrshire Council
Nigel Wanless, Independent Sector Representative
David Donaghy, Staff Representative, NHSAA
Louise McDaid, Staff Representative, NAC
Martin Hunter, Service User Representative
Marie McWaters, Carers Representative
Fiona Thomson, Service User Representative
Jim Nichols, Third Sector Representative

In Attendance :

David Rowland, Head of Health & Community Care
Janine Hunt, Principal Manager (Business Support)
Jo Gibson, Principal Manager (Planning & Performance)
Lisbeth Raeside, Project Manager
Annie Weir, Programme Manager
Norma Bell, Manager (Performance & Planning)
Mary Francey, Senior Manager Community Care
Peter McArthur, Clinical Service Manager, NHS Addictions
Stephen Sheach, Planning Manager, NHS Ayrshire & Arran
Louise Gibson, Lead Dietitian
Madeleine O'Brien, Consultant/Facilitator
Karen Andrews, Business Support Officer
Karen Broadfoot, Clerical Assistant

1.	**APOLOGIES**	
	Apologies were received from Cllr Peter McNamara, Cllr Robert Steel, Dr Ken Ferguson, GP Representative, Sally Powell, Carers Representative, Derek Lindsay, Director of Finance, Laura Friel, Executive Direct (Finance & Corporate Support), Eunice Johnstone, Planning Manager.	

2.	**DECLARATION OF INTEREST**	
	In terms of Standing Order 7.2 and Section 5.14 of the Code of Conduct for Members of Devolved Public Bodies, Jim Nichols and Nigel Wanless declared an interest in Item 5.	
3.	**MINUTE OF MEETING HELD ON 30th OCTOBER 2014**	
	Agreed without amendment.	
4.	**STRATEGIC PLAN**	
	Stephen McKenzie, Chair welcomed members of the Strategic Plan Writing Group to the meeting.	
	The Chair asked for thanks to be conveyed to everyone involved in the production of the Strategic Plan, acknowledging the effort in the compilation of this report.	
	Stephen Brown, CSWO gave a presentation in relation to :- • Progress of the Strategic Plan. • Feedback on the documents produced to date. • Timetable for consultation and engagement.	
	The SIB meeting adjourned at 10.40 a.m. to allow SIB members to participate in group discussions on the draft plan and the priorities detailed in the plan.	
	The meeting reconvened at 11.30 a.m., and members provided feedback on the draft plan and each of the priorities contained within it.	
	These were noted and it was agreed that the Strategic Plan Writing Group note and act on the feedback received.	
	Councillor Anthea Dickson, Chair of the Strategic Plan Writing Group thanked everyone for their participation and conveyed thanks to all involved in the process to date.	
5.	**INTEGRATED CARE FUND**	
	David Rowland, Head of Health & Community Care gave a presentation on the Integrated Care Fund.	

	David Rowland highlighted proposals for the further development of the NAHSCP submission to the Integrated Care Fund. These include :- • Redesign or realignment of existing services and pathways.	
	• Creation of a temporary Change Team to take this work forward.	
	• Reshaping Care for Older People Change Fund carry forward proposals.	
	• Innovation and Ideas Fund process.	
	• The timetable for Integrated Care Fund in North Ayrshire.	
	Members asked questions and sought clarification in relation to :-	
	• Application process for the Innovation and Ideas Fund. Jim Nichols reported that 17 submissions have been received to date with a closing date of 26th November 2014.	
	• Impact on staff employed within current Change Fund projects that will cease after this financial year.	
7.	**DATE OF NEXT MEETING**	
	The next meeting will be held on **Thursday 18th December 2014 at 10.00 a.m., Council Chambers, Cunninghame House, Irvine.**	

The meeting concluded at 12.50 p.m.

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Shadow Integration Board
18th December 2014

Subject:	**Financial Management Report as at 30 September 2014**
Purpose:	To provide an overview of the current financial position of the North Ayrshire Health and Social Care Partnership, as well as the projected outturn for 2014/15 as at 30 September 2014.
Recommendation:	That the Health and Social Care Partnership note content of this report, including specific key actions on significant variances and the actions being taken to bring the budget back into line.

1.	**Introduction**
1.1	This report is to provide an overview of the current financial position of the North Ayrshire Health and Social Care Partnership, as well as the projected outturn for 2014/15 as at 30 September 2014. This report reflects projected expenditure and income and has been prepared in conjunction with relevant budget holders.
1.2	The total annual budget allocation reported at period 4 was £196.66m. This has been increased to £197.103m, based upon the agreements reached in March 2014, as reported to the Health and Social Care Partnership together with the additions noted in section 5 of this report.
2.	**Current Financial Position**
2.1	Against the current budget of £197,103m there is a projected year-end overspend of £5.322m.
2.2	The summary in Appendix 1 details the projected expenditure within the Health Board and North Ayrshire Council. The key issues are:
	<u>Level One Core (projected overspend £3.013m)</u> An overspend of £0.12m is projected for Learning Disabilities mainly due to increases in the number of community packages and direct payment packages. A review of care packages is being undertaken.
	Older People projected overspend of £2.588m due to:
	• Older People's Care at home services £1.174m projected overspend: • Employee Costs – additional temporary staffing and overtime costs required to cover additional workloads as a result of work being handed back by external providers, estimated full year additional cost £712k.

	• Purchased care at home services – projected overspend of £451k due to an increase in both the number of service users and overall service user needs. A review of resource utilisation will be carried out to maximise the use of existing resources in order to ensure that the service is running as efficiently as possible to help to offset increasing demand linked costs. At the same time, the Care at Home Action Plan is being reinvigorated to ensure the current service is optimised to meet local need and work has recently begun to review the models of service delivery to ensure these are safe and sustainable into the future. The financial benefits of this for the current financial year may be limited but this work will help underpin budgeted activities for future years.
	• Older People's residential and nursing care homes are projecting an overspend of £1.201m, based on projected occupancy to the end of the financial year of 924 placements, against a budget of 848. The service started the year with 36 placements more than budget which has contributed to the current projected overspend. Since then in year discharges have been lower than budgeted and admissions have been higher. Admissions levels are in part dictated by the need to meet the delayed discharges target of zero. In year, discharges are 18 less than anticipated and admissions are 27 greater. In previous years the admissions policy to nursing and residential homes led to a high number of long term residents staying in excess of 5 years. For the past couple of years the service has been seeking to address this through enhancing reablement services in order to help more people stay independent and in their own houses for as long as possible and to reduce long term home admissions. To further develop this concept Nursing, AHP and Social Work staff will work together from Pavilion 3 at Ayrshire Central Hospital to form a new, integrated Rehabilitation and Reablement Hub, through which patients will be supported to attain the level of independence required for them to successfully return home with an appropriate Care at Home package. The financial benefits of this for the current financial year may be limited but this work will help underpin budgeted activities for future years.
	An overspend of £0.312m is projected for Physical Disabilities mainly due to increases in residential care packages and direct payment packages. A review of care packages is being undertaken. • The projected overspends above are partially offset by projected underspend in Mental Health Community Teams £0.315m.
	• Primary care prescribing has a projected overspend of £0.17m, primarily resulting from the cost per item prescribed being higher than the original estimate. The projection is based on four months prescribing information so is liable to change during the year.

	• An overspend of £0.16m is now projected for the community nursing budgets. A review of the use of supplementary staffing is underway to address this emerging overspend.
	Level Two – Non District General Hospitals (projected overspend £0.303m) The frail elderly wards at Ayrshire Central Hospital continue to exceed budget despite additional funding. This is due to high occupancy, patients being more frail and high staff sickness levels. Sickness absence in these wards has averaged about 14% for 2014/15. It is hoped that application of the new Promoting Attendance policy will help to reduce absence levels. The development of the rehabilitation and reablement hub described earlier in this report may also help to reduce the overspend.
	Level Three – Lead Partnership Services (projected overspend £1.84m) Lead Partnership mental health services are projecting an overspend of £1.84m.This is due to: • projected overspend of £1m in employee costs within the adult inpatient wards, due to staff in post exceeding establishment as a result of high level of constant observations and high sickness absence. • Cost of unplanned activity (UNPAC) eg. placement of patients in private facilities is much greater than experienced in the past. An increase of 45% from last year's expenditure is projected. In some cases, the increased UNPAC activity is the direct consequence of limited availability of NHS places, resulting in an underspend in the Service Level Agreement which partially offsets the additional costs. Negotiations are underway with the main provider of UNPAC activity to agree a reduced rate and this will reduce the level of overspend. Reviews have been undertaken on all UNPACs activity and as a result of this it is anticipated that there will be some discharges in the near future. It is anticipated that once services move to the new North Ayrshire Hospital the level of overspend will reduce. A low secure forensic in-patient unit will be developed that will reduce the reliance on private providers. It is expected that the design of the wards in the new hospital will reduce the level of staffing required for constant observations.
	Level Four – Children's Services (projected overspend of £0.395m**)** Within Community Paediatrics a £0.030m overspend is projected mainly due to very high costs for one package of care.
	Social work Children's Services are projecting an overspend of £0.365m due mainly to: • Projected overspend of £0.194m on Residential Schools due to additional placements and a decrease in the number of residents who can be co-funded by Education Services. • Projected overspend of £0.286m for fostering placements due to anticipated increases in demand. The Council is in the process of recruiting more internal foster carers to reduce the costs of this service by placing more children with internal carers at significantly lower cost. In addition the Early Intervention and Prevention work is expected to help reduce the overall numbers of children requiring fostered over the next three years.

	• Children with Disabilities care packages are projected to overspend by £0.375m due to an increase in the number of care packages. Resource allocation meetings are being re-established to address this. • The above overspends are partially offset by projected underspends on: ▪ Employee Costs - £0.198m due to delays in recruiting staff at the start of the year. ▪ Kinship and Adoption costs - £0.155m due to demand lower than anticipated ▪ Remand Schools - £0.1m due to placements lower than anticipated ▪ Supported carers - £0.042m due to difficulties in recruiting additional carers
	<u>Support Services (projected underspend of £0.230m)</u> General reduction in central overheads across Social Services and Health.
3.	**Efficiency Update**
	Social Services are continuing the roll out of the new CM2000 system which, once fully implemented, should reduce the costs of Older People services. In addition, a staffing review is being carried out to address the projected overspend on staffing for Older People. On-going action to reduce the level of overspend on Lead Partnership Services consists of: • Minimisation of the use of agency nurses • Review patients on constant observations regularly to ensure that the need for such level of care continues • Ensure compliance with the Promoting Attendance Policy. • Consider whether there are in-house solutions to the use of the private sector which could be appropriate. • Negotiate with private provider to secure a reduction in fees. The adult care package costs have been targeted with efficiencies of £0.830m, to date efficiencies of £0.308m have been achieved. Work is ongoing to review care packages and to consider alternative supported accommodation models. Older People was targeted with efficiency savings of £1m in relation to reablement. To date this has not been achieved and further analysis is being undertaken to analyse this. Other efficiencies within older people include £0.150m in relation to workforce review, this is ongoing at present, also £0.594m to be achieved through costs of care packages, reviews are ongoing. The overall aim is to bring Social Services Community Care costs into line. Efficiency savings of £0.088m were identified for income received from older people service users, at present the projected increase in income received from older people is £0.071m. Elderly mental health wards were targeted with efficiency savings of £0.2m, there is a risk that this will not be achieved as planned. The budget has been reduced to reflect this plan in the second six months of the year, bed closures will need to be delivered to release the savings recurringly. Plans are being finalised to close some NHS beds and notice has been given to the provider at Cumbrae Lodge that beds will close from next April. It is unlikely that savings will be released in 2014/15, however the full £0.2m will be released from April 2015.

4.	**Budget Movements**
	Within Council budgets have been increased in respect of:- • £145k for Early Intervention and Prevention within Mental Health moved from contingency Within Health budgets have been increased in respect of:- • Allocation of nursing investment funding for the second 6 months to 31 March of £91k • Realignment of day hospital and Parkinson's nurse budgets from acute totalling £218k Virement • £71k virement from Adult, Older People and Children's services into Mental Health to fund Mental Health Officers posts and a Practice Assessor post
5.	**Recommendation**
5.1	It is recommended that the Health and Social Care Partnership note content of this report, including specific key actions on significant variances and the actions being taken to bring the budget back into line.

For more information please contact Fiona Neilson, Senior Finance Manager, NHS Ayrshire and Arran on [01292 513301] or Lesley Aird, Interim Head of Finance, North Ayrshire Council on [01294 324542]

Appendix 1
Indicative Health & Social Care
Partnership Budgets: North

Objective Summary	2014/15 Budget			2014/15 Budget			2014/15 Budget			
	Council			Health			Aligned			
	Budget	Projection	Variance	Budget	Projection	Variance	Budget	Projection	Variance	Notes
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Level One Core										
Learning Disabilities	15,248	15,406	158	491	453	(38)	15,739	15,859	120	
Older people	37,846	40,434	2,589	0	0	0	37,846	40,434	2,588	
Physical Disabilities	3,929	4,241	312	0	0	0	3,929	4,241	312	
Mental Health Community Teams	3,364	3,065	(299)	2,118	2,102	(16)	5,482	5,167	(315)	
Addiction	1,388	1,390	2	1,050	1,017	(33)	2,438	2,407	(31)	
Community Nursing			0	3,250	3,410	160	3,250	3,410	160	
Prescribing			0	27,205	27,375	170	27,205	27,375	170	
General Medical Services			0	16,750	16,778	28	16,750	16,778	28	
Resource Transfer, Change Fund, Criminal Justice	(10,781)	(10,800)	(19)	12,379	12,379	0	1,598	1,579	(19)	
Total Level One	**50,994**	**53,736**	**2,743**	**63,243**	**63,514**	**271**	**114,237**	**117,250**	**3,013**	**1**
Level Two - Non District General Hospitals										
Ayrshire Central Continuing Care			0	4,187	4,420	233	4,187	4,420	233	
Arran War Memorial Hospital			0	1,500	1,561	61	1,500	1,561	61	
Lady Margaret Hospital			0	592	601	9	592	601	9	
Total Level Two	**0**	**0**	**0**	**6,279**	**6,582**	**303**	**6,279**	**6,582**	**303**	**2**

	Council			Health			Aligned			
Objective Summary	**2014/15 Budget £000**	**2014/15 Projection £000**	**2014/15 Variance £000**	**2014/15 Budget £000**	**2014/15 Projection £000**	**2014/15 Variance £000**	**2014/15 Budget £000**	**2014/15 Projection £000**	**2014/15 Variance £000**	**Notes**
Level Three - Lead Partnership Services										
Mental Health Services			0	42,900	44,740	1,840	42,900	44,740	1,840	
Family Nurse partnership			0	472	472	0	472	472	0	
Total Level Three	**0**	**0**	**0**	**43,372**	**45,212**	**1,840**	**43,372**	**45,212**	**1,840**	**3**
Level Four - Children's Services			0							
Community Paediatrics			0	569	599	30	569	599	30	
C&F Social Work Services	23,963	24,328	365	0	0	0	23,963	24,328	365	
Health Visiting			0	1,645	1,645	0	1,645	1,645	0	
Total Level Four	**23,963**	**24,328**	**365**	**2,214**	**2,244**	**30**	**26,177**	**26,572**	**395**	**4**
Support Services	6,381	6,290	(58)	**657**	**518**	(139)	7,038	6,808	(230)	**5**
Partnership Total	**81,338**	**84,354**	**3,017**	**115,765**	**118,070**	**2,305**	**197,103**	**202,424**	**5,321**	

Subjective Summary	2014/15 Budget			2014/15 Budget			2014/15 Budget		
	Council			Health			Aligned		
	Budget	Projection	Variance	Budget	Projection	Variance	Budget	Projection	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Costs	40,835	41,025	190	50,628	51,575	947	91,463	92,600	1,137
Property Costs	502	467	(35)	16	16	0	518	483	(35)
Supplies and Services	1,942	2,167	225	1,793	1,838	45	3,735	4,005	270
Prescribing Costs			0	27,205	27,375	170	27,205	27,375	170
Primary Medical Services			0	16,750	16,778	28	16,750	16,778	28
Transport and Plant	510	553	43	0	0	0	510	553	43
Admin Costs	1,215	1,315	100	3,222	3,222	0	4,437	4,537	100
Other Agencies & Bodies	52,112	54,453	2,341	7,185	8,300	1,115	59,297	62,753	3,456
Transfer Payments	1,673	2,171	498	8,966	8,966	0	10,639	11,137	498
Other Expenditure	300	100	(200)	0	0	0	300	100	(200)
Capital Expenditure			0	0	0	0	0	0	0
Income	(17,751)	(17,896)	(145)	0	0	0	(17,751)	(17,896)	(145)
Partnership Total	**81,338**	**84,355**	**3,017**	**115,765**	**118,070**	**2,305**	**197,103**	**202,425**	**5,322**

North Ayrshire Council
Comhairle Siorrachd Àir a Tuath

NHS Ayrshire & Arran

Shadow Integration Board
18 December 2014

Subject:	**Membership of the Strategic Planning Group**
Purpose:	To advise the Shadow Integration Board of the legislative requirements as to the membership and proceedings of the Strategic Planning Group.
Recommendation:	The Shadow Integration Board is asked to approve the proposals outlined in the report as to the membership of the Strategic Planning Group

1. Introduction

1.1 Section 32 of the Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on an Integration Joint Board (IJB) to establish a Strategic Planning Group (SPG). The IJB is responsible for appointing members to the SPG and where appropriate or necessary to remove or replace members. The legislation and supporting Regulations prescribe the groups who must be represented on the SPG. Additional members may be appointed by the IJB.

1.2 The Integration Joint Board is responsible for determining the procedure of its SPG.

2. Current Position

2.1 Section 32 of the Public Bodies (Joint Working) (Scotland) Act prescribes that the following are to be members of the SPG:

a. At least one person nominated by the Health Board
b. At least one person nominated by the local authority
c. A person to represent the interest of each locality
d. Representatives of such groups as prescribed by Regulation (see 2.3 below)

2.2 In respect of locality representatives, it is for the IJB to decide which persons are suitable to represent the interests of a locality and to select the representative. The IJB may select a single person to represent two or more localities.

2.3 The groups prescribed by regulation are:

a. health professionals
b. users of health care
c. carers of users of health care
d. commercial providers of health care
e. non-commercial providers of health care

f. social care professionals
g. users of social care
h. carers of users of social care
i. commercial providers of social care
j. non-commercial providers of social care
k. non-commercial providers of social housing
l. third sector bodies carrying out activities related to health care or social care

2.4 Users of health or social care and carers of users of health or social care must reside within the area of the local authority. Others must operate within the area of the local authority.

2.5 Members of the SPG who are required by law to operate within the area of the local authority, all do so.

2.6 In preparation for the establishment of the North Ayrshire IJB it is necessary to formalise arrangements for the SPG. The appointments to the SPG will have to be formally approved by the IJB at its first meeting but it will enhance the credibility of the initial strategic planning process if the Shadow Integration Board takes steps now to ensure that the membership of the SPG is fully compliant with legislation

2.7 The Strategic Planning Group for the North Ayrshire Shadow Integration Board was formed from the former Community Health Partnership Forum (the Forum). It was recognised that the membership of the Forum required to be strengthened with additional representatives, particularly from Social Work/Social Care. The membership of the SPG and the groups which members can be said to represent are set out in Appendix 1.

3. Gaps and Proposals

3.1 Although there is a broad representation of interests on the SPG there are some omissions, which are set out below. In each case, a proposal is made as to how the situation could be addressed.

3.2 There is no member of the SPG who has been formally nominated by either NHS Ayrshire & Arran or North Ayrshire Council. Councillor Dickson was nominated to the Shadow Integration Board, to which she will shortly take up post as Chair. This leaves the SPG without a nominated Council representative. It is proposed that North Ayrshire Council is invited to nominate a representative, from within existing Council members on the SIB. Stephen McKenzie will fulfil this role on behalf of NHS Ayrshire and Arran as Chair of the SPG.

3.3 There are no members of the SPG who are appointed as representatives of the various North Ayrshire localities. In order to ensure a that localities are appropriately represented on the SPG it is proposed that the Principal Manager, Planning & Performance brings forward proposals to a future meeting of the Shadow Integration Board. This will follow detailed work through the consultation period mapping groups and links within localities.

3.4 A senior officer from North Ayrshire Council's Housing Services is a member of the SPG. Although technically this would comply with the requirement to have a non-commercial provider of social housing on the SPG, legal advice is that including a representative from one of the Registered Social Landlords would more fully comply with the spirit of the Regulation. It is proposed that links are made with the Strategic

Housing Group within North Ayrshire Council, to invite an appropriate nomination from among Registered Social Landlords.

3.5 No member of the SPG is representing non-commercial providers of health care. Whilst there are few non-commercial providers of health care in North Ayrshire, Ayrshire Hospice is a significant partner and so it is proposed that they are approached to nominate a representative.

4. Recommendations

4.1 In summary, the following actions are proposed to ensure that the membership and proceedings of the Strategic Planning Group are fully compliant with all legislative requirements.

4.1.1 North Ayrshire Council are asked to nominate a representative from within SIB membership.

4.1.2 In consultation with North Ayrshire Council Housing Services it is proposed that a representative from among the Registered Social Landlords be identified.

4.1.3 It is proposed that the Ayrshire Hospice is invited to nominate a representative to join the SPG.

4.1.4 When the steps outlined in 3.2 – 3.5 above are complete, the Shadow Integration Board should formally review and appoint the membership of the SPG.

4.1.5 It is proposed that Principal Manager, Planning & Performance, brings forward proposals for the terms of reference of the SPG to a future meeting of the Shadow Integration Board.

4.2 Both the membership and terms of reference of the SPG will require approval at the first meeting of the Integration Joint Board.

5. Implications

Financial Implications

5.1 There are no financial implications arising directly from this report.

Human Resource Implications

5.2 There are no human resource implications arising directly from this report.

Legal Implications

5.3 Work undertaken to prepare for integration will ensure that North Ayrshire Council and NHS Ayrshire & Arran are able to comply with the requirements of the legislation.

Equality Implications

5.4 There are no equality implications.

Environmental Implications

5.5 There are no environmental implications.

Implications for Key Priorities

5.6 The integration of health and social care will contribute to the delivery of the "Healthy and Active North Ayrshire" priority in the 2013 - 2017 Single Outcome Agreement.

6. Consultations

6.1 No specific consultation was required for this report. User and public involvement is a key workstream for the development of the partnership and all significant proposals will be subject to an appropriate level of consultation.

7. Conclusion

7.1 The proposals contained in this report will ensure that the Strategic Planning Group for the North Ayrshire Partnership is compliant with all legislative requirements.

For more information please contact Jo Gibson, Principle Manager – Planning and Performance, North Ayrshire Health & Social Care Partnership on 01294 3177807 or Jogibson@north-ayrshire.gcsx.gov.uk

Appendix 1

Membership of Strategic Planning Group

(names in bold type are members of the Shadow Integration Board)

	Name	Representing	Comments
	Cllr Anthea Dickson (Chair) North Ayrshire Council	North Ayrshire Council	Vice-Chair of Shadow Integration Board
1.	Lesley Aird Interim Head of Finance Finance and Property North Ayrshire Council Cunninghame House Irvine	NAC Finance	
2.	Alex Adrain Divisional Housing Manager, North Ayrshire Council	Housing (interface)	
3.	David Allan Team Manager, Assessment & Enablement	Social care professionals	
4.	Val Fitzpatrick, Social Worker, Service Access	Social care professionals	
5.	Mr Stephen Brown Head of Children and Families and Criminal Justice	Social care professionals	Chief Social Work Officer
6.	Lorne Campbell Business Manager (Development) KA Leisure	KA Leisure	
7.	Mark Gallagher Lead Officer, Alcohol and Drugs Partnership	Social care professionals	
8.	Heather McCubbin Co-ordinator, Learning Disability & Mental Health Team	Social care professionals	
9.	Ms Morna Rae Community Planning NAC	Community Planning Partnership (interface)	
10.	Mr David Bonellie	Health professionals/ Commercial providers of health care	

11.	Derek Barron Associate Nurse Director – Mental Health	Health professionals	
12.	Linda Boyd Health Care Manager – Mental Health	Mental health management team	
13.	Irene Conway	Users of health care	
14.	Dr Ken Ferguson Associate Medical Director University Hospital Ayr	Health professionals	
15.	Carol Fisher Health Care Manager – Specialist Mental Health Services	Mental health management team	
16.	Ms Joanne Anderson Lead Practice Nurse Beith Health Centre	Health professionals	
17.	Louise Gibson Dietetic Lead Integrated Services	Health professionals	
18.	Dr Morag Henderson	Mental Health	
19.	Elaine Hill Physiotherapy Lead University Hospital Ayr	Health professionals	
20.	Fiona Neilson Finance Department NHS Ayrshire & Arran	Finance NHS	
21.	Dr John O'Dowd Consultant in Public Health	Public Health	
22.	David Rowland Head of Service Health & Community Care	Partnership Senior Management Team	
23.	Mr Martin Hunter	Users of health care	
24.	Barbara Hastings Chief Executive Officer The Ayrshire Community Trust	Third sector bodies / non-commercial providers of social care	
25.	Marion McKinna Alpha Homecare	Commercial providers of social care	

26.	Mr Jim Nichols	Third sector bodies / non-commercial providers of social care	
27.	Paul Ryan Gallagher Pharmacy	Health care professionals	
28.	Clive Shephard	Third sector bodies	
29.	Christine Speedwell Carers Centre	Carers of users of health and social care	
30.	Dr John Taylor	Mental Health professionals	
31.	Ms Fiona Thomson	Users of health and social care	
32.	Mr Nigel Wanless Scottish Care	Commercial providers of social care	
33.	Gordon McKay	Staff Representative	
	In attendance		
34.	Norma Bell Manger (Planning and Performance) NAC	Social care professionals	Planning & Performance Team Manager
35.	Marjorie Adams Programme Manager	Children's Services	
36.	Sharon Bleakley Local Officer Scottish Health Council	Scottish Health Council	
37.	Mr Rab Murray	Joint Improvement Team Leader	
38.	Mrs Joanne Sharp Senior Manager – Community Services	Co-chair Adult Officer Locality Group	
39.	Ms Michelle Sutherland	Partnership Facilitator	
	For Information Only		
40.	Mr Jim McCrae Criminal Justice NAC	Criminal Justice	
41.	Ms Liz Moore Director Acute	Acute Services Interface	

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Shadow Integration Board
18 December 2014

Subject:	**Reshaping Care for Older People Change Fund**
Purpose:	To outline the recommendations for Re-Shaping Care For Older People Change Fund initiatives that would benefit a wider population and therefore should be extended through the Integrated Care Fund or mainstreamed using Resource Transfer
Recommendation:	That the Shadow Integration Board (SIB) supports the recommendations to carry forward and extend the 9 projects outlined in this report.

1.	**Introduction**
1.1	The Reshaping Care for Older People is a Scottish Government initiative aimed at improving services for older people by shifting care towards anticipatory care and prevention.
1.2	A £230 million Older People's Change Fund was made available to Health and Social Care Partnerships across Scotland from the 2011-12 financial year. A further £70 million was made available for the 2014-15 financial year. Within North Ayrshire this fund has been managed through the OLG Adults and Older People Group.
1.3	In July this year, the Scottish Government launched its Integrated Care Fund. Although building on the Reshaping Care for Older People Change Fund the new fund relates to adult care and support services, as well as services for older people. These services will support the delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and tackle inequalities.
1.4	At its meeting on the 30 October 2014, the Shadow Integration Board agreed that the Integrated Care Fund process should meet the following objectives: • Enable Partnership service re-design • Continue Re-Shaping Care For Older People Change Fund initiatives that would benefit a wider population • Provide an opportunity for innovation & creativity

1.5	In addition, it was also agreed that Representatives of Health, Social Care, Third and Independent Sectors would review the Re-Shaping Care For Older People Change Fund initiatives that would benefit a wider population and make suggestions to the Officers Locality Group (OLG) in terms of projects and budgets that could be taken forward. Once agreed, these recommendations would then be made to the Shadow Integration Board at their meeting of the 18 December 2014.
2.	**Current Position**
2.1	The following officers were tasked with reviewing the existing Re-Shaping Care For Older People Change Fund initiatives • Jim Nichols – Third Sector • Nigel Wanless – Independent Sector • Helen McArthur – Social Care • Isabel Marr - Health
2.2	An evaluation criteria was developed to evaluate each project against on-going sustainability as well as scored for priority for funding and risk of the service being withdrawn on a scale of 1-5 as below: 1. Critical Risk 2. Substantial Risk 3. Moderate Risk 4. Low Risk 5. No Risk
2.3	Individual officers were asked to evaluate the projects with the criteria outlined above and their scores were fed back to provide an overarching priority rating for each project. It was agreed that priority would be given to projects that scored a 1 or 2, with a recommendation that those scoring 3, 4 or 5 should cease at 31 March 2015. In order to provide additional assurance, it should be noted that Officers feedback was in broad agreement and decisions on scoring unanimous.
2.4	The priorities for continued funding have been collated into a table (outlined in appendix one) which outlines 9 projects totalling **£941,888** that are recommended to be continued for a further year by utilising the Integrated Care Fund. This table also shows recommendations for several services to be mainstreamed using the available £300k Resource Transfer. It is anticipated that a new Carers Strategy and associated contractual arrangements will be established and funded in 2015/15 but £10k is set aside to maintain current arrangements until the new mechanisms are established.
2.5	Appendix two outlines those projects evaluated as having moderate to low risk, scores 3 and 4, with the recommendation that these should not continue into 2016/17. It should be noted that no project scored 5 and was deemed to have no risk.
2.6	Finally, appendix three sets out those projects that have already concluded and will therefore not be continued into 2016/17.
2.7	These proposals were taken to the Officers Locality Group (OLG) held on 2 December 2014. The OLG supported these proposals and agreed they should be proposed to the SIB.

3.	**Proposals**
3.1	It is proposed that the SIB supports the recommendation of the group in terms of Re-Shaping Care For Older People Change Fund projects that could be taken forward as part of the Integrated Care Fund. Full details of the Integrated Care Fund are outlined in a separate paper to the SIB.
4.	**Implications**
4.1	Financial Implications The Integrated Care Fund will further extend the financial envelope available to meet the Strategic Plan. On-going monitoring will be undertaken by the Integration Joint Board.
4.2	Human Resource Implications
	There are likely to be implications for some staff currently involved in delivering services outlined in appendix 2. Individuals who were employed for specific projects will have no post as of 01 April 2015. David Rowland is working with Health and North Ayrshire Council HR colleagues to explore the implications and opportunities around this.
4.3	Equality Implications
	There are currently no implications for equality.
4.4	Environmental Implications
	There are currently no implications for the environment
4.5	Implications for Key Priorities
	There are currently no implications for key priorities
5.	**Consultations**
5.1	The third and independent sector has been involved in developing these proposals.
6.	**Conclusion**
6.1	The Reshaping Care for Older People Change Fund improved services for older people by shifting care towards anticipatory care and prevention. Some elements of this work will now be broadened and extended as part of the integrated Care Fund. It is anticipated the fund will enable the development and expansion of existing service provision as well as provide the opportunity for innovation and creativity.

For more information please contact David Rowland, Head of Service Health & Community Care on 01294 317797 or davidrowland@north-ayrshire.gcsx.gov.uk

Appendix 1

North Ayrshire Reshaping Care for Older People
Change Fund Legacy October 2014
Themes which Scored 1 or 2

Reshaping Care for Older People - Change Fund Legacy

PRIORITY	THEME	FUNDING REQUIRED	RESOURCE TRANSFER	RECOMMENDED ICF FUNDING
1	Dementia Care Home Liaison Nurses	£72,500	£72,500	
2	ICES	£485,000	£51,599	£433,401
	Arran Rehabilitation	£80,095	£80,095	
	Falls Trainer	£14,000		£14,000
3	Social Work Care at Home Out of Hours	£222,000		£222,000
4	Community Capacity*	£150,000		£90,000
5	Dementia Training	£39,189		£39,189
6	Enhanced District Nursing Out of Hours	£95,806	£95,806	
7	Care Home Development Worker Pan Ayrshire	£21,000		£21,000
8	LOTS Resource Workers	£71,298		£71,298
9	Telecare Solutions			
	Telecare Technician	£26,000		£26,000
	Heart Failure Nurse (one third)	£15,000		£15,000
10	Carers Strategy (Community Capacity)**			£10,000
		TOTAL	**£300,000**	**£941,888**

* £60,000 shortfall from existing resources

** £10,000 short -term contingency fund to support Carers Strategy until new contractual mechanisms are established

Appendix 2

North Ayrshire Reshaping Care for Older People
Change Fund Legacy October 2014

Themes which Scored 3, 4, 5

PRIORITY	THEME	PREVIOUS FUNDING	RECOMMENDED FUNDING
1	KA Leisure – Invigorate Falls Programme (3)	£54,000	None
2	Pharmacy Carer and Unpaid Carers (3)	£15,000	None
3	Community Ward (4)	£190,000	None
4	Carers (4)	£40,000 PA (this will be a pro-rata payment to fund any contractual gaps	None
	TOTAL	**£299,000**	

Appendix 3

North Ayrshire Reshaping Care for Older People
Change Fund Legacy October 2014
Themes which are Complete

PRIORITY	THEME	FUNDING	RECOMMENDED FUNDING
1	Lifelong Learning	£25,000	None
2	Housing	£40,000	None
3	Capacity Building	£75,000	None
4	Anticipatory Care Planning	£34,000	None
5	Clinical Pharmacist	£25,000	None
6	Management Costs for Analyst for Care Homes	£30,000	None
7	Care Home Redesign	£80,000	None
	TOTAL	**£309,000**	

Shadow Integration Board
18 December 2014

Subject:	**Integrated Care Fund**
Purpose:	To outline the proposals for the Integrated Care Fund.
Recommendation:	That the Shadow Integration Board approves the recommendation for North Ayrshire Health & Social Care Partnership's Integrated Care Fund Submission.

1.	**Introduction**
1.1	In July this year, the Scottish Government launched its Integrated Care Fund. Although building on the Reshaping Care for Older People Change Fund the new fund relates more broadly to adult care and support services that will support the delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and tackle inequalities.
2.	**Current Position**
2.1	The Integrated Care Fund is available only for one year (2015/16). The funding allocated to the North Ayrshire Partnership through this fund is £2.89million. In the original guidance it states applications for the fund must be made to the Scottish Government by 12 December 2014. However, an extension was provided to enable sign off at the SIB on 18 December 2014. The application must be signed off by representatives of the Shadow Integration Board as well as the third and independent sectors.
2.2	At its meeting on the 30 October 2014 the Shadow Integration Board agreed that the Integrated Care Fund process should meet the following objectives: • Enable Partnership service re-design • Continue Re-Shaping Care for Older People Change Fund initiatives that would benefit a wider population • Provide an opportunity for innovation & creativity
3.	**Proposals**
3.1	Service Re-design In order to ensuring the existing services and pathways are aligned to meet the requirements of the Strategic Plan, it will require realignment or redesign of existing services and pathways. The priority areas for redesign in Mental Health and Adult Services are :-

	• Adult Mental Health • CAMHS • Addictions • Single Point of Contact • Care at Home • Rehab and Reablement Hub • Formation of teams to meet the needs of Practice populations.
	It is anticipated that the integration of services and streamlining of pathways will lead to efficiencies and improved service provision within the existing available resources. A short-term Change Team will be established to take this forward and achieve this.
	It is therefore proposed that a short-term Change Team is required for the period of 1 year for **£802,488**. For a full breakdown of the Resource Plan, please see appendix one.
3.2	<u>Re-Shaping Care For Older People Change Fund</u> The Officer Locality Group (Adults and Older People) has overseen the Reshaping Care for Older People Change Fund. The four Lead Officer representatives third sector, independent sector, social care and health were tasked with evaluating the existing Re-Shaping Care For Older People Change Fund initiatives and presenting proposals for those projects that should be sustained.
	The Individual officers were asked to evaluate the projects against evaluation criteria and their scores were fed back to provide an overarching priority rating for each project. In order to provide additional assurance, it should be noted that Officers feedback was in broad agreement and decisions on scoring unanimous.
	These priorities have been collated into a table (outlined in appendix two) which outlines 9 projects totalling **£941,888** that are recommended to be continued for a further year by utilising the Integrated Care Fund. This table also shows recommendations for several services to be mainstreamed using the available £300k Resource Transfer.
	These proposals were taken to the Officers Locality Group (OLG) held on 2 December 2014. The OLG supported these proposals and agreed they should be recommended to the SIB. A separate SIB report is available outlining this process in more detail.
3.3	<u>Innovation & Ideas Fund</u> At its meeting on the 30 October 2014 the Shadow Integration Board agreed to provide opportunities for innovation & creativity. This would see the launch of a short term Innovation & Ideas Fund to support the identification of suitable initiatives that met the six Integrated Care Fund principles; co-production, sustainability, locality, leverage, involvement and outcomes. In addition they must be in line with North Ayrshire's strategic planning priorities; Tackling inequalities, Integrated Services, Prevention & Early Intervention, Engaging Communities and Improved Mental Health and Well-being. It was agreed that the third and independent sectors will have oversight of the Innovation & Ideas Fund.
	In addition, the SIB agreed that the funding for the Innovation & Ideas Fund would be agreed after costings were finalised on the Service Re-design and Reshaping Care for Older People elements of the application. The funding available for the Ideas and Innovation Fund at **£1,145,624.00**.

	The Ideas & Innovation Fund has attracted significant attention from third sector, independent sector, health and social care services. At the time of writing, the scheme has received 86 ideas with a total value of £4,687,694.52 however; some applications have not included costs.
	There are a number of key themes arising from the Ideas & Innovation Fund proposals. These include promoting health and well-being, self-management, rehabilitation and proactive case management. Further themes and a full outline of the ICF budget can be found in the draft summary table presented at appendix 3. When the final set of projects to be delivered under the Innovation and Ideas scheme have been agreed, this table will be fully populated to illustrate the contribution each element will make to the delivery of the agreed strategic priorities.
	The four lead officers from third sector, independent sector, health and social care will be asked to independently evaluate the innovation and creativity initiatives received using clear evaluation criteria. These scores will be amalgamated into a single score sheet for evaluation at the Group Review Session.
	The four leads will attend a Group Review Session to be held on the 12 January 2015. This review session will be attended by Rab Murray of JIT who will act as as an independent adviser and a critical friend. The four leads will review the amalgamated feedback form and identify suitable projects to take forward with proposed budgets.
	The projects will be contacted and asked to develop a more detailed business case. Where more than one stakeholder has suggested a project, all applicants will be asked to undertake a business case by the 30 January 2015.
	The four leads will attend a Project Evaluation Session to be held on the 2 February 2015. This session will again be attended by Rab Murray of JIT who will act as an independent arbiter to ensure transparency. The four leads will review the projects against evaluation criteria and provide a final list of suggested projects to take forward from 1 April 2015. The recommendations from the leads will be put forwarded to the SIB on 12 February 2015 for their approval.
3.4	The following timescales are therefore proposed

18 December 2014	*SIB update*
19 December 2014	*Email candidates with timescales*
7 January 2015	*Individual leads scoring*
12 January 2015	*Group Review Session*
14 January 2015	*Inform applicants of application progress*
15- 30 January 2015	*Business case development*
2 February 2015	*Project Evaluation Session*
12 February 2015	*Recommendations to SIB*

4.	**Implications**
4.1	Financial Implications The Integrated Care Fund will further extend the financial envelope available to meet the Strategic Plan. On-going monitoring will be undertaken by the Integration Joint Board.

4.2	Human resource Implications There are likely to be implications for some staff currently involved in delivering services no longer sustained under Reshaping Care for Older People. Individuals who were employed for specific projects will have no post as of 01 April 2015. David Rowland is working with Health and North Ayrshire Council HR colleagues to explore the implications and opportunities around this.
4.3	Equality Implications There are currently no implications for equality.
4.4	Environmental Implications There are currently no implications for the environment.
4.5	Implications for Key Priorities There are currently no implications for key priorities.
5.	**Consultations**
5.1	The third and independent sector has been involved in the co-design and development of these proposals.
6.	**Conclusion**
6.1	The integrated Care Fund will provide the North Ayrshire Health & Social Care Partnership with additional resource to meet the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. It is anticipated the fund will enable the development of existing service provision as well as provide the opportunity for innovation and creativity.

For more information please contact David Rowland, Head of Service Health & Community Care on 01294 317797 or davidrowland@north-ayrshire.gcsx.gov.uk

Service Redesign Resource Costs

Function	Estimated Total Cost
Programme Management (1.0 x FTE)	£55,553
Project Support (2 x FTE)	£76,111
Project Management (1.0 x FTE)	£51,592
Backfill for Professional Leadership (8 x FTE)	£378,325
Specialist Technical Posts – Data Analysis, Systems Analysis, etc – (4 x FTE)	£160,907
Total	**£ 722,488**

In addition a further £80,000 has been budgeted for external expert advice, experience and support that may be required on a consultancy basis.

This brings the total spend to **£802,488.**

Appendix 2

North Ayrshire Reshaping Care for Older People
Change Fund Legacy October 2014
Themes which Scored 1 or 2

Reshaping Care for Older People - Change Fund Legacy

PRIORITY	THEME	FUNDING REQUIRED	RESOURCE TRANSFER	RECOMMENDED ICF FUNDING
1	Dementia Care Home Liaison Nurses	£72,500	£72,500	
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10	Carers Strategy (Community Capacity)**			£10,000
		TOTAL	**£300,000**	**£941,888**

* £60,000 shortfall from existing resources

** £10,000 short -term contingency fund to support Carers Strategy until new contractual mechanisms are established

North Ayrshire Council
Comhairle Siorrachd Àir a Tuath

NHS Ayrshire & Arran

Appendix 3

Integrated Care Fund Total Budget

	Tackling Inequalities	Integrating Services	Engaging Communities	Prevention & Early Intervention	Improving Mental Health	Total
RCOP						
ICES	£ 144,467.00	£ 144,467.00		£ 144,467.00		£ 433,401.00
Falls Trainer				£ 14,000.00		£ 14,000.00
OOHs Care at Home				£ 222,000.00		£ 222,000.00
Communit Capacity			£ 90,000.00			£ 90,000.00
Dementia Training					£ 39,189.00	£ 39,189.00
Care Home Development Worker			£ 21,000.00			£ 21,000.00
Telecare				£ 41,000.00		£ 41,000.00
LOTS Resource Workers	£ 23,766.00	£ 23,766.00		£ 23,766.00		£ 71,298.00
Carers Stategy			£5,000	£5,000		£10,000
Category Total						**£ 941,888.00**
Service Redesign						
Adult Mental Health Services	£ 40,124.40	£ 40,124.40	£ 40,124.40	£ 40,124.40	£ 40,124.40	£ 200,622.00
Child and Adolescent Mental Health Services	£ 20,062.20	£ 20,062.20	£ 20,062.20	£ 20,062.20	£ 20,062.20	£ 100,311.00
Addiction Services	£ 20,062.20	£ 20,062.20	£ 20,062.20	£ 20,062.20	£ 20,062.20	£ 100,311.00
Single Point of Contact	£ 25,077.75	£ 25,077.75	£ 25,077.75	£ 25,077.75		£ 100,311.00
Tailoring Services Around GP Practice Populations	£ 25,077.75	£ 25,077.75	£ 25,077.75	£ 25,077.75		£ 100,311.00
Rehabiliation and Reablement Hub	£ 25,077.75	£ 25,077.75	£ 25,077.75	£ 25,077.75		£ 100,311.00
Care at Home Review	£ 25,077.75	£ 25,077.75	£ 25,077.75	£ 25,077.75		£ 100,311.00
Category Total						**£ 802,488.00**
Innovation and Ideas (Emerging Themes)						
Understanding Need						
Promoting Health and Wellbeing						
Promoting Self Management						
Developing Community Capacity, Capability and Resilience						
Signposting to Appropriate Support						
Targeting Care in Localities of Need						
Proactive Case Management						
Telecare						
Training and Education for Service Providers and Users						
Supporting Carers						
Improving Information Sharing						
Alternatives to Acute Care						
Improving the Hospital - Community Interface						
Rehabiliation						
Palliative Care						
Category Total						**£ 1,145,624.00**
Total Commitment						**£ 2,897,000.00**

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Integrated Care Fund Plan Template

PARTNERSHIP DETAILS

Partnership name:	North Ayrshire Health & Social Care Partnership
Contact name(s): See note 1	David Rowland
Contact telephone	01294 317797
Email:	davidrowland@north-ayrshire.gcsx.gov.uk
Date of Completion:	9 December 2014

The plan meets the six principles described on pages 2 and 3 (Please tick √):

Co-production	✓	Leverage	✓
Sustainability	✓	Involvement	✓
Locality	✓	Outcomes	✓

Please describe how the plan will deliver the key points outlined in paragraph 18:

1. The activities that will support the delivery of integrated health and wellbeing outcomes for adult health and social care – and the contribution to wider work designed to tackle health inequalities within Community Planning Partnerships?

Within North Ayrshire we developed a process which will ensure that our Strategic Plan reflects local need, with the overarching vision and strategic imperatives being underpinned by the local Joint Strategic Needs Assessment. In addition to this, the draft Strategic Plan embraces the national health and well-being outcomes and sets out a framework describing the changes in focus, culture and approach required to deliver against these by 2020.

In conjunction with the North Ayrshire Community Planning Partners we are working together to deliver better services and to improve the lives of the people of North Ayrshire This is supported through the three overarching themes of the Single Outcome Agreement (SOA) which are reducing local inequalities of outcome, building community capacity and prevention and early intervention.

As well as the overarching themes the SOA has three key priorities:

- A working North Ayrshire
- A Healthier North Ayrshire
- A Safe and secure North Ayrshire

North Ayrshire Health & Social Care Partnership is specifically responsible for taking the lead with “A Healthier North Ayrshire”.

With this in mind we have set the following 5 Strategic Priorities in our draft North Ayrshire Partnership Strategic Plan:

- Tackling inequalities

- Integrated Services
- Prevention & Early Intervention
- Engaging Communities
- Improved Mental Health & Well-being

Within our Strategic Plan we have further developed a Strategic Action Plan which takes our Strategic Priority Key Objectives and maps them back to the National Health and Well-being Outcomes.

By setting out our commitment to tackling inequalities within the draft Strategic Plan, North Ayrshire Health and Social Care Partnership can be directly held to account for ensuring this is at the heart of all of its community engagement, service redesign and service delivery activities. This is exemplified in the summary table at appendix 1, which clarifies which of the strategic priorities will be delivered through our ambitious service redesign programme.

2. The extent to which activity will deliver improved outcomes in-year and lay the foundations for future work to be driven through Strategic Commissioning?

Within North Ayrshire it is proposed that in order to meet our Strategic Priorities the Integrated Care Fund should meet the following objectives:

- Enable Partnership service re-design
- Continue Re-Shaping Care For Older People Change Fund initiatives that would benefit a wider population
- Provide an opportunity for innovation & creativity

The Integrated Care Fund endeavours to build on the Reshaping Care for Older People Change Fund. Within North Ayrshire the Reshaping Care for Older People Change Fund has enabled the third sector, NHS, local authority, housing and independent sectors to work more effectively together and to share ownership of local change plans as well as foster cultures and behaviours that have improved outcomes for local people.

However we are clear the Integrated Care Fund cannot be used merely as an extension to the Reshaping Care for Older People Change Fund. We are therefore keen to ensure that the Integrated Care Fund enables us to test and drive a wider set of innovative approaches that will enable the partnership to reduce future demand, focus on prevention, early intervention, support adults with multi-morbidity and address issues around inequality.

To enable the partnership to do this, the Shadow Integration Board will retain management of the funding around:

- Partnership service re-design
- Re-Shaping Care For Older People Change Fund initiatives that would benefit a wider population

In order to ensure that existing services and pathways are aligned to meet the requirements of the Strategic Plan, it will require realignment or redesign of existing services and pathways. This will include integration of existing Addictions, Learning Disabilities and Mental Health teams as well as the redevelopment of the Single Point of

Contact concept to aid access to services; redesign of Care at Home Services to ensure capacity meets demand and services interface appropriately with other community and Acute care services; and the development of a specialist, proactive and fully integrated Rehabilitation & Reablement hub based at Ayrshire Central Hospital designed to reduce avoidable unscheduled admissions to acute care and support early discharge.

It is anticipated that the integration of services and streamlining of pathways will lead to efficiencies and improved service provision within the existing available resources. However in order to move these forward we require a temporary Change Team to put these in place. The cost of this team has been budgeted as £802,488.00.

Within North Ayrshire the Re-Shaping Care for Older People Change Fund is managed through the Partnership Officer Locality Group. This group reflects a wide range of representatives from a range of service within North Ayrshire and we are keen to maintain and further develop these relationships and processes. Recently this group were tasked with evaluating the existing Re-Shaping Care For Older People Change Fund initiatives and recommending those that would benefit a wider population.
Using clear evaluation criteria the OLG recommended the continuation of 9 projects totalling £941,888.00 that are recommended to be continued for a further year by utilising the Integrated Care Fund. This will enable these models to be further tested, expanded to a wider cohort of service users and the impact assessed to determine whether they should be mainstreamed in 2016/17.

It is anticipated that these approaches may later be built in to and sustained through the longer term strategic commissioning approach which will be further developed throughout 2015/16.

A high level overview of these services is presented within the table at appendix 1.

3. Relationships with localities, including how input from the third sector, users and carers will be achieved. Such a bottom-up approach should maximise the contribution of local assets including volunteers and existing community networks.

The Shadow Integration Board agreed to provide opportunities for innovation & creativity. This would see the launch of a short term Innovation & Ideas Fund to support the identification of suitable initiatives that encouraged the testing and driving of a wider set of innovative approaches that met the six Integrated Care Fund principles; co-production, sustainability, locality, leverage, involvement and outcomes, as well as the 9 national Health & Well-being Outcomes. It was agreed that the third and independent sectors will have oversight of the Innovation & Ideas Fund.

Project evaluation criteria has been developed that ensure projects are in line with our five strategic planning priorities; Tackling inequalities, Integrated Services, Prevention & Early Intervention, Engaging Communities and Improved Mental Health and Well-being. Specifically out Engaging Communities priority has been written to ensure that we develop our locality work in line with our Community Planning Partners and that the strengths and capacities of communities are embraced and developed.

This process is being led by our colleagues from the Third Sector who have co-ordinated

a wide ranging dissemination of requests for proposals across the statutory agencies, as well as the Third and Independent Sectors, both locally and nationally.

In addition, extra weighting has been given to complex conditions/multi-morbidity, avoidable emergency admissions and support to carers to ensure the specific requirements of the Integrated Care Fund are met.

The SIB agreed that the pot for the Innovation & Ideas Fund would be agreed after costings were finalised on the Service Re-design and Reshaping Care for Older People elements of the application. This now leaves the funding available for the Ideas and Innovation Fund at £1,145,624.00.

In addition, the third and independent sectors, carers and service users are specifically represented in our Shadow Integration Board and Strategic Planning Group who are specifically asked to ensure that information and feedback is passed through their existing networks. And specifically we have a strategic action to find new ways to engage with people that we have not successfully involved before.

4. The long term sustainability of investments and the extent to which the use of the fund will leverage resources from elsewhere.

In terms of our Integrated Care Fund objectives we foresee the following:
Enable Partnership service re-design

- It is anticipated that the integration of services and streamlining of pathways will lead to efficiencies and improved service provision within the existing available resources. Service change will be delivered within existing resources and it is anticipated that our work over the next 12 months will release resources to be reinvested in further service re-design downstream. In addition, we anticipate that the development of the Rehabilitation & Reablement hub will be mainstreamed into the new Ayrshire Central Hospital.

Continue Re-Shaping Care For Older People Change Fund initiatives that would benefit a wider population

- It is anticipated that by the end of 2015/16 period – many of these services will be integrated into mainstream service delivery, ensuring seamless services for people of North Ayrshire and efficient and effective service provision.

Provide an opportunity for innovation & creativity

- It is anticipated that this fund will enable us to test and drive a wider set of innovative approaches that will enable the partnership to reduce future demand, focus on prevention, early intervention, support adults with multi-morbidity and address issues around inequality. It is anticipated that some of these approaches, once tested, may later be built in to and sustained through the longer term strategic commissioning approach. That said, all individuals and groups who have submitted proposals are aware that this is non-recurring funding and that the focus should be on building capacity and capability to deliver care, treatment and services more effectively and efficiently using existing staff resources.

5. How resources will be focused on the areas of greatest need.

As mentioned in section 1, the North Ayrshire Partnership Strategic Plan was developed with the NHS Ayrshire & Arran Joint Strategic Needs Assessment, the Community Planning Partnership Priorities and the local needs faced by services every day.

We have also used the North Ayrshire Areas of Family Resilience Report. This report brings together a range of key statistics to build a detailed socio-economic profile of North Ayrshire communities at neighbourhood level and below. It provides an assessment of local characteristics and conditions that will allow the local Community Planning Partnership (CPP) to develop a common understanding of the geography of strengths and needs across North Ayrshire communities. The majority of data reviewed was drawn from both central and local government sources, including recently published 2011 Census results.

In addition as part of the Ideas and Innovation evaluation criteria we have given additional weighting to initiatives that meet our tackling inequalities priority.

6. How the principles of co-production will be embedded in the design and delivery of new ways of working.

Co-production is embedded into our systems from the start of our service user journey through the implementation of 'My Life, My Care, My Support' approach. All staff work with service users on a Supported Shared Assessment Questionnaire to identify service user outcomes from an early stage. This means regardless whether service or support is required an individual can be signposted to where their needs will be best met through universal services, early intervention and prevention or development of a co-produced support plan. All our support plans are designed to capture the JIT Talking Points Outcomes and these can be further measured to identify progress and capture unmet need both individually and locally.

To support co-production we have developed the award winning Care and Support North Ayrshire (Carena) website and have a number of community connectors who work to link people in, develop information and intelligence, identify need and support decision making.

More widely co-production is being developed at all levels to ensure that involvement and engagement are built in for all our stakeholders including service users, carers, staff and colleagues in the third and independent sectors. This includes the maintenance and development of existing networks and development of new structures includes the Shadow Integration Board and the Strategic Planning Group. The further development of locality arrangements without Community Planning Partners will further enhance the approach.

In addition, as part of the Ideas and Innovation evaluation criteria we have set co-production as one of the gate-keeping criteria which must be met as part of the ICF principles. If this principle is not met then the idea will not be assessed any further.

7. Progress in implementing priority actions for partnerships as described in the forthcoming National Action Plan for Multi-morbidity.

The Partnership has already made good progress in some of the priority actions from the National Action Plan for Multi-morbidity

- As outlined in section 6 we have developed assessment and support planning to embed co-production and an outcome based approach. We hope that initiatives in the Innovation and Ideas fund to enable us people to have better control over their conditions
- As previously mentioned we have developed the award winning Carena website and already have a number of community connectors in place. Again we hope to use the Ideas and Innovation fund to further link community connectors to locality areas and promote community building.
- We have already begun to develop pathways for people with multi-morbidity issues and to reduce health inequalities through our Reshaping Care legacy work with our Integrated Care and Enablement Services. We anticipate the our Ideas and innovation fund will enable us to develop specific actions from the multi-morbidity action plan as these have been given favourable weighting in the evaluation criteria.
- Within the partnership we are committed to developing a visible adaptive leadership. The partnership has already held 2 Management Conferences, to provide our managers with partnership information and undertake engagement. In addition we are developing a partnership Learning Portal. This links in policy, learning and development and continuous professional development. Once created this can easily be used to drive excellence in Integrated Care for Multi-morbidity.

Specifically, in 2015/16 we will focus much of our service redesign efforts on targeting services and resources around GP Practice populations to ensure our community and primary care teams are operating effectively, collaboratively and in a fully integrated manner to ensure the complex needs of individuals with multi-morbidity are met either within their home or their local community.

Linked to this, we will reinvigorate the Single Point of Contact concept to ensure that when an individual experiences an adverse event or exacerbation of their condition, the practitioner they first come into contact with can engage the support of the wider team to ensure the right individual with the right skills and experience can offer the support needed to maintain the individual at home.

Recognising that, on occasion, individuals may have more complex needs, arising from their multi-morbidities, we will create a highly specialist and fully integrated rehabilitation and reablement hub with Medical, Nursing, AHP and Social Work staff working jointly to receive, assess and support individuals to attain and sustain their full potential, maximising their independence to support a return home or to a homely setting. Individuals will be admitted to this hub from both community and acute settings.

Finally, the increased levels of frailty associated with progressing multi-morbidities requires increasing support for individuals to remain at home or in a homely setting. We will therefore review our Care at Home services to ensure they are delivered in a

dynamic manner that responds quickly and positively to changing needs, while interfacing seamlessly with community and acute services to support reductions in avoidable admissions and facilitate early discharge.

8. How it will enable the partnership to produce a progress report based on the above for local publication in autumn 2016.

A Pan-Ayrshire Performance workstream has developed a performance framework to ensure equity of reporting across NHS Ayrshire and Arran and meet the requirements of the Public Bodies (Joint Working) Scotland Act 2104.

In addition, all services will be required to undertake regular reporting against their actions from the Strategic Plan which are linked to the national health and wellbeing outcomes.

Finally, all initiatives that receive funding through the Integrated Care Fund will be asked to complete a regular monitoring template. This will evaluate how the project is meeting it's outcomes, how it is spending its budget and how it intends to sustain itself by the end of the year and/or its plans for project closure. At the end of the year initiatives will be asked to provide an evaluation of their projects and a lessons learned report.

Appendix 1

Integrated Care Fund Total Budget						
	Tackling Inequalities	Integrating Services	Engaging Communities	Prevention & Early Intervention	Improving Mental Health	Total
RCOP						
ICES	£ 144,467.00	£ 144,467.00		£ 144,467.00		£ 433,401.00
Falls Trainer				£ 14,000.00		£ 14,000.00
OOHs Care at Home				£ 222,000.00		£ 222,000.00
Communit Capacity			£ 90,000.00			£ 90,000.00
Dementia Training					£ 39,189.00	£ 39,189.00
Care Home Development Worker			£ 21,000.00			£ 21,000.00
Telecare				£ 41,000.00		£ 41,000.00
LOTS Resource Workers	£ 23,766.00	£ 23,766.00		£ 23,766.00		£ 71,298.00
Carers Stategy			£5,000	£5,000		£10,000
Category Total						**£ 941,888.00**
Service Redesign						
Adult Mental Health Services	£ 40,124.40	£ 40,124.40	£ 40,124.40	£ 40,124.40	£ 40,124.40	£ 200,622.00
Child and Adolescent Mental Health Services	£ 20,062.20	£ 20,062.20	£ 20,062.20	£ 20,062.20	£ 20,062.20	£ 100,311.00
Addiction Services	£ 20,062.20	£ 20,062.20	£ 20,062.20	£ 20,062.20	£ 20,062.20	£ 100,311.00
Single Point of Contact	£ 25,077.75	£ 25,077.75	£ 25,077.75	£ 25,077.75		£ 100,311.00
Tailoring Services Around GP Practice Populations	£ 25,077.75	£ 25,077.75	£ 25,077.75	£ 25,077.75		£ 100,311.00
Rehabiliation and Reablement Hub	£ 25,077.75	£ 25,077.75	£ 25,077.75	£ 25,077.75		£ 100,311.00
Care at Home Review	£ 25,077.75	£ 25,077.75	£ 25,077.75	£ 25,077.75		£ 100,311.00
Category Total						**£ 802,488.00**
Innovation and Ideas (Emerging Themes)						
Understanding Need						
Promoting Health and Wellbeing						
Promoting Self Management						
Developing Community Capacity, Capability and Resilience						
Signposting to Appropriate Support						
Targeting Care in Localities of Need						
Proactive Case Management						
Telecare						
Training and Education for Service Providers and Users						
Supporting Carers						
Improving Information Sharing						
Alternatives to Acute Care						
Improving the Hospital - Community Interface						
Rehabiliation						
Palliative Care						
Category Total						**£ 1,145,624.00**
Total Commitment						**£ 2,890,000.00**

The content of this template has been agreed as accurate by:

……

(name) for the Shadow Joint Board, or for a lead agency,

…….. or ……

(name) for the NHS Board (name) for the Council

…….. ……

(name) for the third sector (name) for the independent sector

When completed and signed, please return to:

Kelly Martin
2ER, St Andrew's House
Regent Road
EDINBURGH
EH1 3DG

Kelly.Martin@Scotland.gsi.gov.uk

Templates should be returned by **12th December 2014**.

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Shadow Integration Board
18th December 2014

Subject:	**Care Opinion**
Purpose:	To outline proposals for participation in the pilot of Care Opinion.
Recommendation:	To agree that the North Ayrshire Health and Social Care Partnership participates within the pilot phase of Care Opinion.

1.	**Introduction**
1.1	Patient Opinion is an independent not for profit certified social enterprise which has been publishing feedback about healthcare across the UK, and responses from providers, since 2005. Stories that are posted on Patient Opinion are moderated before publication and relevant health care bodies are alerted to feedback via email. When responses are posted, Patient Opinion emails the author to let them know.
1.2	Care Opinion is a fully integrated portal to Patient Opinion. The development of Care Opinion will enable increased engagement with people using adult social care services which are regulated by the Care Inspectorate. It will further enable people to share experiences as they cross between health and social care services and present an opportunity for staff at all levels to engage and listen to the experience of people using services. Furthermore it will provide the opportunity for service improvement and development.
1.3	A partnership between the Health and Social Care Alliance Scotland (ALLIANCE) and Patient Opinion with funding and support from the Scottish Government, Reshaping Care for Older People's Team will pilot the use of Care Opinion across two Health Board/Local Authority areas.
2.	**Current Position**
2.1	North Ayrshire Council/NHS Ayrshire and Arran have been selected, along with Fife Council/NHS Fife, as the two pilot sites to participate in Care Opinion.
2.2	The pilot phase of Care Opinion is from November 2014 – September 2015.
2.3	Staff representatives have been identified to be involved with the local planning of the pilot and they will also participate on the national Steering Group throughout the pilot phase. The inaugural meeting of the Steering Group was held on 13 November 2014.

2.4	Engagement and publicity events are proposed to take place across Ayrshire in January 2015.
2.5	Although Care Opinion is a website where people can post their stories it is recognised that other methods of gathering information will be necessary across adult social care services. Therefore as well as the website people will be able to contact Care Opinion via a telephone number where operators will transcribe their stories onto the website. Members of the Alliance, on request, will attend Elderly Forums/Community Groups to gather stories to upload onto the website.
2.6	There will be an evaluation of the pilot phase which will assess the outcome and impact of the pilot activities with a final report completed by August 2015.
3.	**Proposals**
3.1	It is proposed that the North Ayrshire Health and Social Care partnership participates in the Care Opinion pilot.
3.2	That the nominated staff work in partnership with the Alliance and Patient Opinion to provide information, guidance and support to both providers and people using services within the pilot areas.
3.3	That engagement with providers and people using adult social care services is ongoing during the pilot phase to maximise the potential for service developments and improvements.
4	**Implications**
	Financial Implications
4.1	There are no financial implications.
	Human Resource Implications
4.2	There are no Human Resources implications.
	Legal Implications
4.3	There are no legal implications.
	Equality Implications
4.4	There are no equality implications.
	Environmental and Sustainability Implications
4.5	There are no environmental and sustainability implications.
5.	**Consultations**
5.1	Consultation and engagement will be ongoing with providers, people using services and staff during the pilot phase.

6.	**Conclusion**
6.1	The Shadow integration Board is asked to agree that the North Ayrshire Health and Social Care Partnership participate in the pilot phase of Care Opinion across adult social care services.

For more information please contact Helen McArthur, Senior Manager, Community Care, Service Delivery, on 01294 317783 or email hmcarthur@north-ayrshire.gcsx.gov.uk

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Shadow Integration Board
18 December 2014

Subject:	**Organisational Development Support for Shadow Integration Board**
Purpose:	To advise members of the Shadow Integration Board of the proposed next steps for organisational development support.
Recommendation:	The Shadow Integration Board is asked to approve the proposals contained in the report.

1. Introduction

1.1 The Shadow Integration Board (SIB), together with members of the Partnership Senior Management Team, participated in a development day on 21st November. The event was delivered by an independent consultant, Madeleine O'Brien.

1.2 The intention behind providing organisational development support to the SIB is to enable it to grow in confidence and capability into an effective Integrated Joint Board which leads the integration of service for the population of North Ayrshire.

2. Current Position

2.1 Following the development day the consultant was asked to develop proposals for further development work with members of the SIB. The proposals have now been received and are outlined in this report.

2.2 Members will recall that other organisational developments, including visits to services and the development of the Board Champion role have been approved. It is hoped that a member of staff will be in post early in the New Year to help support these initiatives.

3. Proposals

3.1 The aim of the next phase of support to the SIB is to develop a prioritised organisational development framework and development plan for the future IJB. The framework should support the embedding of the structure and processes which will help the IJB to develop effective arrangements to deliver on its key priorities for 2015 – 2018. It should support the culture work required to create a shared vision, values and behaviours for the IJB and it should support effective integrated team working within the IJB and beyond.

3.2 The consultant's proposed approach is firstly to debrief on emerging issues and developments. As part of this a short survey will be circulated to SIB members to ensure that each member has the opportunity to express an opinion about the development day and what they would find helpful over the remaining life of the SIB. A half day workshop will be held with the SIB in late January/ early February. Following that the consultant will hold follow up meetings with members as individuals and as groups. The output from the workshop and follow up meetings will be the production of the organisational development framework and outline organisational development plan for the IJB. Subject to diary availability for the planned events and meetings, this should be available to the SIB at its March meeting.

4. Implications

Financial Implications

4.1 The cost of the proposals can be met from existing budgets.

Human Resource Implications

4.2 There are no human resource implications arising directly from this report.

Legal Implications

4.3 Work undertaken to prepare for integration will ensure that North Ayrshire Council and NHS Ayrshire & Arran are able to comply with the requirements of the legislation.

Equality Implications

4.4 There are no equality implications.

Environmental Implications

4.5 There are no environmental implications.

Implications for Key Priorities

4.6 The integration of health and social care will contribute to the delivery of the "Healthy and Active North Ayrshire" priority in the 2013 - 2017 Single Outcome Agreement.

5. Consultations

5.1 The Chair and Vice-Chair of the SIB have been consulted on the proposals contained in this report..

6. Conclusion

6.1 Continued organisational development support to the SIB will help to ensure that it is able to fulfil its remit and make best use of the skills and experience of every member.

For more information please contact Lisbeth Raeside, Interim Project Manager, North Ayrshire Health & Social Care Partnership on 01294 317705 or lraeside@north-ayrshire.gcsx.gov.uk

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Shadow Integration Board
18 December 2014

Subject:	**Developing a New Hub for Rehabilitation and Reablement in North Ayrshire**
Purpose:	To set out the proposals from the Health and Community Care Management Team for the creation of a new integrated hub for Rehabilitation and Reablement at Ayrshire Central Hospital.
Recommendation:	To endorse the development of new models of care within Pavilion 3 at Ayrshire Central Hospital with the aim of offering an alternative to acute hospital admission, secure early discharge from acute care and support individuals to return home or to a homely setting in line with their needs.

1.	**Introduction**
1.1	Acute services in Ayrshire and Arran have experienced significant pressures in recent years with some of the highest rates of emergency admission in Scotland. In recent months, these pressures have increased with associated impact on community services as increasingly dependent and frail patients require either high levels of care at home packages to return home or are assessed as requiring care home admission.
1.2	Further, as individuals receive improving levels and quality of care at home and in homely settings, the level of discharge from these services reduces, resulting in increased utilisation of services over time as new service users are identified and assessed as requiring support.
1.3	The result of these increasing demands means that delivery against the zero delayed discharge target becomes increasingly difficult as the capacity available in community settings becomes fully utilised and the resource available to support individuals at home or in a homely setting is exhausted.
1.4	These pressures are further exacerbated as staff work under significant strain to maintain flow through acute and community services without the time, space, capacity and shared expertise to fully assess an individual's potential for rehabilitation and reablement.

2.	**Current Position**
2.1	The combined impact of demographic change and levels of long term condition prevalence, which are significantly higher than the Scottish average is leading to increasing ill health and frailty within the local population, with a resulting increase in demand across Care at Home and Care Home services, as well as unscheduled acute care.
2.2	Specifically, within Care at Home Services in North Ayrshire there are year on year increases of 2% in terms of the number of individuals accessing these services and year on year increases of, on average, 5% in terms of the amount of service being delivered to each individual. In meeting this increasing demand, the local team continue to support the early discharge of patients from Acute settings, with a resulting projected overspend of approximately £1.2 million for 2014/15.
2.3	Similarly, the demand for Care Home placements is increasing with referral rates for assessments where a Care Home placement is recommended being 11% higher in October 2014 than at the same period last year. This equates to increase of 30 assessments from 287 in 2013 to 317 in 2014. The result of this increasing demand is a projected overspend of approximately £1.2 million for 2014/15.
2.4	Pressures on these services are likely to increase substantially in 2015/16 as they are required to respond more quickly to the needs of individuals within an acute hospital setting to comply with the requirement to complete assessments and secure discharge within 14 days. This will pose considerable challenges in both workload and financial management.
2.5	Further, CoSLA has circulated a paper for discussion which suggests a 72-hour turnaround for some patients, which, if adopted, will further increase demand and challenges.
2.6	It is therefore evident that the current model of assessment and service delivery cannot continue if the needs of an increasingly frail population with complex and multiple co-morbidities are to be effectively met.
2.7	The Health and Community Care Management Team has identified that Pavilion 3 at Ayrshire Central Hospital is not currently being used to best effect. Originally designed as a rehabilitation facility, this unit has been increasingly used to provide nursing care for individuals who are being discharged from Crosshouse Hospital but are not yet fit to return home.
2.8	This has resulted in increasingly frail and ill patients being cared for by a team who were configured to offer rehabilitation services. The impact of this has been increasing levels of bed occupancy, often in excess of 90% and at times in excess of 95% and low levels of throughput.
2.9	It is believed that this facility can better meet the needs of the local population and support flow through Crosshouse Hospital if it is reconfigured to prevent acute hospital admission and facilitate early discharge from acute settings.

3.	**Proposals**
3.1	On that basis, it is proposed that Pavilion 3 be re-designated as a Rehabilitation and Reablement Hub which will challenge current decision-making and culture with the aim of engaging patients, the families and carers in setting and attaining personal goals and targets for a return to independence.
3.2	In doing so, the care and support offered within this Hub will focus on supporting individuals to return to their home. Key to this will be offering a viable alternative to acute hospital admission through direct access to the facility from community settings and through enabling the earliest possible safe transfer from the acute setting to promote independence and reablement.
3.3	This will be underpinned by a multi-disciplinary approach will be adopted ensuring Medical, Nursing, Allied Health Professions and Social Services staff are based within the facility to offer collective support and specific professional expertise to the tailored rehabilitation and reablement plan for each patient.
3.4	Specifically, this new model of care will: • Accept appropriate referrals from hospital and community services and developing individual outcome focused action plans with service users. • Provide a direct in-reach service to acute care to assess and identify those individuals most likely to benefit from Rehabilitation and Reablement and work with them and their families to establish individual goals and person-centred plan prior to transfer. • Offer a reablement service up to 12-weeks based on assessed needs. • Include carers and families throughout the process and providing practical and emotional support to enable them to continue in their caring role. • Ensure multidisciplinary assessments and supports are continuously updated to reflect ability. • Deliver reablement over seven days accepting appropriate referrals from hospital and Community Services and developing individual outcome focused action plans with service users. • Involve a range of services, professionals and disciplines to ensure maximum impact and benefit. • Develop a reporting framework to measure outcomes for individuals and review the efficiency of the service. • Develop links with neighbourhoods and local services to ensure additional personal outcomes including community involvement and socialisation can be addressed appropriately. • Ensure individuals with complex, chronic long-term needs and those in need of end of life support benefit from access to the most appropriate professionals within an environment best suited to their needs.
3.3	It is proposed that during the first quarter of 2015 the teams are brought together under the leadership of the Health and Community Care Management Team to design, implement and begin testing of the new model of Rehabilitation and Reablement within Pavilion 3.
3.4	Further it is proposed that this model is refined and developed throughout 2015/16 drawing on learning from the new ways of working using small test of change methodology.

3.5	Linked to this, it is proposed that a formal evaluation of the new model of care and effectiveness of the integrated Rehabilitation and Reablement Hub be concluded by 31 December 2015 with a view to agreeing a formal model of care to be sustained into the future.
3.6	Finally, it is proposed that the findings from this evaluation be used to inform the final configuration of beds within the new Community Hospital at Ayrshire Central Hospital to ensure these are utilised to best meet the needs of local people.
4.	**Implications**
	Financial Implications
4.1	Funding totalling £144,000 has been secured from Scottish Government to support attainment of Delayed Discharge targets over the winter months. Working with colleagues in the South and East Ayrshire, North Ayrshire Health and Social Care Partnership staff are working to secure a Return Home support service provided by Red Cross to ensure those individuals who do not need an acute hospital admission can safely go home with appropriate support. This service is likely to cost £22,000 until 31 March 2015. The remaining £122,000 will be available to support enabling work required to deliver the new model of care. The Health and Community Care Management Team are in the process of determining priorities for this funding. Thereafter, the new model will be delivered within existing staffing resources with support from the Service Change Team being funded through the Integration Change Fund.
	Human Resource Implications
4.2	This change will require the relocation of some Medical, Allied Health Profession and Social Work staff to Pavilion 3. Discussions will take place with the relevant staff members well in advance of any change.
	Legal Implications
4.3	There are no legal implications as this proposal is in keeping with the procurement rules.
	Equality Implications
4.4	There are no equality implications.
	Environmental and Sustainability Implications
4.5	There are no environmental and sustainability implications.
	Implications for Key Priorities
4.6	This development supports the delivery of the Integrated Services and Early Intervention and Prevention strategic priorities as set out within the draft Strategic Plan.

5.	**Consultations**
5.1	Initial consultation has taken place with the Medical, Nursing, Allied Health Profession and Social Work team with a commitment to maintain engagement and involvement throughout the model development period.
6.	**Conclusion**
6.1	The Shadow integration Board is asked to agree the following: • The creation of a new, fully integrated Rehabilitation and Reablement Hub within Pavilion 3 at Ayrshire Central Hospital; • The design, implementation, testing and refinement of a new model of care throughout 2015/16; • The formal evaluation of this new way of working by 31 December 2015; • The development of proposals for the utilisation of the 60 Care of the Elderly beds within the new Community Hospital, informed by the findings from this evaluation, to best meet the needs of the people of North Ayrshire.

For more information please contact David Rowland on 01294 317797
or davidrowland@north-ayrshire.gcs.gov.uk

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Shadow Integration Board
18th December 2014

Subject:	**Consultation on Proposals for an Offence of Wilful Neglect or Ill-treatment in Health and Social Care Settings (Scottish Government)**
Purpose:	To seek the views of the SIB on the consultation.
Recommendation:	The SIB are asked to comment on the proposal.

1.	**Introduction**
1.1	The Scottish Government have launched a consultation on their proposal to introduce legislation related to an offence of 'Wilful Neglect or Ill treatment in Health and Social Care Settings'.
1.2	The consultation runs until 2nd January 2015.
2.	**Current Position**
2.1	Within the Mental Health Act (MHA) (S 315) and within the Adults With Incapacity Act (AWI) (S 83) there already exist specific offences related to wilful neglect or ill treatment.
2.2	There have been few convictions under either Act in recent years. 2006-213 under AWI there were four charges brought (three proceedings); under MHA there were 52 charges brought (35 proceedings). [Source Social Work, Scotland via FOI].
3.	**Proposals**
3.1	The Scottish Government are looking for feedback to their consultation paper – which contains 10 specific questions.
3.2	<u>Services covered</u> The new legislation should cover all services irrespective of public or private sector – wilful neglect, ill treatment is unacceptable in any environment.
3.3	<u>Informal Settings</u> The new legislation should not cover informal care settings e.g. family. Neglect or ill treatment in these setting can be dealt with via other legislation, including MHA and AWI Acts.

3.4	Covering Children's services It is inconceivable that we would not introduce the same 'protections' for children as we have for adults. All children's services therefore should be included.
3.5	Voluntary agencies Yes, the legislation should apply in any circumstance where there is a duty of care. In situation where volunteers take on a care role, either paid or unpaid, the duty would apply – in these circumstances wilful neglect or ill treatment is unacceptable.
3.6	The act rather than the outcome Yes, the legislation should cover the act of wilful neglect or ill treatment rather than the outcome of the action. To base the legislation on outcome would be to create a variation in the offence dependant on how much someone suffered or was harmed.
3.7	Applying to organisations Yes, organisations should have a legislative requirement placed on them in addition to individuals within it. Where senior decision makers make active decisions which cause harm, neglect or ill treatment the organisation as well as the 'directing minds' should be culpable.
3.8	When to apply to organisations Organisations should be accountable where decisions at a senior level have been made which directly lead to neglect or harm. Circumstances such as staffing levels, food nutritional requirement, heat etc.
3.9	Penalties equivalent to MHA, AWI There is no compelling reason for the penalties to be different.
3.10	Additional penalties For discussion, this is outwith my area of expertise.
3.11	Protected characteristics The issue of wilful neglect or ill treatment should apply in the same way irrespective of 'protected' characteristics, indeed in some circumstance may enhance protection.
4.	**Implications**
4.1	There are no direct implications for the Partnership at this point
5.	**Consultations**
5.1	This is a Scottish Government consultation and is available from their website.
5.2	Staff from across the partnership have been asked to respond to the Lead Nurse to collate our response.

6.	**Conclusion**
6.1	The SIB are asked to note the consultation document and consider whether we wish to submit a formal response.
6.2	If the SIB wish to submit a formal response they are asked to delegate this to Lead Nurse Derek Barron, based on the discussion at today's meeting.

For more information please contact Derek T Barron, Associate Nurse Director/Lead Nurse on (01563) 826348.

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Consultation on Proposals for an Offence of Wilful Neglect or Ill-treatment in Health and Social Care Settings

October 2014

The Scottish Government
Riaghaltas na h-Alba

CONTENTS

Wilful Neglect/Ill-treatment Consultation

1. This consultation outlines and invites views on the Scottish Government's proposals for a new criminal offence of ill-treatment or wilful neglect of those receiving care or treatment in health and social care settings.

2. The Scottish Government's proposal is to create an offence which is similar to those that presently exist in relation to mental health patients and adults with incapacity. The proposed offence would cover the wilful neglect or ill-treatment of anyone receiving care or treatment in a range of care services.

Introduction

3. People in Scotland receive high quality care and treatment in an array of health and social care situations, the delivery of which is carried out by a variety of dedicated professionals. The vast majority of staff employed in these settings work to the very best of their ability in providing these services, and do so in a manner that respects and protects the dignity and rights of individuals and their families. However, as we know from events elsewhere, for example, at Mid-Staffordshire NHS Foundation Trust, and at Winterbourne View, there can be instances where people receiving care are deliberately mistreated or neglected by those who have been trusted to look after them.

4. Although such incidents of deliberate neglect or mistreatment may be uncommon, we need to ensure that the criminal justice system is able to deal with these cases effectively when they arise.

5. There are existing offences of wilful neglect or ill-treatment in respect of mental health patients (set out in section 315 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and in respect of adults with incapacity (set out in section 83 of the Adults with Incapacity (Scotland) Act 2000). Both of these offences cover distinct groups of people and the purpose of this consultation is to explore extending the scope of the offence of wilful neglect or ill-treatment beyond these groups.

6. The offence that we are proposing to create is not intended to cover instances of genuine error or accident.

7. Other remedies and means of redress, for example under the Human Rights Act 1998, or through formal complaints procedures, will remain available. These will continue to offer an appropriate and accessible route to dealing with situations of concern in which alleged neglect or ill-treatment cannot be attributed to deliberate misconduct.

8. This consultation document outlines five particular areas that we are seeking views on. In summary, these are: the type of care settings which the offence should cover; whether the offence should be based on conduct or outcomes; how the offence should apply to organisations as well as individuals; penalties; and equality issues.

Defining the Offence

(A) Which care settings should be covered

9. We believe that the new offence should cover both health and social care settings. The Scottish Government is currently progressing a programme of integration of adult health and social care in order to improve services for people who use them. Integration will increasingly ensure that the provision of health and social care across Scotland is joined-up and seamless. As we move towards more integrated services we therefore consider that the proposed offence should cover both kinds of settings.

10. Our proposal would cover those who work in providing care and treatment in health and social care, including such care or treatment provided in the following settings in both the statutory and Third Sector sectors (the list is not exhaustive):

    - NHS hospitals
    - Independent hospitals
    - Primary care services
    - Adult care settings (including care homes, care at home, support services, housing support services, adult placement services, short breaks and respite care, services for people in criminal justice supported accommodation)
    - Hospices

11. Annex A provides a list of the professions that we envisage being covered by the proposed offence.

12. In addition to some of the formal health and social care settings listed, there are also a range of informal arrangements for care where that care is provided on the basis of a friendship or a family relationship or friendship. Sometimes people speak about looking after others without realising that they are describing a caring situation.

13. In January 2014, the Scottish Government launched a consultation on legislation to further support carers and young carers across Scotland. Subject to Parliamentary approval, the proposed legislation would introduce a range of measures that will aim to make a meaningful difference to carers to improve their

health and wellbeing and to ensure they have a life alongside caring. The Scottish Government will publish its response to the consultation in Autumn 2014.

14. Given the nature of unpaid caring where it is both carried by virtue of a contract of employment or other contract or as a volunteer, we do not feel that it would be appropriate for the offence to cover the types of care situation where there is no legal obligation or contract in place. Moreover, the care is being provided in a person's home, not in a health or social care setting. If however, a cared-for person in neglected or mistreated by the unpaid carer then the existing offences in statute would apply.

15. We believe that the proposed offence should cover all formal situations where health care is provided for children, for example in NHS hospitals and independent hospitals. However, the range of social care services provided for children is different to those delivered for adults. We would like to hear your views on the types of social care services for children that you think should or should not be covered by our proposals.

16. We would also like to hear your views on whether the offence should cover people providing care or treatment on a voluntary basis on behalf of a voluntary organisation.

QUESTIONS:

Do you agree with our proposal that the new offence should cover all formal health and adult social care settings, both in the private and public sectors?

Do you agree with our proposal that the offence should not cover informal arrangements, for example, one family member (generally termed unpaid carer or darer) caring for another?

Should the new offence cover social care services for children, and if so which services should it cover? Please list any children's services that you think should be excluded from the scope the offence and explain your view.

Should the offence apply to people who are providing care or treatment on a voluntary basis on behalf of a voluntary organisation, whether on a paid or unpaid basis?

(B) Basing the offence on conduct or outcomes

17. We believe that the offence should be based on the conduct of the individual or organisation rather than based on any harm caused as a result of their actions.

18. No measure of deliberate neglect or mistreatment is acceptable and we feel that the criminal law should reflect this. If a threshold of harm was set out in legislation then this could give rise to a situation where two people were subjected to the same ill-treatment or neglect by the same care worker but because one was more seriously harmed than the other, a prosecution could only be brought in respect of the more seriously harmed individual. Furthermore, setting a harm threshold may give rise to uncertainty about when the offence would apply.

19. Neither of the offences in the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000 define a required level of harm and therefore to establish one in constructing the new offence would create an inconsistency.

20. Therefore, we propose that the offence should apply where someone has wilfully neglected or ill-treated another in the settings described, regardless of the harm caused by that neglect or ill-treatment. We would like to hear your views on whether or not this is the most suitable approach to take.

QUESTION:

Do you agree with our proposal that the new offence should concentrate on the act of wilfully neglecting, or ill-treating an individual rather than any harm suffered as a result of that behaviour?

(C) Applying the offence to organisations

21. In order to establish an offence that can be consistently applied across health and social care settings we are considering whether or not the new offence should apply to organisations providing care or treatment, as well as individuals.

22. In terms of existing legislation, the offence of wilful neglect/ill-treatment in section 315 of the Mental Health (Care and Treatment) (Scotland) Act 2003 can apply to organisations, as well as individuals, in specific circumstances. We believe that it is appropriate for the new offence to apply to organisations too but we would like to hear your views on how you think this should be applied.

QUESTION:

Do you agree with our proposal that the offence should apply to organisations as well as individuals?

How, and in what circumstances, do you think the offence should apply to organisations?

(D) Penalties

23. We propose that the penalties for the new offence should reflect those currently set out in legislation for the existing offences relating to mental health patients and adults with incapacity. Both of these offences attract the same penalties:

- On summary conviction: imprisonment for a maximum term of 12 months[1], or to a fine not exceeding the statutory maximum (currently £10,000) or both
- On conviction on indictment: imprisonment for a maximum term of 2 years or to a fine (of an unlimited amount), or both

24. In respect of individuals, we do not consider there to be any clear reasons to depart from the penalties already established for wilful neglect/ill-treatment.

25. In respect of organisations there may be other penalties which could be considered. We are keen to hear if you think the proposed penalties are sufficient and if you think that organisations should be subject to penalties other than fines.

QUESTION:

Do you agree that the penalties for this offence should be the same as those for the offences in section 315 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and section 83 of the Adults with Incapacity (Scotland) Act 2000?

Should the courts have any additional penalty options in respect of organisations? If so, please provide details of any other penalty options that you think would be appropriate.

[1] Maximum term of imprisonment of 12 months, as provided for in section 45 of the Criminal Proceedings etc. (Reform) (Scotland) Act 2007

(E) Equality considerations

26. The Scottish Government's Quality Strategy for NHSScotland asserts our aim of delivering safe, effective and person-centred care. To do so we need to understand the needs of each person who uses health and social care services. Therefore, in the development of our proposed offence we will ensure that we identify any equality impacts for people with a protected characteristic (as defined by the Equality Act 2010).

27. We are undertaking an Equality Impact Assessment (EQIA) which will allow us to fully explore these issues. The results of the EQIA will be published on the Scottish Government's website when completed.

28. This consultation provides an opportunity to obtain stakeholders' views on any possible equality impacts, including impacts on those with protected characteristics. The responses to our consultation will assist in our development of the EQIA.

QUESTION:

What issues or opportunities do the proposed changes raise for people with protected characteristics (age; disability; gender reassignment; race; religion or belief; sex; pregnancy and maternity; and sexual orientation) and what action could be taken to mitigate the impact of any negative issues?

(F) Responding to this consultation paper

29. We are inviting written responses to this consultation paper by 2 January 2015.

30. **Please send your response with the completed Respondent Information Form (see "Handling your Response" below) to:**

    wilfulneglectconsultation@scotland.gsi.gov.uk

    or by post to:

    Dan Curran
    The Quality Unit
    Scottish Government
    GER, St Andrew's House
    EDINBURGH
    EH1 3DG

31. If you have any queries contact Dan Curran on 0131 2444894.

32. We would be grateful if you would use the consultation questionnaire provided or could clearly indicate in your response which questions or parts of the consultation paper you are responding to as this will aid our analysis of the responses received.

33. This consultation, and all other Scottish Government consultation exercises, can be viewed online on the consultation web pages of the Scottish Government website at http://www.scotland.gov.uk/consultations

34. The Scottish Government has an email alert system for consultations, http://register.scotland.gov.uk This system allows stakeholder individuals and organisations to register and receive a weekly email containing details of all new consultations (including web links). It complements, but in no way replaces SG distribution lists, and is designed to allow stakeholders to keep up to date with all SG consultation activity, and therefore be alerted at the earliest opportunity to those of most interest. We would encourage you to register.

Handling your response

35. We need to know how you wish your response to be handled and, in particular, whether you are happy for your response to be made public. Please complete and return the **Respondent Information Form** enclosed with this consultation paper as this will ensure that we treat your response appropriately. If you ask for your response not to be published we will regard it as confidential, and we will treat it accordingly.

36. All respondents should be aware that the Scottish Government are subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process

37. Where respondents have given permission for their response to be made public and after we have checked that they contain no potentially defamatory material, responses will be made available to the public in the Scottish Government Library (see the attached Respondent Information Form), these will be made available to the public in the Scottish Government Library by 21 January 2015 and on the Scottish Government consultation web pages by 30 January 2015. You can make arrangements to view responses by contacting the SG Library on 0131 244 4552. Responses can be copied and sent to you, but a charge may be made for this service.

What happens next?

38. Following the closing date, all responses will be analysed and considered along with any other available evidence to help us reach a decision on creating an offence of wilful neglect/ill-treatment. We aim to issue a report on this consultation process by Easter 2015.

Comments and complaints

39. If you have any comments about how this consultation exercise has been conducted, please send them to the address given in the section ‘Responding to this consultation paper’.

(G) The Scottish Government Consultation Process

40. Consultation is an essential and important aspect of Scottish Government working methods. Given the wide-ranging areas of work of the Scottish Government, there are many varied types of consultation. However, in general, Scottish Government consultation exercises aim to provide opportunities for all those who wish to express their opinions on a proposed area of work to do so in ways which will inform and enhance that work.

41. The Scottish Government encourages consultation that is thorough, effective and appropriate to the issue under consideration and the nature of the target audience. Consultation exercises take account of a wide range of factors, and no two exercises are likely to be the same.

42. Typically Scottish Government consultations involve a written paper inviting answers to specific questions or more general views about the material presented. Written papers are distributed to organisations and individuals with an interest in the issue, and they are also placed on the Scottish Government web site enabling a wider audience to access the paper and submit their responses. Consultation exercises may also involve seeking views in a number of different ways, such as through public meetings, focus groups or questionnaire exercises. Copies of all the written responses received to a consultation exercise (except those where the individual or organisation requested confidentiality) are placed in the Scottish Government library at Saughton House, Edinburgh (K Spur, Saughton House, Broomhouse Drive, Edinburgh, EH11 3XD, telephone 0131 244 4565).

43. All Scottish Government consultation papers and related publications (eg, analysis of response reports) can be accessed at: Scottish Government consultations (http://www.scotland.gov.uk/consultations)

44. The views and suggestions detailed in consultation responses are analysed and used as part of the decision making process, along with a range of other available information and evidence. Depending on the nature of the consultation exercise the responses received may:
    - indicate the need for policy development or review
    - inform the development of a particular policy
    - help decisions to be made between alternative policy proposals
    - be used to finalise legislation before it is implemented

45. Final decisions on the issues under consideration will also take account of a range of other factors, including other available information and research evidence.

46. **While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.**

Annex A — Professions which would be covered by the offence

Please note: this list is not exhaustive and we would welcome comments on it

Health Professionals

- Chiropractors
- Dentists, dental nurses, dental technicians clinical dental technicians, dental hygienists, dental therapists orthodontic therapists
- Doctors
- Optometrists, dispensing opticians, student opticians and optical businesses;
- Osteopaths;
- Professions regulated by the Health and Care Professions Council (HCPC) (which includes arts therapists, biomedical scientists, chiropodists / podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, and speech and language therapists)
- Pharmacists and pharmacy technicians
- Nurses and midwives

Social Care Professionals

Social care workers who work in providing services in the following: care homes, care at home, support services, housing support services, adult placement services, short breaks and respite care, services for people in criminal justice supported accommodation

Annex B — Partial Business and Regulatory Impact Assessment

Title of Proposal

Offence of Wilful Neglect or Ill- treatment in Health and Social Care Settings

Purpose and intended effect

- **Background**

People in Scotland receive high quality care and treatment in an array of health and social care situations, the delivery of which is carried out by a variety of dedicated professionals. The vast majority of staff employed in these settings work to the very best of their ability in providing these services. However, as we know from the events elsewhere, for example, at Mid-Staffordshire NHS Foundation Trust, and at Winterbourne View, there can be instances where people receiving care are deliberately mistreated or neglected by those who have been trusted to look after them.

Although such incidents of deliberate neglect or mistreatment may be uncommon, we need to ensure that the criminal justice system is able to deal with these cases effectively when they arise.

There are existing offences of wilful neglect or ill-treatment in respect of mental health patients (set out in section 315 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and in respect of adults with incapacity (set out in section 83 of the Adults with Incapacity (Scotland) Act 2000). Both of these offences intentionally relate to narrowly defined groups of people and we feel that there is good reason to extend the offence of wilful neglect or ill-treatment beyond these groups.

- **Objective**

The Scottish Government's proposal is to create an offence which is similar to those that presently exist in relation to mental health patients and adults with incapacity. The proposed offence would cover the wilful neglect or ill-treatment of anyone receiving care or treatment in a range of health and care services.

- **Rationale for Government intervention**

No measure of deliberate neglect or mistreatment is acceptable and we feel that the criminal law should reflect this. Only certain groups are currently protected under the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000). In order to ensure consistency and address a current gap in legislation the Scottish Government considers it should introduce a criminal offence of wilful neglect or ill-treatment beyond these groups to cover all individuals receiving care in a formal health or social care setting.

The Government has five objectives that underpin its core purpose. This legislation will contribute to the National Objectives of Healthier Scotland, through

improving health care quality, and Safer and Stronger.

It will also contribute to two of the 16 national outcomes:

- we live longer, healthier lives,
- we live our lives safe from crime, disorder and danger

Consultation

The legislation will be developed in a collaborative way involving colleagues from across and outwith the Scottish Government.

- **Within Government**
  We are working with colleagues across the Scottish Government to develop this legislation. This includes, but is not restricted to, the following teams: Primary Medical Services; Integration and Reshaping Care; Children's Rights and Wellbeing; and Criminal Law and Licensing. This approach ensures that current Scottish Government policy will be reflected in the on-going development of this legislation and will ensure that all appropriate stakeholders and stakeholder groups can offer comment of these proposals.
- **Public Consultation**
  The formal consultation will run for a period of 12 weeks from 10 October 2014.
- **Business**
  We will identify relevant organisations to meet with during the consultation period and update this section at Final BRIA stage.

Options

Option 1: Do nothing

Under option 1 the situation would remain as it is at present. The offences outlined within the Mental Health (Care and Treatment) (Scotland) Act 2003 and in respect of adults with incapacity in the Adults with Incapacity (Scotland) Act 2000 would remain but there would be no expansion of protection to wider patient groups.

Option 2 : create an offence of Wilful Neglect or Ill-treatment in Health and Social Care.

Under option 2 there would be a new offence of wilful neglect which would cover all formal health and social care settings, both in the private and public sectors.

Sectors and groups affected

The new offence would cover all care in delivered in the following settings and services:

- NHS hospitals
- Independent hospitals
- Hospices
- Primary care services
- Adult care homes
- NHS ambulance services
- Independent ambulance services

The legislation would apply to all providers of health and social care services and

patients in all these settings would be afforded the protection of this legislation. This in turn, means that all parts of the justice system including the police and the Crown Office and Procurator Fiscal Service (COPFS) could be affected.

Benefits

Option 1: there would be no action and therefore no additional benefits. There is a potential disbenefit that patients not covered by the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Adults with Incapacity (Scotland) Act 2000 could be at increased risk of suffering wilful neglect or ill-treatment.

Option 2: this would provide consistency for patients, irrespective of their mental capacity or mental health. All patients in all formal health and social care settings would be afforded the protection of legislation.

The legislation and associated sanctions may have a deterrent effect. The prevention of ill treatment would then result in benefits for both individuals and society. Should incidents of wilful neglect and/or ill-treatment occur then the legislation would ensure that those responsible were held fully accountable.

It is not possible to quantify the benefits from deterrent effect, increased consistency and accountability.

Costs

Option 1: there would be no action and therefore no cost to government or to providers of health and social care services. There is a potential cost to patients not covered by the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Adults with Incapacity (Scotland) Act 2000 who could be at increased risk of suffering wilful neglect or ill- treatment.

Option 2: the offence should not create sizable additional costs or liabilities on individual practitioners and/or providers beyond what is normally expected of quality of care. However we know that, very occasionally, there will be examples of behaviour that can be classed as wilful neglect or ill-treatment. It is these rare occurrences that the legislation seeks to both deter and address.

<u>Number of cases.</u>

It is difficult to estimate the number of cases that might be brought forward under any new legislation.

Number of patients affected:
Within NHSScotland the number of patients treated in acute specialities in 2012/13 was 698,369[2]. Laing and Buisson estimate that across the UK, 1.64 million patients were admitted for surgical procedures in independent hospitals . Pro rata by population this suggests around 136,000 patients in Scotland. However we know that private health insurance coverage is lower in Scotland than across many parts of the UK and compared with the UK average (8.5% vs. 12%) . An estimate of 95,000 is therefore likely to be more realistic and may still be an overestimate. This gives an estimate of 794,000 inpatients across the public and private sector.

The Care home census of 2013 showed nearly 36,600 individuals resident at the time. These are mainly elderly, over 65 years, but this number includes adults of working age. Excluding those with mental health problems or learning disability leaves 33,687. Around 50,400 of those aged over 65, and 10,500 younger adults received a care home service in 2012-13.[3] Again, around 4,500 of the younger adults have mental health or learning disabilities: excluding them gives a total across residential and home care of approx. 90,000 individuals.

It is acknowledged that many of the above individuals may also access hospital services in the course of a year so this may be an overestimate.

GP services, dentists, A&E attendances and ambulance journeys have been excluded from this estimate (which may counter the previous overestimate) as it is considered that there is a lower risk of wilful neglect, mainly due to the relatively short time that would be spent in those care settings although the legislation will cover these.

So although not exhaustive this initial estimate suggests that around 884,000 additional users of health and social care services in Scotland would be covered by extending the legislation.

In terms of the potential number of additional cases that might be generated there is very little evidence on which to base an estimate. There have been very few prosecutions under the Mental Health (Care and Treatment) (Scotland) Act 2003 and none under the Adults with Incapacity (Scotland) Act 2000.

Scottish Government:
There will be costs associated with the provision of information on the new legislation. The Government would need to consider whether it wished to undertake a public education campaign to make people aware of any change in the law. There would also potentially be costs involved in providing literature/guidance for care

[2] http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/
[3] http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/Data/HomeCare/HSCDHomecare

providers including care homes and the range of health professionals.

SG/NHS Boards/providers
The Scottish Government and NHS Education for Scotland (NES) would need to consider if it was necessary to introduce any additional staff training.

Justice system
Should there be additional cases identified under the extension of the legislation then there could be costs for the police, Crown Office and Procurator Fiscal Service (COPFS) and defendants. Unless the number of cases proved to be substantial it is assumed that these would have minimal impact on the justice system and could be incorporated into normal workloads.

Defendants
Should prosecutions result from the legislation defendants, unless they are eligible for legal aid, may incur the costs of mounting a defence. We are not, at present, able to quantify these.

Scottish Firms Impact Test
This proposal is designed to reinforce a culture of safety and quality for patients in Scotland in all health and social care settings. There have, to date, been no consultations with Scottish firms who may be affected. The consultation which this document accompanies actively seeks the views of businesses who may be affected by these proposals and who the consultation document has been forwarded to..

Competition Assessment
1. Will the proposal directly limit the number or range of suppliers?
The proposal will not directly affect the number or range of suppliers of health and/or social care. The legislation will apply to all health and care settings and all formal care givers.

2. Will the proposal indirectly limit the number or range of suppliers?
The proposal will not indirectly affect the number or range of suppliers of health and/or social care. The legislation will apply to all health and care settings and all formal care givers. It does not constitute a barrier to entry into the market.

3. Will the proposal limit the ability of suppliers to compete?
The legislation will apply to all health and care settings and all formal care givers. Much of the activity covered will be within NHSScotland. It will have no impact on competition within the health and social care sector.

4. Will the proposal reduce suppliers' incentives to compete vigorously?
The legislation will apply to all health and care settings and all formal care givers.

Much of the activity covered will be within NHSScotland. Suppliers within the private sector will all be equally affected. There will be no impact on their ability to compete.

Test run of business forms
No new forms for business are anticipated.

Legal Aid Impact Test
As part of the Bill development process we will liaise with the Scottish Government Access to Justice Team to gauge whether any proposed legislation will affect Legal Aid. This will be detailed within the final BRIA.

Enforcement, sanctions and monitoring
It is proposed that the penalties for this offence should be the same as those for the offences in section 315 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and section 83 of the Adults with Incapacity (Scotland) Act 2000.

The consultation is seeking views on this, in particular whether the courts should have any additional penalty options in respect of organisations.

Implementation and delivery plan
October 2014 – launch of consultation process.

- **Post-implementation review**
  A review process will be considered as the legislation is developed.

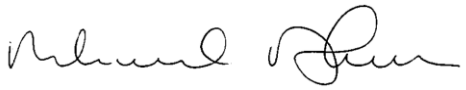
Summary and recommendation
Option 2 is the option on which the Scottish Government wishes to consult.

- **Summary costs and benefits table**

This will be detailed in the full BRIA, following consultation and accompanying the Bill and financial memorandum.

Declaration and publication
I have read the Business and Regulatory Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options. I am satisfied that business impact will be assessed with the support of businesses in Scotland.

Signed:



Date: 10th October 2014

Michael Matheson
Minister for Public Health

Scottish Government Contact point:
WilfulNeglectConsultation@scotland.gsi.gov.uk

Annex C — Summary of Consultation Questions

Do you agree with our proposal that the new offence should cover all formal health and adult social care settings, both in the private and public sectors? Please explain your views.

Yes ☐ No ☐

Comments

Do you agree with our proposal that the offence should not cover informal arrangements, for example, one family member caring for another?

Yes ☐ No ☐

Comments

Should the new offence cover social care services for children, and if so which services should it cover? Please list any children's services that you think should be excluded from the scope the offence and explain your view.

Yes ☐ No ☐

Comments

Should the offence apply to people who are providing care or treatment on a voluntary basis on behalf of a voluntary organisation?

Yes ☐ No ☐

Comments

Do you agree with our proposal that the new offence should concentrate on the act of wilfully neglecting, or ill-treating an individual rather than any harm suffered as a result of that behaviour?

Yes ☐ No ☐

Comments

Do you agree with our proposal that the offence should apply to organisations as well as individuals?

Yes ☐ No ☐

Comments

How, and in what circumstances, do you think the offence should apply to organisations?

Yes ☐ No ☐

Comments

Do you agree that the penalties for this offence should be the same as those for the offences in section 315 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and section 83 of the Adults with Incapacity (Scotland) Act 2000?

Yes ☐ No ☐

Comments

Should the courts have any additional penalty options in respect of organisations? If so, please provide details of any other penalty options that you think would be appropriate.

Yes ☐ No ☐

Comments

What issues or opportunities do the proposed changes raise for people with protected characteristics (age; disability; gender reassignment; race; religion or belief; sex; pregnancy and maternity; and sexual orientation) and what action could be taken to mitigate the impact of any negative issues?

Comments

Consultation on Proposals for an Offence of Wilful Neglect or Ill-treatment in Health and Social Care Settings

RESPONDENT INFORMATION FORM
Please Note this form **must** be returned with your response to ensure that we handle your response appropriately

1. Name/Organisation
Organisation Name

Title **Mr** ☐ **Ms** ☐ **Mrs** ☐ **Miss** ☐ **Dr** ☐ **Please tick as appropriate**

Surname

Forename

2. Postal Address

Postcode	**Phone**	**Email**

3. Permissions - I am responding as…

Individual	/	**Group/Organisation**
☐	**Please tick as appropriate**	☐

(a) Do you agree to your response being made available to the public (in Scottish Government library and/or on the Scottish Government web site)?

Please tick as appropriate
☐ **Yes** ☐ **No**

(b) Where confidentiality is not requested, we will make your responses available to the public on the following basis

Please tick ONE of the following boxes

(c) The name and address of your organisation **will be** made available to the public (in the Scottish Government library and/or on the Scottish Government web site).

Are you content for your **response** to be made available?

Please tick as appropriate
☐ **Yes** ☐ **No**

Yes, make my response, name and address all available ☐

or

Yes, make my response available, but not my name and address ☐

or

Yes, make my response and name available, but not my address ☐

(d) We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Please tick as appropriate ☐ **Yes** ☐ **No**

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The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

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DPPAS37846 (10/14)

Shadow Integration Board
18th December 2014

Subject:	**Duty of Candour Consultation (Scottish Government)**
Purpose:	To seek the views of SIB members
Recommendation:	That the SIB considers their response to the questions asked in the consultation

1.	**Introduction**
1.1	The Scottish Government is consulting on their proposal to introduce legislation on a requirement that organisations providing health and social care in Scotland tell people if physical or psychological harm has occurred as a result of their care or treatment.
1.2	The consultation runs until 14th January 2015. A copy of the consultation is attached at Appendix 1.
2.	**Current Position**
2.1	Regulated health and care professionals are already required to tell people about instances of harm.
2.2	The Nursing & Midwifery Council (NMC) and General Medical Council (GMC) are explicit in their requirements that registrants should be candid with people harmed by their practice. Currently they are consulting in updating their "Professional Duty of Candour' guidelines – this is being carried out on behalf of all the regulators. There is currently no explicit requirement on social workers relating to a duty of candour.
2.3	Extending the individuals' duty of candour to include an organisational duty is fundamentally a good thing and, given the numerous instances where organisations have failed to disclose harm, it is difficult to adopt any other stance.
2.4	Most areas of our services will already embrace the duty of candour, this isn't new. Most social workers (and social work services) will already have this embedded in how they work. Most mental health services will have this embedded in how they work. This gives rise to the question why we need this additional legislative framework.

3.	**Proposals**
3.1	The proposal is that the Scottish Government introduce legislation requiring: a) Organisation to adopt a duty of candour, b) Organisations to record all instance of disclosure of harm, c) Organisations to publish instances of disclosure of harm, d) Organisation to train staff on how to disclose harm, e) Organisations ensure appropriate support is in place for staff, the person harmed and/or their family.
3.2	Currently Health Boards and Local Authorities can be directed, via performance outcome frameworks, on what they must measure and collect. Performance frameworks can include a requirement to report on duty of candour cases, if the Scottish Government so wishes.
3.3	The proposal as it stands appears to take little cognisance of the new and emerging structures around Health & Social Care Partnerships (HSCPs). It proposes that existing structures are the vehicle for monitoring and reporting i.e. through health boards and local authorities.
3.4	From the consultation document it appears that processes that exist within the NHS, Significant Adverse Event Reviews (SAER), as monitored by HIS, are not working as intended. It seems rather odd therefore to place an additional burden on the system without first fixing the part that isn't working – this is especially true as the examples given in the consultation paper are in fact 'disclosable events' as proposed by the new legislation and already included in SAER processes.
3.5	The proposal would introduce a legislative requirement to disclose events that may not have been subject to review. However, a more positive approach could be that it may provide an imperative for organisations (NHS) to appropriately address their Significant Adverse Event processes. There again this misses the duality of HSCPs.
3.6	The consultation asks if the same duty should apply to children's services. If we are going to introduce the duty of candour in adult services is would seem anomalous, indeed wrong, to exclude children from the same protection.
3.7	There is no clear definition or understanding of harm, most notably related to psychological harm.
3.8	Having a requirement to publication strategy is laudable in terms of openness and transparency, however it will simply represent another industry of administration. The key point isn't how many disclosures have happened, it is that the disclosures are happening – counting something simply because it can be counted doesn't add value, and could be considered as demonstrating a lack of trust.
3.9	Annual review processes already exist – monitoring that disclosures are taking place and that it is the culture of an organisation to disclose harm can be tested at that point. Collecting 'numbers' neither demonstrates quality of the process or efficacy, it is likely to lead to a league table approach around disclosures that is unhelpful.

4.	**Implications**
4.1	Without a clear definition or understanding of 'harm' that is applicable within an integrated system the proposal leaves too much scope for interpretation and divergence of practice.
4.2	Although we (in the Partnerships) do have hospitals where 'physical harm' via treatment may occur, many or our services do not have the 'hands on' or invasive element to them where physical harm may occur. We therefore require a great explanation and understanding of psychological harm in relation to the duty to disclose.
4.3	Neither the NHS nor the Local Authority currently have in place a register of when and to whom a disclosure has been made, with the exception of when a Significant Adverse Event has been established (NHS). This administrative process would need to be established. It will inevitably create an additional administrative burden with little/no discernable added value.
4.4	The risk matrix (Ch 3) does not adequately address understanding related to 'disclosable events'. This section is predominantly an NHS section, the addition of 'social care services' in the narrative (9.14) doesn't alter the thrust of this section. It appears little effort has been made to understand or explain harm from a social care perspective.
4.5	Consideration needs to be given to the additional training resource that would be required to role this out to every professional (H&SC), it is not sufficient to have a 'team' of disclosure experts, we know from experience that people want to hear from those involved with them, indeed frequently those that may have made the mistake.
4.6	Greater consideration is required as to how we can achieve this without taking staff away from delivering services. Noting of course that most regulators have this duty in some form in their Code of Conduct for professional staff, ergo staff should have some knowledge of how to go about doing this if required.
4.7	Additionally the guidelines form the NMC and GMC make it clear that the individual registrant, in most cases, should personally make the disclosure of harm to the patient.
5.	**Consultations**
5.1	This is a public consultation widely available on the Scottish Government website.
6.	**Conclusion**
6.1	The introduction of an organisation Duty of Candour is indeed a positive thing.
6.1	As it currently stands making this a legislative duty requires further exploration and detailed consideration, detail that is not in the consultation document.
6.2	In relation to Children's Services – if we introduce a Duty of Candour for adult services this must absolutely include children.

6.3	There needs to be greater engagement around the HSCPs as to what this will mean for them, relying on ‘old’ structures is not a positive aspect of the proposal.
6.4	It is however to be welcomed that organisation will have the duty placed on them, which in turn will support staff to feel safe(r) when disclosing harm.
6.5	Two questions remain: Do we need legislation to achieve the desired outcome? Does the proposal, as laid out, add value or create additional reporting requirement without adding safeguards?
6.6	The SIB is asked to consider the consultation document and offer views.

For more information please contact Derek T Barron, Associate Nurse Director/Lead Nurse on (01563) 826348

Consultation on Proposals to Introduce a Statutory Duty of Candour for Health and Social Care Services

October 2014

The Scottish Government
Riaghaltas na h-Alba

CONTENTS Page

1. INTRODUCTION

1.1. This consultation invites views on proposals to introduce legislation that will require organisations providing health and social care in Scotland to tell people if there has been an event involving them where the organisation has recognised that there has been physical or psychological harm as a result of their care or treatment.

1.2. "Transparency – especially when things go wrong is increasingly considered necessary to improving the quality of health care. By being candid with both patient and clinicians, health care organizations can promote their leaders' accountability for safer systems, better engage clinicians in improvement efforts, and engender greater patient trust"[1]

1.3. However barriers to being open after serious safety incidents have been identified to include fear, worry, embarrassment and lack of institutional support. [2]

1.4. Although much of the international evidence and current practice in this area has focussed on health services, it is proposed that in Scotland this duty will apply to providers of both child and adult social care services as well as health services.

2. Background

2.1. The Berwick Report[3] emphasised the importance of the requirement that people affected by serious incidents should be notified and supported.

2.2. It is internationally recognised that between 10-25% of episodes of healthcare (in general hospital, community hospital and general practice) are associated with an adverse event.[4] However, it has been recognised that as few as 30% of incidents resulting in harm are disclosed to people who have been affected. Denial and dismissal of mistakes often results in distress and people spending several years seeking the truth, accountability and apology.[5]

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[1] Kachalia, A (2013) "Improving Patient Safety through Transparency", *New England Journal of Medicine*, 369, 18, 1677.
[2] Pinto, A., Faiz, O., & Vincent, C. (2012). Managing the after effects of serious patient safety incidents in the NHS: an online survey study. *BMJ quality & safety*, qhc-2012.
[3] Department of Health (2013). A promise to learn – a commitment to act: improving the safety of patients in England. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf (Accessed 03rd October 2014)
[4] The Health Foundation (2011). Evidence scan: Levels of Harm. Available at: http://www.health.org.uk/publications/levels-of-harm/ (Accessed 21st September 2014),
[5] Halligan, A. W. F. (2014). Implications for medical leaders of the proposed Duty of Candour. *Clinical Risk*, *20*(1-2), 29-31.

2.3. Improvements in arrangements to support the disclosure of harm, is a key element supporting a continuously improving culture of safety.[6] There are several healthcare systems and organisations worldwide that have introduced initiatives or arrangements to support open disclosure of harm. For example:

- In early 2002, the Michigan Healthcare System changed that way that it responded to instances of patient harm and injury. The public declaration on the requirement for honesty and transparency was subsequently associated with a steady reduction in the numbers and costs of clinical claims being made.[7] When claims were made, the time taken for processing or settlement of such claims was reduced. It has been suggested that this may also impact positively on psychological and physical recovery.

- The Australian Healthcare System has a National Open Disclosure Standard that requires all adverse incidents to be disclosed.[8]

- In the USA, Baystate Health[9] and the Veterans Health Administration[10] are two further healthcare systems who have implemented systems that required disclosure.

2.4. From November 2014 the Care Quality Commission in England will include the duty of candour among the standards to be met by healthcare providers in England. These will form part of the inspection and monitoring regime operating in England. This includes a range of new enforcement powers, including civil penalties and criminal proceedings for repeated failures. The duty of candour will also apply to adult social care services in England from April 2015.[11]

2.5. We want to introduce an organisational duty of candour in Scotland. This will require services to make sure that they are open and honest with people when something has gone wrong with their care and treatment resulting in harm. It will also require training and support to be provided for staff involved with disclosure and support to be available to people who have been affected by an instance of harm.

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[6] Etchegaray, JM., Gallagher, TH., Bell, SK et al. (2012). Error disclosure: a new domain for safety culture assessment. BMJ Quality and Safety, 21, 594-599.

[7] Boothman, R. C., Imhoff, S. J., & Campbell Jr, D. A. (2012). Nurturing a culture of patient safety and achieving lower malpractice risk through disclosure: lessons learned and future directions. *Frontiers of health services management*, *28*(3), 13.

[8] Fletcher, M, Barraclough, B., Bate, J. et al. (2003). New wine in old bottles: a national standard for open disclosure – the Australian experience. Clinical Risk, 9, 225-228.

[9] Peto, RR, Tenerowicz, LM, Benjamin, EM et al (2009). One System's Journey in Creating a Disclosure and Apology Program, The Joint Commission Journal on Quality and Patient Safety, 35, 10, 487-496.

[10] Eaves-Leanos, A., & Dunn, E. J. (2012). Open disclosure of adverse events: transparency and safety in health care. *Surgical Clinics of North America*, *92*(1), 163-177.

[11] The duty of candour applies only to adult social care services in England as the Care Quality Commission does not regulate child social care services.

2.6. The introduction of a statutory duty of candour would support a move toward a planned, co-ordinated and consistent approach that supported respectful disclosure of episodes of harm. This is a central element of good practice for adverse event management. Research in this area has identified that there is a gap between that which is regarded as good practice in respect of disclosure and reality. Statutory reform has been recognised as an important element that is likely to support improvements.

2.7. Any new duty will need to be reflective of and aligned with existing disclosure requirements. For example, social care services already work within a framework where statutory reporting requirements (e.g. for child protection, vulnerable adults) necessitate reporting of harm episodes. In addition people accessing social care services tend to have established longer term relationships with professionals that support candour in practice.[12]

2.8. It has been recognised that disclosure of harm requires advanced communication skills. Programmes have been developed to improve the preparation of doctors to make such disclosures, and to deal with emotional elements that are linked with this task.[13] The content of these programmes is equally relevant and applicable to other care professionals.

2.9. Healthcare professionals have raised concerns that schemes supporting disclosure may undermine their professionalism. Others have expressed concerns that introduction of requirements for candour to legislation would cause fear among healthcare professionals that would not be conducive to their work to improve the quality and safety of services. There are a range of factors that have been consistently shown to facilitate disclosure of harm and some that impede disclosure. The most commonly reported factors are outlined below:

Known Barriers to Disclosure[14]

Fear
Culture of secrecy and/or blame
Lack of confidence in communication skills
Fears that people will be upset
Doubt that disclosure is effective in improving culture

[12] 'Duty of Candour – An Adult Social Care Perspective. Think Local. Act Personal. http://www.thinklocalactpersonal.org.uk/_library/The_Duty_of_Candour_-_an_Adult_Social_Care_Perspective_March_2014.pdf (Accessed 26th September 2014)

[13] Bonnema, R. A., Gonzaga, A. M. R., Bost, J. E., & Spagnoletti, C. L. (2012). Teaching error disclosure: advanced communication skills training for residents. *Journal of Communication in Healthcare*, *5*(1), 51-55.

[14] Iedema, R., Allen, S., Sorensen, R., & Gallagher, T. H. (2011). What prevents incident disclosure, and what can be done to promote it? *Joint Commission journal on quality and patient safety*, *37*(9), 409-417.

Factors Facilitating Disclosure[15]

Accountability
Honesty
Restitution
Trust
Reduction re Risk of Claim

Factors Inhibiting Disclosure[16]

Professional or institutional repercussion
Legal liability
Blame
Lack of confidentiality
Negative family reaction

[15] Kaldjian, L. C., Jones, E. W., & Rosenthal, G. (2006). Facilitating and impeding factors for physicians' error disclosure: a structured literature review. *Joint Commission Journal on Quality and Patient Safety*, *32*(4), 188-198.
[16] Kaldjian, L. C., Jones, E. W., & Rosenthal, G. (2006). Facilitating and impeding factors for physicians' error disclosure: a structured literature review. *Joint Commission Journal on Quality and Patient Safety*, *32*(4), 188-198.

3. Proposals in this consultation paper

3.1. The Scottish Government intends to introduce a statutory requirement on organisations providing health and social care to have effective arrangements in place to demonstrate their commitment to disclose instances of physical or psychological harm. The proposals have been intentionally focused on an organisational duty. The introduction of this duty will form a further dimension of the arrangements already in place to support continuous improvements in quality and safety culture across Scotland's health and care services.

3.2. This consultation paper invites views on proposals that are intended to support a consistent approach to disclosure of events that have resulted in physical or psychological harm to users of health and social care services. In particular the proposals build on the progress made through the implementation across NHSScotland of the 'Learning from adverse events through reporting and review: A national framework for NHSScotland'[17] The testing that is currently ongoing within NHSScotland on 'Being Open' guidance is also likely to be helpful in framing stakeholder engagement and the further development of proposals.[18] There are also elements of the review of significant case reviews in Scotland regarding disclosure and involvement of families that will inform the scope and detail of proposed legislation.[19]

3.3. This paper has been divided into the following chapters:

Chapter 1 - Existing approaches regarding candour
Chapter 2 - Proposed requirements on organisations
Chapter 3 – Disclosable events
Chapter 4 - Monitoring of the statutory duty of candour
Chapter 5 - Responding to this consultation paper
Chapter 6 - The Scottish Government consultation process

[17] http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=3b248733-5f86-4379-9a28-35beae432004&version=-1 (Accessed 25th September 2014)
[18] http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=784df33e-be1a-4b63-9516-3d2edf31ada8&version=-1 (Accessed 26th September 2014)
[19] http://www.scotland.gov.uk/Publications/2012/10/5974/2 (Accessed 25th September 2014)

4. CHAPTER 1: Existing approaches regarding candour

4.1. There has been strong support for the benefits of improving organisational arrangements for disclosure of harm in recent years. The Dalton-Williams review[20] clearly outlined the expectations that all those involved in caring roles have a responsibility to be open and honest to those in their care. The recommendations from this review are summarised below from 4.2 to 4.4.

4.2. Organisations should support the development of a culture that values and supports staff to be candid. Providing health and social care services is associated with risk and things will inevitably go wrong from time to time. When this happens, people want to be told honestly what happened, what will be done in response, and to know how actions will be taken to stop this happening again to someone else in the future. This is one of a series of actions that should form part of organisational focus and commitment to learning, improvement and support of a culture where there is psychological safety.

4.3. Organisations must ensure that there is a clear commitment to ensure that a culture of candour is built as part of a wider culture of safety, learning and improvement. This includes the development of a process to ensure candour and open disclosure, systems and processes to assure that actions arising from learning are implemented and that staff are trained and support in work to improve a culture of candour.

4.4. The review recommended that there should be a statutory duty on organisations and that this would provide a powerful signal of what is considered essential and this should act as an important catalyst for care organisations to improve their systems and commit to a learning culture for their staff.

4.5. Healthcare Improvement Scotland have visited all NHS Boards in Scotland as part of the national programme supporting learning following adverse events. This confirmed that there is variation across the country in respect of the rigour and standard of open disclosure and support for families and staff when harm occurs.

4.6. Extracts from the review reports illustrate the variation that currently exists across the NHS in Scotland:

> "The three significant cases showed evidence of a consistent, robust approach to the involvement of patients and families throughout the process"

[20] https://www.rcseng.ac.uk/policy/documents/CandourreviewFinal.pdf (Accessed 25th September 2014)

"…there was no consistent approach for involving patients, families and carers in the incident investigation, or a systematic process for documenting these events."

"Of the four cases we reviewed, only two documented some level of engagement with the family or relatives"

"We were unable to identify from the policy how NHS Board X actually involves patients, families or carers in investigations of adverse events"

"However the level of support provided to staff was sometimes variable"

"The level of engagement with the patient or family varied across the six cases"

"Most policies lacked guidance on how to involve stakeholders and there were significant inconsistencies in practice"

4.7. The observations made by Healthcare Improvement Scotland are consistent with observations from work that has shown that ethical and policy guidance has largely failed on its own to improve rates of disclosure.[21]

4.8. The 2013 Health and Care Survey[22] asked respondents whether they believed a mistake was made in their treatment or care by their GP practice. 6% of respondents believed such a mistake had been made in their treatment or care. Of those that felt a mistake had been made in their treatment or care:

7% indicated that it did not require a response

Of those that required a response:

19% were completely satisfied with how it was dealt with
44% were satisfied to some extent
38% of those where were not satisfied

4.9. The Care Inspectorate regulate around 14,000 care services including care homes, care at home, childminders, daycare of children, adoption and fostering, housing support, secure care, school accommodation, nurse agencies, and offender accommodation. All services are required to notify the Care Inspectorate of the death of a service user and the circumstances of the death under The Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002. Additional requirements are placed on providers of care home services to notify the Care Inspectorate of any serious injury of a

[21] O'connor, E., Coates, H. M., Yardley, I. E., & Wu, A. W. (2010). Disclosure of patient safety incidents: a comprehensive review. *International Journal for Quality in Health Care*, , 22(5), 371-379..
[22] http://www.scotland.gov.uk/Resource/0045/00451272.pdf

service user, accident or any allegation of misconduct by the provider or any person who is employed by the care service.

4.10. For care services registered on or after 1 April 2011, additional notification requirements are in place. These are not specified in legislation, but are determined by Care Inspectorate under the terms of the Social Care and Social Work Improvement Scotland (Registration) Regulations 2011 and includes accidents, incidents or injuries to a person using a service. The Care Inspectorate regards accidents requiring notification as unforeseen events resulting in harm or injury to a person using the service which results in a GP visit or a visit or referral to hospital. An incident is defined as a serious, unplanned event that had the potential to cause harm or loss, physical, financial or material. The Care Inspectorate also requires notification of allegations of abuse in relation to a person using a service. These additional notification requirements relate to all services regulated by the Care Inspectorate except childminders.

4.11. Ethically and morally health and care professionals are already required to tell people about instances of harm. However of the eight UK wide professional regulatory bodies only the General Medical Council (GMC) and Nursing and Midwifery Council's (NMC) standards explicitly require their registrants to be candid with people harmed by their practice. The General Pharmaceutical Council has a standard that requires their registrants to respond 'appropriately' when care goes wrong however it does not specify that this involves being candid with the patient. As a result the NMC has been working with the GMC to develop guidance on candour on behalf of all of the regulators. The Professional Standards Authority is overseeing this work, with the intention that all the regulatory bodies will undertake to modify their codes of conduct and guidance to reflect a common position on candour.

5. CHAPTER 2: Proposed requirements on organisations

5.1. The statutory duty of candour would apply to health and care services provided by NHS Boards, Local Authorities, all organisations providing services regulated by the Care Inspectorate, independent hospitals, independent hospices, General Practices, community pharmacies, dental practices and optometry practices. As this is an organisational duty, it would not apply to individuals providing services, for example, childminders.

5.2. The statutory duty will require that an organisation must act in an open and transparent way with people when things go wrong. It will outline the minimum requirements that must be in place to support the duty of candour and require that reports are made to describe the implementation of arrangements.

6. What would be required of organisations?

6.1. As soon as it is reasonably practicable after becoming aware that there has been adverse event resulting in harm, the organisation must ensure that the relevant person is notified that this has happened. This will involve the provision of a step by step account of the facts of what happened, including as much or as little information as the person has expressed their wish for.

6.2. If an organisation becomes aware of an event that has resulted in harm after a period of more than a month after the index event, the relevant person should also be provided with an explanation for the delay and the organisation should identify the actions necessary to improve systems for the monitoring and reporting of harm.

6.3. There must be an offer of reasonable support provided to the person harmed, relatives and staff who have been involved with the event. The person undertaking the disclosure may be different for each disclosure episode. It is recognised that this flexibility will be required to reflect the importance of existing relationships with care professionals and the diverse nature of scenarios across health and social care that will come within the scope of the duty.

6.4. The responsibility will rest with organisations to ensure that all staff who are asked to be involved with disclosure have access to the relevant training, supervision and support before, during and after their involvement with disclosure communications.

6.5. The notification that is made to the relevant person should be given personally by a suitably trained representative of the organisation and should include an account of all of the facts known at the time of disclosure and the plans for the event to be reviewed. It will be for the organisation to determine who is most appropriate to disclose the harm episode.

6.6. The relevant person must be informed of the further steps to be taken to review the event and be given the opportunity to have their questions considered by the review process.

6.7. The organisation must provide an apology and must confirm all of the actions taken in a written record. The contents of this will inform the regular public reports of disclosable events and organisational response to these.

6.8. The relevant person must also receive a written summary of the face to face meeting.

7. Reporting on Disclosure Arrangements

7.1. All organisations would be required to report publically on the nature of adverse incidents that have been disclosed to people and confirm that requirements of the organisational duty of candour have been met.

7.2. Organisations would also be required to report on the ways in which they have supported staff in the development and maintenance of the skills required to ensure respectful disclosure by staff who are required to be involved with this.

7.3. Organisations should also publish annually their policies and procedures to support openness and transparency, this must include the arrangements in place to support staff training and development in these advanced communication skills. These reports should be submitted to the relevant organisation (which will differ for each care provider).

7.4. Organisations would be required to ensure that they have arrangements in place to ensure that if any adverse event/incident is reported that this is considered and a decision made whether this is a disclosable event.

7.5. Organisations would also be required to include a summary in their reports of the support that is available to patients, families and staff following an disclosable event. They would also need to describe the provision to ensure that training and development support has been implemented to ensure best practice in disclosure.

7.6. Guidance will be produced to assist organisations in implementation of the organisational duty of candour, which will include resources to support the process of notification, staff support and public reporting.

7.7. In many cases the requirements of organisations (disclosure, support and reporting periodically) will already be in place through local procedures for handling complaints or responding to adverse events/significant events, thereby minimising additional administrative demands on organisations. For example, NHS Boards already receive and monitor reports from GP practices on complaints and significant events. Social care services already have procedures in place to report on harm in respect of children and vulnerable adults.

8. Summary of Organisational Requirements for Duty of Candour

- Identify instances when there has been an event resulting in physical or psychological harm.
- Report the occurrence of these instances in person to the relevant person.
- Apologise.
- Offer the opportunity to be involved in review of the events.
- Offer access to emotional and practical support following the event (to staff, patients and relatives).
- Confirm in writing the details of the personal discussion.
- Have arrangements to ensure that those involved with disclosure have the necessary knowledge and skill to undertake this work.
- Identify and inform relevant person of the learning that was identified following the disclosure and review of the adverse event.
- Report publically (according to an agreed frequency) on all 'disclosable events', including on details of the organisational training and support arrangements in place to deliver the organisational duty of candour. The learning and improvement actions arising from disclosable events would also be included.
- If there have been delays in being notified of an instance of harm, organisations should report on actions being taken to improve on monitoring and reporting arrangements.

Question 1: Do you agree that the arrangements that should be in place to support an organisational duty of candour should be specified in detail ?

Question 2: Should the organisational duty of candour encompass the requirement that adequate provision be in place to ensure that staff have the support, knowledge and skill required ?

Question 3a: Do you agree with the requirement for organisations to publically report on disclosures that have taken place ?

Question 3b Do you agree with the proposed requirements to ensure that people harmed are informed ?

Question 3c Do you agree with the proposed requirements to ensure that people are appropriately supported ?

Question 4: What do you think is an appropriate frequency for reporting ?

Question 5 : What staffing and resources that would be required to support effective arrangements for the disclose of instances of harm ?

9. CHAPTER 3: Disclosable events

9.1. In order for organisations to implement effective arrangements for disclosure of episodes of harm, they need to be clear about the definition of harm that will be used to decide when disclosure is appropriate. The statutory duty of candour legislation would include a nationally agreed definition of the types of harm that would trigger the organisational duty of candour. These definitions need to be developed and informed through dialogue with health and social care professions, taking due recognition of the different context, nature and requirements in health and social care settings.

Definitions of Adverse Events Resulting in Harm

9.2. In healthcare, the National Framework for Adverse Events has proposed that it is possible to define episodes of harm considering events in accordance with the impact on the person who has experienced the event. The following definitions were proposed:

9.3. Category I – Events that may have contributed to or resulted in permanent harm, for example death, intervention required to sustain life, severe financial loss (£>1m), ongoing national adverse publicity (likely to be graded as major or extreme impact on NHSScotland risk assessment matrix, or category G, H or I from National Co-Ordinating Council for Medication Error Reporting (NCCMERP) index).

9.4. Category II – Events that may have contributed to or resulted in temporary harm, for example initial or prolonged treatment, intervention or monitoring required, temporary loss of service, significant financial loss, adverse local publicity (likely to be graded as minor or moderate impact on NHSScotland risk assessment matrix).

9.5. These definitions rely on reference to the NHSScotland Risk Assessment Matrix and NCCMERP Index. These definitions are wider in scope than that proposed for the new legislation, for example an 'Extreme' event in the Risk Assessment Matrix would include an event that attracted national media coverage – which may not necessarily reflect that there had been an episode of physical or psychological harm. Equally these definitions may not work intuitively for social care provision.

9.6. It is recognised that there is not a consistent approach to definition of what constitutes an adverse event where disclosure should take place. We have also recognised that each instance must be considered on its individual merits, taking account of the specific clinical and care elements of individual care episodes.

9.7. Organisations would require to demonstrate through their reporting that they have arrangements in place to consider events in relation to the agreed definition of physical or psychological harm, and that when they have determined harm has not occurred the decision-making process that has informed this decision.

9.8. The issues that will need to be taken into account in considering what constitutes a disclosable event are outlined in this chapter. This will need to encompass the different contexts that influences safety and harm incidents within health and social care services.

Disclosable event

9.9. Disclosable events would be defined as unintended or unexpected event that occurred or was suspected to have occurred that resulted in death, injury or prolonged physical or psychological harm being experienced by a user of health and/or social care services.

9.10. Disclosable events in relation to health care would involve the death of someone receiving care where the death relates to the event itself (as opposed to the natural course of their illness or underlying condition).

9.11. Events involving harm that involve the permanent lessening of bodily, sensory, motor, physiological or intellectual functions (including removal of the wrong limb or organ or the occurrence of brain damage) would be disclosable.

9.12. Returns to surgery, an unplanned re-admission to hospital, a prolonged episode of care, extra time in hospital or as an out-patient, cancellation of treatment or transfer to intensive care should also be included within the scope of events that result in harm.

9.13. Prolonged pain and prolonged psychological harm also needs to be taken into account when framing definitions (e.g. prolongation for a continuous period of 28 days).

9.14. The shortening of the life expectancy of someone using social care services would be disclosable. If a user of social care services required treatment by a healthcare professional in order to prevent death this should come within the scope of the duty to disclose. The occurrence of an injury that, if left untreated would lead to death, impairment, harm or shortened life expectancy would also be within the scope of disclosable events for social care providers. This would not include a shortening of life expectancy as a result of a long-term condition where this is an expected outcome.

9.15. Children's social care services, alongside keeping children safe, are primarily focused on a child developing as well as it can and reaching his or her full potential. Decisions taken to that effect, such as taking children into care, may have unintended consequences, though it may not always be possible to attribute trauma to any particular action.

Question 6a: Do you agree with the disclosable events that are proposed ?

Question 6b: Will the disclosable events that are proposed be clearly applicable and identifiable in all care settings ?

Question 6c: What definition should be used for 'disclosable events' in the context of children's social care?

Question 7: What are the main issues that need to be addressed to support effective mechanisms to determine if an instance of disclosable harm has occurred ?

10. CHAPTER 4: Monitoring of the statutory duty of candour

10.1. The proposed organisational duty of candour would be monitored through the existing performance monitoring, regulation and/or scrutiny arrangements that apply to the organisation. This will differ according to the organisation responsible for the provision of care. This has been proposed in recognition of the importance of embedding organisational requirements within existing mechanisms that are already familiar to providers of health and social care. The consequences that will be applied to those who do not demonstrate that they are implementing a duty of candour will vary depending on the organisation concerned.

10.2. The duty of candour is to apply to all providers of health and social care. The intention is to consider the extent to which such a duty can be monitored using the existing regulatory mechanisms in Scotland. These are outlined below in respect of Scottish Government, Healthcare Improvement Scotland and the Care Inspectorate. Disclosure, reporting and follow-up of harm episodes is regarded as a key dimension of good corporate governance and, as such, it is expected that the proposed new duty will support and enhance existing provisions already in place.

Scottish Government

10.3. National Health Service (Scotland) Act 1978 states that it shall be the duty of each Health Board to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals. This is referenced in regulations governing services provided by independent contractors such as General Practitioners (National Health Service (General Medical Services Contracts) Regulations 2004) and pharmacists (National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009).

Healthcare Improvement Scotland

10.4. Healthcare Improvement Scotland (HIS) was created through the Public Services Reform (Scotland) Act 2010, which amended the National Health Service (Scotland) Act 1978 ("the 1978 Act"), on 1 April 2011. The HIS strategic plan 2011-2014 sets out the purpose for the organisation as;

> "Our purpose is to support healthcare providers in Scotland to deliver high quality, evidence-based, safe, effective and person-centred care; and to scrutinise those services to provide public assurance about the quality and safety of that care."

10.5. The 1978 Act places a number of statutory duties upon HIS, including:

- a general duty of furthering improvement in the quality of healthcare
- a duty to provide information to the public about the availability and quality of services provided under the health service

- when requested by the Scottish Ministers, a duty to provide to the Scottish Ministers advice about any matter relevant to the health service functions of HIS

10.6. The 1978 Act sets out the functions of Scottish Ministers that HIS is to exercise:

- Functions in relation to supporting, ensuring and monitoring the quality of healthcare provided or secured by the health service including providing quality assurance and accreditations;
- Functions in relation to supporting, ensuring and monitoring the duty to encourage public involvement of each NHS board
- Functions in relation to supporting, ensuring and monitoring the duty to encourage equal opportunities of each NHS board
- Functions in relation to the evaluation and provision of advice to the health service on the clinical and cost effectiveness of new and existing health technologies including drugs

10.7. The 1978 Act also sets out the general principles in accordance with which HIS must exercise its functions, which includes that:

- the safety and well-being of all persons who use services provided under the national health service and independent health care services are to be protected and enhanced
- Good practice in the provision of those services is to be identified, promulgated and promoted
- Provision of those services taking account of guidance and information published or endorsed by HIS should be promoted and encouraged.

10.8. The 1978 Act provides HIS with powers to inspect any service provided by the National Health Service or independent health care services, in pursuance of its general duty of furthering improvement in the quality of healthcare in Scotland.

10.9. It also sets out that HIS must conduct joint inspections with other scrutiny authorities when requested by Scottish Ministers.

<u>The Care Inspectorate</u>

10.10. The Care Inspectorate (formal name Social Care and Social Work Improvement Scotland) was established on 1 April 2011 under the Public Services Reform (Scotland) 2010 Act as the new single improvement and scrutiny regulator in Scotland for social work and social care (taking over the functions of its predecessors, the Care Commission, the Social Work Inspection Agency and some of the functions of HMIE.

10.11. The Care Inspectorate's statutory duties include:

- Furthering improvement in the quality of social services.

- Undertaking joint inspections of services for adults and children.

- Providing information to the public about the availability and quality of social services.

- Providing advice to Ministers about any matter relevant to the functions of the Care Inspectorate.

- Taking into account standards and outcomes relating to care services and social work services and the Scottish Social Services Council's codes of practice in the performance of its functions.

10.12. The Care Inspectorate regulate around 14,000 individual care services. This includes registering/deregistering and inspecting services, supporting services improve, investigating complaints and undertaking enforcement action. The Care Inspectorate also scrutinise the delivery of local authority social work functions.

Monitoring of Organisational Duty of Candour

10.13. The introduction of a statutory duty of candour would require that monitoring of implementation be undertaken in accordance with the statutory provisions set out in this Chapter and operational arrangements set out in Chapter 1.

Question 8: How you think the organisational duty of candour should be monitored ?

Question 9: What should the consequences be when it is discovered that a disclosable event has not been disclosed to the relevant person ?

11. CHAPTER 5: Responding to this consultation paper

11.1. We are inviting written responses to this consultation paper between 15th October 2014 and 14th January 2015.

11.2. There are a number of consultation questions on which the Scottish Government would welcome views. Please do not feel obliged to answer all the questions. Equally, if you would like to comment on any other aspects of the proposals, the Scottish Government would welcome your views.

11.3. We would be grateful if you could use the separate consultation questionnaire provided to answer the questions posed throughout the consultation paper. The questions appear in full in the consultation questionnaire at Annex A and on the downloadable consultation response form (for electronic completion).

11.4. Please send your completed consultation questionnaire and Respondent Information Form (see "Handling your Response" below) to:

Dutyofcandourconsultation@scotland.gsi.gov.uk

or
The Quality Unit
Scottish Government
GER St Andrew's House
Regent Road
Edinburgh
EH1 3DG

11.5. If you have any queries contact Professor Craig White, Divisional Clinical Lead, Quality Unit on 0131 244 4049.

11.6. We would be grateful for responses to be completed electronically and sent by email where possible. This will aid handling and analysis of all responses.

11.7. This consultation, and all other Scottish Government consultation exercises, can be viewed online on the consultation web pages of the Scottish Government website at http://www.scotland.gov.uk/consultations.

11.8. You can telephone Freephone 0800 77 1234 to find out where your nearest public internet access point is.

11.9. The Scottish Government now has an email alert system for consultations (SEconsult: http://www.scotland.gov.uk/consultations/seconsult.aspx). This system allows stakeholder individuals and organisations to register and receive a weekly email containing details of all new consultations (including web links). SEconsult complements, but in no way replaces SG distribution lists, and is designed to allow stakeholders to keep up to date with all SG consultation activity, and therefore be alerted at the earliest opportunity to those of most interest. We would encourage you to register.

Handling your response

11.10. We need to know how you wish your response to be handled and, in particular, whether you are happy for your response to be made public. Please complete and return the Respondent Information Form (at Annex A and on the downloadable consultation response form) which forms part of the consultation questionnaire as this will ensure that we treat your response appropriately. If you ask for your response not to be published we will regard it as confidential, and we will treat it accordingly.

11.11. All respondents should be aware that the Scottish Government are subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process

11.12. Where respondents have given permission for their response to be made public and after we have checked that they contain no potentially defamatory material, responses will be made available to the public in the Scottish Government Library. (See the attached Respondent Information Form), these will be made available to the public in the Scottish Government Library and on the Scottish Government consultation web pages by 27 March 2015 . You can make arrangements to view responses by contacting the SG Library on 0131 244 4552. Responses can be copied and sent to you, but a charge may be made for this service.

What happens next?

11.13. Following the closing date, all responses will be analysed and considered along with any other available evidence to help us reach a decision on the terms of introducing a statutory duty of candour for health and social care services. We aim to issue a report on this consultation process by 27 March 2015

Comments and complaints

11.14. If you have any comments about how this consultation exercise has been conducted, please send them to Professor Craig White at the above address.

12. CHAPTER 6: The Scottish Government consultation process

12.1. Consultation is an essential and important aspect of Scottish Government working methods. Given the wide-ranging areas of work of the Scottish Government, there are many varied types of consultation. However, in general, Scottish Government consultation exercises aim to provide opportunities for all those who wish to express their opinions on a proposed area of work to do so in ways which will inform and enhance that work.

12.2. The Scottish Government encourages consultation that is thorough, effective and appropriate to the issue under consideration and the nature of the target audience. Consultation exercises take account of a wide range of factors, and no two exercises are likely to be the same.

12.3. Typically Scottish Government consultations involve a written paper inviting answers to specific questions or more general views about the material presented. Written papers are distributed to organisations and individuals with an interest in the issue, and they are also placed on the Scottish Government web site enabling a wider audience to access the paper and submit their responses[5]. Consultation exercises may also involve seeking views in a number of different ways, such as through public meetings, focus groups or questionnaire exercises. Copies of all the written responses received to a consultation exercise (except those where the individual or organisation requested confidentiality) are placed in the Scottish Government library at Saughton House, Edinburgh (K Spur, Saughton House, Broomhouse Drive, Edinburgh, EH11 3XD, telephone 0131 244 4565).

12.4. All Scottish Government consultation papers and related publications (eg, analysis of response reports) can be accessed at: Scottish Government consultations (http://www.scotland.gov.uk/consultations)

12.5. The views and suggestions detailed in consultation responses are analysed and used as part of the decision making process, along with a range of other available information and evidence. Depending on the nature of the consultation exercise the responses received may:

- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

12.6. Final decisions on the issues under consideration will also take account of a range of other factors, including other available information and research evidence.

12.7. While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body**.**

Annex A Partial Business and Regulatory Impact Assessment

Title of Proposal

To Introduce a Statutory Duty of Candour for Health and Social Care Services

Purpose and intended effect

- **Background**

Improvements in arrangements to support the disclosure of harm, is a key element supporting a continuously improving culture of safety.[23] There are several healthcare systems and organisations worldwide that have introduced initiatives or arrangements to support open disclosure of harm. The Berwick Report[24] emphasised the importance of the requirement that a patient or carer affected by serious incidents should be notified and supported.

It is internationally recognised that between 10-25% of episodes of healthcare (in general hospital, community hospital and general practice) are associated with an adverse event.[25] However, it has also been recognised that as few as 30 per cent of incidents resulting in harm are disclosed to people who have been affected. Denial and dismissal of mistakes often results in distress and people spending several years seeking the truth, accountability and apology.[26]

Healthcare Improvement Scotland have visited all NHS Boards in Scotland as part of the national programme supporting learning following adverse events. This confirmed that there is variation across the country in respect of the rigor and standard of open disclosure and support for families and staff when harm occurs. The Scottish Government wants to introduce an organisational duty of candour in Scotland. This will require services to make sure that they are open and honest with people when something has gone wrong with their care and treatment.

- **Objective**

The Scottish Government intends to introduce a statutory requirement on organisations providing health and social care to have effective arrangements in place to demonstrate their commitment to disclose instances of physical or psychological harm. The proposals have been intentionally focused on

[23] Etchegaray, JM., Gallagher, TH., Bell, SK et al. (2012). Error disclosure: a new domain for safety culture assessment. BMJ Quality and Safety, 21, 594-599.

[24] 'A promise to learn– a commitment to act. Improving the Safety of Patients in England National Advisory Group on the Safety of Patients in England', August 2013, Department of Health. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf (Accessed 25th September 2014).

[25] The Health Foundation (2011). Evidence scan: Levels of Harm. Available at: http://www.health.org.uk/publications/levels-of-harm/ (Accessed 21st September 2014),

[26] Halligan, A. W. F. (2014). Implications for medical leaders of the proposed Duty of Candour. *Clinical Risk*, *20*(1-2), 29-31.

organisational duties and specifically developed to ensure that this includes all of the elements that will need to be in place to support continuous improvements in quality and safety culture across Scotland's health and care services.
Ethically, morally and professionally health and care professionals are already required to tell people about instances of harm. The clear requirement for candour in professional standards and codes of conduct are complementary to the proposed introduction of a duty on organisations.

From November 2014 the Care Quality Commission in England will include the duty of candour among the standards to be met by healthcare providers in England. These will form part of the inspection and monitoring regime operating in England. This includes a range of new enforcement powers, including civil penalties and criminal proceedings for repeated failures. From April 2015 this will be extended to providers of adult social care services.

- **Rationale for Government intervention**

The observations made by Healthcare Improvement Scotland are consistent with observations from work that has shown that ethical and policy guidance has largely failed on its own to improve rates of disclosure[27]. There has been strong support for the benefits of improving organisational arrangements for disclosure of harm in recent years.

The 2013 Health and Care Survey[28] asked respondents whether they believed a mistake was made in their treatment or care by their GP practice. 6% of respondents believed such a mistake had been made in their treatment or care. Of those that felt a mistake had been made in their treatment or care:

7% indicated that it did not require a response

Of those that required a response:

19% were completely satisfied with how it was dealt with
44% were satisfied to some extent
38% of those where were not satisfied

The Dalton-Williams review[29] recommended that there should be a statutory duty on organisations and that this would provide a powerful signal of what is considered essential and this should act as an important catalyst for care organisations to improve their systems and commit to a learning culture for their staff.

[27] O'connor, E., Coates, H. M., Yardley, I. E., & Wu, A. W. (2010). Disclosure of patient safety incidents: a comprehensive review. *International Journal for Quality in Health Care*, , 22(5), 371-379..
[28] http://www.scotland.gov.uk/Resource/0045/00451272.pdf

[29] https://www.rcseng.ac.uk/policy/documents/CandourreviewFinal.pdf (Accessed 25th September 2014)

The Scottish Government has five strategic objectives that underpin its core purpose - to create a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth. This proposal will contribute to the strategic objective of "healthier" by increasing the quality of health and social care that individual's experience.

Consultation

The legislation will be developed in a collaborative way involving colleagues from across and outside the Scottish Government.

- **Within Government**
  We are working with colleagues across the Scottish Government to develop this legislation. This includes, but is not restricted to the following teams: Primary Medical Services; Pharmacy, Integration and Reshaping Care; Children's Rights and Wellbeing; Chief Medical Officer, Chief Social Work Adviser, Chief Dental Officer and Chief Nursing Officer's Directorates. The nature and scope of the proposals have been shaped through dialogue with policy colleagues. This has also directly influenced the consultation questions that will be asked.

- **Public Consultation**
  The formal consultation will run for a period of 12 weeks from 15 October 2014.

- **Business**
  We will identify relevant organisations to meet with during the consultation period and update this section at Final BRIA stage.

Options

Option 1: do nothing. Ethically, morally and professionally, health and care professionals are already required to tell people about instances of harm. This duty would remain although there would be no statutory duty on organisations to ensure a culture and organisation that supports a consistent approach to disclosure of adverse events.

Option 2: to Introduce a Statutory Duty of Candour for organisations providing Health and Social Care The statutory duty will require that an organisation must act in an open and transparent way with people when things go wrong. It will outline the minimum requirements that must be in place to support the duty of candour and require that reports are made to describe the implementation of arrangements.

Requirements for Health and Social Care Organisations

1. As soon as it is reasonably practicable after becoming aware that there has been adverse event resulting in harm, the organisation must ensure that the relevant person is notified that this has happened. This will involve the provision of a step by step account of the facts of the event, including as much or as little information as the person has expressed their wish for.

2. There must be an offer of reasonable support provided to the patient, relatives and staff who have been involved with the event. The person undertaking the disclosure may be different for each disclosure episode.

3. The responsibility will rest with organisations to ensure that all staff who are asked to be involved with disclosure have access to the relevant training, supervision and support before, during and after their involvement with disclosure communications.

4. The notification that is made to the relevant person should be given in person by a suitably trained representative of the organisation and should include an account of all of the facts known at the time of disclosure and the plans for the event to be reviewed. It will be for the organisation to determine who is most appropriate to disclose the harm episode.

5. The relevant person must be informed of the further steps to be taken to review the event and be given the opportunity to have their questions considered by the review process.

6. The organisation must provide an apology and must confirm all of the actions taken in a written record, the contents of which will inform the quarterly report.

7. The relevant person must also receive a written summary of the face to face meeting.

Reporting on Disclosure Arrangements

1. All organisations would be required to report publically on a quarterly basis the nature of adverse incidents that have been disclosed to people and confirm that requirements of the organisational duty of candour have been met.

2. Organisations would also be required to report on the way in which they had supported staff in the development and maintenance of the skills required to ensure respectful disclosure by staff who are required to be involved with this.

3. Organisations should also publish annually their policies and procedures to support openness and transparency, this must include the arrangements in place to support staff training and development in these advanced communication skills. These reports should be submitted to the relevant organisation (which will differ for each organisation).

4. Organisations would be required to ensure that they have arrangements in place to ensure that if any adverse event is reported that this is considered and a decision made whether this is a disclosable event.

5. Organisations would also be required to include a summary in their reports of the support that is available to patients, families and staff following an disclosable event. They would also need to describe the provision to ensure that training and development support has been implemented to ensure best practice in disclosure.

Sectors and groups affected

The statutory duty of candour would apply to health and care services provided by NHS Boards, Local Authorities, all organisations providing services regulated by the Care Inspectorate, independent hospitals, independent hospices, General Practices, community pharmacies, dental practices and optometry practices.

Any or all patient/clients, and their families, treated in a formal healthcare setting could be affected. As this is an organisational duty, it would not apply to individuals providing services, for example, childminders.

Benefits

Option 1: do nothing

There would be no change to current policies and practice or to individual professional responsibilities. There would be no additional benefits.

Option 2: to Introduce a Statutory Duty of Candour for Health and Social Care

The legislation aims to make providers of health and social care increase transparency and openness in the organisation, facilitating a culture in which staff are supported to report incidents where harm may have been caused. Staff will be encouraged to speak candidly to service users and/or relatives in the event of harm (including death) resulting from treatment.

This will reduce the level of distress and frustration that people experience when they do not receive the information that they're seeking. This benefit is unquantifiable.

It is anticipated that, initially, there will be an increase in the level of reporting of incidences, providing an increase in learning opportunities. This should result in increased awareness of patient safety and ultimately a reduction in avoidable incidences of harm. This benefit is difficult to quantify.

Overall, a requirement which encourages openness and honesty across all organisations within the health and social care sector may increase both staff and patient satisfaction. This benefit is difficult to quantify.

Costs

Option 1: do nothing

Ethical, professional and policy guidance is generally insufficient in significantly improving rates of disclosure. Under current policies there may be a lack of support for professionals from their employer organisations resulting in a reluctance or failure to report adverse events. This in turn means patients and service users are not fully informed, nor do individuals and organisations have the opportunity to learn from any adverse event.

Option 2: to Introduce a Statutory Duty of Candour for Health and Social Care

Although ethically, morally and professionally health and care professionals are already required to tell people about instances of harm, by introducing an obligation on organisations which is intended to support a consistent approach to disclosure, it is likely to result in an increased number of incidents disclosed. It is also likely to significantly enhance staff wellbeing as a result of improved support and training for disclosure.

Although it is internationally recognised that between 10-25% of episodes of healthcare (in general hospital, community hospital and general practice) are associated with an adverse event[30] and it has been recognised that as few as 30 per cent of incidents resulting in harm are disclosed to people who have been affected, it is not possible to quantify how many additional disclosures of harm this legislation might generate in Scotland .

There are likely to be a number of costs associated with the introduction of this legislation and any increase in reporting.

<u>Scottish Government</u>

The Government will need to consider whether it wishes to undertake a public education campaign to make people aware of any change in the law. There would also potentially be costs involved in providing literature/guidance for care providers including care homes and the range of health professionals. It is likely that this could be part of work to emphasise policy commitments on quality, safety and improvement work in health and social care.

[30] The Health Foundation (2011). Evidence scan: Levels of Harm. Available at: http://www.health.org.uk/publications/levels-of-harm/ (Accessed 21st September 2014),

SG/NHS Boards/providers: training

It has been recognised that being candid is an advanced communication skill. Programmes have been developed to improve the preparation of doctors to make such disclosures, and to deal with emotional elements that are linked with this task.[31] The Scottish Government in collaboration with NHS Education for Scotland (NES) would need to consider if and how to introduce any additional staff training. This might involve adding to existing training packages both for staff in training and those already qualified. Information on possible training content and focus will be obtained from stakeholders during the consultation period.

Within the NHS alone, there are approx 104,000 employees involved in delivering care (this excludes admin, support and health science workers) and there are over 192,000 employed in delivering social care services[32] across public, private and voluntary sectors. Different types/levels of training may be appropriate for different staff groups. For example although it will be everyone's responsibility to identify and report when an adverse event occurs, it may be appropriate to target training to particular senior staff groups who would then communicate with patients/clients.

All Providers

All health and social care providers will have to ensure that they have policies and procedures in place that reflect the statutory duty imposed to disclose adverse events. These will need to be communicated to staff. There will be a resource cost involved particularly in developing and disseminating these policies for the first time. These may be defined as transitional costs. It is anticipated that these activities would form part of routine management responsibilities.

Increased numbers of disclosure may result in an increased need for additional training for staff on specific issues. These will only be identified once incidents are reported.

There may be a small risk of increased litigation from an increased number of disclosures of adverse events although international evidence is that a statutory duty on disclosure results in a reduction in the number and costs of medical claims[33].

[31] Bonnema, R. A., Gonzaga, A. M. R., Bost, J. E., & Spagnoletti, C. L. (2012). Teaching error disclosure: advanced communication skills training for residents. *Journal of Communication in Healthcare*, *5*(1), 51-55.

[32] http://www.sssc.uk.com/

[33] Kachalia, A (2013) "Improving Patient Safety through Transparency", *New England Journal of Medicine*, 369, 18, 1677. & Boothman RC, Blackwell AC, Campbell DA Jr, Commiskey E, Anderson S. 'A better approach to medical malpractice claims? The University of Michigan experience' *Journal of Health and Life Sciences Law* 2009; 2: 125-159 & Kraman SS, Hamm G, 'Risk Management: Extreme Honesty May be the Best Policy' *Annals of Internal Medicine* 1999; 131(12): 963-967

All organisations would be required to report publically on a quarterly basis the nature of adverse incidents that have been disclosed to people and confirm that requirements of the organisational duty of candour have been met. Although this is an additional requirement it is assume that this could be incorporated into existing routine reporting.

Organisational Support for staff

For both staff who report incidents and those who communicate these to patients/carers it will be necessary for organisations to ensure that there are adequate supports in place and that staff are made aware of these. It is possible that additional resources will be required for larger organisations who might wish to enhance staff support available through specialists in psychological care, counselling and/or occupational health. Smaller organisations could incur costs associated with the provision of access to such support if this is not already in place.

Support for patients/clients/carers

There is evidence that honesty, openness and apologies are important to patients when there has been an error in treatment and that it may make them less likely to seek recompense through the courts. However it is important that not only are they given the information by an appropriately trained professional but that there is support available to them, should it be required, to deal with the information and any implications associated with that information. Additional demands for access to clinical psychologists, specialist nurses and/or counsellors could be made. Demands are likely to be met within existing services, though this will depend on the extent of service provision in place. This will be considered during the consultation period.

Monitoring & enforcement

It is proposed that the Scottish Government, Healthcare Improvement Scotland and the Care Inspectorate are involved in monitoring and enforcing. Although these would be additional responsibilities the Scottish Government considers that it would be a small increase in workload when integrated with existing monitoring, reporting and inspection arrangements and it is not anticipated that this would require significant additional staff or resource. Further information on this will be obtained throughout the consultation period.

Scottish Firms Impact Test

Throughout the formal consultation period officials will meet with a range of stakeholders, including organisations, businesses and patients/clients who are likely to be affected by any proposed legislation. The outcome of these meetings will be analysed and presented as part of the full BRIA.

Competition Assessment

Will the proposal directly limit the number or range of suppliers?

No, the proposal will not limit the range of suppliers within the market. It does not restrict the right to supply services in any way.

Will the proposal indirectly limit the number or range of suppliers?

No, the proposal will increase the standards of care expected but is not expected to indirectly affect the number of suppliers.

Will the proposal limit the ability of suppliers to compete?

No, the proposal will apply equally to all providers of health and social care.

Will the proposal reduce suppliers' incentives to compete vigorously?

No, it will reduce informational asymmetry between patients/clients and healthcare providers. Where a market exists, it will increase competition.

Test run of business forms

There are no new forms for businesses planned.

Legal Aid Impact Test

As part of the on-going development process we will liaise with the Scottish Government Legal Systems Division to gauge whether any proposals will have an impact on the legal aid system. This will be detailed within the full BRIA

Enforcement, sanctions and monitoring

Option 1: this option would require no additional monitoring or enforcement.

Option 2:

Monitoring and enforcement: organisations will be expected to report quarterly on all disclosable events including information on the arrangements in place to deliver duty of candour and the learning and improvement subsequent to these events.

It is intended to use the existing regulatory mechanisms within Scotland available through the Scottish Government, Healthcare Improvement Scotland and the Care Inspectorate. Particular sections of the health and social care market would report to assigned agencies. These proposed arrangements for reporting and monitoring are part of the consultation and the Scottish Government would welcome comments on these.

Sanctions: a decision on possible sanctions and/or penalties has yet to be reached. The Scottish Government invites, through the consultation, suggestions on possible sanctions for non-compliance with a duty of candour.

Implementation and delivery plan

15 October 2014 - 14 January 2015

- Consultation launch
- Publication of Partial BRIA & EQIA with consultation document October 2014
- Engagement with stakeholders including health professionals, health boards, care home providers

- **Post-implementation review**

Any review process will be considered as the legislation is developed.

Summary and recommendation

Option 2: to Introduce a Statutory Duty of Candour for Health and Social Care is the Scottish Government's preferred option. The Scottish Government is committed to improving the quality of all health and social care. This includes ensuring a culture in which staff are supported to report incidents where harm may have been caused. The statutory duty will complement the existing professional responsibilities of healthcare professionals. It will provide the structures in which staff can be supported to give clear explanations of events to patients/clients/carers and support providers to use the lessons learned.

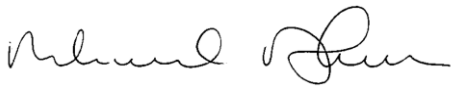
- **Summary costs and benefits table**

This information will be detailed in the full BRIA and financial memorandum that accompanies detailed proposals.

Declaration and publication

I have read the Business and Regulatory Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options. I am satisfied that business impact has been assessed with the support of businesses in Scotland.

Signed:



Date: 13 October 2014

Minister's name Michael Mathieson
Minister's title Minister for Public Health

Scottish Government Contact point: Craig White, Divisional Clinical Lead, The Quality Unit

EQUALITY IMPACT ASSESSMENT

The purpose of carrying out an Equality Impact Assessment is to aid the Scottish Government in discharging its Public Sector Equality Duty under section 149 of the Equality Act 2010. The Scottish Government is required to assess the impact of applying a new or revised policy or practice against the needs in the public sector equality duty - to eliminate unlawful discrimination, to advance equality of opportunity and to foster good relations.

The protected characteristics that must be profiled against the policies are:

Age
Sex
Pregnancy and maternity
Disability
Race
Religion or belief
Gender Reassignment
Sexual Orientation

To help inform our Equality Impact Assessment of the policy proposals to reform FAI legislation, it would be helpful if you could answer the following question.

Please tell us about any potential impacts, either positive or negative, you feel any or all of the proposals in this consultation may have on a particular group or groups of people.

Comments

Annex B
CONSULTATION QUESTIONNAIRE

Question 1 :
Do you agree that the arrangements that should be in place to support an organisational duty of candour should be outlined in legislation ?

Yes ☐ No ☐

Comments

Question 2:
Do you agree that the organisational duty of candour encompass the requirement that adequate provision be in place to ensure that staff have the support, knowledge and skill required ?

Yes ☐ No ☐

Comments

Question 3a: Do you agree with the requirement for organisations to publically report on disclosures that have taken place ?

Yes ☐ No ☐

Comments

Question 3b: Do you agree with the proposed requirements to ensure that people harmed are informed ?

Yes ☐ No ☐

Comments

Question 3c: Do you agree with the proposed requirements to ensure that people are appropriately supported ?

Yes ☐ No ☐

Comments

Question 4:
What do you think is an appropriate frequency for such reporting ?

Quarterly ☐ Bi-Annually ☐ Annually ☐ Other ☐ (outline below)

Comments

Question 5:
What staffing and resources that would be required to support effective arrangements for the disclose of instances of harm ?

Comments

Question 6a:
Do you agree with the disclosable events that are proposed ?

Yes ☐ No ☐

Comments

Question 6b: Will the disclosable events that are proposed be clearly applicable and identifiable in all care settings ?

Yes ☐ No ☐

Comments

Question 6c:
What definition should be used for ‘disclosable events’ in the context of children’s social care?

Comments

Question 7
What are the main issues that need to be addressed to support effective mechanisms to determine if an instance of disclosable harm has occurred ?

Comments

Question 8:
How do you think the organisational duty of candour should be monitored ?

Comments

Question 9:
What should the consequences be if it is discovered that a disclosable event has not been disclosed to the relevant person ?

Comments

End of Questionnaire

CONSULTATION ON PROPOSALS TO INTRODUCE A STATUTORY DUTY OF CANDOUR FOR HEALTH AND SOCIAL CARE SERVICES

RESPONDENT INFORMATION FORM
Please Note this form **must** be returned with your response to ensure that we handle your response appropriately

1. Name/Organisation
Organisation Name

Title **Mr** ☐ **Ms** ☐ **Mrs** ☐ **Miss** ☐ **Dr** ☐ **Please tick as appropriate**

Surname

Forename

2. Postal Address

Postcode	**Phone**	**Email**

3. Permissions - I am responding as…

Individual	/	**Group/Organisation**
☐	**Please tick as appropriate**	☐

(a) Do you agree to your response being made available to the public (in Scottish Government library and/or on the Scottish Government web site)?

Please tick as appropriate
☐ **Yes** ☐ **No**

(b) Where confidentiality is not requested, we will make your responses available to the public on the following basis

Please tick ONE of the following boxes

(c) The name and address of your organisation **will be** made available to the public (in the Scottish Government library and/or on the Scottish Government web site).

Are you content for your **response** to be made available?

Please tick as appropriate
☐ **Yes** ☐ **No**

Yes, make my response, name and address all available ☐

or

Yes, make my response available, but not my name and address ☐

or

Yes, make my response and name available, but not my address ☐

(d) We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Please tick as appropriate ☐ **Yes** ☐ **No**

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St Andrew's House
Edinburgh
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DPPAS37848 (10/14)

Shadow Integration Board
18th December 2014

Subject:	**Multi Agency Public Protection Arrangements (MAPPA) Annual Report**
Purpose:	To advise the Board of main points arising from the South West Scotland Community Justice Authority Area MAPPA Annual Report for 2013/14 and to highlight the main issues facing MAPPA in the next year.
Recommendation:	That the Board notes the main points in the report.

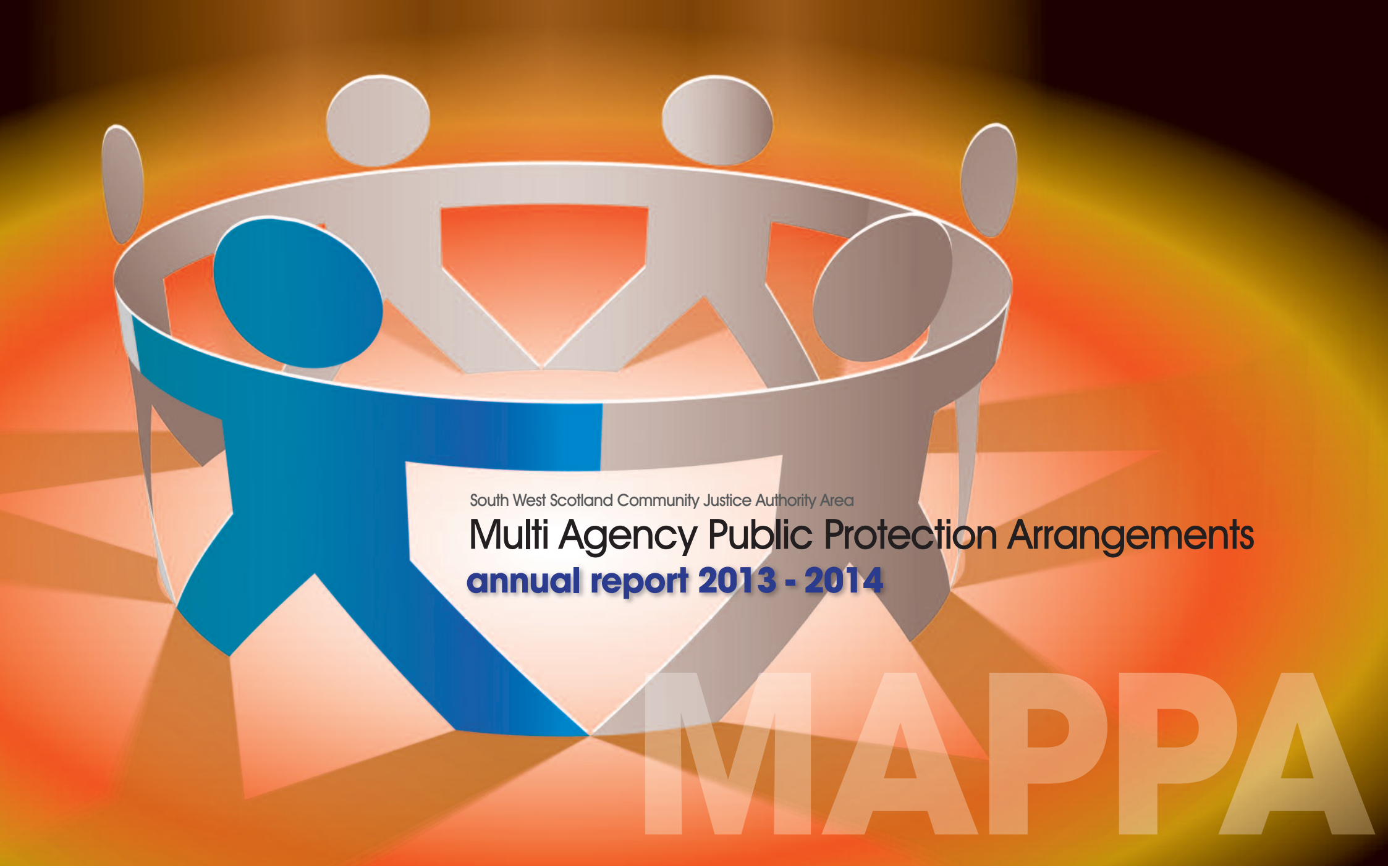
1.	**Introduction**
1.1	The background to MAPPA can be traced to the introduction of the Sex Offender Act in 1997. This act required offenders who were convicted of sexual offences to register with the Police, the registration period ranges from 5 years to an indefinite time period for those sentenced to a custodial sentence of over 30 months. The Police and Criminal Justice Social Work (CJSW) were required work jointly in order to risk assess and risk manage offenders placed on the sex offender register.
1.2	The Management of Offenders etc (Scotland) Act 2005 introduced a statutory function for Responsible Authorities - Local Authorities, Scottish Prison Service, Police and Health Service (in terms of restricted patents) to establish joint arrangements for the assessment and management of certain offenders who pose a risk of harm to the public. The Act also placed a responsibility on what was termed "Duty to Co-operate" agencies such as Health Service (in respect of registered sex offenders), Housing Providers, and other organisations, to share information, search records for any involvement with named offenders, and participate and contribute meaningfully to the Risk Management Plan in accordance with their statutory function.
1.3	The legislation in respect of sex offenders, under Section 10 (1) (a) of the Act, was fully enacted, however the legislation for violent offenders under 10 (1) (b) of the act was never enacted. This Section covered anyone convicted of a violent offence on indictment who would be subject to statutory supervision either on a Court Order or on Licence on release from custody. However, Section 10 (1) (C) of the Act which covered restricted patients who had committed and act of violence was enacted. Therefore the focus for MAPPA has been on registered sexual offenders (RSOs) and restricted patients.

1.4	There are three levels at which risk is managed at: 1.4.1 Level 1 (ordinary risk management – low/medium risk offenders, offenders where the risk can be managed by one agency, process subject to reviews but no specific meeting is necessary (although in Ayrshire joint meetings are held); 1.4.2 Level 2 (local inter-agency risk management – where the complexity of risk is such that more than one organisation needs to be formally involved, meeting chaired by Manager CJSW if offender is subject to supervision, and if not by a Police DCI/DI); 1.4.3 Level 3 (Multi Agency Public Protection Panels - for those defined as the 'critical few' who pose a high or very high rise, which should be chaired by a Social Work Head of Service of Police Superintendent.
1.5	In the South West of Scotland governance is provided through the MAPPA Strategic Oversight Group (SOG) which is made up of senior managers from the responsible authorities. The Chair of the SOG has responsibility for reporting on MAPPA progress to the four Chief Officer Groups (COGs) in the South West of Scotland. There is also a MAPPA Operational Managers meeting which is responsible for implementation of SOG decisions.
1.6	There is a statutory responsibility for agencies involved in MAPPA to publish an annual report on the work undertaken in that financial year. The MAPPA Annual for 2013-2014 was published in October 2014 and can be obtained via the following link: http://www.swscja.org.uk/mappa-annual-report.html. This is the seventh annual report for the South West of Scotland Community Justice Authority area. The report provides information on how MAPPA operates, what has been achieved in the last year, sets future plans and reviews challenges.
2.	**Current Position**
2.1	The main statistical information contained in the report is as follows: 2.1.1 There were 373 RSOs at liberty and living in the South West of Scotland area as of March 31st 2014, which is an increase of 7.2% on the previous year (there were 98 RSOs at liberty and living in North Ayrshire as of 31st as of March 2014, an increase of 6.5% on the previous year); 2.1.2 369 of the 373 (99%) were male and the age distribution indicates that almost 80% were aged 31 or over (this age distribution differs significantly from the general offender population where the majority of individuals are aged 30 or under); 2.1.3 328 of the 373 (88%) complied with their Sex Offender Notification Requirements (SONR) compared to 85% in the previous year; 2.1.4 336 individuals, 90%, were managed at Level 1 and the other 10% were being managed at Level 2 (in North Ayrshire 93% were managed at Level 1 and 7% at Level 2); 2.1.5 10 individuals were returned to custody for a breach of their statutory conditions during this year (none from North Ayrshire), in the previous year 8 individuals had been returned to custody (two from North Ayrshire);

	2.1.6 There were 14 restricted patients at liberty and living in the South West of Scotland area as of March 31st 2014, an increase of 3 individuals from the previous year;(six of these were from North Ayrshire). 2.1.7 All 14 restricted patients were being managed at MAPPA Level 1.
2.2	The main developments introduced during 2013/2014 are: 2.2.1 The MAPPA Coordinator posts were amended to strategically support the work of the SOG and new posts of MAPPA Strategic Coordinator and MAPPA Operational Coordinator were created and staff have been recruited; 2.2.2 A new model for the management of Level 1 individuals was developed and is being trialled in North Ayrshire; 2.2.3 A Multi Agency Assessment Violent Offender (MAAVO) procedure was piloted which uses MAPPA processes for sharing information on very high risk violent offenders.
2.3	There are three main issues facing MAPPA in the forthcoming year: 2.3.1 A thematic inspection of MAPPA will commence in 2015, focusing on RSOs, which will involve: • reviewing legislation, research, annual reports, significant case reviews in order to identify trends and themes; • An analysis of SOG position statements (self evaluations); • a quantitative analysis of the Violent and Sex Offender Register (ViSOR); • meetings with frontline staff, managers and stakeholders, site visits, focus groups, observations of MAPPA meetings and a qualitative analysis of case-files. 2.3.2 As noted in Section 1.3 the Scottish Government did not enact the legislation for violent offenders, but they now undertaking a scoping exercise for the extension of MAPPA to some violent offenders. The extension of MAPPA to violent offenders is not being proposed under 10 (1) (b) of the act, but under Section 10 (1) (e) of the Act. Section 10 (1) (e) of the Act was initially intended for “potentially dangerous offenders”. The current focus is on identifying how many violent offenders would be involved in MAPPA. 2.3.3 There is also a change in how MAPPA meetings will be structured and a change to the MAPPA document set to reflect this. This model will require a pre meeting to agree the risk assessment prior to the MAPPA meeting. This new model was to be introduced in December 2014, but has been postponed until 2015 and is to be piloted and evaluated in a local authority area.
3.	**Proposals**
3.1	That the Board notes the information from the MAPPA Annual Report.

4.	**Implications**
4.1	There are no implications arising from this report.
5.	**Consultations**
5.1	No consultation is required.
6.	**Conclusion**
6.1	The MAPPA Annual Report reflects the work undertaken and the developments made in the South West of Scotland in the last year in order in order to improve the protection of the public.
6.2	MAPPA was introduced in order to help protect the public from the most serious offenders in our communities. The agencies and individuals involved in the MAPPA process believe that MAPPA has improved working relationships between the responsible authorities and duty to cooperate agencies and therefore has consequently improved public protection. The forthcoming thematic inspection of MAPPA will identify the extent to which MAPPA has met its aims.
6.3	The work currently being undertaken regarding extending MAPPA to some violent offenders and the change in the structure of MAPPA meetings are being considered to further improve MAPPA's capacity to protect the public.

For more information please contact Jim McCrae on 01294 317784/ jmccrae@north-ayrshire.gov.uk



South West Scotland Community Justice Authority Area

Multi Agency Public Protection Arrangements

annual report 2013 - 2014

MAPPA

Dumfries & Galloway Council

NHS Ayrshire & Arran

North Ayrshire Council
Comhairle Siorrachd Àir a Tuath

South Ayrshire Council

NHS Dumfries & Galloway

Police Scotland
Keeping people safe

East Ayrshire Council

MAPPA
South West Scotland
Community Justice Authority Area

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Foreword - Chair of the Strategic Oversight Group

Welcome to the 2013/14 Annual Report of the Multi Agency Public Protection Arrangements (MAPPA) in the South West Scotland Community Justice Authority (CJA) area. This is the second Annual Report I have overseen during my tenure as Chair of the Strategic Oversight Group (SOG). In this report, we outline some of the positive work we have carried out this year and our priorities for the coming year.

The Annual Report is a statutory responsibility placed upon all of the agencies involved in the MAPPA process, however it encompasses much more than this. It gives us an opportunity to show all of those we serve how these agencies work together to manage certain groups of dangerous and sexual offenders within our communities. By working together we aim to manage these offenders effectively and reduce the risk that they pose to individuals or to the wider community. We recognise that this is critical work and that the public expects us to do everything that we possibly can to prevent the offenders we manage from being in a position to commit crime or harm anyone.

Each of the agencies round the MAPPA table is committed to working together to make sure that information is exchanged and that joint working is woven into every aspect of our everyday statutory responsibilities. By working this way we can make sure that we manage offenders effectively, identifying those who pose an increased risk and taking action to reduce the risk they pose to others.

During the past year we consolidated some of the practices we introduced during 2012/2013, making sure that there was a clear understanding of what we are trying to achieve within the CJA area, particularly where it concerns violent offenders. Our process of consolidation and standardisation has led us to introduce new processes for the management of Level 1 Offenders and for the scanning of potential addresses for offenders. We have also agreed a programme of restructuring within the MAPPA office, with an overall increase in staff members and better use of resources across the whole of the CJA area.

In last year's Annual Report we highlighted 2 ongoing Significant Case Reviews (SCR) and described the actions we were taking to implement the findings of both. Both of these SCRs have now concluded and all recommendations have been implemented within the CJA area or referred to the Scottish Government for consideration. During the past year we have conducted one Initial Case Review (ICR) which remains ongoing at the time of writing.

In the coming year we will set a high level 3 year Strategic Plan. This Strategic Plan will focus upon the ongoing development of the MAPPA process to ensure it continues to operate in an efficient and effective manner. We will develop annual work plans that will detail how we will carry forward this Strategic Plan, taking account of changes and issues identified as a result of our self evaluation exercises.

We await the outcome of the Scottish Government's consultation on the future of Community Justice services and the timetable for the introduction of Health and Social Care Partnerships in each of our local authority areas, both of which should be known in 2014. These will undoubtedly impact upon the existing MAPPA arrangements within the South West Scotland CJA area and the SOG will play a crucial role in ensuring their smooth implementation.

We also await the outcome of the Scottish Government's MAPPA Extension Advisory Group, which is considering the guidance to underpin the introduction of the legislation for the management of violent offenders. While the South West Scotland CJA Area SOG has previously agreed to introduce a process to manage certain violent offenders, this has no legislative backing and uses a MAPPA style process to bring agencies together. The formal enactment of the provision for the management of violent offenders may have a considerable impact upon resources within the CJA area, dependant upon the terms of the guidance and the number of offenders involved. The SOG will monitor this and inform Chief Officers accordingly.

Finally, we await the results of the ongoing Consultation by the Scottish Government on new MAPPA guidance and will continue to contribute whole-heartedly to this. Again, we will continue to monitor the impact that the new guidance may have on resources within the CJA Area, and advise Chief Officers accordingly.

I therefore commend this Annual Report to you and assure you that as we move forward in to 2014/2015, all the agencies involved in MAPPA within the South West Scotland CJA area remain committed to working in partnership to protect our communities.

Hugh Carswell
Chair of the Strategic Oversight Group
Head of Children's Services
South Ayrshire Council

What is MAPPA and how does it work?

Since the introduction of the Management of Offenders etc. (Scotland) Act 2005, local authorities, the police, health boards and Scottish Prison Service have been required to work together to assess and manage certain dangerous and sexual offenders who pose a risk of harm to the public.

These agencies work together to provide Multi Agency Public Protection Arrangements (MAPPA), which have now been in place in Scotland since April 2007. In support of the legislation, the Scottish Government issues guidance to all of the agencies involved in MAPPA. At the moment the MAPPA legislation applies only to Registered Sex Offenders (RSO) and to Restricted Patients (mentally disturbed offenders who are treated in hospital or in the community) who must inform authorities of their address on release and other key information such as passport and bank details. As previously indicated, the South West Scotland CJA Area SOG has agreed to introduce a process to manage certain violent offenders, however, this has no legislative backing and uses a MAPPA style process to bring agencies together for a small number of offenders who pose a very real risk.

More information about the Management of Offenders etc. (Scotland) Act 2005 and the current Scottish Government MAPPA Guidance can be found at the links below:

www.legislation.gov.uk/asp/2005/14/contents

www.scotland.gov.uk/publications/2012/01/12094716/1

To manage any offender, the very first step must be to assess the level of risk posed by that person. The level of risk posed by offenders can vary according to circumstance and can move up or down. The level of risk is assessed using Scottish Government approved risk assessment tools, examination of the nature of the offence and the individual circumstances of the case. The professional judgement of the caseworkers involved also plays a part in this process. All of this information is gathered, shared and discussed to agree how to best manage each offender in order to make sure that we protect the public and prevent crime. At the moment the MAPPA legislation applies only to Registered Sex Offenders (RSO) and to Restricted Patients (mentally disordered offenders who are who are treated in hospital and in the community). As previously highlighted, the South West Scotland CJA area SOG has agreed a process to manage certain violent offenders, however, this has no legislative backing and uses a MAPPA style process to bring agencies together.

Each offender is risk assessed following registration or, for Restricted Patients, following admission to hospital. Every case is then reviewed through the MAPPA process on a regular basis. Once a risk assessment has been carried out we formulate a Risk Management Plan to mitigate those risks at the appropriate level of management. This requires the identification of what risks and protective factors are present in an individual case in order to identify the corresponding level of MAPPA management required. There are 3 levels at which offenders are managed through the MAPPA process.

- ***Level 1*** - 'routine risk management' - where the risks posed by an offender can be managed by one agency such as Police, Criminal Justice Social Work or Health.
- ***Level 2*** - 'multi-agency risk management' - where the active involvement of multiple agencies is required to manage and actively reduce the risk of serious harm posed.

- ***Level 3*** - 'multi agency public protection panels' where a range of agencies are involved at a senior level to allocate the resources necessary to manage the case due to the high risk of harm posed by the offender and/or complexities in the case.

Risk management plans include measures to increase an individual's capacity to control their behaviour and self manage. We balance this with restrictive measures to exercise control over that behaviour. We enforce these restrictive measures or orders in accordance with either a statutory or non-statutory framework. A variety of different statutory orders (i.e. parole licence, non-parole licence, extended sentence, Community Payback Orders, Compulsion Order and Restriction Order and civil preventative orders) can be imposed where the risk presented by an individual makes additional enforceable measures necessary.

Assessing and managing risk is not a precise science. While we make every effort to ensure the public is protected, it is simply not possible for agencies to precisely predict when or if offending behaviours may occur. However, we can use the evidence in an individual case, alongside what is known about similar offenders from research literature, to identify relevant risk and protective factors. This is why we must communicate closely and share information with each other. Teamwork and cooperation results in a more comprehensive assessment of risk making it easier for us to intervene effectively. Where we identify that the risk posed by an offender is increasing, we can take a number of actions to try and reduce the potential harm that can be caused.

These include:

- Surveillance of high-risk offenders
- Multi agency environmental scanning to inform decisions on accommodation
- Rehabilitative programmed interventions to reduce re-offending
- Recall to prison for any serious breach of the conditions of release or court order
- Provision of suitable accommodation where offenders can be closely watched or put under an appropriate curfew
- ViSOR (Violent and Sex Offender Register; a UK wide database accessed by Police, Scottish Prison Service and Criminal Justice Social Work). ViSOR allows agencies to effectively record and share information regarding violent and sexual offenders and can be researched and used as an investigative tool by Police
- Electronic monitoring which restricts the movement of offenders within specified times
- Applying for a court order to restrict their behaviour or contact with certain people.
- Disclosure of information to those believed to be at risk of harm from an offender. This will only be done as a last resort and will be accompanied by a victim safety plan to ensure that all appropriate measures are in place to protect the individual.

All of this means that we can work closely together, sharing information and taking action when required. However, it is important people understand that an offender's return to the community is a crucial part of their rehabilitation. Often the offender will have served a prison sentence and may be released back into the same community, often returning to the same family home. This allows them to be fully supported by their family and friends and to return to a stable environment. However, during this time they will be robustly managed by all of the agencies involved in MAPPA who will meet regularly to share information, assess risk and take the various actions detailed above.

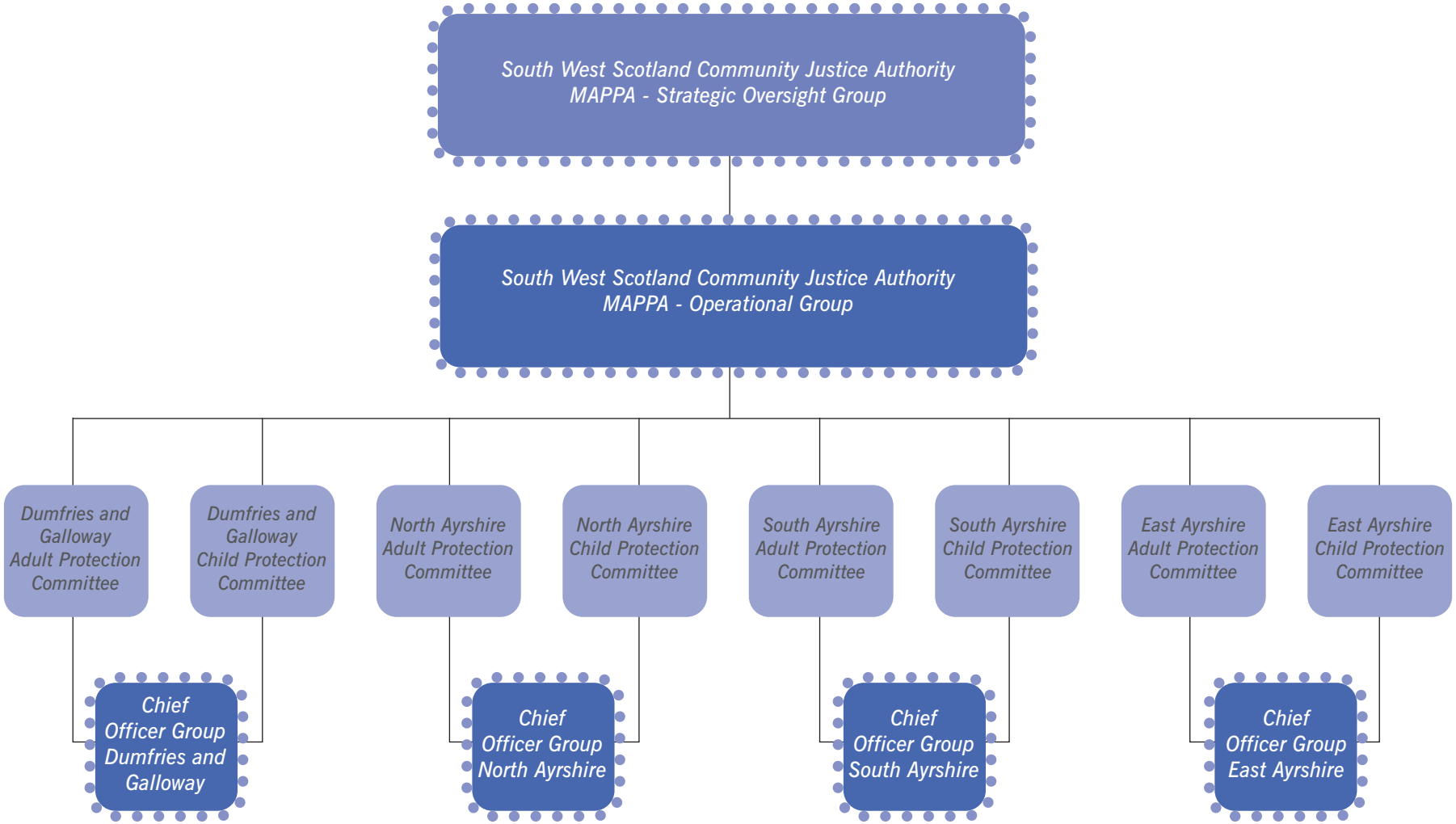
How is MAPPA regulated?

In the South West Scotland CJA area, a 2-tier structure is in place to manage MAPPA at an operational and strategic level.

The SOG manages MAPPA at a strategic level and comprises senior representatives from each of the partner agencies. The SOG meets regularly and monitors the operation of MAPPA, making changes to improve effectiveness where required. As well as providing local leadership, the SOG is also responsible for performance monitoring and quality assurance of the MAPPA process and for the coordination and submission of the Annual Report.

At present, the MAPPA Operational Group (MOG) oversees the day-to-day operation of MAPPA in the CJA Area and comprises key operational post holders within each of the agencies involved in MAPPA. In SWS CJA area, there are four Chief Officers Groups operating within the respective local authority areas; Dumfries and Galloway, East Ayrshire, North Ayrshire and South Ayrshire. The chair of the SOG is responsible for providing the Chief Officer Groups with regular updates on the progress of MAPPA within the South West Scotland CJA area as well as within the relevant local authority area.

MAPPA Strategic Oversight Group:
Governance and Reporting arrangements



What we have done during the past year?

As you can see from the statistics (Annex 1) the total number of both registered sex offenders and restricted patients managed through MAPPA has increased during the last reporting year.

The statistics included in Annex 1 provide a clear picture of individuals subject to MAPPA and we will continue to monitor these numbers to ensure that we have sufficient resources to manage the offenders within our area. In particular we will continue to be mindful of any increase in offender numbers associated with the extension of the MAPPA legislation to violent offenders and advise Chief Officer Groups accordingly.

During the past year we have:

- Worked in partnership to assess and manage the risk posed by registered sex offenders and restricted patients.
- Conducted annual registration reviews in accordance with the Sexual Offences Act 2003 (Remedial) (Scotland) Order 2010. For adult RSOs this happens at the 15 year point in their registration, and at 8 years for those convicted while aged under the age of 18. The final decision to remove any sex offender from sex offender registration rests with the Chief Constable.
- Shared all appropriate information with partners in the MAPPA process, including the Department of Work and Pensions (DWP). This process allows MAPPA to share information with the DWP about the risks posed by individuals, for employment and training vetting, to ensure they have no access to potential victims.
- Carried out regular auditing, quality assurance and performance monitoring across a range of MAPPA processes, sharing the learning from these with those involved in MAPPA.
- Held a total of 235 Level 2 MAPPA and 8 Level 3 MAPPP Meetings (RSO and Restricted Patient)
- Ensured that the minutes and risk management plans for each MAPPA meeting were produced and circulated within the required timescales.
- Incorporated the Level of Service Case Management Inventory (LS/CMI) risk of harm assessments more effectively into the MAPPA process, amending both practice and documents to achieve this.
- Introduced the new community sex offender group-work programme 'Moving Forward Making Changes' across each of the local authority areas.
- Contributed to the ongoing Consultation on Redesigning the Community Justice System started by the Scottish Government in December 2012 and to the work of the Scottish Government's MAPPA Extension Advisory Group.
- Further refined and implemented/introduced a South West Scotland CJA area process to manage certain violent offenders. This process has no legislative backing and uses a MAPPA style process to bring agencies together to manage these offenders.

- Introduced a standardised model for Environmental Risk Assessment of accommodation for offenders, ensuring that offenders are appropriately housed and that all information is shared.
- Designed and implemented a consistent process for the management of Level 1 Offenders, which is now being trialled within a local authority area.
- Restructured the MAPPA Office, creating the post of MAPPA Manager to address strategic issues, support the work of the SOG and improve administration of the MAPPA process across the CJA Area. We have also introduced an additional clerical post to support this.
- Supported Police Scotland in the operation of Keeping Children Safe – The Community Sex Offender Disclosure Scheme which allows people to raise concerns about those who have access to children *www.scotland.police.uk/keep-safe/safety-advice/children-and-young-people/child-protection-keeping-children-safe*

Future Plans

The introduction of the strategic MAPPA Manager's post will allow us to begin to drive significant change in how we go about our business and ensure that we are constantly evaluating all of processes and procedures.

During 2014/15 we aim to:

1 Introduce a high level 3 year Strategic Plan. This Strategic Plan will have as its focus the ongoing development of the MAPPA process to ensure it continues to operate in an efficient and effective manner.

2 Develop annual work plans detailing the actions involved in implementing our Strategic Plan. These will be based around three key portfolio themes and will be used as the basis for reporting our progress each year. These three portfolio themes will be:

i. Operational Practice and Process

ii. Performance

iii. Public information and Engagement

3 To design and agree a robust performance framework, gathering key information about current levels of performance and identifying areas for improvement.

4 Set out a clear training pathway for staff managing offenders within MAPPA framework and ensure they are effectively supported in their development of appropriate knowledge and skills.

5 Hold an annual, externally facilitated, strategic development day focusing on a structured self evaluation exercise to identify areas of focus and themes in annual work plans for 2014/15 in support of our 3 year Strategic Plan.

6 Fully implement the Scottish Government's MAPPA Guidance 2014, considering all aspects of the guidance from a SWS CJA area perspective, with further development work around specific areas such as information sharing.

7 Review all Memorandum of Understanding and Information Sharing Protocols, commencing a 2 year review cycle.

8 Consider the implications of the legislative extension of MAPPA to violent offenders, advising Chief Officers accordingly

9 Ensure that the MAPPA model within South West Scotland CJA Area reflects and gives effect to the outcome of the Scottish Government's review of Community Justice services and the implementation of Health and Social Care Partnerships.

Statistical Information: Annex 1

Table 1 – Registered Sex Offenders

2012 – 2013		2013 – 2014	
a) Number of Registered Sex Offenders		**a) Number of Registered Sex Offenders**	
i) at liberty and living in your area on 31st March 2013	348	i) at liberty and living in your area on 31st March 2014	373
b) the number of RSOs having a notification requirement who:		**b) the number of RSOs having a notification requirement who:**	
i) complied with notification requirements	295	i) complied with notification requirements	328
ii) were reported for a breach of notification requirements	53	ii) were reported for a breach of notification requirements	45
c) the number of "wanted" RSOs on 31st March 2013	1	c) the number of "wanted" RSOs on 31st March 2014	0
d) the number of "missing" RSOs on 31st March 2013	1	d) the number of "missing" RSOs on 31st March 2014	0

Table 2 – Civil Orders Applied and Granted in Relation to RSOs

	2012 – 2013	2013 – 2014
a) Sexual Offences Prevention Orders (SOPO S) in force on 31 March	43	47
b) SOPO S imposed by courts between 1 April & 31 March	N/A	4
c) Risk of Sexual Harm Orders (RSHO s) in force on 31 March	0	1
d) Number of RSO s convicted of breaching SOPO conditions between 1 April & 31 March	9	5
e) Number of people convicted of a breach of a RSHO between 1 April & 31 March	0	1
f) Number of Foreign Travel Orders imposed by courts between 1 April & 31 March	0	0
g) Number of Notification Orders imposed by courts between 1 April & 31 March	0	0

Table 3 – Registered Sex Offenders

	2012 – 2013	2013 - 2014
REGISTERED SEX OFFENDERS (RSO's)		
a) Number of RSOs managed by MAPPA level as at 31 March:		
1) MAPPA Level 1:	319	336
2) MAPPA Level 2:	29	37
3) MAPPA Level 3:	0	0
b) Number of Registered Sex Offenders convicted of a further group 1 or 2 crime between 1st April and 31st March:		
1) MAPPA Level 1:	4	6
2) MAPPA Level 2:	1	1
3) MAPPA Level 3	0	0
c) Number of RSO s returned to custody for a breach of statutory conditions between 1 April and 31 March (including those returned to custody because of a conviction for a group 1 or 2 crime):	12	10
d) Number of indefinite sex offenders reviewed under the terms of the Sexual Offences Act 2003 (Remedial) (Scotland) Order 2011 between 1 April and 31 March:	6	2

e) Number of notification continuation orders issued under the terms of the Sexual Offences Act 2003 (Remedial) (Scotland) Order 2011 between 1 April and 31 March:	1	0
f) Number of notifications made to Jobcentre Plus under the terms of the Management of Offenders etc. (Scotland) Act, 2005 (Disclosure of Information) Order 2010 between 1 April and 31 March:	65	79
g) Number of RSO s subject to formal disclosure:	7	0

Table 4 – Restricted Patients

RESTRICTED PATIENTS (RP'S):	**2012 – 2013**	**2013 – 2014**
a) Number of RP S:		
1) Living in your area on 31st March:	11	14
2) During the reporting year:	17	14
b) Number of RP s per order:		
1) CORO:	12	8
2) HD:	1	0
3) TTD:	3	0
c) Number within hospital/community:		
1) State Hospital:	8	9

2) Other hospital no suspension of detention (SUS):	4	2
3) Other hospital with unescorted SUS:	0	1
4) Community (Conditional Discharge):	3	5
d) Number managed by MAPPA level on 31 March:		
1) MAPPA Level 1	11	14
2) MAPPA Level 2	2	0
3) MAPPA Level 3	0	0
e) Number of RPs convicted of a further group 1 or 2 crime between 1 April and 31 March:		
1) MAPPA Level 1:	0	0
2) MAPPA Level 2:	0	0
3) MAPPA Level 3:	0	0
f) No of RPs on Suspension of detention:		
1) who did not abscond or offend:	0	8
2) who absconded:	0	0
3) who absconded and then offended:	0	0
4) where absconsion resulted in withdrawal of	0	0

suspension of detention:		
g) No. of RPs on Conditional Discharge:		
1) who did not breach conditions, were not recalled, or did not offend:	1	5
2) who breached conditions (resulting in letter from the Scottish Government):	0	0
h) recalled by Scottish Ministers due to breaching conditions:	0	0
I) recalled by Scottish Ministers for other reasons:	0	0

Table 5 – Delineation of RSOs by Age on 31st March

2012 – 2013			2013 - 2014		
Age	**Number**	**%**	**Age**	**Number**	**%**
Under 18	2	0.6	**Under 18**	1	0
18-20	10	2.9	**18-20**	13	3
21-30	64	18.4	**21-30**	66	18
31-40	60	17.2	**31-40**	62	17
41-50	72	20.7	**41-50**	73	20
51-60	67	19.2	**51-60**	84	23
61-70	54	15.5	**61-70**	57	15
71-80	16	4.6	**71-80**	14	4
81-90	3	0.9	**81-90**	3	1
91-100	0	0	**91-100**	0	0
Total	**348**	**100**	**Total**	**373**	**100**

Table 6 – Delineation of Population of RSOs on 31st March

2012 – 2013			2013 - 2014		
	Number	**%**		**Number**	**%**
Sex			**Sex**		
Male	342	98.3	**Male**	369	99
Female	6	1.7	**Female**	4	1
Total	348	100	**Total**	373	100

Table 7 – Delineation of RSOs by Ethnicity on 31st March

2012 - 2013			2013 – 2014		
Ethnic Origin	**Number**	**%**	**Ethnic Origin**	**Number**	**%**
White Scottish	246	71	White Scottish	282	76
Other British	60	17	Other British	77	21
Irish	7	2	I rish	7	2
Gypsy Traveller	0	0	Gypsy Traveller	0	0
Polish	0	0	Polish	0	0
Other white ethnic group	31	9	Other white ethnic group	1	0
Mixed or multiple ethnic group	1	0.25	Mixed or multiple ethnic group	1	0
Pakistani, Pakistani Scottish or Pakistani British	1	0.25	Pakistani, Pakistani Scottish or Pakistani British	2	1
Indian, Indian Scottish or Indian British	0	0	Indian, Indian Scottish or Indian British	0	0
Bangladeshi, Bangladeshi Scottish or Bangladeshi British	0	0	Bangladeshi, Bangladeshi Scottish or Bangladeshi British	0	0

Chinese, Chinese Scottish or Chinese British	1	0.25	Chinese, Chinese Scottish or Chinese British	1	0
Other Asian	0	0	Other Asian	0	0
African, African Scottish or African British	1	0.25	African, African Scottish or African British	0	0
Other African	0	0	Other African	0	0
Caribbean, Caribbean Scottish or Caribbean British	0	0	Caribbean, Caribbean Scottish or Caribbean British	0	0
Black, Black Scottish or Black British	0	0	Black, Black Scottish or Black British	0	0
Other Caribbean or Black	0	0	Other Caribbean or Black	0	0
Arab, Arab Scottish or Arab British	0	0	Arab, Arab Scottish or Arab British	2	1
Other ethnic group	0	0	Other ethnic group	0	0
Subject declined to define ethnicity	0	0	Subject declined to define ethnicity	0	0
Subject does not understand	0	0	Subject does not understand	0	0
Total	**348**	**100**	**Total**	**373**	**100**

Table 8 – Number of RSOs managed under Statutory Conditions and/or Notification Requirements on 31st March

2012 – 2013			2013 - 2014		
	Number	%		Number	%
On statutory supervision	128	36.8	**On statutory supervision**	155	42
Subject to Notification Requirements only	220	63.2	**Subject to Notification Requirements only**	218	58
Total	**348**	**100**	**Total**	**373**	**100**

Number of MAPPA Level 2 & 3 MAPPA meetings held

2012 – 2013			2013 - 2014		
	Level 2	**Level 3**		**Level 2**	**Level 3**
RSO	224	3	**RSO**	230	8
Restricted Patient	4	0	**Restricted Patient**	5	0
Total	**228**	**3**	**Total**	**235**	**8**

Glossary of Terms: Annex 2

ACPO(S): the Association of Chief Police Officers in Scotland.

CPA: Care Programme Approach - a process which organises the multi-disciplinary care and treatment of patients with mental health problems. Regular review meetings are held where needs are identified and plans put in place to meet these needs. Risk assessment and risk management are an integral part of this process.

CJA: Community Justice Authority.

CJSW: Criminal Justice Social Work.

DWP: Department of Work and Pensions.

Integrated Chronology: A chronology, sometimes referred to as a timeline, is a record of summarised significant events or changes in circumstances, relating to a specific individual. For individuals subject to MAPPA it will highlight previous events in order to identify any emerging risks and needs, to assist the multi-agency professionals involved to respond appropriately. A chronology should be factual and the source of information included within it should be clear. The purpose of using this tool is to increase awareness about the specific risks and protective factors of each individual subject to MAPPA and to respond to risks quickly and effectively.

MAPPA: Multi Agency Public Protection Arrangements.

MAPPP: Multi Agency Public Protection Panel.

Missing: a Sex Offender should be considered as Missing in the following circumstances; Where the current whereabouts of an offender is unknown and Police enquiries to establish their whereabouts have been unsuccessful. The risk management process may therefore not be achievable and there exists a requirement to trace the individual and address the risk he/she may pose and establish if further offences have been committed. Those offenders who have left the territorial jurisdiction of the United Kingdom and whose location abroad is known are not considered as missing. The requirement to comply with the registration process is suspended whilst offenders are out with the UK. Where appropriate, consideration should be given to establishing whether the offender has committed an offence relative to notification of his/her foreign travel. In this situation if an arrest warrant is issued relative to such an offence the offender should be regarded as Wanted.

NASSO: The National Accommodation Strategy for Sex Offenders. More information in relation to this can be found on the Scottish Government website; www.scotland.gov.uk/Topics/Built-Environment/Housing/16342/management/highrisk/sexoffenders

OLR: Order For Lifelong Restriction - where the High Court considers that the risk criteria are met, a Risk Assessment Order (RAO) may be made after conviction and the resultant risk assessment report will inform the Court's judgement on whether an OLR should be imposed. Further information can be found on the Risk Management Authority website.

PDP: Potentially Dangerous Persons. The criteria under which someone is considered a PDP and therefore to be included within MAPPA as an SVO are as follows:

1 convicted of an indictable serious and violent offence and who presents an enduring risk of harm to members of the public

2 where the index conviction involved murder but where a significant element of sexual violence occurred and which is not registerable under the Sex Offenders Act

3 where an individual is making repeated threats of violence and harm which are deemed as life threatening to individuals or members of the public

4 those from prison released under the Order for Life Long Restriction arrangements

5 those individuals made subject to a Risk of Sexual Harm Order. (ROSH).

According to these criteria not every violent offender will be considered for inclusion in MAPPA. There will be a number of violent individuals in the community who are being successfully managed through other arrangements. The agreed changes are specific to the 'critical few' or highest risk of harm offenders in the community.

Responsible Authorities: Further information detailing the agencies identified as being the responsible authorities can be found at www.legislation.gov.uk/asp/2005/14/section/10

RP: Restricted Patient – This is an offender defined under the Management of Offenders etc (Scotland) Act 2005 section 10, 11 (a) to (d). Restricted patients are defined as those patients who are convicted of an offence and put on a Compulsion Order and Restriction Order (CORO) under sections 57A and 59 of the Criminal Procedure (Scotland) Act 1995, or who have been found insane in bar of trial, or acquitted by reason of insanity, and placed on a CORO under s.57 (2)(a) and (b) of the 1995 Act. A CORO is without limit of time. The definition also includes prisoners on a Hospital Direction (made under s.59A of the 1995 Act) or a Transfer for Treatment Direction (made under s.136 of the Mental Health (Care and Treatment) (Scotland) Act 2003). These orders are defined in the Management of Offenders etc. (Scotland) Act 2005, Section 10 (11) paragraphs (a) to (d).

RSO: Registered Sex Offender -.When a person is convicted of an offence listed in Schedule 3 of the Sexual Offences Act 2003, they automatically become subject to the sex offender notification requirement. Those made subject to a Sexual Offences Prevention Order (SOPO) or who are convicted of a breach of a Risk of Sexual Harm Order (RSHO) are also automatically required to comply with this notification requirement.

SVO: Serious and Violent Offender defined as an offender convicted on indictment and sentenced to more than four years imprisonment for an offence inferring personal violence. Only serious and violent offenders who also meet the criteria to be considered a PDP (please see above) are currently being included within MAPPA processes in SWS CJA.

SOLO: Sex Offender Liaison Officer – usually a housing officer.

S.P.S: Scottish Prison Service.

Statutory Supervision: includes Life Licence, Parole Licence, Non Parole Licence, Extended Sentence Order, Order for Lifelong Restriction, Short term Sex Offender Licence, Community Payback Order, Probation Order, and Community Service Order.

ViSOR: Violent and Sex Offenders Register.

Wanted: An RSO should be considered as wanted where it is known that an offender is actively avoiding Police in response to Police enquiries to trace that individual relative to offences they may have committed or in relation to other matters for which it is required that they be interviewed. This may include those occasions where an offender is the subject of an arrest warrant.

Further Sources of Useful Information: Annex 3

Risk Management Authority, Publications, Rated:
http://www.rmascotland.gov.uk/try/

Risk Management Authority, Publications, Frame;
http://www.rmascotland.gov.uk/try/frame/

Criminal Justice and Licensing (Scotland) Act 2010:
http://www.legislation.gov.uk/asp/2010/13/contents

Management of Offenders Act 2005:
http://www.legislation.gov.uk/asp/2005/14/contents

Sexual Offences Act 2003:
http://www.legislation.gov.uk/ukpga/2003/42/contents

Scottish Government, Public Safety:
http://www.scotland.gov.uk/Topics/Justice/public-safety/protection

Scottish Government, Restricted Patients:
http://www.scotland.gov.uk/Topics/Health/Services/Mental-Health/Restricted-Patients

Scottish Government, MAPPA Guidance:
http://www.scotland.gov.uk/Topics/Justice/public-safety/protection/reports

Stop It Now Scotland:
http://www.stopitnow.org.uk/scotland.htm

Disclosure Scotland Protection of Vulnerable Groups Scheme:
http://www.disclosurescotland.co.uk/guidance/index.html

Association of Chief Police Officers Scotland, Keeping Children Safe:
http://www.acpos.police.uk/keepingchildrensafe/Index.html

General Register Office Population Statistics:
http://www.gro-scotland.gov.uk/statistics/at-a-glance/index.html

Shadow Integration Board
18th December 2014

Subject:	**Director's Report**
Purpose:	To advise members of the North Ayrshire Shadow Integration Board of developments in the North Ayrshire Health & Social Care Partnership
Recommendation:	That members of the Shadow Integration Board note progress made to date.

1. Introduction

1.1 This report presents a high level overview for members of the Shadow Integration Board (SIB) of the work undertaken both locally and with the other Ayrshire partnerships towards the establishment of a North Ayrshire Joint Integration Board by 1 April 2015.

2. Current Position

2.1 The Strategic Alliance Integration Sub-Group (SAISG) continues to meet weekly to co-ordinate work across the three local authorities and NHS Ayrshire & Arran. A substantial amount of work is now being undertaken locally on the review and development of services. Brief details of some of the main initiatives are set out in this report.

National Developments

2.2 Since the date of the previous SIB meeting civil servants have issued more detailed guidance on the process and timescale for approving integration schemes. Previously it was understood that submission of an integration scheme during January would allow partnerships to form on 1 April. The timetable now issued, however, is that schemes would need to be submitted in the first week of January to allow the full review and approval process to be completed by that date. The approval process includes review by civil servants, drafting of a Scottish Statutory Instrument and Ministerial approval. The Statutory Instruments then need to lie in Parliament for 28 days. The timescale for approval of the Ayrshire integration schemes by the Board of NHS Ayrshire and Arran and the respective Ayrshire Councils cannot now be brought forward. It is therefore anticipated that the Ayrshire partnerships will be able to form by mid-May. We do still expect the schemes to have received ministerial approval by the end of March and will work to ensure that the Partnership is established as a legal entity at the earliest possible opportunity.

2.3 The full set of Regulations relating to the integration of health and social care have now been laid in Parliament and will all have come into force by the end of the year. Regulations concerning the Integration Scheme, delegation of services by NHS Boards and local authorities and the national health and wellbeing outcomes were dealt with in the October report. The remaining regulations deal, among other matters, with the Integration Joint Board, the content of the Integration Joint Board's performance report and the membership of the Strategic Planning Group.

2.4 The Regulations are broadly as expected and will be taken account of as the work to establish the Partnership progresses. The Regulation concerning the Integration Joint Board itself will be addressed as part of the Standing orders for the IJB. The Regulation on the membership of the Strategic Planning Group is the subject of a separate report to the SIB.

2.4 Scottish Government has issued its Clinical and Care Governance Framework which was developed by a group co-chaired by the Deputy Chief Medical Officer and the Chief Social Work Adviser. The framework identifies the roles, accountabilities, responsibilities and actions that will be required to ensure governance arrangements in support of the principles of the Public Bodies (Joint Working) (Scotland) Act 2014. The regulatory bodies will use this framework in their work. Locally, the Ayrshire Clinical and Care Governance workstream are reviewing the framework and will advise on any work that has to be done locally in response to it.

Ayrshire Developments

2.5 The Regulation concerning the Integration Scheme requires a statement covering corporate support services. Support services are currently provided to the Partnership in a variety of ways: by staff working within the Partnership; by the corporate services teams in NHS Ayrshire and Arran and North Ayrshire Council and by a mixture of both. The revised version of the Integration Scheme will contain a commitment by the Health Board and the Councils to continue to provide support until new models of service have been developed. Models for support in the priority areas of finance, human resources and ICT are to be developed by March next year with other support services being developed during 2015/2016.

North Ayrshire Developments

2.10 After a number of informative consultation sessions work has been finalised on the consultation version of the Partnership's strategic plan. A progress report on the plan is the subject of a separate report to the SIB.

In addition, work is being finalised on the Partnership's submission for the Integrated Care Fund. This breaks down submissions into three key areas; Integrated Partnership Services, extension of Reshaping care Fund projects and Innovation & Ideas Fund. This is the subject of a separate report to the SIB.

2.11 Consultation on the draft integration scheme for the Ayrshire Health and Social Care Partnerships will have concluded by the time the SIB meets. The revised version will take account of the changes made in the regulations. We also had early sight of the first version of the framework which will be used to review the integration schemes when they have been submitted to Scottish Ministers and have taken account of this in developing the final version. The Board of NHS Ayrshire and Arran will consider the final version at meetings in January and if approved, the integration scheme will be submitted to Scottish Ministers for approval.

2.12 Work is underway to complete the Partnership's management team, including the recruitment to the Head of Mental Health post. The structure of the next tier of management is being developed with the aim to have this in place by the start of the new financial year.

Service Developments

2.13 Recognising the need to develop improved relationships, systems and processes with colleagues in Acute Services to improve discharge planning, we will be initiating a pilot liaison service to offer a Single Point of Contact within the Care at Home Team. Starting within a clearly defined area of Acute Care, this pilot will afford ward staff and their discharge co-ordinators the opportunity to plan discharges for North Ayrshire residents, ensuring access to the right level of homecare to support each individual thereby reducing the likelihood of subsequent emergency admissions.

2.14 Together with South and East Ayrshire we are working with colleagues from the Red Cross to specify, fund and deliver a Return to Home service to support individuals who can be safely discharged directly from A&E with a minimal support. This will involve direct support to the individual, ensuring they are safe in their home and highlighting any deficits in their care at home package where this is in place.

2.15 Work is underway to define a new model of specialist Rehabilitation and Reablement within Pavilion 3 at Ayrshire Central Hospital. This will see the existing nursing team working alongside AHPs and Social Work staff to identify individuals who have potential to regain a level of independence that would see them return home; work with these individuals to set and achieve personal goals; and engage their families and / or carers to prepare for their return home. This facility will offer step-up care from community settings and provide a proactive in-reach service to Crosshouse Hospital to identify individuals likely to benefit from this type of care, ensuring their timely discharge to the rehabilitation setting.

2.16 Building on the direction set and aspiration expressed for the future delivery of rehabilitation services on Arran, work is now commencing on the development of a time bound change programme that will make full use of the Arran War Memorial Hospital and Montrose House facilities, as well as the full range of community settings from which formal and informal services are currently delivered. This will seek to build on the current dynamic, flexible and innovative services currently being delivered to secure a range of services tailored to local need that are delivered in the right way at the right time in the right place by the individual best equipped to support local people in rehabilitating as fully as possible to regain maximum independence.

2.17 Locality Addictions manager Anne Lee, with the support of one of our graduate interns, will work over the next few months to develop and draft a service specification that will help bring together the formerly separate Council and Health services in North Ayrshire. Some of the key priorities will be to develop an integrated referral and allocation pathway, single duty system and point of contact to ensure a better and more seamless experience for those who use the service. We have chosen to focus first on the Addiction Service as most of the staff are already co-located in Caley Court.

2.18 The initial cut of data from the survey work undertaken by Dartington Social Research Unit has been produced. The survey has captured the views of 633

parents of children aged eight or under and a total of over approximately 8,200 children aged 9-16 and provides a quality indication of what life is like for children growing up in North Ayrshire. Children and Families managers within the Health and Social Care Partnership, alongside managers from other agencies within the Community Planning Partnership are now beginning to make sense of the data and Dartington will provide further detail over the coming weeks that will help us identify strengths and gaps in Children's Services. Once the data has been ordered and analysed, the findings will be presented to a SIB/IJB meeting next year.

2.19 On 27th November 2014 the Scottish Government carried out their routine Mental Health in Scotland Implementation Review visit. The areas covered by the visit were :-

- **Employability** – positive outcomes in North Ayrshire for people with mental illness.
- **Self Management** – Mental Health Self Management Group being piloted within North Primary Care Mental Health Team.
- **Working with People in Distress** – multi-agency seminar held on "Trauma throughout the Lifespan". The North HSCP will also pilot a multi-agency group to develop a model to improve co-ordination of support and treatment for people in distress.
- **Access to Psychological Therapy HEAT Target** – update on recent productivity/efficiency analysis on working towards the target.
- **Scottish Patient Safety Programme** – noted the continuing good work on the two workstreams (Safety Medicines Management and Control, Restraint and Seclusion).
- **Child and Adolescent Mental Health** – update on progress on HEAT targets.
- **Addictions** – update on Peer Support Model.
- **Inpatient Services (Adult)** – update on the developments with the new North Ayrshire Community Hospital.
- **Elderly Mental Health Services** – update on HEAT targets and services across the three Ayrshire local authorities.

3. Proposals

3.1 The programme plan continues to be delivered through the identified workstreams. Progress against the plan is subject to scrutiny by the Strategic Alliance and by the Chief Executives of the three Ayrshire councils and NHS Ayrshire and Arran. Members of the SIB are asked to continue their support for this process.

4. Implications

Financial Implications

4.1 There are no financial implications arising directly from this report.

Human Resource Implications

4.2 There are no human resource implications arising directly from this report. The human resource implications for each proposal for the Partnership will be considered as they are developed.

Legal Implications

4.3 Work undertaken to prepare for integration will ensure that North Ayrshire Council and NHS Ayrshire & Arran are able to comply with the requirements of the legislation.

Equality Implications

4.4 There are no equality implications.

Environmental Implications

4.5 There are no environmental implications.

Implications for Key Priorities

4.6 The integration of health and social care will contribute to the delivery of the "Healthy and Active North Ayrshire" priority in the 2013 - 2017 Single Outcome Agreement.

5. Consultations

5.1 No specific consultation was required for this report. User and public involvement is a key workstream for the development of the partnership and all significant proposals will be subject to an appropriate level of consultation.

6. Conclusion

6.1 The partners are making good progress in delivering the integration programme plan. Robust programme management arrangements are in place to ensure that key milestones are met.

For more information please contact Iona Colvin, Director, North Ayrshire Health & Social Care Partnership on 01294 317723 or icolvin@north-ayrshire.gsx.gov.uk

Integration Scheme Framework Workstream Update – December 2014	
A number of workstreams have not formally met since the last report however they have been undertaking ongoing revision and follow-up work as part of the finalisation of the draft Integration Scheme for submission. Consequently, the November position has been restated in some cases.	
Workstream	**Update**
Finance	The financial section of the Integration Scheme is subject to review as comments are received through the consultation process and in view of the regulations. Work is ongoing in respect of the guidance on financial assurance to reflect this in the local arrangements which will be key to the financial governance arrangements of the Integration Joint Boards. The finalised guidance on the planning and management of Large Hospital and "Lead Partnership" services on which the Ayrshire partners have worked with the Scottish Government has been issued. Work continues on “due diligence” of the baseline budgets for Large Hospital and Lead Partnership services and the financial arrangements that will govern the planning and management of these budgets. Work continues to develop and refine protocols and procedures to underpin the Integration Scheme. The arrangements for the Chief Financial Officer have been agreed.
ICT Communications & Information Management	ICT Requirements/Information Management – Work is ongoing on the IT and connectivity needs of the Intermediate Care and Enablement Services (ICES) across the three partnerships. ICT Technical Issues - The technical sub group is continuing to work on ensuring compatibility of devices and connectivity across partner agencies and is working on a few test sites within the North Ayrshire Partnership at this time. The Pan Ayrshire Information Sharing Protocol has been revised and is awaiting formal approval by partners. Work will continue to move towards adopting the Scottish Accord Sharing of Personal Information (SASPI) documentation / model by April 2015 and supporting the Partnerships to develop service level agreements. (November 2014 position)
Legal	The workstream continues to review the legal actions required

Integration Scheme Framework Workstream Update – December 2014	
	for the development of the Integration Scheme and provide guidance to other workstreams. The focus of the workstream is now on ensuring that following the consultation process the finalised Integration Scheme is legally competent. (November 2014 position)
Public Health & Health Improvement	In view of the proposed national review of public health, the interim arrangements will continue and the workstream is preparing a completion report. (November 2014 position)
Performance	The Group reviewed the work undertaken to date on the development of a Data Dictionary (the comprehensive listing of all appropriate performance measures and indicators) and reviewed the changes to the Model Integration Scheme Template and the subsequent changes to be made to the Performance Workstream Section. The Group anticipated that no further meetings were necessary at this time subject to finalisation of the Data Dictionary and the content for inclusion in the Integration Scheme. The workstream will prepare a completion report (November 2014 position)
Clinical and Care Governance	The Workstream continues to further refine the text currently included in the Clinical and Care Governance Section of the Integration Scheme. The Workstream will meet again on 12 December to discuss how it might develop guidance for the three Ayrshire Partnerships on giving practical effect to the overall approach set out in the Integration Scheme.
Framework for Strategic Plan	The group has been re-established to focus on sharing information, addressing lead partnership plans and interface issues, and developing an Ayrshire wide overview of strategic commissioning in the three partnerships. The development of all three Strategic Plans is progressing. The South Ayrshire Partnership draft strategic plan will be submitted to the Shadow Integration Board on 11 December 2014 and arrangements are in place to develop a public facing version of the draft plan. The draft Strategic Plan for the North Ayrshire, comprising a public facing summary plan and more detailed plan, was submitted to the Shadow Integration Board on 21 November. The draft public facing plan has been completed for the East Ayrshire Partnership and the second draft of the plan was presented to the Shadow Integration Board on 27 November. Consultation on the three draft Strategic Plans to commence and will be completed by March 2015.

Integration Scheme Framework Workstream Update – December 2014	
	The workstream has commented on the draft national guidance on preparing a Strategic (Commissioning) Plan. As part of the development of the planning cycle approach, a meeting is scheduled in December between the public health consultants. This will discuss the process for the 2015/16 review of the plans, including possible priorities for needs assessment, for ratification by the Shadow Integration Boards.
Human Resources & Organisational Development	Human Resources: The main focus is on continuing to develop protocols to support recruitment and developing the Workforce and Development Strategy. A small sub group has been established to progress this. Organisational Development (OD): The work is focused on supporting Partnerships to implement their OD strategy which includes support to SIBs, Strategic Planning Groups and employees. In addition OD support is available to assist with planning for engagement on the Strategic Plan. (November 2014 position)
Communications	The workstream is continuing to link into the national group. (November 2014 position)
User and Public Involvement	The workstream is developing user and public involvement within Partnership localities to support the Strategic Plans and is working closely with OD and Communications workstreams to support this. Consultation and engagement on the draft Strategic Plans will be the main focus of activity over the coming months. A joint meeting with Communications workstream was held to discuss the development of a Participation and Engagement Strategy. It was agreed that although there may be shared aspects, a draft strategy will be developed by each partnership. (November 2014 position)
Corporate & Other Services	The process for reviewing corporate support services has been agreed by the Chief Executives, subject to agreeing terms of reference for the groups involved in this work. The priorities are agreed as Finance, Human Resources and ICT. The method of delivering these services is to be agreed by March 2015 with other services to be reviewed during 2015/16.

Shadow Integration Board
18th December 2014

Subject:	**Scottish Patient Safety Programme Mental Health (SPSPMH)**
Purpose:	To update the SIB on progress with SPSPMH
Recommendation:	That the Shadow Integration Board notes the content of the report.

1.	**Introduction**
1.1	SPSP-MH is a 4 year programme with an overall aim of reducing harm experienced by individuals in receipt of care from mental health services, with a focus initially on adult psychiatric inpatient units and forensic inpatient units.
1.2	The programme is part of the national Scottish Patient Safety Programme, the MH element has been ongoing since 2012.
2.	**Current Position**
2.1	We are in phase two of the programme, spreading learning from the earlier phase.
2.2	All adult mental health inpatient services are now involved in the programme (including Forensic and Rehabilitation Service).
4.	**Implications**
4.1	There are no direct implications from this paper, however the programme itself will provided safer services, focused on individuals.
4.2	SPSPMH will reduce avoidable harm and reduce the opportunity for the experience of physical, psychological, social and sexual harm.
4.3	Communication and collaboration with service users will improve, focused on reducing harm as this is a central element of the programme.
5.	**Consultations**
5.1	There are no specific consultations related to this paper.

6.	**Conclusion**
6.1	The SIB are asked to note the content of the attached paper.
6.2	The SIB are asked to receive a presentation on SPSPMH at a future SIB meeting to more fully explore the programme.

For more information please contact Derek T Barron, Associate Nurse Director/Lead Nurse on (01563) 826348

Ayrshire and Arran NHS Board

Scottish Patient Safety Programme - Mental Health (SPSP-MH)

Executive Sponsor: Prof Fiona McQueen, Executive Nurse Director

Authors: Samantha McEwan, Clinical Improvement Practitioner / Improvement Advisor, Mental Health Services
Diane Murray, Assistant Director, Clinical Improvement
Derek Barron, Associate Nurse Director, Mental Health Services

Date: 31.10.14

Recommendation

The Board is asked to receive the information regarding progress made so far at this stage of the Scottish Patient Safety Programme in Mental Health and to support the proposals for the next part of the programme.

Summary

SPSP-MH is a 4 year programme with an overall aim of reducing harm experienced by individuals in receipt of care from mental health services, with a focus initially on adult psychiatric inpatient units and forensic inpatient units.

At this stage of Phase two of the programme The Mental Health Services Directorate is currently spreading learning from the earlier phase of the programme to further clinical areas and starting to test out elements of the remaining work streams. All adult mental health inpatient services are now involved in the programme, which includes the Forensic and Rehabilitation inpatient service and the community forensic mental health service.

Key Message:

This paper sets out the progress and results since the paper of May 2014 and describes the proposals for future implementation of the programme in Ayrshire and Arran.

Glossary of Terms (insert any abbreviations referred to in your paper)	
NHS A&A	NHS Ayrshire and Arran
SPSP	Scottish Patient Safety Programme
SPSP-MH	Scottish Patient Safety Programme – Mental Health
IPCU	Intensive Psychiatric Care Unit
MDT	Multi Disciplinary Team
Prn	Pro re nata
SPC	Statistical Process Control
CFMHT	Community Forensic Mental Health Team
NES	NHS Education for Scotland

1 Background

SPSP-MH is a 4 year programme with an overall aim of avoiding or reducing harm experienced by individuals in receipt of care from mental health services, with a focus initially on adult mental health inpatient units and forensic inpatient units. In a mental health context patient safety is concerned with avoiding or reducing the opportunity for the experience of physical, psychological, social and sexual harm. Communication and collaboration with service users to reduce harm is a central element of the programme. In relation to service user involvement SPSPMH work to date in the Directorate of Mental Health Services in NHS Ayrshire and Arran has previously reported on:

- The use of the Scottish Recovery Indicator 2 to assess and develop person centred, recovery focused services.
- Service user involvement in contributing to their own safety planning in IPCU
- Efforts to provide and increase engagement in therapeutic activities in IPCU
- Use of the Patient Safety Climate Survey in IPCU
- Approaches to engage service user involvement in safer management of their medicines.
- Service user and carer representation on the SPSPM local implementation group to influence direction of the work programme.

There are 4 optional and one mandatory work streams to SPSPMH:

- Risk Assessment and safety planning
- Safer medicines management
- Communication at transitions
- Restraint and seclusion
- Leadership (mandatory)

2 Current situation

The Scottish Patient Safety Programme in Mental Health (SPSP-MH) is now entering the second part of Phase Two. This report outlines the successes, challenges and plans for the future of the programme within NHS Ayrshire and Arran.

Having initially tested the first two of the work streams listed above, in addition to the mandatory leadership work stream, the Directorate of the Mental Health Service in NHS Ayrshire & Arran is now in varying stages of testing, implementing or consolidating all of the work streams in all adult inpatient areas.

Improvement methodology is being used to test and embed successful changes in practice. Data is being gathered against a range of national harm reduction outcome measures and local process measures. Systems are in place to support frequent data collection.

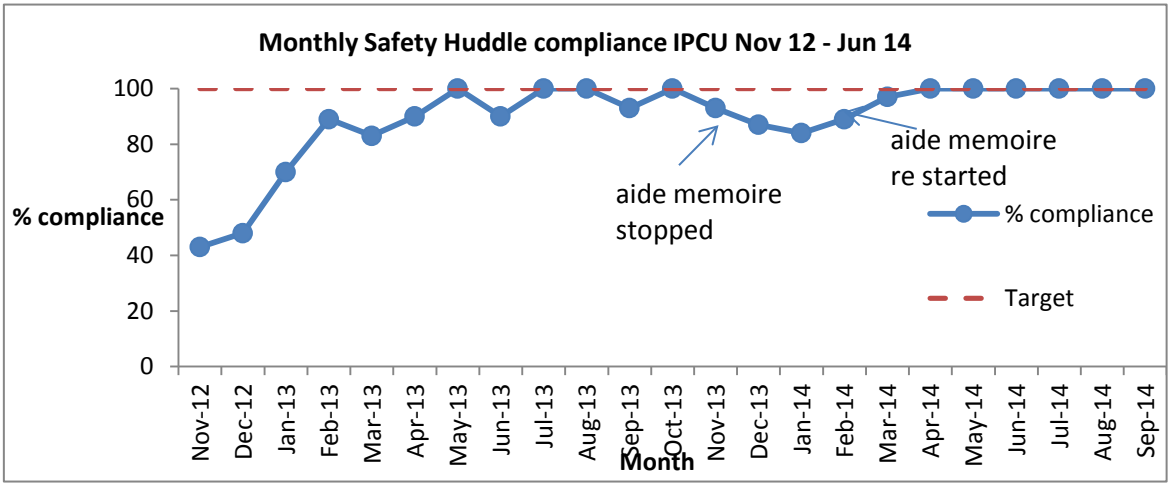
Bi monthly leadership reports submitted to the SPSPMH team at Healthcare Improvement Scotland have been noted for the broad range of process measures developed and being reported on.

A summary of progress in the work streams is listed below with supporting evidence in the form of run / SPC charts to highlight improvements.

2.1 Risk Assessment & Safety Planning Work stream

IPCU has now consolidated this work stream and continue to make progress in safety planning, safety huddles, therapeutic activities and daily goal setting. Run chart 1 below highlights continued safety huddle compliance in IPCU.

Run Chart 1

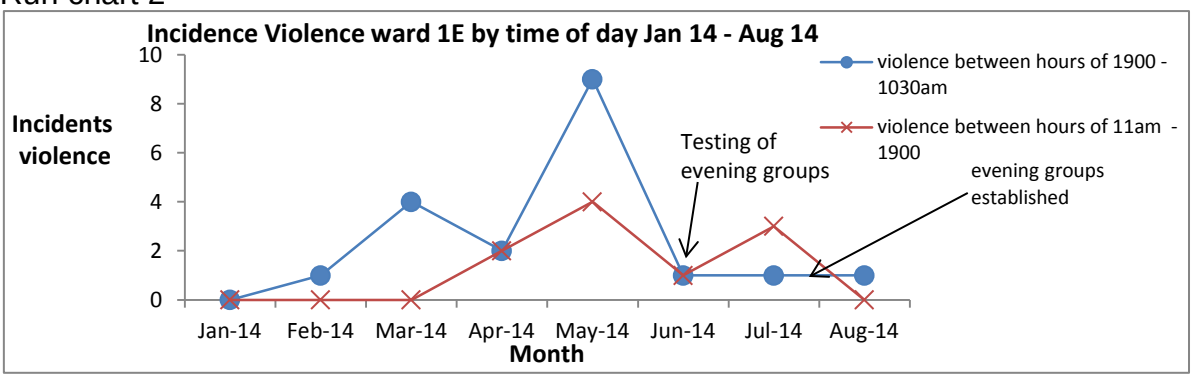


Ward 1E are now testing the Risk Assessment and Safety Planning work stream. Due to a pattern noted in the time of day in occurrence of violence and self harm, evening therapeutic group activity has been tested with an initial aim of groups taking place 4 nights per week. The target has now been increased to 6 evenings per week. This work is being led by nursing assistant staff in the ward, which has contributed to a sense of personal development.

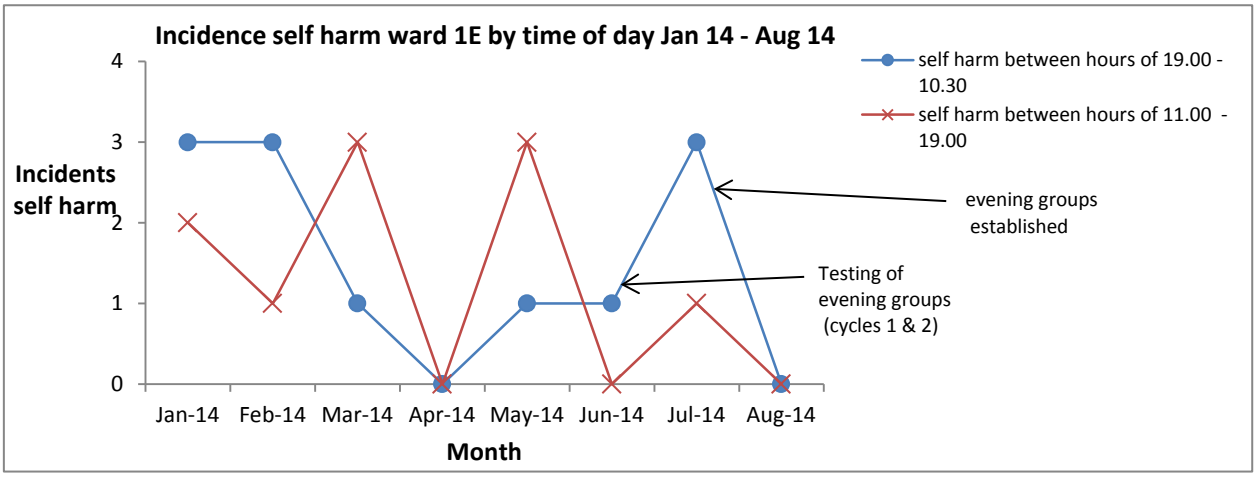
There has been an initial reduction noted in night time violence so far with night staff also noting that patients are sleeping better and for longer periods. This work has involved several tests of change to develop flexibility around medicine dispensing times and supper time being moved to later. See run charts 2 and 3 for information on incidence of violence and self harm by time of day and therapeutic activity.

The main challenge in achieving consistency of the groups is when several patients require to be nursed on enhanced observation which limits staff availability to deliver group activities. Service users have been positive about the groups and are discussing the possibility of co facilitating their own groups, such as music groups. Ward 1E are also working to ensure consistency of the content of safety plans and communication about risk issues. Run charts 4 and 5 evidence these activities.

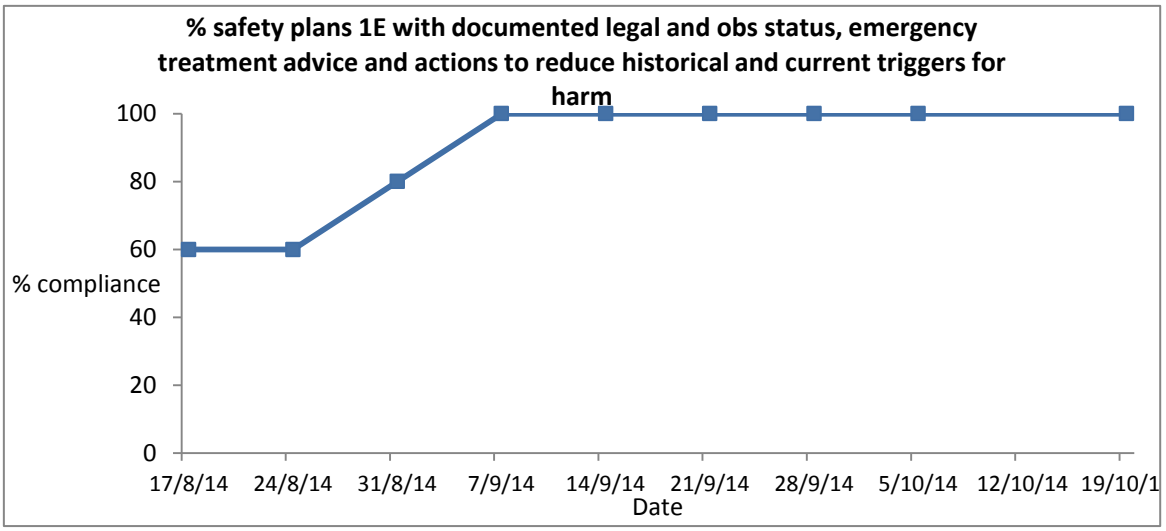
Run chart 2



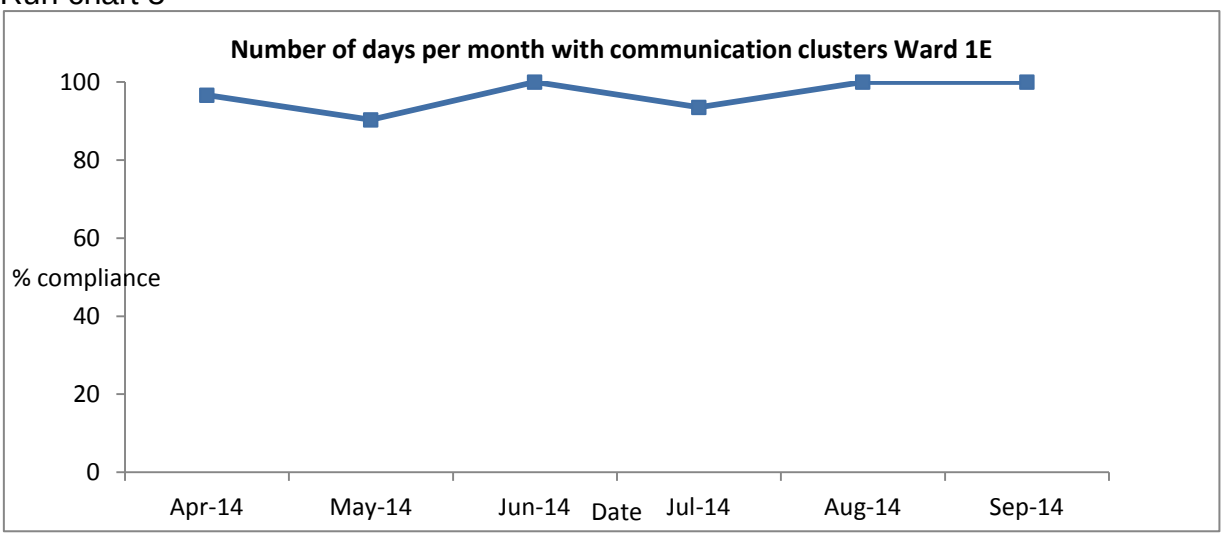
Run chart 3



Run chart 4



Run chart 5



2.1 Restraint and Seclusion work stream

IPCU have begun testing this work stream. Data continues to be gathered and displayed in the ward in “safety cross” format on incidence of restraint, number of individuals who feel safe, engagement with daily safety goal setting, and safety huddle compliance.

Staff are engaging service users in preventative discussion about difficult incidents and the potential for restraint to maintain safety, and their preferred avoidance of use of restraint where possible. Debrief of service users during restraint when it does occur is being tested and staff have begun to record this during October to determine and develop consistency of debrief.

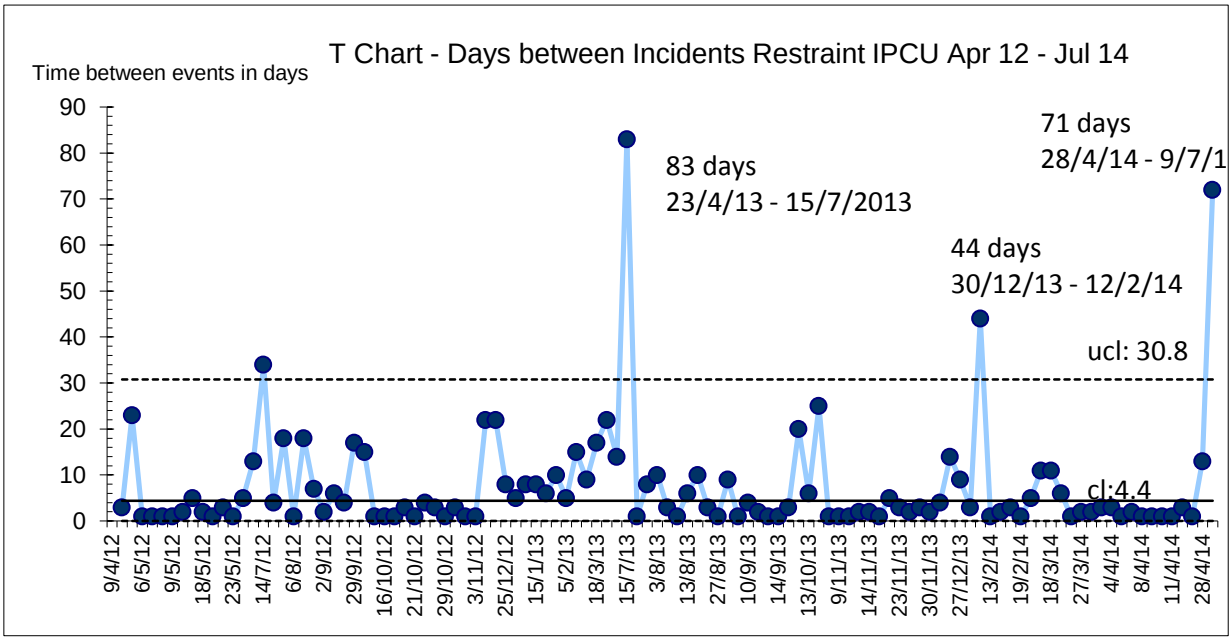
At the recent national Restraint and Seclusion work stream development group NES presented a draft debrief / review of restraint tool for testing which aims to ensure staff and service user wellbeing and to drill down to the root cause of the incident which led to restraint in order to promote learning and prevent recurrence of restraint where possible.

IPCU are aiming to test the use of this during their safety huddle in the first instance and will feedback findings to the work stream group to further influence the development of the tool.

Ward 1E will begin testing this work stream at the beginning of 2015.

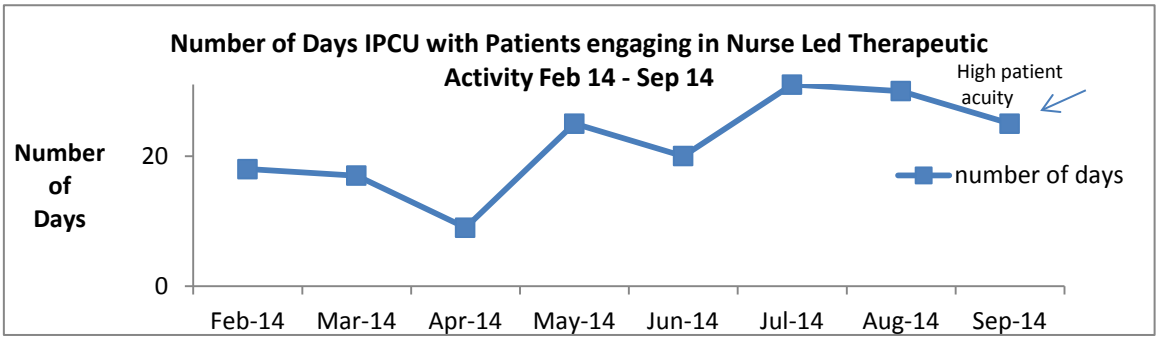
IPCU have now experienced 3 large periods of time without incidence of restraint. A pattern was noted between compliance with safety huddles, number of therapeutic groups and days between restraint. See t chart below which details the number of days between incidence of restraint.

T Chart



Run chart 6 below highlights IPCU's work in engaging service users in nurse led therapeutic activities. This has involved flexibility of individualised approaches and staff perseverance, particularly when nursing service users who are acutely unwell and at risk of violence.

Run chart 6

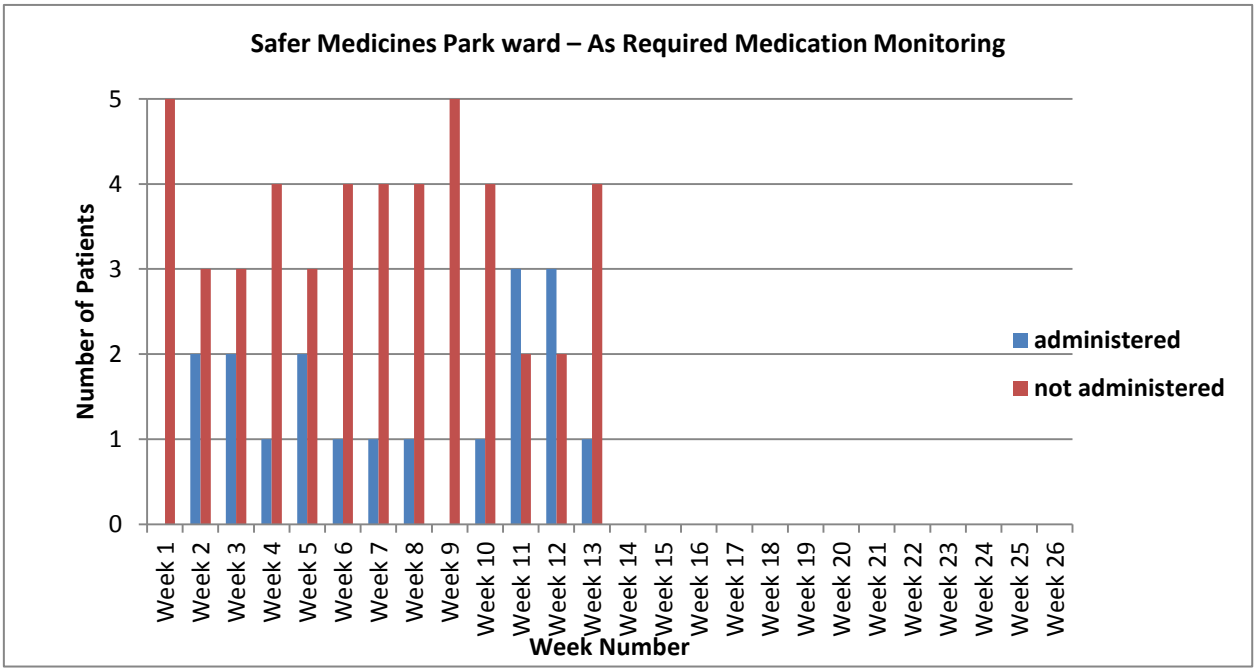


2.3 Safer Medicines Management Work stream

Reliable processes in medicines management are vital to ensure medicines are safely prescribed, administered and managed by individuals and their families /carers. Park ward are continuing to implement and consolidate elements of this work stream. The previous paper in May 2014 reported the establishment of error free prescribing, individualised dispensing and medicines reconciliation.

As part of the work stream Park ward have recently undertaken a review of "as required" psychotropic medication to identify levels of prescribing and administration. As required medicine administration has the potential to increase the risk of high dose / high risk medicines usage due to the combination with regularly prescribed psychotropic medication.

Low levels of as required administration were found. See bar chart below which demonstrates this. Patients are not routinely prescribed as required medicines and each individual's prescription for as required medicine has a review date in order to assess the benefit and usage of the medication to ensure appropriate and safe use or discontinuation.



Park ward and the remaining acute wards have introduced ECG monitoring on admission due to the increased risk of prolonged QT interval for individuals receiving psychotropic medicines, which can lead to adverse cardiac events.

Park ward are also in the process of developing an admission checklist, for testing by the junior doctors in November 2014, for physical health monitoring which will undertake cholesterol testing and other blood tests, BMI and waist circumference, chest x ray where appropriate. This is due to the increased risk of physical illness and associated earlier mortality experienced by people with mental illness compared with the general population.

The checklist will include an alert for individuals who are prescribed Clozapine and further physical health screening where required – such as for constipation as bowel impaction is a serious side effect of this medication. Initial treatment will commence where abnormal results are detected with information being passed to the GP/ community services during the discharge process.

Side effects of medication are being assessed as well as individuals' support needs to self manage their medicine when at home. Service users are not consistently given information on their medicines prescription when they leave hospital as copies of the discharge letter are not generally given to patients. A leaflet is being developed by Park ward which will be completed prior to discharge with the service user detailing their medicines and follow up support arrangements. Carers will also be given this information where appropriate. This work takes into account the aims of the Communication at Transition work stream which the ward will be testing in due course.

Ward 1D have started individualised dispensing of medicines with the support of Pharmacy staff. Whilst some data collection around process measures has taken place, this ward has not been able to sustain consistent testing and related measuring of activities around service user involvement in medicine management and associated discharge planning.

This was reported to have been due to staffing changes. New ward leads for the programme have now been identified and more continuous data should be available for the next reporting period. Once these initial activities have been established 1D will test further interventions by Park ward as mentioned above regarding physical health monitoring and discharge planning.

Following a recent visit to the Forensic and Rehabilitation Service by the SPSPMH national team, the service has now become involved in the programme.

In relation to safer medicines Glenrosa ward are planning to test individualised dispensing and self management of medicine.

Physical health, which potentially overlaps the Safer Medicines Management work stream, and arguably all mental health work streams as well as the Primary Care SPSP Programme, is an area that the Mental Health Directorate influenced the SPSPMH national team in terms of encouraging a focus on this in the next phase of the Programme. This also led to the provision of a physical health world cafe session at the recent regional SPSPMH event, facilitated by NHS Ayrshire and Arran Forensic and Rehabilitation Service.

Lochranza ward has been carrying out physical health screening for some time which includes a monthly “Lumps and Bumps” assessment on a monthly basis which is undertaken just prior to the individual’s MDT review so that further action can be taken if necessary.

This is an important aspect of holistic care given that this is a male patient group who have been in hospital for several years and do not access General Practice routinely, and who traditionally tend not to volunteer any physical health concerns. Data is now being collected to determine compliance with this and the nature of concerns that have been highlighted for further attention.

The ward have also been attempting to ensure bowel screening for all individuals aged over 50 years but are currently experiencing challenges where patients are not registered with a GP.

2.4 Communication at Transition

The Forensic and Rehabilitation service are starting to test elements of this work stream. Elgin ward are working to ensure consistency of recording of Specified Person Status for individuals detained under the Mental Health Act (2003) and to ensure that they are aware of their rights in relation to this. A measurement system has now been set up to measure consistency of patients receiving notification of their status, what it relates to, their rights and when it will be reviewed. The Forensic service is also planning to develop improved information sharing processes between Courts and the Community Forensic Mental Health Team.

Lochranza and Kildonan wards are keen to test the “5 Must Do’s with Me” element of the Person Centred Care Programme in relation to quality interaction and intervention and MDT review process. This element may also be considered around the development of a project to improve carer and family wellbeing and involvement in care, taking into account the Triangle of Care which is being launched by the Carers Trust Scotland presently and sets out best practice for involvement of carers in mental health services. Family and carer involvement and wellbeing is often central to ensuring patient safety.

2.5 Leadership and Culture

The Staff Safety Climate Survey has recently been repeated in IPCU and the acute inpatient wards. Focus groups have been undertaken with staff to surface some of the issues and successes highlighted by the survey and these will be fed back to the Associate Nurse Director for action.

Advocacy Service has agreed to facilitate the Patient Safety Climate Survey in IPCU and the acute inpatient wards before the end of the year now that the survey has been redrafted by service user groups and the SPSPMH national team.

There continues to be active engagement by the local programme leads and clinical staff on the national SPSPMH delivery and work stream development groups. The work stream test areas and local implementation group have AHP and medical leads.

3. Challenges

Staff engagement with SPSPMH is generally positive in all test areas.

As anticipated, some challenges have surfaced around data collection as the number of test sites have expanded, however this has been minimal and each of the test sites are on board with the need to collect data to guide and evidence improvement. Several staff have engaged with the Board’s Improvement Science Fundamentals Programme to develop capacity and capability to progress the work of the SPSPMH.

One of the difficulties around this is the lack of a central data collection source for the variety of information requiring to be reported on. Three elements of the national outcome data have not been reliably reported on due to difficulty of the relevant databases to capture the information required. This is in relation to bed numbers data, enhanced observation data and emergency detention data specific to each ward.

There is no longer additional resource supporting the roll out of the programme. The use of the Breakthrough Series Collaborative approach is being considered in relation to the Forensic and Rehabilitation Service as it would help facilitate large numbers of staff coming together at structured time periods to learn, report on progress and develop further priorities. This may ensure the most benefit of the limited resource available.

Patient acuity of illness and the requirement for enhanced observation levels at times limits the capacity of individuals to engage in therapeutic activities. While therapeutic interaction and safety huddles have appeared to reduce incidence of violence and restraint locally, there appears to be no conclusions nationally yet about the factors which reduce incidence of these events. This is potentially due to lack of consistency of interventions being tested or measurement of them among Boards. No other Boards are

testing safety huddles or are specifically measuring therapeutic activity engagement as part of the Programme, which would enable further scrutiny of effectiveness.

However of the Boards who are testing debrief in relation to restraint use, there has been a 20% reduction in restraint noted.
These challenges are not unique to the mental health programme and have been observed in other SPSP programmes.

4. Proposal

- Mental Health Service Directorate should follow nationally agreed guidance on the focus of phase two with regard to work stream implementation, consolidation and spread.

- The Programme takes a structured approach which enables the evidencing of person and family centred care beyond the use of the Scottish Recovery Indicator. “The 5 Must Do’s with Me” elements of the Person Centred Care Programme would provide such a structured approach to supporting family /carer wellbeing and involvement in care as part of the programme.

- The importance of physical health and its overlap with the wider SPSP is considered and supported. Minimum quality standards for preventative physical health monitoring of individuals on Clozapine within NHS Ayrshire and Arran require to be agreed and implemented consistently. This is beyond the scope of SPSPMH alone however the Mental Health Service Directorate would anticipate the partnership of relevant agencies in relation to this.

- The Corporate Management Team notes the progress made to date in the Scottish Patient Safety Programme in Mental Health.

- The Corporate Management Team approves the future plan for the programme for local services.

- The Corporate Management Team seeks further progress reports at regular intervals to ensure scrutiny and gain assurance that SPSP-MH is being implemented successfully in NHS Ayrshire and Arran.

4. Resource implications

See Challenges in **3.**

5 Risk assessment and mitigation

The greatest risk in taking forward the new SPSP-MH work streams is the scale of the endeavour in relation to the available improvement capacity and capability.

A dedicated Clinical Improvement practitioner has been assigned to mental health. She

has undertaken improvement advisor education to support and build improvement capacity and capability within mental health.

6 Conclusions

Clinicians and support teams have worked well to implement the patient safety programme in mental health with encouraging results demonstrated in the test sites as described in this paper. Continued effort and effective clinical engagement is required to enable the next phase of the mental health programme.

Monitoring Form

Policy/Strategy Implications	Delivering the National Patient Safety Programme
Workforce Implications	Building quality improvement capacity and capability is required across NHS Ayrshire and Arran and with partner Organisations
Financial Implications	None at this time
Consultation (including Professional Committees)	Mental Health
Risk Assessment	The greatest risk in taking forward the new SPSP-MH work streams is the scale of the endeavour in relation to the available improvement capacity and capability. A dedicated Clinical Improvement practitioner has been assigned to mental health. She is currently undertaking improvement advisor education to support and build improvement capacity and capability within the mental health.
Best Value - **Vision and leadership** - **Effective partnerships** - **Governance and accountability** - **Use of resources** - **Performance management**	By improving standardisation, reducing waste and variation and preventing harm, care will be provided in a cost effective manner.
Compliance with Corporate Objectives	Improving patient safety.
Single Outcome Agreement (SOA)	Not required – this is an internal report.
Impact Assessment This is a national programme which has been impact assessed at a national level.	

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