For meeting on

11 JANUARY 2018

Agenda 2018

East Dunbartonshire Health & Social Care Partnership Board

NHS Greater Glasgow and Clyde

East Dunbartonshire Health & Social Care Partnership

A meeting of the East Dunbartonshire Health and Social Care Partnership Integration Joint Board will be held within the **Committee Room, 12 Strathkelvin Place, Kirkintilloch, G66 1XT** on **Thursday, 11th January 2018** at **9.30 am** to consider the undernoted business.

Ian Fraser, **Chair**
East Dunbartonshire Health and Social Care Partnership Integration Joint Board

12 Strathkelvin Place
KIRKINTILLOCH
Glasgow
G66 1XT
Tel: 0141 232 8237

A G E N D A

Sederunt and apologies

Any other business - Chair decides if urgent

Signature of minute of meeting HSCP Board held on; **9 November 2017**

Seminar**: Duty of Candour – 9am to 9.30am**

Item	Contact officer	Description	Page
STANDING ITEMS			
1.	Ian Fraser	Expressions of Interest	
2.	Martin Cunningham	Minute of HSCP Board held on 9th November 2017	1-8
3.	Susan Manion	Chief Officers Report	**Verbal**
GOVERNANCE ITEMS			
4.	Jean Campbell	Financial Performance Budget 2017/18	9-20
5.	Jean Campbell	Financial Plan 2018/19	21-30
6.	Fiona McCulloch	Quarter 2 Performance Report 2017-18	31-64
7.	Fiona McCulloch	Amendments to the Integration Scheme	65-68
8.	Frances McLinden	Oral Health Report	69-92
9.	Paolo Mazzoncini	Annual Chief Social Work Officer Report	93-120

10.	Martin Brickley/Jenny Proctor	Public, Service User & Carer Representative Support Group	121-124
11.	Lisa Williams	East Dunbartonshire HSCP Clinical & Care Governance minutes of meeting on 5th September and 22nd November 2017	125-138
12.	Tom Quinn	East Dunbartonshire HSCP Staff Partnership Forum minutes of 27th November 2017	139-146
STRATEGIC ITEMS			
13.	Sandra Cairney	East Dunbartonshire HSCP Draft Strategic Plan	147-186
14.	Susan Manion	Learning Disability Strategy & Implementation Plan	187-190
15.	Sandra Cairney	East Dunbartonshire Local Outcomes Improvement Plan 2017- 27	191-198
16.	Fiona McCulloch	Carers (Scotland) Act 2016 Implementation	199-216
17.	Gillian Notman/Lisa Williams	Overview of the new GP Contract	217-296
18.	Paolo Mazzoncini/David Aitken	Adult Mental Health Services Transformation	297-302
19.	Susan Manion	East Dunbartonshire HSCP Strategic Planning Group Minutes of 14th November 2017	303-306
ITEMS FOR INFORMATION / NOTING - NIL			
FUTURE HSCP BOARD AGENDA ITEMS			
20.	Susan Manion	HSCP Schedule of Topics/Business Plan	307-308
		Date (s) of next meeting **Thursday 15th March 2018** - Council Committee Room, Southbank Marina **Future dates;** 10th May 2018 28th June 2018 Seminar on **10/05/18** commencing at 9am.	

Minute of meeting of the Health & Social Care Partnership Board held within the Committee Room, 12 Strathkelvin Place, Kirkintilloch on **Thursday, 9 November 2017.**

Voting Members Present: EDC Councillors **MECHAN, MOIR & MURRAY**

NHSGGC Non-Executive Directors **FRASER, FORBES & RITCHIE**

Non-Voting Members present:

S. **Manion**	Chief Officer - East Dunbartonshire HSCP
A. **Bowman**	Acute Services Representative
M. **Brickley**	Service User Representative
W. **Hepburn**	Chief Nurse & Professional Nurse Advisor
A. **Jamieson**	Carer Rep - Substitute
A. **McCready**	Trades Union Representative
P. **Mazzoncini**	Chief Social Work Officer and Head of Childrens Services
J. **Proctor**	Carers Representative
I. **Twaddle**	Service User – Substitute Representative
L. **Williams**	Clinical Director for HSCP
J. **Campbell**	Chief Finance and Resource Officer
	Ian Fraser (Chair) presiding

Also Present:

C. **Bancroft**	Podiatry Team Leader
S. **Cairney**	Head of Strategy, Planning & Health Improvement
M. **Cunningham**	Corporate Governance Manager
P. **Higgins**	Podiatry Manager
L. **Johnston**	Clinical Service Manager Oral Health
F. **McCulloch**	Planning Manager
F.P. **McLinden**	General Manager, Oral Health Directorate
G. **Notman**	Change & Re-design Manager
T. **Quinn**	Head of People & Change

APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of G. Cameron – Trades Union Rep, G. Thomson – Vol Sector Rep. and I. Twaddle – Service User Rep – Sub.

DECLARATION OF INTEREST

The Chair sought intimations of declarations of interest in the agenda business, there being none received the Board proceeded with the business as published.

HEALTH & SOCIAL CARE PARTNERSHIP (HSCP) BOARD
9 NOVEMBER 2017

1. MINUTE OF MEETING – 31 AUGUST 2017

Subject to 1 correction there was submitted and noted minute of the meeting of the HSCP Board held on 31 August 2017.

2. CHIEF OFFICER'S REPORT

The Chief Officer addressed the Board and summarised the national and local developments in relation to the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 since the last meeting of the Partnership Board. Details included:-

- HSCP Staff Awards held at Kilmardinny House, Bearsden on 18/09/17 – very well attended and a great success, celebrating the achievements of staff across the Partnership.
- Ceartas Conference, Integration Progress – KHCC, 2nd floor
- West of Scotland Delivery Group - update
- Annual GG&C Review meeting – Cabinet Secretary for Health & Sport present.
- Meeting with local MSPs – future periodical meetings, sharing information and briefing on key issues.

Following consideration the Board welcomed members' comments regarding the general enthusiasm of employees at the Awards ceremony and agreed that where possible this should be developed further and thereafter the Board noted the Report.

3. ED HSCP CORPORATE RISK REGISTER

The Chief Finance and Resources Officer submitted a Report, copies of which had previously been circulated, which provided the Board with an update of the Corporate Risks and how they were managed.

Following discussion, the Board reviewed the report and appendices and thereafter approved the content of the ED HSCP Corporate Risk Register.

4. FINANCIAL PERFORMANCE PERIOD 6 & BUDGET 2017/18 UPDATE

A Report by the Chief Finance & Resources Officer, copies of which had previously been circulated, updated the Board on the financial performance of the partnership as at period 6 of 2017/18 and provided an update on the finalised budget for 2017/18.

The Chief Finance & Resources Officer was heard in response to members' questions and emphasised the importance of prudent financial management to achieve resilience against future financial pressures and the ability to deliver against the Strategic Plan in terms of identified savings and/or service re-design.

In the ensuing consideration, the Board heard of the varying positions across the other GG&C HSCPs, noted the evaluation criteria for commissioning and tendering of services balanced against value for money. Thereafter the Board:-

a. Noted the performance of the budget which was reporting a projected overspend for the year as at period 6 of 2017/18.

b. Noted the position in relation to the achievement of savings identified to as part of the budget settlement to the partnership for 2017/18.

c. Noted the management actions being taken to mitigate pressures and the potential use of partnership reserves to achieve financial balance for 2017/18

d. Noted the risks associated with the delivery of a balanced budget as detailed in 1.19 of the report, and

e. Approved the proposed action in respect of the additional savings required in respect of the allocation from East Dunbartonshire Council

5. INTERMEDIATE CARE UNIT – EVALUATION REPORT

A Report by the Chief Finance & Resources Officer, copies of which had previously been circulated, informed the Board of the evaluation of the intermediate care pilot

The Change & Re-Design Manager provided an update on the 8 bedded unit at Westerton Care Home and responded to members questions regarding the impact on service users particularly when they were unable to continue their care in Westerton and on the general future for mainstreaming the pilot which had benefitted from highly skilled staff and teams working together.

Following further consideration, the Board noted the Report.

6. ED HSCP BOARD COMPLAINTS HANDLING PROCEDURES

A Report by the Head of Strategy, Planning & Health Improvement, copies of which had previously been circulated, advised the HSCP Board of the requirement to develop a Complaints Handling Procedure that covers the specific business of the Board.

Following further consideration, the Board noted the general view expressed at other GG&C HSCPs regarding the benefits and difficulties of consolidating 3 complaints processes into 1 to ensure transparency of purpose and process for the general public.

Thereafter the Board approved the ED HSCP Board Complaints Handling Procedure.

7. SELF DIRECTED SUPPORT – AUDIT COMMISSION – FOLLOW UP EVALUATION

A Report, by the Chief Social Work Officer and Head of Children & Criminal Justice Services, copies of which had previously been circulated, informed the Board of the key recommendations contained within the Audit Commission's Progress Report on Self Directed Support (2017) and advised of East Dunbartonshire HSCP's achievements and further developments related to those recommendations.

The Chief Social Work Officer and Head of Children & Criminal Justice was heard in response to members' questions and in particular regarding the clarity of understanding of the 3 main SDS options required by service users and their carers. The Board also

noted the importance and commitment to face-to-face communication to support service users when considering these options

Thereafter the Board considered the Audit Commission's key recommendations for the continued development of Self Directed Support and approved the further developments proposed within East Dunbartonshire.

8. ADULT SUPPORT & PROTECTION THEMATIC REVIEW

A verbal update by the Chief Social Work Officer and Head of Children & Criminal Justice Services, advised the Board of the recent visit by HM Inspectorate of Constabulary in Scotland (HMICS) including a general outline plan of ASP within East Dunbartonshire and general feedback from employees involved in the visit.

In summing up the Chief Social Work Officer and Head of Children & Criminal Justice Services confirmed that the general feeling from the Inspectorate was a positive review of the areas covered. The Report covering the visit would be available January / February 2018.

9. PERFORMANCE IMPROVEMENT REPORT – QUARTER 1

A Report by the Head of Strategy, Planning & Health Improvement, copies of which had previously been circulated, informed the Board of progress made against an agreed suite of performance targets and measures across the HSCP strategic priorities for the period April – June 2017.

Following consideration the Board approved the revised layout of the report and noted the Quarter 1 Performance Report.

10. PUBLIC SERVICE USER & CARER REPRESENTATIVE SUPPORT GROUP

A joint Report by the Service User Representative and the Carers Representative, copies of which had previously been circulated, outlined the processes and actions undertaken in the development of the Public, Service User & Carer Representatives Support Group (PSUCRSG)

Following discussion, and having heard the Service User and Carer Representatives in response to questions, the Board noted the report.

11. ED HSCP – CLINICAL & CARE GOVERNANCE GROUP – 26 JULY 2017 - MINUTES

The Board noted the Minutes of the Clinical Care & Governance Group meeting of 26 July 2017.

12. ED HSCP AUDIT COMMITTEE – 26 SEPTEMBER 2017 - MINUTES

The Board noted the Minutes of the ED HSCP Audit Committee meeting of 26 September 2017. The Board also ratified the decision to nominate the Chair of the Audit Committee and the Vice Chair of the HSCP Board to sign off the Final Audited Annual Accounts.

13. ED HSCP STAFF PARTNERSHIP FORUM – 18 SEPTEMBER 2017 - MINUTES

A Report by the Head of HR, copies of which had previously been circulated, provided the Board with re-assurance that staff governance was monitored and reviewed within the HSCP. The Board noted the draft minutes, which included the following key topics:-

- The success of the staff awards presentation at Kilmardinny House and the time taken by staff to put on the information stands.
- The success of the presentation on Staff Governance to the NHSGGC Staff Governance Committee in August 2017.
- The work presently underway to:-develop a Partnership set of Values and Behaviours; and to encourage staff to complete the survey
- An update on the contribution that staff have made to the Strategic Plan for 2018-21.

14. ED HSCP CLIMATE CHANGE DUTIES

A Report by Head of Strategy, Planning & Health Improvement, copies of which had previously been circulated, advised the HSCP Board of their responsibility to prepare reports on compliance with climate change duties.

The Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015 came into force in November 2015 as secondary legislation made under the Climate Change (Scotland) Act 2009. The Order requires bodies to prepare reports on compliance with climate change duties. This includes 'An integration joint board established by order under section 9(2) of the Public Bodies (Joint Working) (Scotland) Act 2014(c)' (referred throughout this document as Integrated Joint Boards.

Following further consideration the Board approved the Climate Change Duty Report.

15. STRATEGIC PLAN DEVELOPMENT- UPDATE

A verbal update by the Head of Strategy, Planning & Health Improvement advised the Board on the progress being made to consult, engage and develop the revised HSCP Strategic Plan which would be submitted to the Board meeting on 11 January 2018.

Following further consideration the Board noted the information.

16. MOVING FORWARD TOGETHER: NHS GGC's HEALTH & SOCIAL CARE TRANSFORMATIONAL STRATEGY PROGRAMME

A Report by the Head of Strategy, Planning & Health Improvement, copies of which had previously been circulated, advised the Board of work being carried out by NHS Greater Glasgow & Clyde to develop a Transformation Strategy for NHS services within the Health Board area.

Following further consideration the Board:-

a) Noted the report
b) Agreed to ongoing involvement of officers from the HSCP in work to develop the Moving Forward Together Strategy, and
c) Delegated authority to the Chief Officer to identify an appropriate member(s) to represent the HSCP Board and HSCP on the Stakeholder Reference Group.

17. SPRINGFIELD HOUSE, BISHOPBRIGGS - PODIATRY SERVICE RE-LOCATION

A Report by the Podiatry Manager – East Quadrant, copies of which had previously been circulated, outlined the processes and actions undertaken to engage with patients and service users on the relocation of the Podiatry Service from Springfield House. These were shown via a timeline of events, which described the engagement planning timeline, the outcomes from the engagement process, and a progress to date as depicted in the chart attached to the report.

The Board heard from the Podiatry Team Leader who commented on the report and was heard in response to members' questions.

Following further consideration the Board noted the report.

18. ED HSCP STRATEGIC PLANNING GROUP – MINUTES OF MEETINGS – 23 MAY & 15 AUGUST 2017

A Report by the Chief Officer, copies of which had previously been circulated, provided the Board with minutes of the actions of the Strategic Planning Group.

Following discussion, the Board noted the minutes.

19. REGIONAL DELIVERY PLAN FOR THE WEST OF SCOTLAND – POSITION PAPER

A Report by the Chief Officer, copies of which had previously been circulated, presented the Position Paper and Discussion documents submitted to the Scottish Government by the West of Scotland Regional Implementation Lead - John Burns CEO for Ayrshire and Arran NHS Board.

Following discussion the Board noted the report.

20. UPDATED ARRANGEMENTS – ED HSCP - STRATEGIC MANAGEMENT TEAM

A Report by the Chief Officer, copies of which had previously been circulated, outlined the operational management and governance arrangements, which were in place for all the functions delegated to the Integration Joint Board. The assurance that these were in place was required to be provided by the Chief Officer as outlined in the HSCP Integration Scheme.

Following discussion the Board noted the updated management arrangements.

20. HSCP BUSINESS PLAN / SCHEDULE OF TOPICS 2017/18

The Chief Officer provided an updated schedule of topics for HSCP Board meetings 2017/18.

Following consideration, the Board noted the information.

21. DATE OF NEXT MEETING – 11 JANUARY 2018

The HSCP Board noted that the next meeting would be held on Thursday 11 January 2018 in the Council Chambers.

Future dates were also provided as under:-

15th March 2018 10th May 2018 28th June 2018

The Board noted that Seminars would be held on 11/1/18 and 10/5/18 - commencing at 9am before the main agenda business.

Agenda Item Number: 4

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	Financial Performance Period 8
Report By	Jean Campbell, Chief Finance & Resources Officer Tel: 0300 1234510 Ext 3221
Contact Officer	Jean Campbell, Chief Finance & Resources Officer Tel: 0300 1234510 Ext 3221

Purpose of Report	To update the Board on the financial performance of the partnership as at period 8 of 2017/18.

Recommendations	The Integration Joint Board is asked to: a. Note the performance of the budget which is reporting a projected overspend for the year as at period 8 of 2017/18. b. Note the position in relation to the achievement of savings identified to as part of the budget settlement to the partnership for 2017/18. c. Note the management actions being taken to mitigate pressures and the potential use of partnership reserves to achieve financial balance for 2017/18 d. Note the risks associated with the delivery of a balanced budget as detailed in 1.25

Relevance to HSCP Board Strategic Plan	The Strategic Plan is dependent on effective management of the partnership resources and directing monies in line with delivery of key priorities within the plan.

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

Financial:	The performance to date is showing that the budget is under pressure in respect of the financial allocation from the Council to meet the demand pressures for Social Work services. This will continue to be monitored as the year progresses.

Legal:	None.

Economic Impact:	None

Sustainability:	The financial position of the partnership provides for a level of sustainability in the short to medium term; however acceleration of service re-design is required to meet the financial challenges in the longer term.

Risk Implications:	There are a number of financial risks moving into futures years giving the rising demand in the context of reducing budgets which will require effective financial planning as we move forward.

Implications for East Dunbartonshire Council:	Effective management of the partnership budget will give assurances to the Council in terms of managing the partner agency's financial challenges.

Implications for NHS Greater Glasgow & Clyde:	Effective management of the partnership budget will give assurances to the Health Board in terms of managing the partner agency's financial challenges

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	**x**

MAIN REPORT

1.1 The financial performance for the Health & Social Care Partnership is based on the period 8 reporting cycle for the period to the 30th November 2017. The position can vary between now and the year end as a result of unknown demand pressures, given the volatile nature of Social Work budgets and winter pressures throughout the hospital and community settings placing a seasonal burden on partnership budgets.

1.2 The position as at Period 8 is outlined in the table below:-

Partnership Expenditure	Annual Budget £000	YTD Budget £000	YTD Actual £000	YTD Variance £000	Actual Out-turn Variance £000
NHS Community Budgets	22,008	14,774	14,749	25	440
ED Social Care Fund £250m +£100m)	6,000	4,000	4,000	0	0
Oral Health	10,094	6,548	6,341	307	0
FHS & Prescribing	43,556	29,585	29,585	0	0
Adult Social Care	39,379	23,165	25,022	(1,857)	(2,150)
Children & CJ Services	11,296	7,439	7,705	(266)	(866)
Care of Gardens	78	52	52	0	0
Adaptations (PSHG)	450	300	300	0	0
Care and Repair	214	143	143	0	0
Fleet	452	301	301	0	0
SUB-TOTAL	**133,527**	**85,307**	**87,098**	**(1,791)**	**(2,575)**
Acute Set Aside	17,381	11,587	11,587	0	0
TOTAL	**150,908**	**96,894**	**98,685**	**(1,791)**	**(2,575)**

HSCP Budget Outturn

1.3 The current position indicates a projected overspend of £2.6m for the Health & Social Care Partnership (HSCP) for the year to 31st March 2018. This represents an increase in the projected overspend of £0.9m based on the previous report and relates primarily to a refinement in the capturing of financial information to inform projections on Adult Social Work services. The year to date position is showing pressure on budget of £1.8m which is consistent with the year-end projection. This variation primarily relates to pressures in Adult Social Work and Children's Social Work Services. There is some capacity in community health budgets and Oral Health Services in relation to vacancies from retrials and maternity leave within dental nursing.

1.4 The projected pressures for the partnership relate to Social Work services, primarily in relation to residential and fostering placements for Children. This is due to a combination of additional demands and restrictions on placements within our in-house residential provision being held in the expectation that a number of Asylum Seeking children will be placed within East Dunbartonshire. This is being offset to some extent through vacancy management within Children's SW Services.

1.5 In addition projected overspends are forecast on adult Social work budgets as a result of demand pressures from children transitioning into adult learning disability and mental health services and challenging savings targets, ahead of the formal review of learning disability commencing, as part of the budget process for 2017/18.

1.6 There continues to be a small underspend position in relation to NHS Community budget as a result of capacity within delayed discharge funding, additional savings identified to mitigate pressure on prescribing which look unlikely to be required in year. There is emerging pressure across a number of areas in relation to challenging turnover savings applied at the time of setting the budgets which will require to be closely monitored as the year progresses but are being managed within the overall allocation to the partnership for health services.

1.7 There are a number of management actions in place to mitigate the forecast position including vacancy management, review of residential placements including placements held for children seeking asylum given the uncertainty around the timescales for placing these children and a review of assessment timescales to adhere to statutory requirements for ensuring completion of assessment and provision of service.

1.8 In the event that the overspend position remains then this could result in a call on the general reserves held by the partnership. General reserves are currently £2.7m for the partnership and provide some resilience to manage in year pressures, however once these are utilised there will be limited scope to create further reserves for future years.

1.9 <u>NHS Budget Outturn</u>
Appendix 1 provides a detailed breakdown of the partnership NHS budgets for the 8 month period to the 30th November 2017.

1.10 The projected out turn for the health element of the partnership budget is that of £440k underspend at this point in the financial year.

1.11 The current year to date position shows an underspend of £331k which relates in the main to Oral Health Services as a result of vacancies within the non-consultant and dental nursing areas following a number of retirals as well as better stock control and ordering of instruments and sundries contributing to a favourable variance.

1.12 There are some emerging payroll pressures in relation to Adult Community and Mental Health Services for the elderly as a result of challenging turnover savings as part of the savings programme for 2017/18 and this will be closely monitored as the year progresses.

1.13 There is some in year capacity in relation to delayed discharge monies to be fully allocated to key priority areas as part of service redesign initiatives and additional savings which were identified toward prescribing pressure which will not be required in year which contribute to the forecast position for NHS Community services.

1.14 GP Prescribing costs are not available until two months after the month in which prescriptions are dispensed which means expenditure is available for April – September 2017. This was showing that prescribing expenditure, for East Dunbartonshire, was running ahead of budget at that point to the tune of £164k. Work programmes are underway which will focus on maximising efficiencies in this area and deliver prescribing within budget. There remain risks in relation to drugs on short supply and price increases which will be monitored as the year progresses.

1.15 The overall GP prescribing expenditure position for NHSGG&C is showing significant pressure on budget of £2.1m with worst case scenario projections for the NHS Board of a year-end overspend of £7.5m. This is a consequence of continued short supply of certain drugs across Scotland. There continues to be a risk sharing arrangement in place for 2017/18 across the GG&C board area and this will be managed within the NHSGGC board budgets.

1.16 Social Work Budget Out turn

Appendix 2 provides a detailed breakdown of the partnership's Social Work budgets for the 8 month period to the 30th November 2017.

1.17 The projected outturn for the Social Work element of the partnership budget is that of an overspend of £3m at this point in the financial year. This is caveated with continued concerns regarding the delay in processing payments to care providers which are starting to be reflected in the financial information system and inform the latest projections and a recognition of the volatility of SW budgets with changes in caseloads or packages having a significant impact on expenditure projections.

1.18 The current year to date position shows an overspend of £2.1m which relates to pressures in relation to residential and fostering placements for children and pressures on Adult Social Work placements and daycare provision.

1.19 In relation to Children's SW Services, there are significant numbers of vacancies across Children's services which are mitigating, to some extent, pressures in relation to residential placements for Children. There was no additional funding to meet commitments at the budget setting process, therefore measures to manage this budget through vacancy management will continue until the volume of placements can be safely reduced.

1.20 The budget position is compounded by the holding of placements within our in house residential unit for children seeking asylum, however the timescales for these children coming to East Dunbartonshire is uncertain and alternative placements are being considered. This would allow an element of re-patriation of children placed out with East Dunbartonshire where appropriate and would provide some relief on budget pressures in the interim. In addition a review is underway on all current placements to establish potential alternatives which support better longer term outcomes for children currently supported in residential schools

1.21 In relation to Adult Social Work services, there are pressures within adult learning disability and mental health services as a result of children transitioning and seeking support to access daycare and supported living services in place of education. In addition there were a number of challenging savings in learning disability where delays are impacting on achieving a balanced budget but where proper consideration is necessary to ensure effective outcomes for service users when considering future models and alternative to sleepovers and alternative delivery models at Pineview

supported accommodation. This will form part of the wider Learning Disability Review which commenced in mid-November when the Project Manager took up post.

1.22 The other budgets delegated to the partnership include Care of Gardens, Adaptations to private sector housing, care & repair services and fleet. Expenditure tends to match budget albeit there is historically some pressure in relation to care of Gardens which will be monitored as the year progresses.

1.23 2017/18 Partnership Savings

In relation to the partnership savings approved as part of the 2017/18 budget settlement, there are a number of areas where there has been a delay in progressing initiatives or where assumptions made in respect of vacancy management being sufficient to cover demand pressures in Children's Services have not been met. This provides a projected gap and savings shortfall of £2.0m, including £500k of unidentified savings. This is currently contributing to partnership pressures as reported above. A detailed breakdown is attached as **Appendix 3.**

.

1.24 Partnership Reserves

The partnership reserves total £5.3m as at 1st April 2017. This includes £2.6m of ear-marked reserves to facilitate service re-design and specific Scottish Government initiatives in furtherance of the strategic priorities of the partnership. This also includes a general reserve of £2.7m which will provide some resilience to meet future demand pressures, mitigate budget risks and mitigate the shortfall in savings initiatives not managed within overall budget during the year.

1.25 Financial Risks

The most significant risks that will require to be managed during 2017/18 are:

- Prescribing Expenditure - Prescribing cost volatility represents the most significant risk within the NHS element of the partnership's budget. At this stage of the year it is not possible to make an informed assessment of the in year position against budgets and to estimate the likely out-turn for 2017/18, however based on previous year experience this will require close ongoing monitoring.
- Achievement of Savings Targets – there are elements of the savings targets which have yet to be identified and where there are significant dependencies and complexities to be considered in order to effectively deliver on these.
- Demographic Pressures - Increasing numbers of older people is placing significant additional demand on a range of services including Home Care. In addition, achieving the required reductions in delayed discharges and hospital bed usage is creating increased demand on older people services and resulting in increased levels of self-directed support payments. These factors increase the risk that overspends will arise and that the partnership Board will not achieve a balanced year end position.
- Un Scheduled Care - The pressures on Acute budgets remains significant with a large element of this relating to pressure from un-scheduled care. If there is no improvement in partnership performance in this area (targeted reductions in occupied bed days) then there may be financial costs directed to partnerships in recognition of this failure to deliver.
- Children's Services - managing risk and vulnerability within Children's Services is placing significant demand pressures on residential placements which will increase the risk of overspend which may impact on achieving a balanced year end position.

- Financial Systems – the ability to effectively monitor and manage the budgets for the partnership are based on information contained within the financial systems of both partner agencies. This information needs to be robust and current as reliance is placed on these systems for reporting budget performance to the Board and decisions on allocation of resources throughout the financial year.
- Living Wage – the costs associated with implementing the living wage are subject to ongoing negotiation with care providers and there are elements around sustainability and future sleepover arrangements which may have recurring cost implications.

NHS Greater Glasgow & Clyde

East Dunbartonshire Hscp: Summary by Care Group Report as at Month 8, Financial Year 2017.

Care Group	Annual Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000	Period Budget £'000	Period Actuals £'000	Period Variance £'000
Alcohol + Drugs - Community	690.1	460.1	465.2	(5.1)	57.5	65.8	(8.3)
Adult Community Services	4,318.7	2,875.8	2,900.4	(24.6)	360.5	385.2	(24.7)
Integrated Care Fund	684.2	14.0	14.0	0.0	2.7	1.2	1.5
Child Services - Community	1,439.6	961.1	915.6	45.4	120.1	118.1	2.0
Fhs - Prescribing	18,920.3	12,917.6	12,917.9	(0.3)	1,718.0	1,718.1	(0.1)
Fhs - Gms	12,987.3	8,742.2	8,742.2	0.0	1,024.4	1,024.4	0.0
Fhs - Other	12,932.1	8,815.0	8,815.0	0.0	1,036.8	1,036.8	0.0
Learn Dis - Community	611.8	407.4	324.4	82.9	50.6	39.0	11.6
Men Health - Adult Community	1,356.0	903.6	924.0	(20.4)	112.7	114.2	(1.5)
Men Health - Elderly Services	1,010.3	672.8	698.5	(25.7)	83.7	87.4	(3.7)
Oral Health	10,880.5	7,077.4	6,770.5	307.0	867.6	829.7	37.9
Other Services	2,760.9	1,451.2	1,476.9	(25.7)	160.2	161.3	(1.1)
Planning & Health Improvement	719.4	473.6	476.1	(2.5)	46.5	47.3	(0.8)
Resource Transfer - Local Auth	15,345.8	10,184.3	10,184.3	0.0	1,273.0	1,273.0	0.0
Expenditure	84,657.0	55,956.1	55,625.0	331.0	6,914.3	6,901.5	12.8
Adult Community Services	(0.2)	(0.2)	(0.2)	0.0	0.0	0.0	0.0
Fhs - Other	(1,283.2)	(890.3)	(890.3)	0.0	(116.5)	(116.5)	0.0
Men Health - Adult Community	(218.7)	(152.6)	(152.6)	0.0	(19.7)	(19.7)	0.0
Men Health - Elderly Services	(161.8)	(91.8)	(91.8)	0.0	(11.5)	(11.5)	0.0
Oral Health	(786.2)	(529.3)	(529.3)	0.0	(63.9)	(63.9)	0.0
Other Services	(213.1)	(152.3)	(152.3)	0.0	(0.5)	(0.5)	0.0
Planning & Health Improvement	(28.2)	(28.2)	(28.2)	0.0	(6.9)	(6.9)	0.0
Resource Transfer - Local Auth	(307.0)	(204.7)	(204.7)	0.0	(25.6)	(25.6)	0.0
Income	(2,998.4)	(2,049.4)	(2,049.4)	0.0	(244.6)	(244.6)	0.0
East Dunbartonshire Hscp	**81,658.6**	**53,906.7**	**53,575.6**	**331.0**	**6,669.7**	**6,656.9**	**12.8**

Appendix 2

GENERAL FUND REVENUE MONITORING 2017/18 SUMMARY FINANCIAL POSITION as at Period 8: 26 November 2017		Annual Budget	Budget Period 8	Expenditure Period 8	Projected Annual	Variation at period 8	Projected Year End Variation
		£000	£000	£000	£000	£000	£000
INTEGRATED HEALTH AND SOCIAL CARE							
ADULT SOCIAL CARE							
1	**Employee Costs**	13,680	8,956	9,340	13,829	384	149
	Detailed analysis of payroll costs to date are in progress and will continue to inform future reports. This involves comparison of actual posts to budgeted and liaison with service managers in order to ascertain when vacancies will be filled. At this stage projections show that there will be a small variation to budget. There is an overspend as a result of bringing the Pineview service in house which is being offset with reserves in the current year, a number of posts in older people services supported through NHS income. Overtime within homecare will continue to be monitored as an area of recurring pressure, however the filling of vacancies in this area has allevaited pressure in year.						
2	**Property Costs**	108	78	70	118	-8	10
	Underspends in utilities are due to profiling and are anticipated to overspend this year. Unbudgeted rates charges in respect of Pineview have incurred.						
3	**Supplies and Services**	944	621	495	947	-126	3
	Spend on equipment and adaptations is tightly controlled within budget limits with critical and substantial criteria continuing to be applied in this area. This is being monitored through the Equipu contract. The underspend is in relation to timing of partnership invoices for Period 08. Additional supplies and services expenditure in relation to John Street, Kelvinbank nd Pineview is anticipated.						
4	**Agencies and Other Bodies**	41,847	24,991	25,664	44,265	673	1,418
	At this stage there is increased commitment against Daycare, Homecare, Supported Accommodation and Supported Living. There is pressure in learning disability services as a consequence of challenging savings targets and the impact of children transitioning into Adult Services from Childcare. This, however, is being offset by a lower than anticipated cost of Residential Care homes. These commitments include an estimation of all uplifts in respect of the introduction of the Scottish Government's Living Wage and the backlog in data entry into the Carefirst system. This also includes costs associated with previous financial years. This is volatile area for the partnership as any changes in caseload or packages can have a significant impact on commitments. This will continue to be monitored as the year progresses.						
5	**Budget Savings**	-502	-330	0	0	330	502
	The gap in the savings programme to be addressed through total resourcing and other transformational savings is expected to be taken as a one off in year recharge with plans for recurring delivery to be identified going forward into future years.						
6	**Transport and Plant**	416	242	263	416	21	0
	Transport costs are currently overspending and will be monitored closely throughout the year.						
7	**Admin and Other Costs**	146	95	-77	149	-172	3
	Underspends are due to profiling. Additional expenditure for the recovery café can now be reported, however other administrative expenditure will be monitored and may offset in future reports.						
8	**Health Board Resource Transfer Income**	-10,795	-7,197	-10,002	-10,795	-2,805	0
	Resource transfer income is on schedule at period 08. The actual income figure includes £2.8m of reserves.						
9	**Other Income**	-6,465	-4,291	-731	-6,400	3,560	65

GENERAL FUND REVENUE MONITORING 2017/18 SUMMARY FINANCIAL POSITION as at Period 8: 26 November 2017	Annual Budget £000	Budget Period 8 £000	Expenditure Period 8 £000	Projected Annual £000	Variation at period 8 £000	Projected Year End Variation £000
Social Care Funding has still to be invoiced and will be processed in the next period. An under recovery in service user and other local authority recharges is anticipated for homecare, Kelvinbank and older peoples services. This, however is partly offset by additional income receipts for telecare.						
Total - Adult Social Care	**39,379**	**23,165**	**25,022**	**42,529**	**1,857**	**2,150**
CHILDREN'S SOCIAL WORK & CRIMINAL JUSTICE						
1 Employee Costs	**5,587**	**3,658**	**3,427**	**5,320**	**-231**	**-267**
There has been a high number of vacancies to date during 2017/18. Detailed analysis of costs to date are in progress and will inform future reports. This involves comparison of actual posts to budgeted and liaison with service managers in order to ascertain when vacancies will be filled. Any savings realised through vacancies will cover any committed overspend in agencies and other bodies.						
3 Property Costs	**92**	**72**	**37**	**77**	**-35**	**-15**
A reduction in assumed rates charges for Ferndale and other property costs have materialised this financial year.						
4 Supplies and Services	**116**	**77**	**71**	**116**	**-6**	**0**
No variation on budget is expected at this time.						
5 Agencies and Other Bodies	**6,222**	**4,095**	**4,615**	**7,328**	**520**	**1,106**
There is currently pressure on Voluntary Organisations payments, Homecare and Foster Carers' Allowances. This is partly offset with a higher than anticipated underspend against Payments to Link Carers, Custody Allowances, Adoption Allowances, Community Care Services and Supported Accommodation.						
6 Transport and Plant	**84**	**49**	**63**	**96**	**14**	**12**
To date there has been pressure on transport costs for children. This has been forecast as an overspend for the current fiancial year.						
7 Admin and Other Costs	**134**	**88**	**76**	**164**	**-12**	**30**
Hgher than anticipated spend is projected in relation to pathways payments (leaving care), Section 17 payments and memebership fees and subscriptions. Savings in hospitality will partly offset this pressure.						
8 Income	**-939**	**-600**	**-584**	**-939**	**16**	**0**
No variation on budget is expected at this time.						
Total - Children's Social Work & Criminal Justice	**11,296**	**7,439**	**7,705**	**12,162**	**266**	**866**
Total Integrated Health and Social Care	**-50,675**	**-30,604**	**-32,727**	**-54,691**	**-2,123**	-3,016

East Dunbartonshire HSCP
Budget 2017/18
Savings Proposals Approved

Proposal	2017/18 Saving (£000)	Saving Achieved	Shortfall	Note
Review of Social Care Funding (£107m)	700	700	-	Achieved - uplift of 2.5% offered to Social Care providers to meet living wage requriements.
Re-commissioning for Complex Autism Service	400	-	400	Project Group established to progress commissioning process - period of stability in place to ensure sustainability
Review of Complex Needs Support	100	100	-	Achieved
Review of Commissioning Priorities	95	95	-	Achieved
Review of External Homecare Provision	81	-	81	Project Team established, however a number of key dependencies identified within the Council which will delay the progression of these savings. Currently exploring viability of interim arrangements, however do not expect this to be fully implemented in 2017/18.
Transformational Savings – Terms & Conditions	-	-	-	The element of savings relating to Social Work have been partially identified and, subject to IJB, approval will be taken as an in year recharge, therefore will not contribute to the overall partnership savings programme.
Review of Social Work Budget Pressures	1,370	520	850	The current position within Children's SW services is projecting pressures of £1.2m on residential placements and this is only partially being covered through vacancy management measures.The net effect is being reported as a projected year end overspend through the budget miontoring reports.
Review of Homecare	100	-	100	Project Team established, however a number of key dependencies identified within the Council which will delay the progression of this savings. Currently exploring viability of interim arrangements, however do not expect this to be fully implemented in 2017/18.
Review of Learning Disability	100	50	50	Project Team established to review sleepover arrangements across care at home services - expect a half year saving.
Review of Mental Health	50	50	-	Process of engagement with provider underway.
Review of Older People Daycare	50	25	25	Daycare strategy agreed - implementation progressing.
Review of Intermediate Care Model	100	100	-	Achieved
Review of Integrated Structures			-	Workforce Planning underway - potential savings yet to be identified
Review of Outsourced Transport & Taxi Contracts			-	Tendering process underway - potential savings yet to be identified
Oracle Procure to Pay (P2P)			-	Roll out of system underway - potential savings yet to be identified

Proposal	2017/18 Saving (£000)	Saving Achieved	Shortfall	Note
Unidentified Savings	500	-	500	Areas identified in relation to transformation savings to be taken as an in year recharge if approved through the IJB.
Introduce staff turnover saving of 4% across all pay budgets	590	590	-	This has been taken from the budget and will be monitored as the year progresses.
Management Re-structuring	165	165	-	Achieved
Integrated Care Fund	300	300	-	Achieved
Development Monies	65	65	-	Achieved
School Nursing	17	17	-	Review of School nursing delayed - currently being met from vacancies.
Review of Contractual Uplifts	201	201	-	Achieved
Review of Health Improvement Budgets	89	89	-	Achieved
Review of Woodlands Service	28	28	-	Achieved
	5,101	3,095	2,006	

Agenda Item Number: 5

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	Financial Planning 2018/19
Report By	Jean Campbell, Chief Finance & Resources Officer Tel: 0300 1234510 Ext 3221
Contact Officer	Jean Campbell, Chief Finance & Resources Officer Tel: 0300 1234510 Ext 3221

Purpose of Report	To update the Board on the financial planning for the partnership for 2018/19.

Recommendations	The Integration Joint Board is asked to: a. Note the position on the financial planning assumptions for the partnership based on the latest known position for both the Council and the NHS Board for 2018/19. b. Approve the areas for consideration that have been identified to date to meet the financial challenge for the IJB and agree to progress the detail of these for further consideration by the IJB.

Relevance to HSCP Board Strategic Plan	The Strategic Plan is dependent on effective management of the partnership resources and directing monies in line with delivery of key priorities within the plan.

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

Financial:	The financial landscape for the partnership is challenging for 2018/19 and beyond due primarily to the settlements for both Local Authorities and Health Boards.

Legal:	None.

Economic Impact:	None

Sustainability:	The financial position of the partnership is dependent on the

	settlements from the Local Authority and the Health Board. The level of reserves is expected to be significantly eroded during 2017/18, therefore it is key to obtain a fair settlement for 2018/19 in order to achieve a level of sustainability in the short to medium term. The acceleration of service re-design is required to meet the financial challenges in the longer term.

Risk Implications:	There are a number of financial risks moving into futures years given the rising demand in the context of reducing budgets which will require effective financial planning as we move forward.

Implications for East Dunbartonshire Council:	The impact and risks to the services delivered through the partnership will be significant in the event of a poor financial settlement to meet the ongoing statutory and demand pressures for health and social care services.

Implications for NHS Greater Glasgow & Clyde:	The impact and risks to the services delivered through the partnership will be significant in the event of a poor financial settlement to meet the ongoing statutory and demand pressures for health and social care services..

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	**x**

MAIN REPORT

1.1 The Integration Scheme between East Dunbartonshire Council and NHS Greater Glasgow & Clyde sets out the arrangements for the determination of the amounts to be paid to the IJB from the respective parties in furtherance of the delivery of the Strategic Plan.

1.2 The Scottish Government has announced its draft financial settlement and distribution for both Local Authorities and Health boards for 2018/19, which includes specific reference to HSCP's, on the 14th December 2017 and work is underway to determine what this means for the respective parent bodies. A copy of the 'Draft Budget 2018/19 – Indicative Allocation' letter is included as **Appendix 1.**

1.3 The indicative financial allocation is based upon current assessments of the Council and the Health Board financial landscapes, the announcements made as part of the SG financial assessment and planning assumptions for the ED HSCP.

1.4 The current financial landscape for the partnership for 2018/19 provides for an expected increase in the budget requirement of £5.4m based on assumptions in respect of pay inflation, contractual increases (primarily around care home placements and living wage) and demographic pressures in relation to social work placements for learning disability, Children's services and prescribing. This is detailed in the table below:-

	Social Work Functions (£000)	**Health Functions (£000)**	**TOTAL (£000)**
Budget 2017/18	50,909	98,980	149,889
Pay Inflation	392	434	826
Contractual Inflation	1,511		1,511
Demographic Pressures	2,462	1,113	3,575
Other Changes	683		683
SG Monies (Share of £66m)	(1,138)		(1,138)
Indicative Budget 2018/19	**54,800**	**100,527**	**155,327**
Increase	**3,890**	**1,547**	**5,437**

1.5 Pay Inflation – the Scottish Government lifted the pay cap of 1% for the public sector, therefore assumptions around the pay uplift for 2018/19 were made of 1.5% for local authority Pay and 2% for Health Pays. The Draft Budget Letter dated the 14th December made further recommendations of 3% pay increases for public sector workers earning £30,000 or less, a cap of 2% on the increase for workers earning more than £30,000

and a further cap of £1,600 for those earning £80,000 and above. An analysis of the impact of these recommendations is underway and the final position will be subject to negotiation and agreement with Trades Unions of behalf of public sector workers.

1.6 Contractual Inflation – this relates primarily to expected increases in relation to the National Care Home Contract (5%) and price increase associated with the living wage (2.5%). The former increase is currently the subject of negotiation with COSLA and Scottish Care and could be as high as 9& depending on the outcome of these discussions.

1.7 Demographic Pressures – there are a range of pressures in relation to Social Work, primarily across Learning Disability and Children's Services with increasing demand for residential and fostering placements and the impact of Children transitioning into adult services and the need for supported accommodation, daycare and support to live independently within the community. There are also some pressures on care at home services for older people and pressures on prescribing as a result of drugs continuing to be in short supply and increases in demand.

2 Indicative Financial Settlement - Partner Agencies

2.1 Local Authority

The Council have presented a number of reports to Full Council on the 9th November and the 21st December 2017 setting out the financial planning outlook for the Council.

2.2 This provides for an overall funding gap for the Council of £21.074m in 2018/19, £10.939m in 2019/20 and £10.886m in 2020/21. This includes sustained financial pressures within the Health & Social Care Partnership of **£3.890m** associated with pay inflation, contractual increases and demand pressures for residential and foster care placements within Children's Services, pressures associated with increased adult (learning Disability and Mental Health)placements within supported accommodation, supported living and daycare primarily to support children transferring into Adult Services and some pressure in relation to homecare for older people. This has been adjusted for monies announced through the Scottish Government financial settlement for Social Care Pressures detailed below.

2.3 The Scottish Government announced its draft financial settlement on the 14th December 2017. This provides for an additional £66m as part of the settlement for Local Government. This is provided to meet a range of pressures in relation to Social Care including the continued commitment to the living wage, sleepovers, implications of the implementation of the Cares Act and increases to the Free Personal Care allowances. This equates to an additional **£1.138m** for East Dunbartonshire HSCP and can be used in part to mitigate the pressures detailed above. An indicative breakdown of the funding is as follows:-

Area of Pressure	SG Allocation	ED Indicative Allocation
Living Wage	£30m	£0.518m
Sleepovers	£10m	£0.172m
Carers Act	£19m	£0.328m
Free Personal Care	£2m	£0.034m
H&SC Consequentials	£5m	£0.086m
TOTAL	**£66m**	**£1.138m**

2.4 There are a number of scenarios for the partnership dependant on the financial settlement from the Local Authority. These include the inclusion of an uplift in the settlement recognising pay and contractual inflation, flat cash, similar budget reduction to that applied in 2018/19 and a 5% budget reduction in line with expected reductions to the local government settlement. This provides for a funding gap for the partnership ranging from £1.3m to £6.4m on Social Work services.

2.5 Work is underway to identify proposals for savings options which will include the following areas:-

- Learning Disability Review – including review of daycare provision, review of sleepovers, review of supported accommodation and development of a Resource Allocation system.
- Mental Health Review – including review of support services and supported living care packages.
- Review of Addictions Services
- Review of Eligibility Criteria – including access to respite, supported living services and care at home for Older People and a review of transport arrangements for Children's and Adult SW Services.
- Implementation of a monitoring system for purchased care at home services
- Review of Daycare Services for Older People and the implementation of the Daycare Strategy for Older People including consolidation of provision in the West Locality
- Review of Sheltered Housing Provision
- Review of Charging arrangements for Adults and Children Services
- Review of Care of Gardens
- Review of balance of care provided within Children's Services
- Review of fostering arrangements

2.6 <u>NHS Greater Glasgow & Clyde</u>
The NHS Board have been considering a range of financial planning assumptions and the impact of the financial settlement announced on the 14th December.

2.7 NHS Boards across Scotland will receive an uplift in their baseline funding of 1.5% and there has been some indication that this will be passed onto partnerships.

2.8 Also within the settlement, there was an increase in the level of investment in the Scottish Government's Reform Programme to facilitate progress in delivering the commitment that more than half of frontline spending will be on community health services by the end of the current parliament. This equated to an additional £175m across Scotland across a number of areas, relevant to HSCP's, including:

- Transformational Change Funding in support of regional delivery plans for implementation of new service delivery models and improved elective performance and digital capability.
- Primary Care funding to enable the expansion of multi-disciplinary teams to improve patient care and strengthen the role of GP's within local communities.
- Mental Health funding to support an increase in the workforce of 800 workers over the next 5 years and transformation of CAMHs. The expectation of this funding is that this will see an increase in total spending on mental health service which may have implications for the GG&C Mental Health Strategy.

- Alcohol & Drug Partnerships will see additional funding of £20m to support a renewed focus on this area in the development of treatment and support services.

2.9 There are a number of scenarios for the partnership dependant on the financial settlement from the Health Board. These include the inclusion of an uplift in the settlement recognising pay and contractual inflation, flat cash, and a 5% budget reduction on community health expenditure in line with NHS GG&C financial planning assumptions for 2018/19. This provides for a funding gap for the partnership ranging from £1.1m to £2.8m on Community Health Services.

2.10 Work is underway to identify proposals for savings options which will include the following areas:-

- Review of Learning Disability Community Health Functions
- Review of Addictions Services
- Review of Support to Re-ablement Services
- Review of Post Diagnostic Service
- Review of Turnover Savings
- Review of Delayed Discharge Monies
- Review of Un-scheduled Care Commitment in line with performance targets

2.11 The impact for the Health & Social Care Partnership provides for a total funding gap ranging from £2.4m to £9.2m as detailed below:-

Partner contributions	**2018/19 Budget Requirement £000**	**2018/19 (Indicative Allocation) £000**	**Anticipated Shortfall £000**
Local Authority contribution	54,800	53,486 – 48,364	1,314 – 6,436
NHS Contribution	100,527	99,414 – 97,730	1,113 – 2,797
TOTAL Contribution to the IJB	**155,327**	**152,900 – 146,094**	**2,427 – 9,233**

2.12 It should be noted that this is subject to change and there may be a number of changes to assumptions following confirmation from the respective partners on the final allocations to the IJB. Further updates on the final allocations and areas for consideration will be brought back to future meetings.

.

.

.

Health Finance Directorate
Christine McLaughlin, Director

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0131-244 3464
E: christine.mclaughlin@gov.scot

Chief Executives, NHS Scotland

Copy to: NHS Chairs
NHS Directors of Finance
Integration Authority Chief Officers

Issued via email

Our Ref: A19675337

14 December 2017

Dear Chief Executives

Draft Budget 2018-19 – Indicative Allocation

Following the announcement of the Scottish Government's Draft Budget for 2018-19 by the Cabinet Secretary for Finance and the Constitution in Parliament today, I am writing to provide details of the funding settlement for Health Boards and the indicative 2018-19 baseline budget for Territorial and National Boards. A breakdown of the total is provided in the annex to this letter.

A central component of the settlement for the Portfolio is that it will allow for progress to be made in delivering the commitment that more than half of frontline spending will be in community health services by the end of this parliament. The funding in 2018-19 is designed to support a further shift in the share of the frontline NHS budget dedicated to mental health and to primary, community and social care. The Cabinet Secretary for Health and Sport expects NHS Boards and Integration Authorities to contribute to this Programme for Government commitment and it will be essential that this is clearly evidenced as part of plans for 2018-19.

Investment in Reform

Funding for reform will increase by £175 million, to £303 million in 2018-19.

	2017-18 (£m)	2018-19 (£m)	Increase for 2018-19 (£m)
Transformational Change Fund	25.0	126.0	101.0
Primary Care	60.0	110.0	50.0
Mental Health	30.0	47.0	17.0
Trauma Networks	5.0	10.0	5.0
Cancer	8.0	10.0	2.0
Total Investment in reform	**128.0**	**303.0**	**175.0**

The components of these lines and the approach to allocating reform funding will be set out by individual policy areas in advance of the new financial year.

Baseline Funding

Territorial Boards will receive a cash terms uplift of 1.5%. In addition to this, those Boards furthest from NRAC parity will receive a share of £30 million, which will mean that no Board is further than 0.8% from NRAC parity in 2018-19.

The four patient facing National Boards, (Scottish Ambulance Service, NHS24, Golden Jubilee and The State Hospital) will each receive a cash terms uplift of 1.0%. In addition, the Scottish Ambulance service will receive a further £6 million to support the implementation of their strategy. NHS National Services Scotland, Healthcare Improvement Scotland, NHS Education for Scotland and NHS Health Scotland will receive a flat cash settlement.

The National Board savings requirement of £15 million in 2017-18 will be made recurring in 2018-19. This savings requirement is not yet reflected in the National Board baseline allocation and will be agreed in advance of the new financial year.

When combining the £175 million increase in investment in reform, with an increase of £179 million in baseline funding for NHS Boards, the total additional funding for frontline NHS Boards will amount to £354 million (3.7 per cent) in 2018-19.

Pay Policy

The Scottish Government has set out its 2018-19 pay policy, which recommends a 3% pay increase for public sector workers earning £30,000 or less and a cap of 2% on the increase in the pay bill for staff earning more than £30,000. In addition, there will be a cap on the pay increase for highest paid, with a maximum cash increase of £1,600 for those earning above £80,000.

The pay settlement for NHS staff will of course be subject to the NHS pay reviews process as in previous years.

Core Areas of Investment

Transformational Change
The transformational change fund of £126 million will provide support to the regional delivery plans for implementation of new service delivery models, improved elective performance and investment in our digital capability.

Mental Health
Through our new Mental Health Strategy, we are shifting the balance of care towards mental health, increasing the level of investment in mental health services and improving support in the crucial period from birth to young adulthood. To support this, in 2018-19 a further £17 million will be invested, which will go towards the commitment to increase the workforce by an extra 800 workers over the next 5 years; and for transformation in CAMHS. In order to maximise the contribution from this direct investment, this funding is provided on the basis that it is in addition to a real terms increase in existing 2017-18 spending levels by NHS Boards and Integration Authorities. As a result therefore, it is expected that NHS Boards and Integration Authorities ensure that total spending on mental health and CAMHS services in 2018-19 will increase as a minimum by £17 million above inflation. Directions regarding the use of £17 million will be issued in year.

Primary Care
Investment in the Primary Care Fund will rise to £110 million in 2018-19. This will support the transformation of primary care by enabling the expansion of multidisciplinary teams for improved

patient care, and a strengthened and clarified role for GPs as expert medical generalists and clinical leaders in the community.

Social Care
As in 2017-18, Territorial NHS Boards are required to transfer £350 million from baseline budgets to Integration Authorities to support social care. A further £5 million will be allocated in 2018-19 on a recurring basis to Boards to be transferred to Integration Authorities in relation to war pensions and guaranteed income payments.

As part of the settlement for Local Government, £66 million has been provided to Local Authorities recognising a range of pressures in relation to Social Care. This funding will be allocated directly to Local Authorities from the Scottish Government and will not pass through NHS Board baselines.

NHS Boards should ensure that 2018-19 budget settlements for Integration Authorities are in place in advance of the new financial year.

Alcohol and Drug Partnerships
In 2018 a refreshed alcohol framework will be in place which will continue to take on Scotland's often problematic relationship with alcohol misuse. This renewed focus on alcohol and drugs will be backed by additional investment of £20 million in treatment and support services and further detail will be provided on this before the start of the financial year. This funding is not included in Board baseline budgets and is in addition to the £53.8 million that was allocated to Board baselines in 2017-18. Our expectation is that following the budget we will, as last year, write outlining the allocation by Board area and associated Ministerial expectations.

Capital Funding
We will continue to prioritise funding for existing commitments and Boards should assume an unchanged initial capital formula allocation.

Annual Plan
We will shortly set out the requirements for an annual plan, which will replace the previous Local Delivery Planning process and will link into the Regional and National Delivery Plans. This will set out a number of principles to be delivered in relation to finance and wider performance.

Yours sincerely

[redacted]

CHRISTINE MCLAUGHLIN
Director of Health Finance
Scottish Government

Annex

2018-19 Draft Budget Funding Allocations

	2017-18 Budget Bill	Recurring Allocation Adjustments	Total 2017-18 Allocation	Uplifts	Total 2018-19 Allocation	Distance from NRAC parity
Territorial Boards	£m	£m	£m	£m	£m	%
Ayrshire and Arran	683.6	-0.3	683.3	11.6	694.9	(0.8%)
Borders	197.7	-0.1	197.6	3.0	200.6	1.1%
Dumfries and Galloway	284.9	-0.1	284.8	4.3	289.1	2.8%
Fife	624.7	-0.2	624.5	12.1	636.6	(0.8%)
Forth Valley	496.7	-0.1	496.6	10.3	506.8	(0.8%)
Grampian	902.4	-0.2	902.1	18.5	920.6	(0.8%)
Greater Glasgow & Clyde	2,123.5	-0.9	2,122.6	31.8	2,154.5	1.8%
Highland	592.6	-0.2	592.4	12.0	604.3	(0.8%)
Lanarkshire	1,135.9	-0.4	1,135.5	20.7	1,156.1	(0.8%)
Lothian	1,356.0	-0.6	1,355.4	29.0	1,384.3	(0.8%)
Orkney	46.7	0.3	47.0	0.7	47.7	(0.4%)
Shetland	47.5	0.4	47.9	0.7	48.7	(0.4%)
Tayside	721.3	-0.2	721.1	13.7	734.8	(0.8%)
Western Isles	71.6	0.3	72.0	1.1	73.0	11.3%
Total	**9,285.1**	**-2.3**	**9,282.8**	**169.4**	**9,452.0**	
Special Boards						
National Waiting Times Centre Board	51.9	1.5	53.4	0.5	54.0	
Scottish Ambulance Service	229.3	0.0	229.3	8.6	237.9	
NHS National Services Scotland	324.7	3.5	328.2	0.0	328.2	
Healthcare Improvement Scotland	24.7	0.1	24.7	0.0	24.7	
The State Hospital	34.4	0.0	34.4	0.3	34.8	
NHS 24	65.2	0.4	65.6	0.7	66.3	
NHS Education for Scotland	420.0	0.0	420.0	0.0	420.0	
NHS Health Scotland	18.4	0.0	18.4	0.0	18.4	
Total	**1,168.6**	**5.5**	**1,174.1**	**10.1**	**1,184.3**	
TOTAL	**10,453.7**	**3.2**	**10456.9**	**179.5**	**10,636.3**	
Investment in Reform				**175.0**		
Total additional funding for frontline Boards				**354.5**		

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

Agenda Item Number: 6

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	Quarter 2 Performance Report 2017-18
Report By	Sandra Cairney Head of Planning, Strategy & Health Improvement
Contact Officer	Fiona McCulloch, Planning, Performance & Quality Manager Fiona.mcculloch@ggc.scot.nhs.uk 0141 355 2395

Purpose of Report	The purpose of this report is to inform the Board for progress made against an agreed suite of performance targets and measures, relating to the delivery of the HSCP strategic priorities, for the period July - September 2017 (Quarter 2).

Recommendations	It is recommended that the Health & Social Care Partnership Board: Notes the content of the Quarter 2 Performance Report

Relevance to HSCP Board Strategic Plan	The quarterly performance report contributes to the ongoing requirement for the Board to provide scrutiny to the HSCP performance against the Strategic Plan priorities.

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

Financial:	None

Legal:	None

Economic Impact:	None

Sustainability:	None

Risk Implications:	None

Implications for East Dunbartonshire Council:	The Integration Joint Board's performance framework will include performance indicators previously reported to the Council.

Implications for NHS Greater Glasgow & Clyde:	The Integration Joint Board's performance framework will include performance indicators previously reported to the Health Board

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	☒
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☐
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

East Dunbartonshire Health & Social Care Partnership

QUARTER 2 2017/18 PERFORMANCE REPORT

sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

SECTION 1
Introduction

1.1 Introduction

This HSCP Quarterly Performance Report provides an agreed suite of measures that report on the progress of the priorities set out in the Strategic Plan. Information is reported from national and local NHS sources and East Dunbartonshire Council sources to provide the most up to date information available. For clarity and ease of access, the data are set out in defined sections in accordance with where the data are sourced and reported. However, all the indicators set out in Sections 3-5 are inter-dependant, for example, good performance in social care targets contribute to improved performance in the health and social care targets.

Each indicator is reported individually. Charts and tables are provided to display targets, trend data, and where available, improvement trajectories. A situational analysis is provided to describe activity over the reporting period, and improvement actions are provided for all indicators that are below target.

The sections contained within this report are as listed and described below.

Section 2 Performance summary
This section provides a summary of status of all the performance indicators provided in this report by indicating which indicators have improved and which have declined.

Section 3 Health & Social Care Delivery Plan
The data for unscheduled acute care is historical and work is ongoing at a national level to report more recent information. This report provides the latest available data for those indicators identified as a priority nationally.

Section 4 Social Care Core Indicators
This is the updated report of the Social Care core dataset, provided by EDC Corporate Performance & Research team.

Section 5 NHS Local Delivery Plan (LDP) Indicators
LDP Standards refer to a suit of targets which are set annually by the Scottish Government, and which define performance levels which all Health Boards are expected to either sustain or improve.

Section 6 Children's Services Performance
This is the updated report of Children's Services performance, provided by EDC Corporate Performance & Research team.

Section 7 Criminal Justice Performance
This is the updated report of the Criminal Justice performance, provided by EDC Corporate Performance & Research team.

Section 8 Corporate Performance
This is the updated report on the monitoring of workforce sickness / absence, Knowledge & Skills Framework (KSF), Personal Development Plan (PDP) & Personal Development Reviews (PDR).

SECTION 2
Performance Summary

- Positive Performance (on target) improving (14 measures)
- Positive Performance (on target) declining (2 measures)
- Negative Performance (below target) improving (4 measures)
- Negative Performance (below target) declining (4 measures)

Positive Performance (on target & improving)

Ref.	
3.1	Number of Emergency Admissions
3.2	Number of unscheduled hospital bed days; acute specialities
3.3	Delayed Discharge bed days
4.2	Percentage of people 65 or over with intensive needs receiving care at home
4.3	Percentage of service users (65+) meeting the target of 6 weeks from completion of community care assessment to service delivery
4.4	Number of people 75+ with a telecare package
5.2	Percentage of patients who started treatment within 18 weeks of referral
5.4	Number of alcohol brief inteventions delivered
5.6	18 weeks referral to treatment for specialist Child & Adolescent Mental health Services
6.1	Percentage of Child Care Integrated Assessments (ICA) for SCRA completed within target timescales (20 days)
6.3	Percentage of first Child Protection review conferences taking place within 3 months of registration
6.5	Percentage of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated
6.6	Percentage of Children receiving 27/30 Assessment
7.2	Percentage of CJSW submitted to Court by due date

Positive Performance (on target but declining) is reported in

Ref.	
4.1	The number of homecare hours per 1,000 population aged 65+
5.5	Sustain & embed smoking quits,at 12 weeks post quit, in the 40% SIMD areas

Negative Performance (below target but maintaining/improving)

Ref.	
4.7	Percentage of Adult Protection cases where timescales have been met
5.3	Percentage of people newly diagnosed with dementia accessing a minimum of one year's post-diagnostic support
6.2	Percentage of Initial Case Conferences taking place within 21 days of referral
6.4	Balance of care for Looked After Children: Percentage of children bein looked after in the community

Negative Performance (below target and declining)

Ref.	
4.5	Number of new permanent admissions to care home for 65+
4.6	Number of people aged 65+ in permanent care home placements
5.1	Percentage of clients waiting no longer than 3 weeks from referral to drug or alcohol treatment
7.1	Percentage of individuals beginning a work placement within 7 days of receiving a Community Payback Order

The following targets relate to unscheduled acute care and focus on areas for which the HSCP has devolved responsibility. They are part of a suite of indicators set by the Scottish Government, and all HSCPs were invited to set out local objectives for each of the indicators. They are reported to and reviewed quarterly by the Scottish Government Ministerial Steering Group for Health & Community Care (MSG) so that the Group can monitor the impact of integration.

3.1 Number of emergency admissions
3.2 Number of unscheduled hospital bed days; acute specialities
3.3 Delayed Discharge bed days

3.1 Number of Emergency Admissions

Rationale: Unplanned emergency acute admissions are focussed on reducing inappropriate use of hospital services and shifting the focus from a reliance on hospital care towards proactive support in the community setting.

Figure 3.1 Rolling year trend in number of Unplanned Acute Emergency Admissions

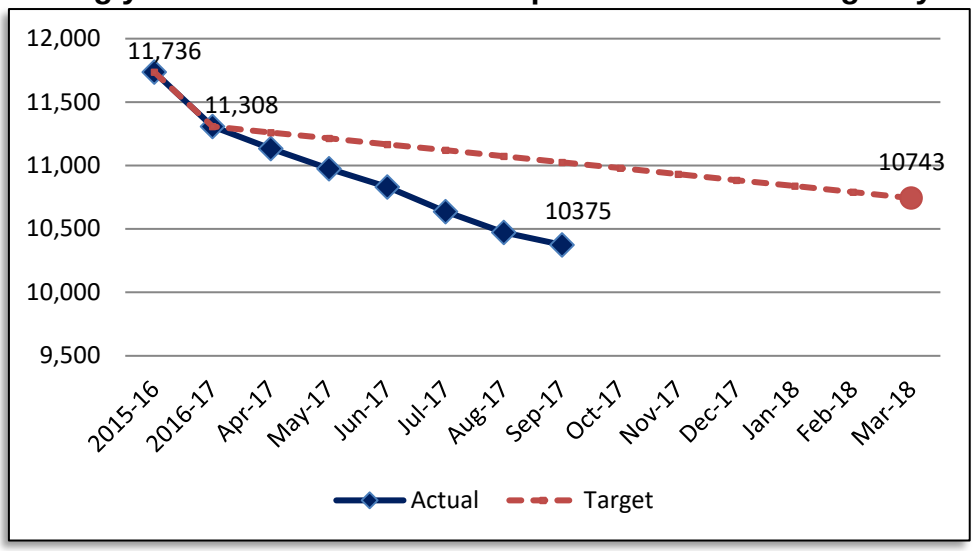


Table 3.1 Quarterly number of Unplanned Acute Emergency Admissions

Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	2017/18 (quarter)
2,739	2,550	2,540	2539	2,698

Situational Analysis:
Development of rapid access to health and comprehensive home care to prevent avoidable hospital admissions. Also introduced specialist Care Home Liaison service to support those at risk of admissions in care homes.

Improvement Actions:
Winter planning arrangements in place to minimise unscheduled attendances. Increase the number of Care Home Liaison Nurses. Exploring the use of Electronic Knowledge Information Summary (Ekis)

3.2 Number of unscheduled hospital bed days; acute specialities

Rationale: Unscheduled hospital bed days are focussed on reducing inappropriate use of hospital services and shifting the focus from a reliance on hospital care towards proactive support in the community setting.

Figure 3.2 Rolling year trend in number of Unscheduled Hospital Bed Days

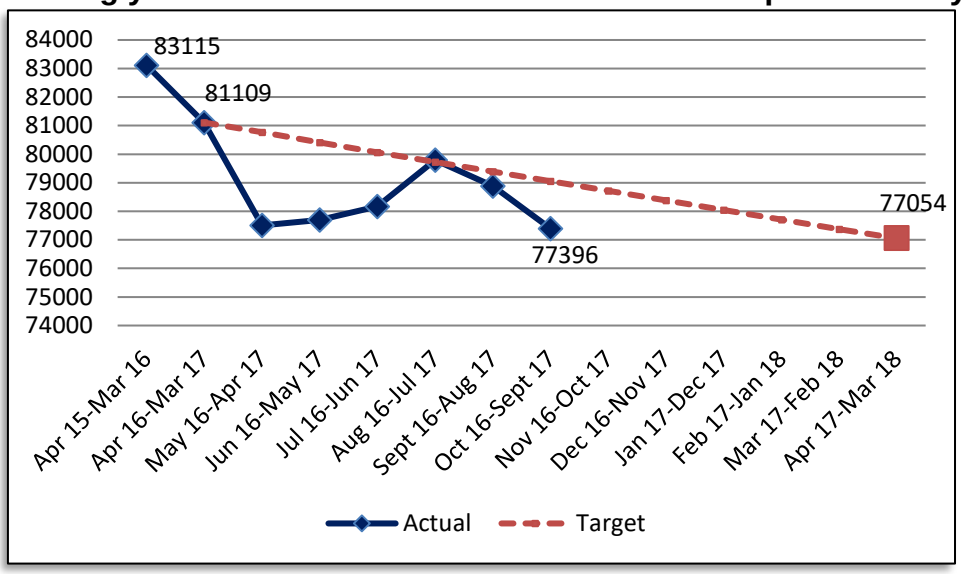


Table 3.2 Quarterly number of Unscheduled Hospital Bed Days

Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	2017/18 (quarter)
19,543	20,626	18,153	17,132	18,586

Situational Analysis:
The reduction of admissions contribute to the progress made in the reduction of unscheduled bed days. There is a 2 hour access to Homecare services to support early discharge.

Improvement Actions:
Working with Acute in order to identify individuals who are ready for discharge.

3.3 Delayed Discharge bed days

Rationale: People who are ready for discharge will not remain in hospital unnecessarily

Figure 3.3 Rolling year trend in number of Delayed Discharge Bed Days

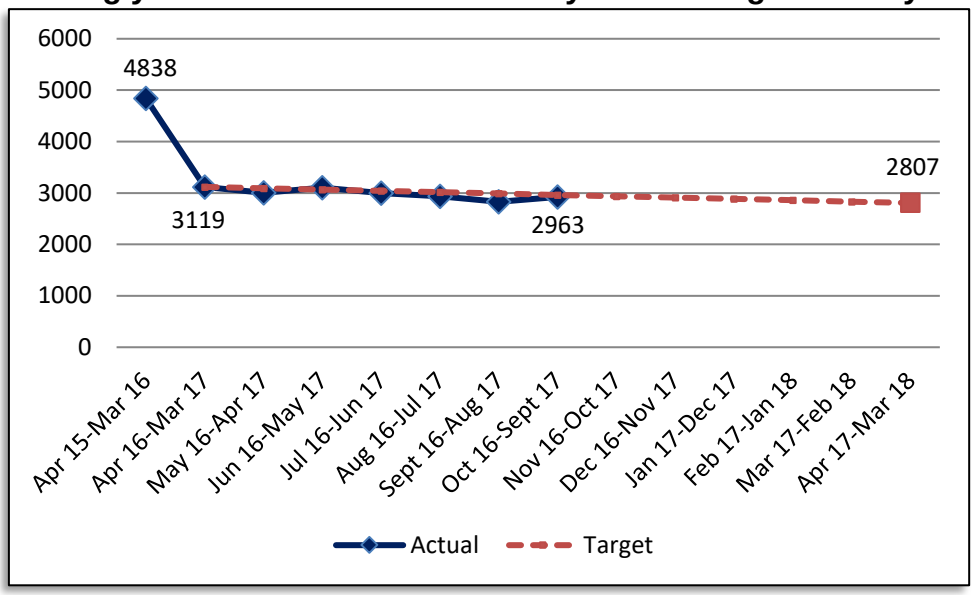


Table 3.3 Quarterly number of Delayed Discharge Bed Days

Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	2017/18 (quarter)
823	751	690	653	702

Situational Analysis:
Maintained performance against target through weekly operational meetings to discuss those at risk of delay and take actions to expedite discharge. The success of the Intermediate Care unit is also contributing to performance being maintained.

Improvement Actions:
Continue with the initiatives and actions in place

SECTION 4
Social Care Core Indicators

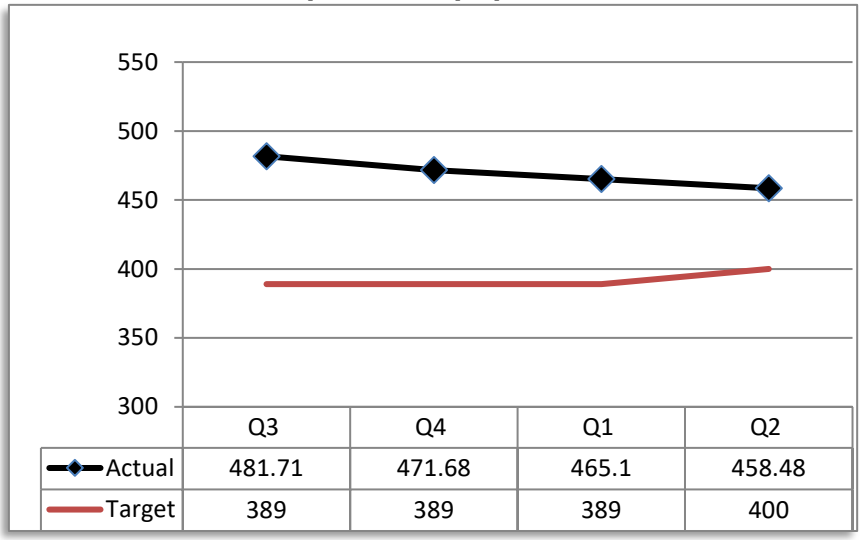
This section provides an updated report of Social Care core dataset and includes data collated by East Dunbartonshire Council Performance & Research Team. Although reported separately from the Health and Social Care data, the following indicators are integral to achieving the targets set out in Health and Social Care Delivery Plan and HSCP Unscheduled Care Plan.

4.1 The number of homecare hours per 1,000 population aged 65+
4.2 Percentage of people 65 or over with intensive needs receiving care at Home
4.3 Percentage of customers (65+) meeting the target of 6 weeks from completion of community care assessment to service delivery continues to surpass the target
4.4 Number of people 75+ with a telecare package
4.5 Number of new permanent admissions to care homes for 65+
4.6 Number of people in permanent care home placements
4.7 Percentage of Adult Protection cases where the required timescales have been met

4.1 The number of homecare hours per 1,000 population aged 65+

Rationale: Key indicator required by Scottish Government to assist in the measurement of Balance of Care.

Figure 4.1 No. of homecare hours per 1,000 population 65+



	Q3	Q4	Q1	Q2
Actual	481.71	471.68	465.1	458.48
Target	389	389	389	400

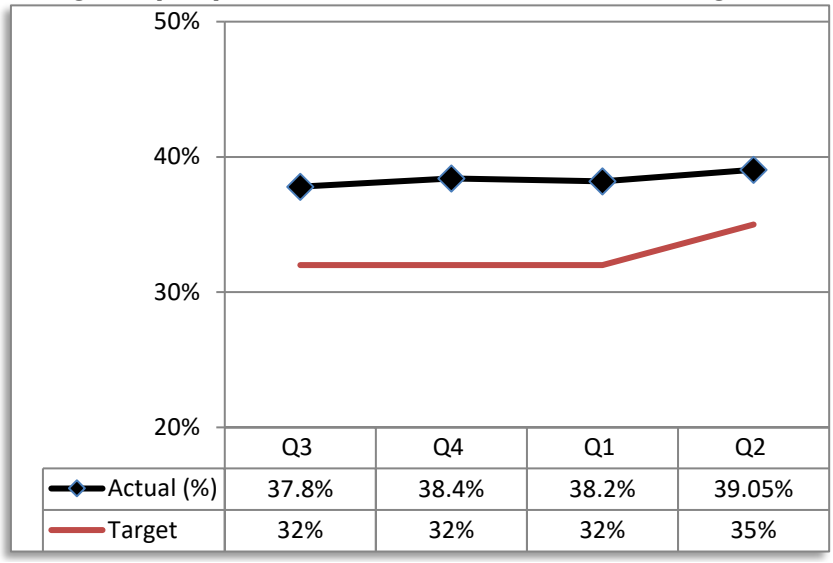
Situational Analysis:
This indicator is a measure of the increase in community-based support, than in a hospital or care home. In the last 10 years, performance has more doubled in East Dunbartonshire and is now consistently performing better than Scotland as a whole. There has been a marginal reduction during the course of the last 3 quarters, which is being monitored operationally.

Improvement Actions:
The target has been increased to 400 in Q2 in order to reflect the longer term upward trend and to focus on sustainability of positive gains over the past few years.

4.2 Percentage of people 65 or over with intensive needs receiving care at Home

Rationale: It is a priority to ensure that home care and support for people is available, particularly those with high levels of care needs. As the population ages, and the number of people with complex care needs increases, the need to provide appropriate care and support becomes even more important.

Figure 4.2 Percentage of people with intensive needs receiving care at home



	Q3	Q4	Q1	Q2
Actual (%)	37.8%	38.4%	38.2%	39.05%
Target	32%	32%	32%	35%

Situational Analysis
The HSCP performed in the top quartile compared to the other local authority areas during 2017. The target has been increased in Q2 to 35% to reflect this improvement and to encourage sustained performance.

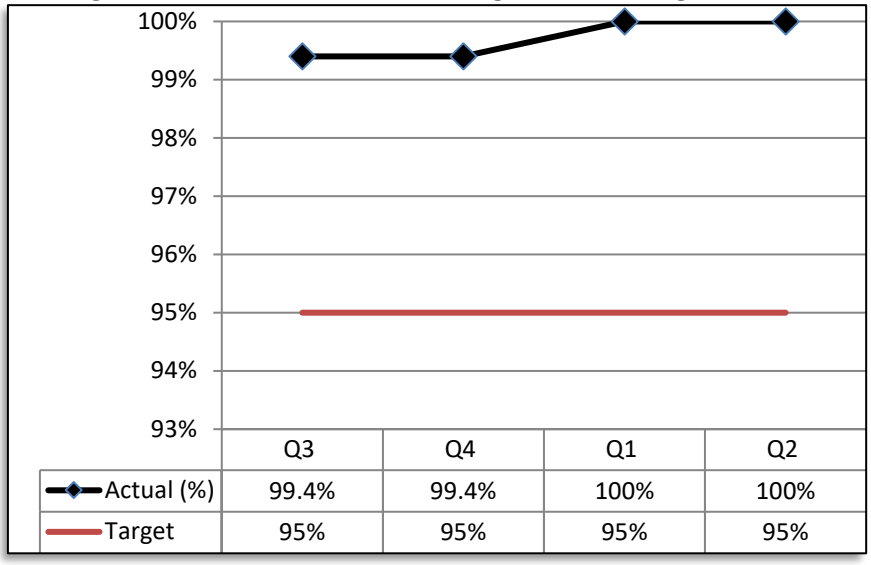
The indicator is calculated on service in the last full week of the month. Performance in Q2 has increased from previous quarter and remains above target.

Improvement Actions:
HSCP performance is in the top quartile nationally for this indicator, so the emphasis is on sustained improvement.

4.3 Percentage of service users (65+) meeting the target of 6 weeks from completion of community care assessment to service delivery

Rationale Local authorities have a duty for first undertaking community care assessments for those in need, and is then responsible for developing packages of care to meet identified need, planning services and commissioning services. Operating within target timescales encourages efficiency and minimises delays for service-users.

Figure 4.3 Percentage of service users meeting 6 week target



	Q3	Q4	Q1	Q2
Actual (%)	99.4%	99.4%	100%	100%
Target	95%	95%	95%	95%

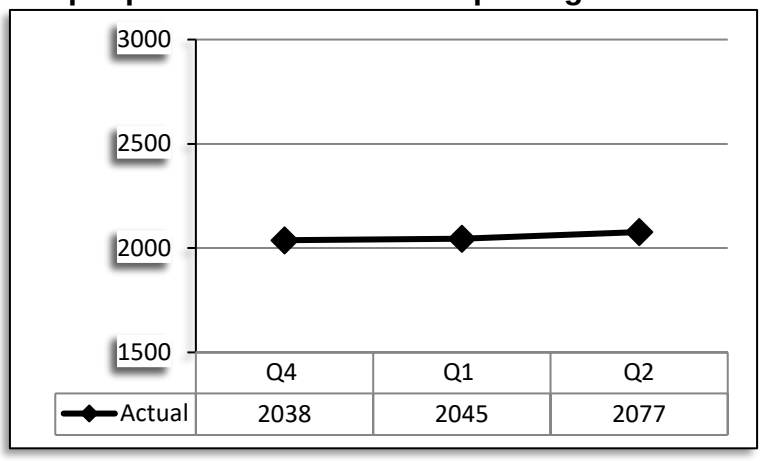
Situational Analysis:
This used to be a national performance indicator, but was withdrawn due to difficulties faced by larger authorities to aggregate performance data. The HSCP retained this indicator as a quality measure of service.

Improvement Action:
A target of 95% remains the target, which is very challenging by any standards. We have consistently exceeded this target over the past 12 months.

4.4 Number of people 75+ with a telecare package

Rationale: Innovative approaches such as telecare, uses new technology helping people to remain at home and live as independently as possible.

Figure 4.4 Number of people 75+ with a telecare package



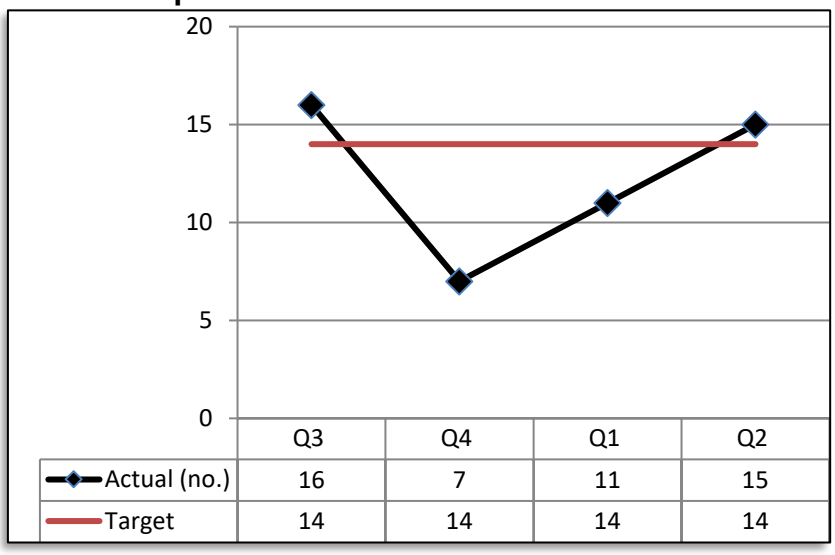
Situational Analysis:
Telecare / Telehealth working group will focus on improving the implementation of appropriate individual telecare packages across client groups. A draft strategy has been circulated to staff for comment .

Improvement Actions:
The HSCP is currently developing a robust recording system for Telecare which will include setting clear targets. Q2 is an average of the overall total of people receiving telecare mainly of those with community alarms.

4.5 Number of new permanent admissions to care homes for 65+

Rationale: Key Indicator required by Scottish Government. Avoiding new permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions.

Figure 4.5 Number of new permanent admissions to care homes 65+



	Q3	Q4	Q1	Q2
Actual (no.)	16	7	11	15
Target	14	14	14	14

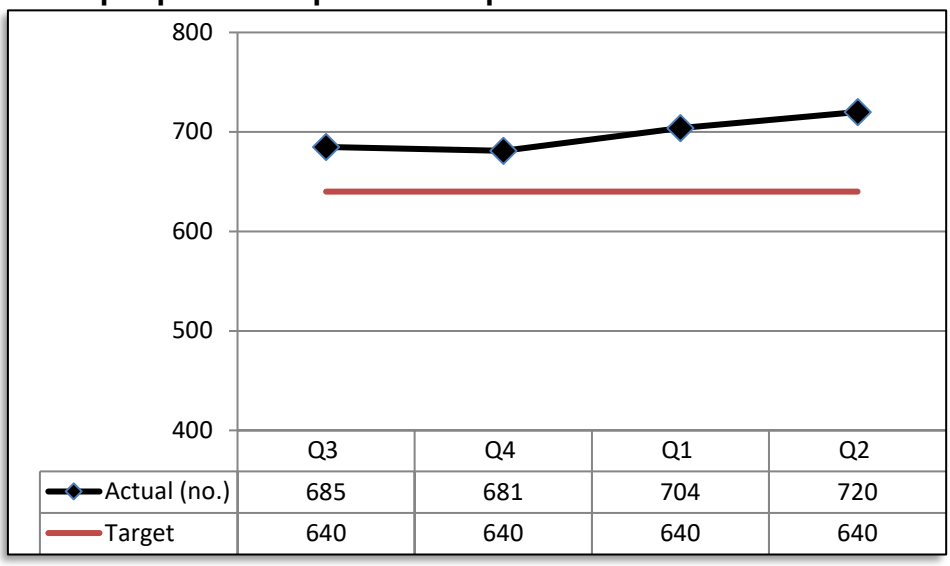
Situational Analysis:
There is a continued increase in new permanent admissions to care homes during Q2. The impact of the policy change in relation to complex and continuing care remains unclear, however, the expected impact is an increase in care home admissions for these patients.

Improvement Actions:
Continue to monitor new admissions, particularly in relation to complex continuing care.

4.6 Number of people aged 65+ in permanent care home placements

Rationale: Key Indicator required by Scottish Government. Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions.

Figure 4.6 No. of people 65+ in permanent placements



	Q3	Q4	Q1	Q2
Actual (no.)	685	681	704	720
Target	640	640	640	640

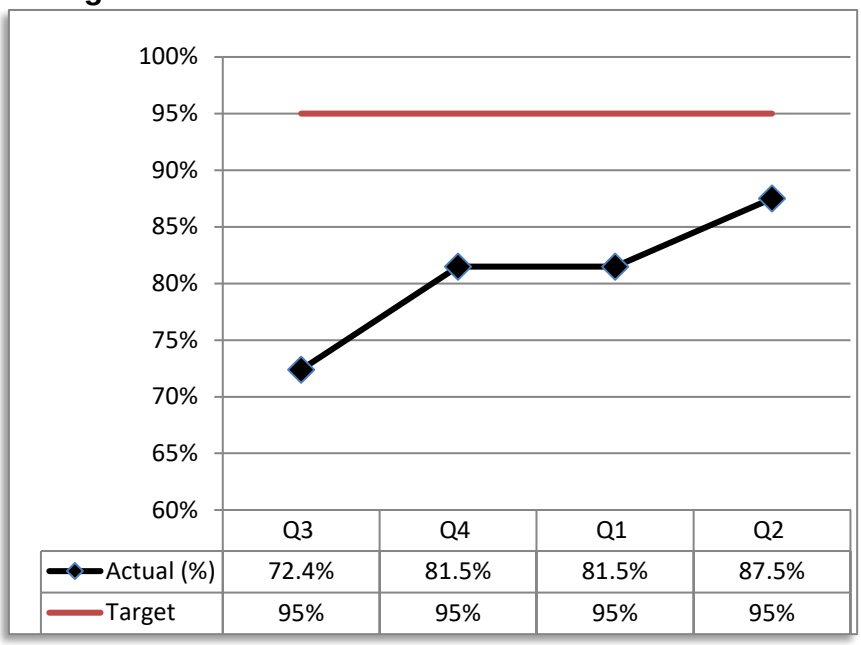
Situational Analysis:
There has been an increase in the care home estate within East Dunbartonshire resulting in self placing / self funding individuals which contributes to the increase in admissions rates.

Improvement Actions:
Monitor the relationship between permanent care home placements and care at home data.

4.7 Percentage of Adult Protection cases where the required timescales have been met

Rationale: The Health & Social Care Partnership have a statutory duty to make inquiries and intervene to support and protect adults at risk of harm. It is crucial that such activities are carried out in a timely and effective fashion. This indicator measures and monitors the speed with which sequential ASP actions are taken against timescales laid out in local social work procedures.

Figure 4.7 Percentage of Adult Protection cases where timescales were met



	Q3	Q4	Q1	Q2
Actual (%)	72.4%	81.5%	81.5%	87.5%
Target	95%	95%	95%	95%

Situational Analysis:
Referral rates continue to average 20% above the previous 3 years data, indicative of a stable increase in demand for ASP services.

Improvement Actions:
An internal review of referral handling processes has been initiated to determine if there is any scope to amend these to improve performance levels. It is also not possible to reduce the steps within the inquiry process. This would involve an increased risk that inadequate assessments are made by staff, leaving adults at risk of harm. A pilot scheme has been introduced to amend recording requirements for a subset of completed inquiries. This will be evaluated after Q4. Performance targets will be reviewed for 2018-19 taking into account regional benchmarking information where this is available.

SECTION 5
NHS Local Delivery Plan Indicators

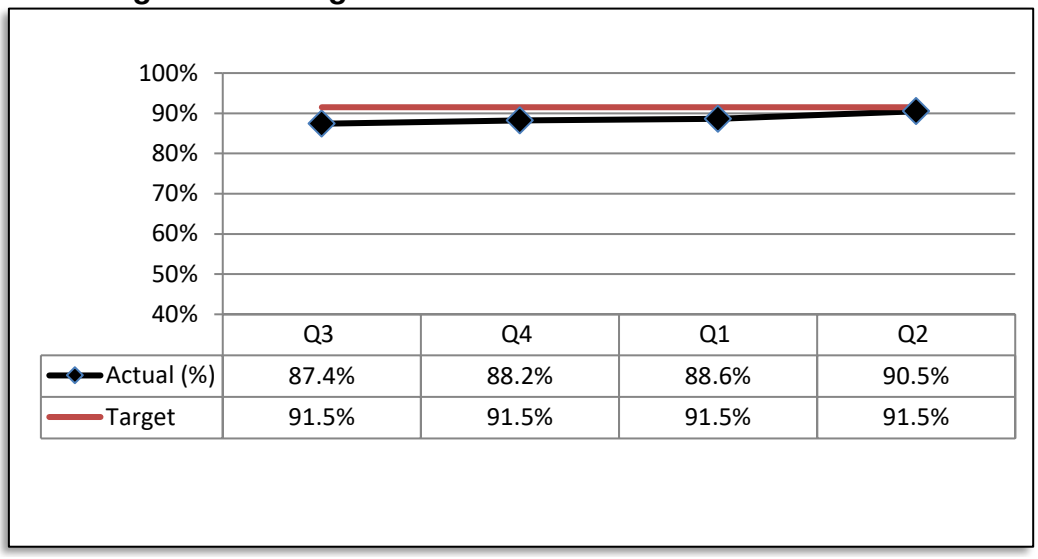
LDP Standards refer to a suit of targets which are set annually by the Scottish Government, and which define performance levels which all Health Boards are expected to either sustain or improve. The HSCP has devolved responsibility for a number of the LDP Standards, namely:

5.1 Drugs & Alcohol Treatment Waiting Times
5.2 Psychological Therapies Waiting Times
5.3 Dementia Post Diagnostic Support
5.4 Alcohol Brief Interventions
5.5 Smoking Cessation
5.6 CAMHS

5.1 Percentage of clients waiting no longer than 3 weeks from referral to drug or alcohol treatment

Rationale: Those with a drug or alcohol problem should wait no more than three weeks from referral to receiving appropriate treatment that supports their recovery. The target is 91.5% receive treatment within the timescale.

Figure 5.1 Waiting times - Drug & Alcohol Treatment



	Q3	Q4	Q1	Q2
Actual (%)	87.4%	88.2%	88.6%	90.5%
Target	91.5%	91.5%	91.5%	91.5%

Situational Analysis:
In Q2 we have largely maintained the number of people seen within three weeks for alcohol and drug treatment to support recovery.

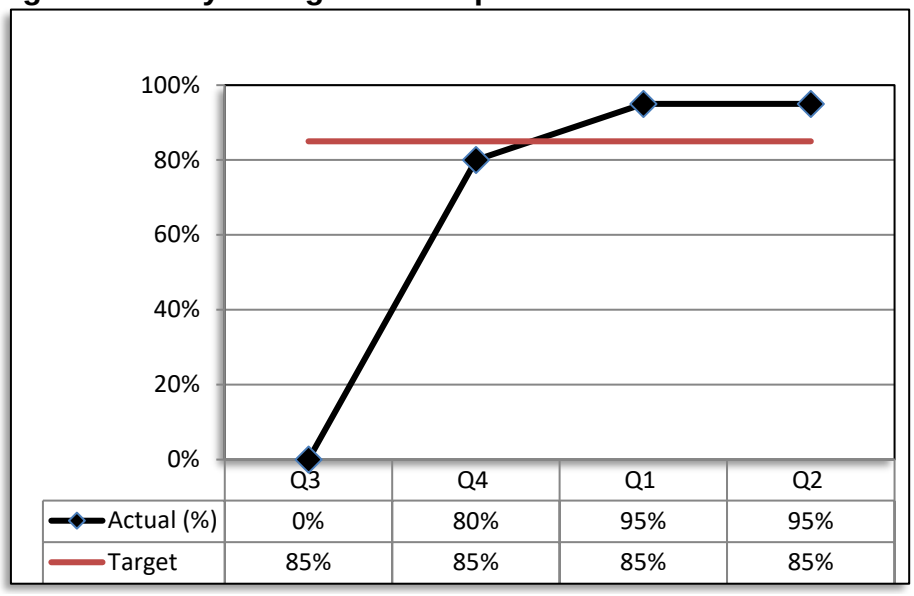
Improvement Actions:
Using EMIS (Electronic Management Information System) we have updated our referral process and recording systems to enable improved integrated referral analysis and action. The Nurse Team Leader is now responsible for monitoring waiting times within East

Dunbartonshire Alcohol & Drug Service (EDADS) health to improve accurate data collection.

5.2 Percentage of patients who started Psychological Therapies treatment within 18 weeks of referral

Rationale: This target supports the Scottish Government's commitment that a patient will not have to wait any longer than 18 weeks from GP referral to the start of their treatment, and includes psychological services

Figure 5.2 Waiting times - Psychological Therapies



	Q3	Q4	Q1	Q2
Actual (%)	0%	80%	95%	95%
Target	85%	85%	85%	85%

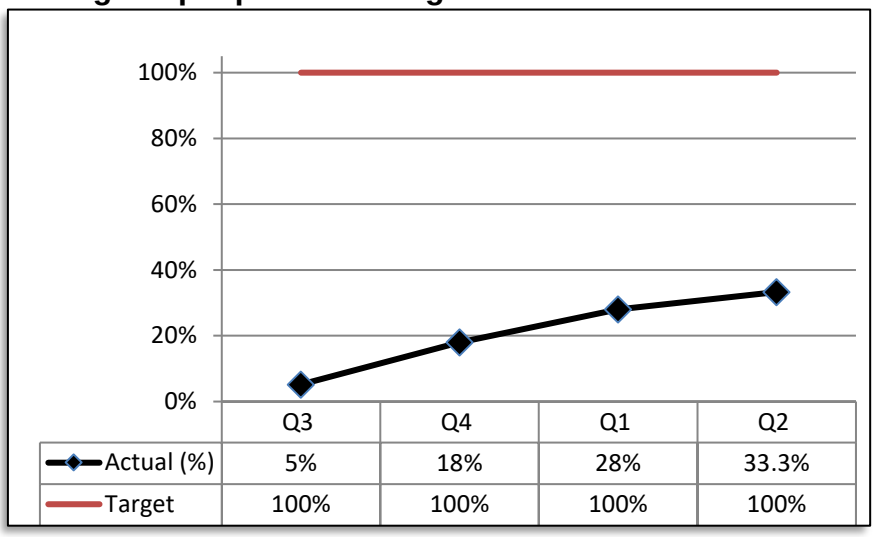
Situational Analysis:
Data for Q2 has not been collated by Greater Glasgow & Clyde (GG&C) due to the roll out of the Electronic Management Information system (EMIS) across all HSCPs. The data provided are from local intelligence for this quarter and is therefore provisional.

Improvement Action:
Continue to monitor data

5.3 Percentage of people newly diagnosed with dementia accessing a minimum of one year's post-diagnostic support

Rationale: The Scottish Government made a commitment to improving post-diagnostic support (PDS) for those who received a diagnosis of dementia.

Figure 5.3 Percentage of people accessing PDS



	Q3	Q4	Q1	Q2
Actual (%)	5%	18%	28%	33.3%
Target	100%	100%	100%	100%

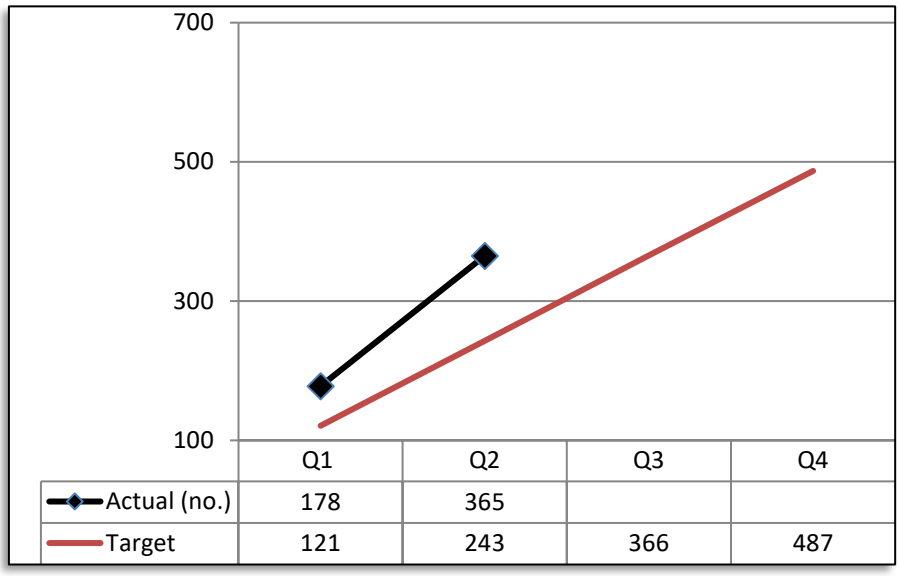
Situational Analysis:
There was significant pressure on the service due to a number of staff resignations and delay in recruiting, this resulted in those already in receipt of the service required to be reallocated to the remaining staff which then created delays in appointing new patients. All staff are now in post and the waiting list is reducing. The new Dementia Strategy for Scotland 2017 -2020 has extended the PDS guarantee to "continue for the duration of their time living with dementia, or until such times as their needs change, and they require greater care coordination." This is likely to create additional pressures on the service and will require ongoing monitoring.

Improvement Action:
There is ongoing work reviewing the current service model to make it more sustainable going forward. Robust caseload supervision is in place to maximise activity and throughput.

5.4 Number of alcohol brief interventions delivered

Rationale: NHS Boards and their Alcohol and Drug Partnership (ADP) partners have embedded and sustained alcohol brief interventions in a variety of settings including primary care, A&E, antenatal, to identify and support those whose alcohol intake is above recommended limits, and offer support to reduce their intake.

Figure 5.4 No. of ABIs delivered



	Q1	Q2	Q3	Q4
Actual (no.)	178	365		
Target	121	243	366	487

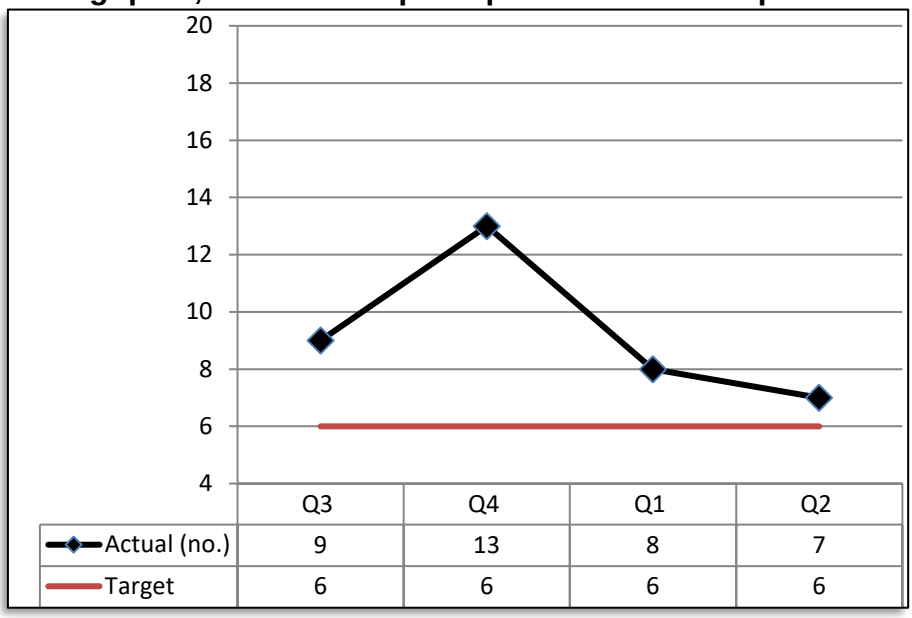
Situational Analysis:
The HSCP continues to deliver a high volume of Alcohol Brief Interventions exceeding the target set by GGC. This service is delivered within both GP Practices and across wider community settings. The completion rates from GP practices continues to be prove a challenge, whilst the conversion rates from the wider settings remains high.

Improvement Action:
The service is principally delivered through a contracted commissioned service. This contract is subject to review, with the aim to improving the Primary Care aspect of delivery.

5.5 Sustain and embed smoking quits, at 12 weeks post quit, in the 40% SIMD areas

Rationale: NHS Boards to tackle health inequalities by significantly reducing smoking rates amongst local communities, in line with the national target to reduce smoking prevalence to 5% or less by 2034.

Figure 5.5 Smoking quits, at 12 weeks post quit - 40% most deprived



	Q3	Q4	Q1	Q2
Actual (no.)	9	13	8	7
Target	6	6	6	6

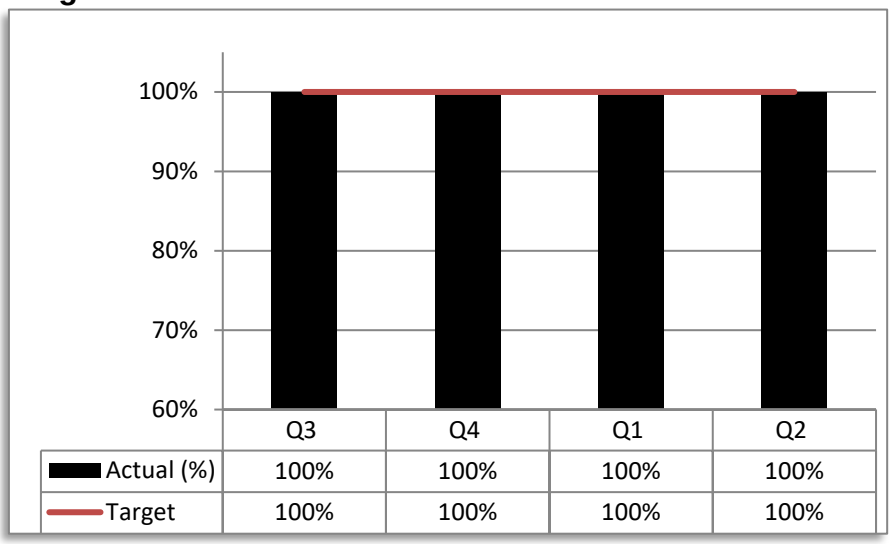
Situational Analysis:
The HSCP continues to exceed the GGC target for quit rates.

Improvement Action:
The service model is under review and its anticipated that future delivery will move from a local service to one a single service delivered by GGC.
Local performance will be monitored to ensure we continue to offer a service in East Dunbartonshire, and one that continues to meet its target.

5.6 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services

Rationale: Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services.

Figure 5.6 Waiting times - CAMHS



	Q3	Q4	Q1	Q2
Actual (%)	100%	100%	100%	100%
Target	100%	100%	100%	100%

Situational Analysis:
The CAMHS teams involved with East Dunbartonshire children and young people continue to achieve the referral to treatment target, recording that 100% achieved the 18 week target.

Improvement Actions:
We continue to monitor the waiting lists and activity data in relation to the 18 week RTT target. The CAMHS teams continue to operate to the service model and ensure capacity and demand are in balance and access to the service is efficient.

SECTION 6
Children's Service Performance

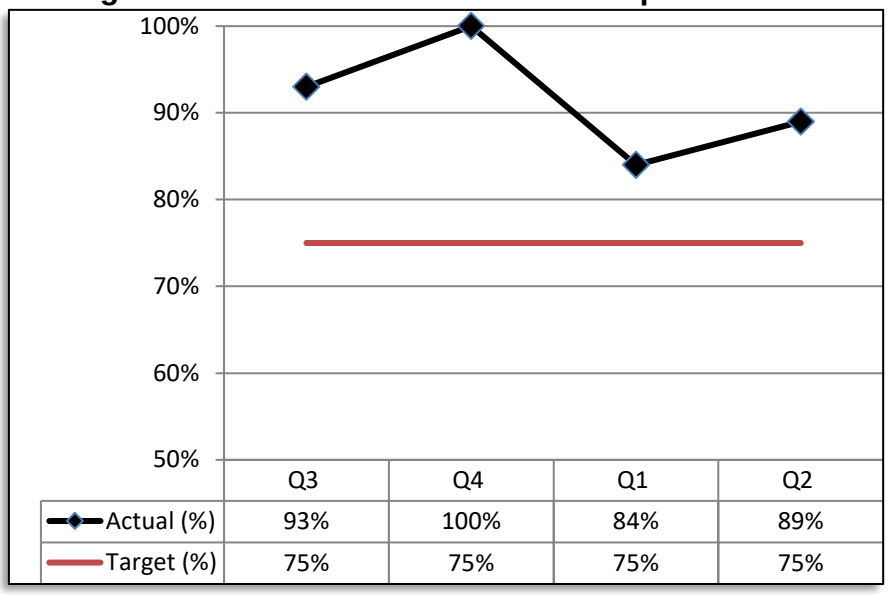
This section provides an updated report performance against key Children and Families indicators. The indicators reported are:

6.1 Percentage of Child Care Integrated Assessments (ICA) for SCRA completed within target timescales (20 days)
6.2 Percentage of Initial Child Protection Case Conferences taking place within 21 days from receipt of referral
6.3 Percentage of first Child Protection review conferences taking place within 3 months of registration
6.4 Balance of care for Looked After Children: Percentage of children being looked after in the community
6.5 Percentage of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated
6.6 Percentage of Children receiving 27/30 month Assessment

6.1 Percentage of Child Care Integrated Assessments (ICA) for Scottish Children Reported Administration (SCRA) completed within target timescales (20 days)

Rationale: This is a national target that is reported to SCRA and Scottish Government in accordance with time intervals.

Figure 6.1 Percentage of Child Care ICA for SCRA Completed



	Q3	Q4	Q1	Q2
Actual (%)	93%	100%	84%	89%
Target (%)	75%	75%	75%	75%

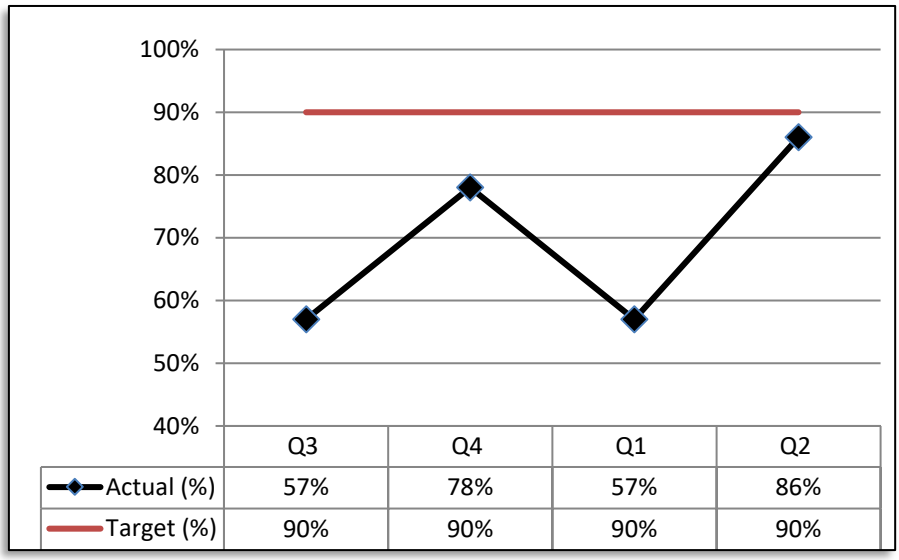
Situational Analysis:
Performance in this area has increased from the previous quarter and also continues to be above the national target. 9 Integrated Care Assessment reports (covering 16 children) were submitted to Scottish Children's Reporter Administration during Q2, 8 of which were submitted within requested timescale.

Improvement Action:
Continue to ensure all social work staff have regular supervision and completion of assessment reports is discussed to ensure timescales are met.

6.2 Percentage of Initial Child Protection Case Conferences taking place within 21 days from receipt of referral

Rationale: Local standard set by East Dunbartonshire Child Protection Committee.

Figure 6.2 Percentage of Initial Case Conferences taking place within 21 days of referral



	Q3	Q4	Q1	Q2
Actual (%)	57%	78%	57%	86%
Target (%)	90%	90%	90%	90%

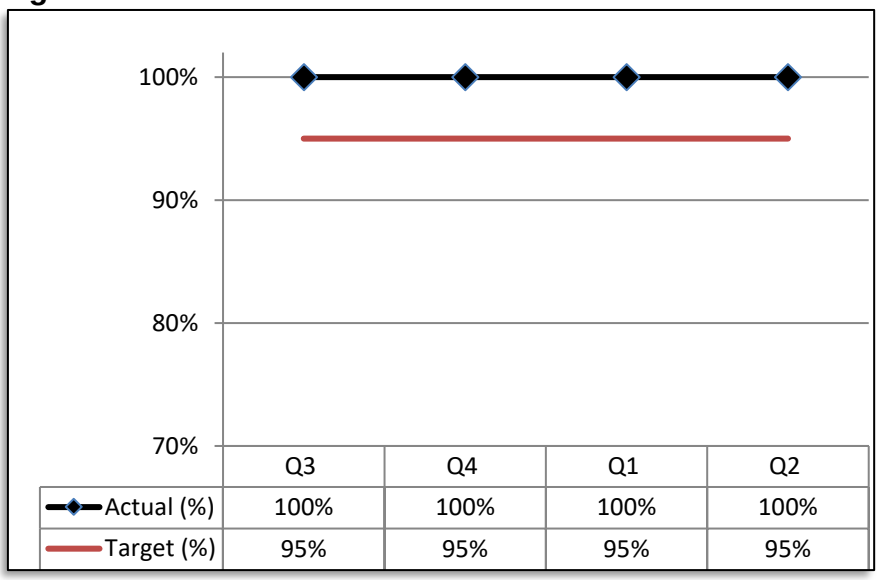
Situational Analysis:
14 Initial Child Protection Case Conferences were held during Quarter 2, 12 of which were within timescale. However for the other 2, ongoing work had been undertaken with these families in terms of monitoring and assessments in the interim until the decision was reached to go to Case Conference. The children remained safe throughout this period.

Improvement Action:
Continue to ensure Child Protection procedures are followed through the Child Protection Investigation ensuring children's safety is paramount.

6.3 Percentage of first Child Protection review conferences taking place within 3 months of registration

Rationale: Local standard set by East Dunbartonshire Child Protection Committee.

Figure 6.3 Percentage of first review conferences taking place within 3 months of registration



	Q3	Q4	Q1	Q2
Actual (%)	100%	100%	100%	100%
Target (%)	95%	95%	95%	95%

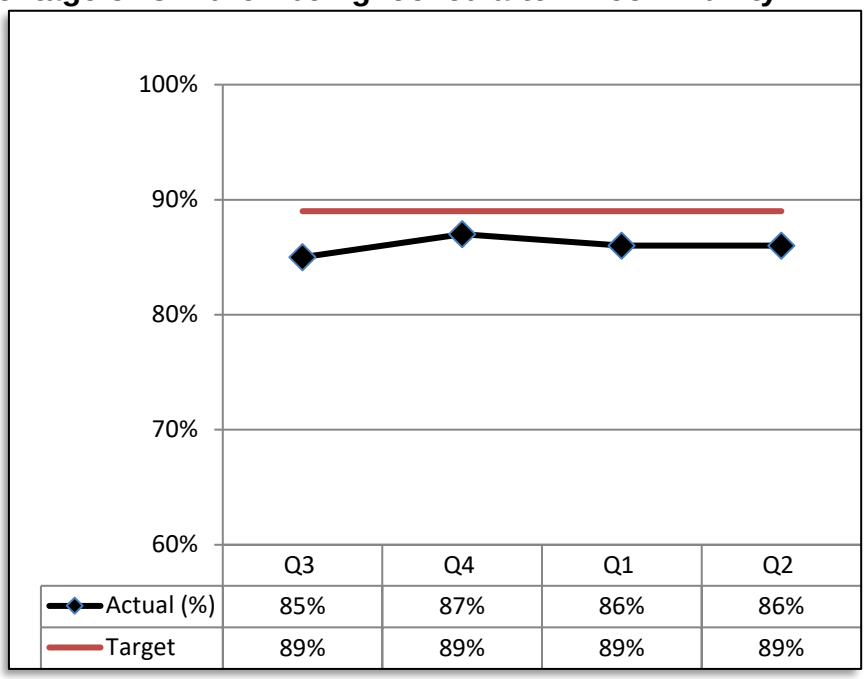
Situational Analysis:
Performance in Q2 remains above target. Six first Child Protection Reviews took place during this quarter, all were within the 3 month timescale.

Improvement Action:
Ensure standards continue to be met.

6.4 Balance of care for Looked After Children: Percentage of children being looked after in the community

Rationale: National performance indicator reported to Scottish Government and monitored by Corporate Parenting Bodies.

Figure 6.4 Percentage of Children being looked after in community



	Q3	Q4	Q1	Q2
Actual (%)	85%	87%	86%	86%
Target	89%	89%	89%	89%

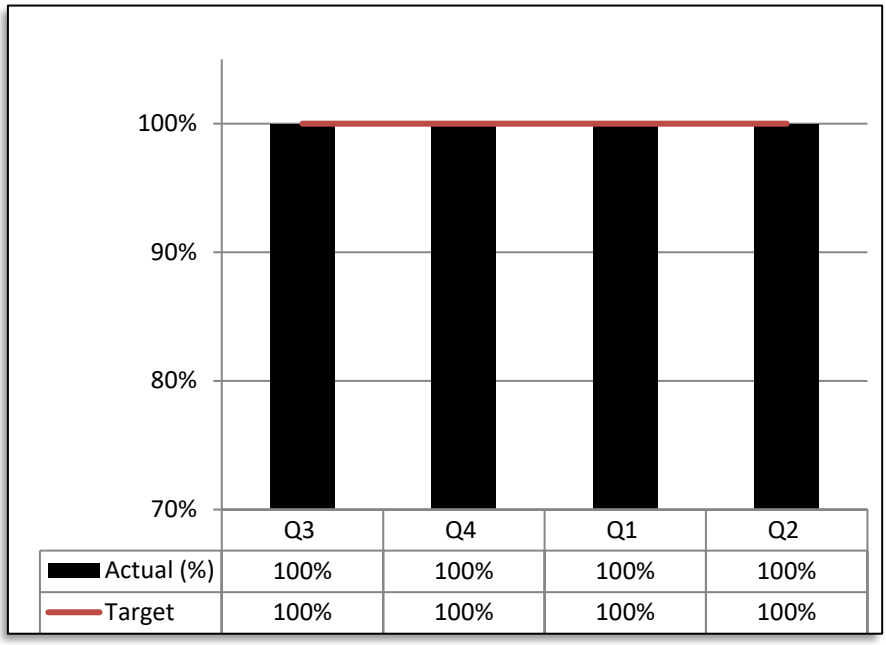
Situational Analysis:
Performance at the end of Q2 remains the same as the previous quarter, and is still slightly below the target. There has been a decrease by 6 children in community placements and a decrease by 1 child in the number of residential placements, making an overall decrease in Looked After Children.

Improvement Actions:
Ensure assessments of need and risk are integrated, comprehensive and fully meet the child's needs. This includes consideration of interventions to meet assessed needs which are community based promotes the child's safety at home.

6.5 Percentage of first Looked After & Accommodated (LAAC) reviews taking place within 4 weeks of the child being accommodated

Rationale: This is a local standard reflecting best practice and reported to Corporate Parenting Board

Figure 6.5 Percentage of first reviews taking place within 4 weeks of accommodation



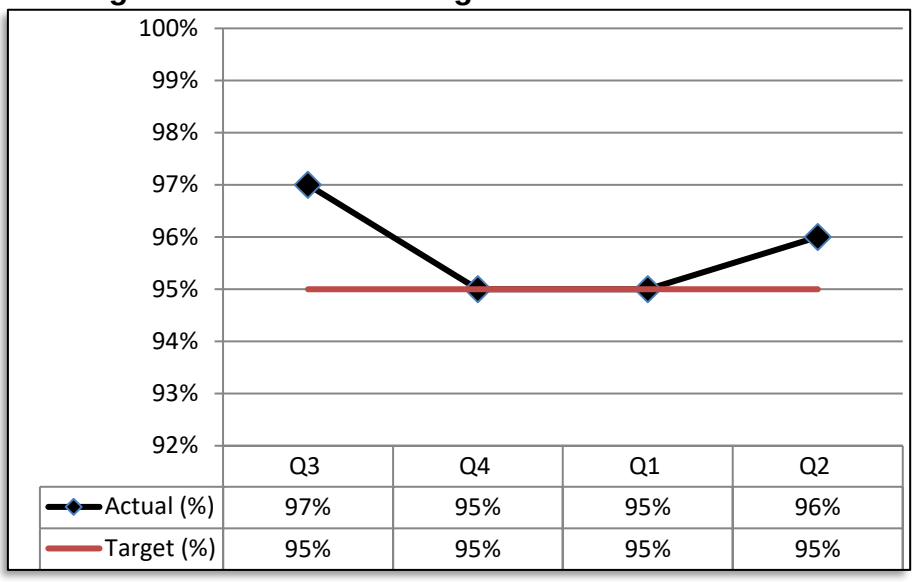
Situational Analysis:
Performance in Q2 remains on target. There were only 2 first Looked After and Accommodated Children Reviews held during Q2, both of which took place within the target timescale.

Improvement Actions:
Continue to ensure standards are met.

6.6 Percentage of Children receiving 27/30 month Assessment

Rationale: The Scottish Government set a target that by 2020, at least 85% of children within each SIMD quintile of the CPP will have reached all of their developmental milestones at the time of their 27 – 30 month child health review.

Figure 6.6 Percentage of Children receiving 27/30 month assessment



	Q3	Q4	Q1	Q2
Actual (%)	97%	95%	95%	96%
Target (%)	95%	95%	95%	95%

Situational Analysis:
This indicator relates to early identification of children within the SIMD quintiles with additional developmental needs. Where additional needs are identified, children will be referred onto specialist services. Performance has remained fairly consistent over the past 3 years. Data reports are monitored on a monthly basis to support early identification of variances and allow improvement plans to be development if required. During Q2 7.7% children were identified as requiring onward referral to specialist services.

Improvement Action:
The Children & Families team will maintain / improve performance by monitoring monthly data and responding to any trends identified. With the implementation of the Universal Pathway there is acknowledgement that there is ongoing work required to ensure staffing levels are in place to support the pathway.

Standing Operating Procedure to be implemented to address percentage of non attendees. This will be reviewed as part of the monitoring process already in place.

SECTION 7
Community Justice Performance

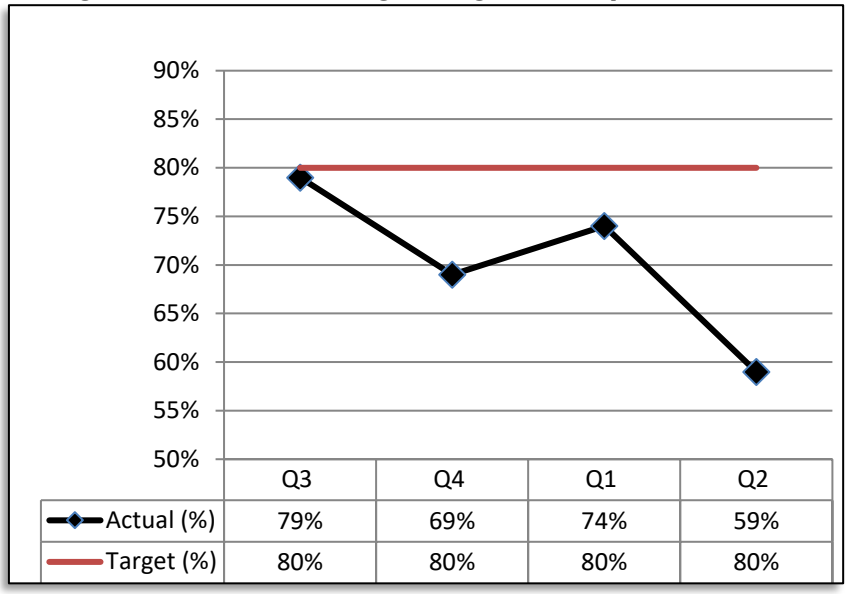
This section provides an updated report performance against key Criminal Justice indicators. The indicators reported are:

7.1 This section provides an updated report performance against key Children and Families indicators. The indicators reported are:
7.2 Percentage of CJSW submitted to Court by due date

7.1 Percentage of individuals beginning a work placement within 7 days of receiving a Community Payback Order

Rationale: The CJSW service must take responsibility for individuals subject to a Community Payback Order beginning a work placement within 7 days.

Figure 7.1 Percentage of individuals beginning a work placement within 7 days



	Q3	Q4	Q1	Q2
Actual (%)	79%	69%	74%	59%
Target (%)	80%	80%	80%	80%

Situational Analysis:
Performance in Q2 remains under target, and has declined from previous quarter. During this quarter 39 individuals were offered a work placement, to which a total of 23 commenced with an unpaid work placement within the agreed timescale. Reasons as to why individuals didn't begin a work placement were as follows: 9 clients failed to attend; 1 had paid employment; 2 currently undertaking unpaid work; 3 clients were ill; 1 had a late notification from Court. The shortfall was as a result outwith the service's control.

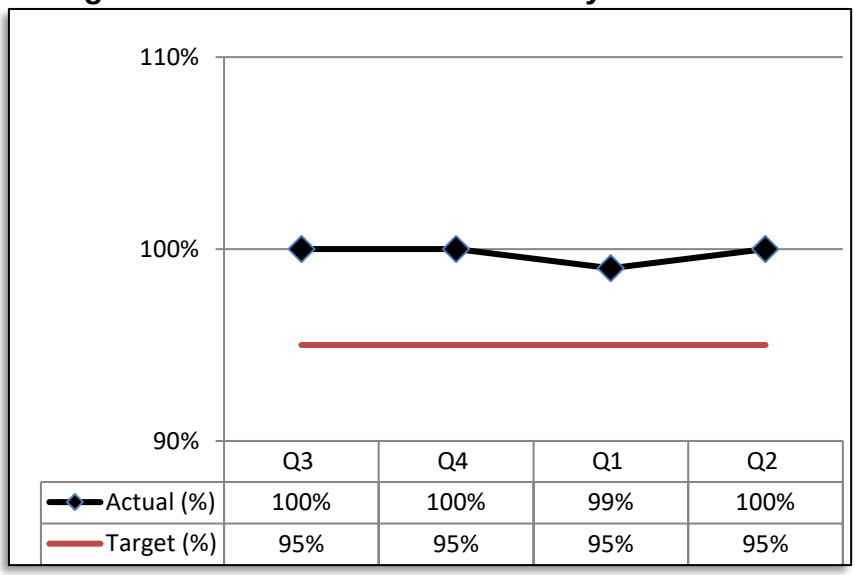
Improvement Action:
In relation to non-compliance Justice Services are reviewing the 'first seen' signed instruction (at the CJSW report stage) which directs that any service users made subject to an unpaid work order must attend to sign the order and begin a work placement within 7 days. This signed agreement will notify service users that failure to do so is likely to result in the Order being returned to court and the document cited as evidence within any potential breach proceeding.

Justice Services are also aiming to revisit the local arrangement with Glasgow Court and their unpaid work services to reinforce the process above to individuals made subject to an order at Glasgow Sheriff Court.

7.2 Percentage of CJSW submitted to Court by due date

Rationale: National Outcomes & Standards (2010) states that the court will receive reports electronically from the appropriate CJSW Service or court team (local to the court), no later than midday on the day before the court hearing.

Figure 7.2 Percentage of CJSW submitted to Court by due date



	Q3	Q4	Q1	Q2
Actual (%)	100%	100%	99%	100%
Target (%)	95%	95%	95%	95%

Situational Analysis:
Performance in Q2 has exceeded the target. Seventy Four (74) reports were submitted to Court during this quarter all of which were submitted within the target timescale.

Improvement Action:

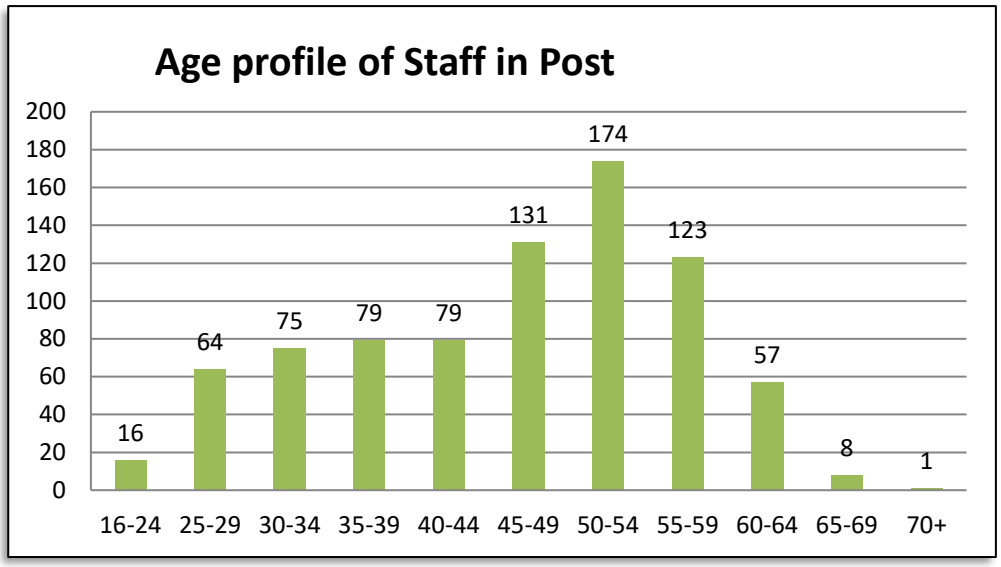
SECTION 8
Corporate Performance

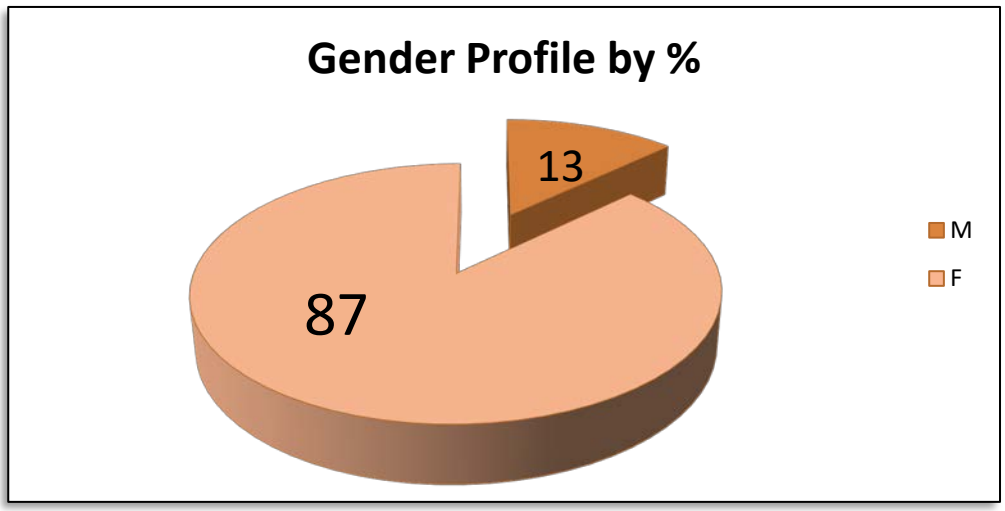
The following data focus on corporate performance indicators, namely:

- Workforce Demographics
- Sickness / Absence Health Staff and Social Care Staff
- Knowledge & Skills Framework (KSF) / Personal Development Plan (PDP) / Personal Development Review (PDR)

Workforce Demographics

Employer	Headcount		WTE	
	June 2017	Sept 2017	June 2017	Sept 2017
NHSGGC	265	261	225	221.03
EDC	553	570	468	478.9
Total	813	831	693	699.93





Sickness / Absence Health and Social Care Staff

Month	EDC	NHS HSCP
Apr-17	7.76	2.4
May-17	7.16	4.86
June - 17	5.95	6.10
July 17	5.29	5.24
Aug 17	5.76	4.16
Sept 17	6.85	3.92
Average	6.46	4.45

Absence is well managed within the HSCP, the main issues in both Health and Social Care is aligned with staff moving from short term to longer term absence due to health conditions.

KSF / PDP / PDR

	Apr	May	Jun	Jul	Aug	Sept
KSF %	65	65	64	65	54	57
PDP %	68	67	69	67	53	57
Trajectory %	80	80	80	80	80	80

KSF (Knowledge & Skills Framework) is the NHS staff review process to ensure that staff are competent to undertake the tasks associated with their role and have the appropriate learning and development planned across the year.

PDR	
Quarter	**% Complete on system**
Q1	36.15
Q 2	63.19

PDR (Performance, Development Review) is the Council process for reviewing staff performance and aligning their learning and development to service objectives and deliver requirements.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	Amendments to the Integration Scheme
Report By	Susan Manion, Chief Officer
Contact Officer	Fiona McCulloch Planning, Performance and Quality Manager Fiona.mcculloch@ggc.scot.nhs.uk 0141 355 2395

Purpose of Report	In order to implement the Carers (Scotland) Act 2016, the Scottish Government must incorporate provisions stemming from the Carers Act into regulations that support the Public Bodies (Joint Working)(Scotland) Act 2014. The changes in regulations require the Health Boards and Local Authorities to amend their Integration Schemes, working with Integration Authorities, to take account of the new provisions. The purpose of this paper is to inform the Board of the current actions and process in place to amend the East Dunbartonshire Integration Scheme.

Recommendations	It is recommended that the HSCP Board note the content of this paper

Relevance to HSCP Board Strategic Plan	The delegated functions are included within the draft HSCP Strategic Plan 2018-21

Implications for Health & Social Care Partnership

Human Resources	N/A

Equalities:	N/A

Financial:	N/A

Legal:	N/A

Economic Impact:	N/A

Sustainability:	N/A

Risk Implications:	N/A

Implications for East Dunbartonshire Council:	N/A

Implications for NHS Greater Glasgow & Clyde:	N/A

Direction Required to Council, Health Board or Both	**Direction To:**	**Tick**
	1. No Direction Required	
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

1.0 MAIN REPORT

1. The Carers (Scotland) Act 2016 comes into effect on 1 April 2018. In order to implement the Carers Act, the Scottish Government has incorporated provisions stemming from the Carers Act into those regulations that support the Public Bodies (Joint Working) (Scotland) Act 2014 relating to functions for delegation.

2. An amendment has been made through the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017, which covers Section 21 of the Carers Act and places a duty on Integration Authorities to set local eligibility criteria for carer support in relation to adult services and where appropriate the delegated functions relating to children's services

3. Two further statutory instruments came into force on 18 December 2017:

   - The Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017 which identifies a number of functions that *must* be delegated.
   - The Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Amendment Regulations 2017, which identifies function that *may* be delegated.

4. In order to accommodate these changes, Health Boards and Local Authorities require to amend their Integration Schemes to include the new duties put in place by the Carers Act for delegation to Integrated Authorities

5. In accordance with the required process, Health Boards and Local Authorities need to ensure that identified stakeholders within the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 are informed of the proposed changes. Following this process and approval by East Dunbartonshire Council and NHSGG&G, the revised Integration Scheme will be submitted to the Scottish Ministers for approval.

6. The timeline and process for amending the Integration Scheme is as follows:

- **18th December** - The regulations come into force and the amendments are made to the Integration Scheme
- **8th January 2018** - Prescribed Consultees are informed of the proposed changes (this doesn't require consultation because it the revision is a result of the Regulations)
- **11th January 2018** - HSCP Board informed of the proposed revisions.
- **20th February 2018** - Revised Integration Scheme taken to GG&C Board to be formally approved.
- **1st March 2018** - Revised Integration Scheme taken to the EDC Committee GG&C Board to be formally approved.
- **2nd March 2018** - Deadline for submission of revised Scheme to Scottish Government.
- **15th March 2018** - HSCP Board informed of formally approved changes to the Integration Scheme.

Agenda Item Number: 8

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	Oral Health Report
Report By	Frances McLinden – General Manager OHD
Contact Officer	Frances McLinden – General Manager OHD Frances.McLinden@ggc.scot.nhs.uk 0141 201 4271

Purpose of Report	To provide an overview of the activities carried out by the Oral Health Directorate within East Dunbartonshire HSCP.

Recommendations	To note the content.

Relevance to HSCP Board Strategic Plan	This report supports the strategic aims of the HSCP Board in relation to health improvement, the provision of general dental services and the priority group work carried out for oral health in the HSCP.

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

Financial:	None

Legal:	None

Economic Impact:	None

Sustainability:	None

Risk Implications:	None

Implications for East Dunbartonshire Council:	None

Implications for NHS Greater Glasgow & Clyde:	Review and agree direction of oral health services for HSCP area.

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	☒
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☐
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

1.0 MAIN REPORT

1.1 This report provides and overview of the oral health services provided throughout East Dunbartonshire HSCP.

1.2 This report provides performance data in relation to oral health programmes and monitoring of oral health activities in East Dunbartonshire.

NHS GG&C
Oral Health Directorate
Performance Report
(2017)

East Dunbartonshire HSCP

Foreword

This report outlines the activities carried out by the Oral Health Directorate within East Dunbartonshire.

We have looked to highlight where progress is being made and where the challenges remain to improve oral health and reduce inequalities for the population of East Dunbartonshire.

East Dunbartonshire can be proud of the progress made in improving oral health, particularly in addressing inequalities linked with deprivation, but there are still improvements to be made.

Overall Child Oral Health in East Dunbartonshire has steadily improved at a local level. However, registration of very young children with an NHS dentist remains low and needs dedicated actions to address.

The Scottish Government has set challenging targets for child dental health: by 2022, there needs to be a 10% increase in Primary 1 and Primary 7 children who have “no obvious decay” as reported through the NDIP programme.

To meet these and other oral health targets will require continued partnership working and community development with our colleagues in East Dunbartonshire HSCP and elsewhere.

We will strive to work collaboratively, innovatively and effectively to improve the health of the population in East Dunbartonshire. We will continue to deliver a safe, person-centred, effective and efficient oral health service across East Dunbartonshire.

Frances McLinden
General Manager and Lead Officer for Dental Services NHS GG&C Oral Health Directorate

Table of Contents

GENERAL DENTAL SERVICES

There are 26 independent contractor practices providing NHS dentistry in East Dunbartonshire. These practices provide General Dental Services (GDS) and in addition 3 practices provide sedation services. East Dunbartonshire has 2 practices that provide only orthodontic services meaning no patients are registered with them for GDS.

Registration with NHS Dental Services

Data available from Information Services Division (ISD) (September 2016) shows the proportion of patients registered in East Dunbartonshire are:

- 89.3% Children (compared to 94.1% Scotland; 95.0% GG&C)
- 91.8% Adults (compared to 91.1% Scotland: 94.8% GG&C)

The registration data for children in East Dunbartonshire are lower than the data for GG&C and for Scotland. The proportion for registered adult patients in East Dunbartonshire is also lower than the average for GG&C, but slightly higher for Scotland. There are possible explanations for the data. A number of patients (particularly adults) may be registered with non-NHS dentists, or may travel outside of East Dunbartonshire for dental treatment. As data is not collected for non-NHS dental practices, it is not possible to determine numbers of patients seeking treatment outside of the NHS. This explanation may not hold as robustly for children, as dentists may hold list numbers with NHS GG&C to provide NHS dental registration and treatment for children, whilst providing non-NHS treatment for parents.

More detailed data on dental registrations from ISD[1] highlights a continuing issue relating to the registration of very young children (aged 0-2 years). In East Dunbartonshire the proportion of children aged 0-2 years who are registered with a dentist is 50.9%. This compares to 48.4% for Scotland and 52.3% for NHS GG&C. and is largely unchanged from the previous year (50.8%).

Registration data provides only details of patients registered with an NHS dentist. Data is available for participation, which is defined as contact with General Dental Services for patients who are registered with an NHS dentist for an examination or treatment in the previous two years. Detailed participation data at an HSCP level is not available.
However, it is probable the proportion of patients with routine or regular dental attendance is lower than the proportion of patients registered with an NHS dentist.

[1] **Dental Statistics - NHS Registration and Participation Statistics as at 31 March 2017**
http://www.isdscotland.org/Health-Topics/Dental-Care/Publications/data-tables2017.asp?id=1843#1843

The most recent quarterly data available for Childsmile Practices activity demonstrates 4 practices with no activity.

The Oral Health Directorate performs an administrative function in relation to clinical governance in all NHS practices within East Dunbartonshire. This is to ensure that General Dental Services are delivered to high professional standards and includes carrying out Combined Practice Inspections and Sedation Practice Inspections in line with General Dental Service Regulations.

East Dunbartonshire Health & Social Care Partnership

NHS Greater Glasgow and Clyde

Details for NHS Dental Practices at December 2017

Practice_Name	Address1	Address2	Postcode	Date of Combined PI	Date of Sedation PI	Orthodontic Practice	Sedation Practice	Childsmile activity (Y/N)	Age 0-2	Age 3-5	Age 6-12	Age 13-17	Age 18-64	Age 65+	Grand Total
Kessington Dental Practice	53 Milngavie Road		G61 2DW	03/10/17				Y	73	190	512	358	3,465	1,034	**5,632**
Boclair Dental Care	91 Milngavie Road	Bearsden	G61 2EN	13/12/13				Y	90	131	318	140	1,779	667	**3,125**
Dental FX	84 Drymen Road	Bearsden	G61 2RH	14/12/16				Y	19	39	148	100	1,043	216	**1,565**
Park Cottage Dental Practice	8a Roman Road	Bearsden	G61 2SW	08/11/17				Y	69	134	358	278	1,651	373	**2,863**
Chartwell Dental Care	148-150 Drymen Road	Bearsden	G61 3RE	15/09/17				Y	35	80	273	279	940	52	**1,659**
Bearsden Dental Care	8 - 12 Ledi Drive	Bearsden	G61 4JJ	15/09/17	14/09/17		Y	Y	159	270	731	475	4,403	1,722	**7,760**
Milngavie Orthodontics	Suite 1, 13 Main Street	Milngavie	G62 6BJ	10/02/16		Y		N	-	-	-	-	-	-	**-**
Milngavie Dental Care	Suite 6, Douglas House	42 Main Street, Milngavie	G62 6BU	08/09/17				N	6	20	75	53	293	173	**620**
Allander Dental Care	7 Stewart Street	Milngavie	G62 6BW	16/12/14				Y	82	251	633	558	6,401	2,603	**10,528**
Jennings Dental Care	4 Station Road	Milngavie	G62 8AB	10/12/14				N	63	128	358	260	2,747	1,377	**4,933**
Woodhill Dental Care	176 Woodhill Road	Bishopbriggs	G64 1DH	21/08/17				Y	52	98	318	279	1,387	215	**2,349**
Oak Tree Dental Bishopbriggs	180 Woodhill Road	Bishopbriggs	G64 1DH	18/08/15				Y	46	101	327	186	2,100	430	**3,190**
Bishopbriggs Dental Care	17 Arnold Avenue	Bishopbriggs	G64 1PE	07/05/15				Y	99	174	436	278	3,311	1,123	**5,421**
Dental Care By Claire Tierney Bds Mfds	Unit 1	122 Kirkintilloch Road	G64 2AB	24/02/15				Y	39	73	229	153	1,381	326	**2,201**

Dental Professionals Bishopbriggs	171 Kirkintilloch Road	Bishopbriggs	G64 2LS	01/11/17				Y	62	124	340	293	3,807	1,203	**5,829**
F J Murphy	4 Morar Crescent	Bishopbriggs	G64 3DQ	16/08/17				Y	34	88	208	148	1,597	672	**2,747**
Torrance Dental Practice	22-24a Main Street	Torrance	G64 4EL	13/09/17				Y	27	48	149	118	1,165	327	**1,834**
Kirkintilloch Orthodontic Clinic	22 West High Street	Kirkintilloch	G66 1AA	23/10/17		Y		N	-	-	-	-	-	-	**-**
Cowgate Dental Surgery	11 Cowgate	Kirkintilloch	G66 1HW	16/02/15				Y	72	136	354	204	2,888	819	**4,473**
Oak Tree Dental Kirkintilloch	14-16 Townhead	Kirkintilloch	G66 1NL	04/02/16				Y	91	158	375	221	2,748	665	**4,258**
Hazel Hiram Dental Care	26 Townhead		G66 1NL	09/05/17				Y	45	59	152	121	1,442	481	**2,300**
Alasdair MacKenzie Dental Healthcare	69 Townhead	Kirkintilloch	G66 1NN	20/09/17	07/05/15		Y	Y	50	102	398	329	3,687	1,152	**5,718**
Marina Dental Care	Southbank Marina, 8 Strathkelvin Place	Kirkintilloch	G66 1XQ	27/10/15				Y	140	308	699	451	5,419	1,886	**8,903**
Richard Skillen Dental Care	95 Hillhead Road	Kirkintilloch	G66 2JD	07/11/17				Y	24	33	152	140	952	415	**1,716**
Millersneuk Dental Practice	112 Kirkintilloch Road	Lenzie	G66 4LQ	18/07/17	13/11/15		Y	Y	109	184	477	312	1,282	198	**2,562**
Campsie Dental Practice	127 Main Street	Lennoxtown	G66 7DB	31/08/16				Y	63	107	260	166	2,009	572	**3,177**
TOTAL AT DECEMBER 2017									**1549**	**3036**	**8280**	**5900**	**57897**	**18701**	**95363**
TOTAL AT MAY 2017									**1411**	**2920**	**7803**	**5931**	**54120**	**16319**	**88504**

East Dunbartonshire Health & Social Care Partnership

NHS Greater Glasgow and Clyde

PUBLIC DENTAL SERVICE

The Public Dental Service (PDS) provides comprehensive dental care and oral health education to priority group patients, including those with special needs, adult and paediatric learning disabilities, medically compromised and all groups of children. Treatment is provided in clinics, schools and nurseries, care homes, outpatient daycentres, hospital units, domiciliary visits, prisons and undergraduate outreach clinics.

We are in the process of conducting a review of the Public Dental Service the outcome of which will be available in early 2018. As part of this review we are looking to produce a dental premises strategy for the Board. This should include not just PDS sites but also locations of GDP practices within each HSCP area and overall within the Board.

Location and services delivered by the PDS

Locations/Services	Paediatric Dentistry	Special Care Dentistry	Adult Special Care – General Anaesthetic Assessment	Adult Special Care – General Anaesthetic	Adult Special Care – Intravenous Sedation	General Dental Services	Oral Hygiene Services	Domiciliary Care
Kirkintilloch Health Centre	√						√	√

DENTAL PUBLIC HEALTH

The oral health of children in NHS GG&C has improved significantly over the last 20 years. A major contributing factor in this has been the implementation of the Childsmile Programme. Children in East Dunbartonshire have generally demonstrated better levels of oral health than the average for GG&C and Scotland, supported by data from the National Dental Inspection Programme (NDIP).

NDIP Data for Primary 1 (Detailed Inspections 2014/16)

% of Primary 1, with no obvious decay experience		
	2014	2016
Scotland	68.2%	69.4%
NHSGGC	65.3%	68.2%
East Dunbartonshire	75.6%	81.3%

Pr 1 Mean dmft for Children With dmft>0		
	2014	2016
Scotland	3.97	3.93
NHSGGC	4.10	4.07
East Dunbartonshire	3.6	3.6

NDIP Data for Primary 7 (Detailed Inspections 2013/15)

% of Primary 7, with no obvious decay experience		
	2015	2017
Scotland	75.3%	77.1%
NHSGGC	72.5%	73.1%
East Dunbartonshire	81.4%	83.5%

Pr 7 Mean DMFT for Children With DMFT>0		
	2015	2017
Scotland	2.16	2.16
NHSGGC	2.27	2.24
East Dunbartonshire	1.9	2.1

Comparison of data between 2014 and 2017 suggests a steady improvement in oral health at a local and national level. The proportion of children who do not have obvious dental decay is higher in East Dunbartonshire than in GG&C and Scotland for both P1 and P7 children and this has improved from the previous NDIP data. Where children have decay experience, the average dmft/DMFT (number of decayed, missing or filled teeth) is lower in East Dunbartonshire than the average for GG&C and Scotland, but, for both P1 and P7 children, the dmft/DMFT in East Dunbartonshire has not improved since the last NDIP data collection point, and has actually worsened slightly for the P7 group.

Analysis of detailed inspection data at HSCP level may have less precision than data at a NHS Board or national level (as it is from a sampled population). However, the detailed data still support the position that the oral health of children in East Dunbartonshire is better than the average for GG&C and Scotland as a whole. While the percentage with no obvious decay results are generally supportive of continued improvement, the fact that oral health is not improving in those with decay requires attention

The NDIP programme also reports on all children attending state schools in P1 and P7 at a more basic level. This provides an overall assessment of oral health. Data are reported as three categories. The B and C category definitions changed in 2015/16 to reflect an assessment which now relates only to dental decay. Careful interpretation and comparison with previous results are therefore required.

- Category A- should arrange to see the dentist as soon as possible, if the child has not had a recent appointment, on account of severe decay or abscess; or

- Category B- should arrange to see the dentist in the near future, if the child has not had a recent appointment, on account of evidence of current or previous decay ; or

- Category C- no obvious decay experience but should continue to see the family dentist on a regular basis

School level data for P1 and P7 Basic NDIP for East Dunbartonshire (2016/17) is illustrated overleaf. A summary of the totals (and proportions) of each category letter is also displayed, together with corresponding summaries for the year 2015-2016 for comparison.

East Dunbartonshire Health & Social Care Partnership

NHS Greater Glasgow and Clyde

Summary of Basic P1 NDIP Programme 2016/17

Letter A: should arrange to see the dentist as soon as possible, if the child has not had a recent appointment, on account of severe decay or abscess
Letter B: should arrange to see the dentist in the near future, if the child has not had a recent appointment, on account of evidence of current or previous decay
Letter C: no obvious decay experience but should continue to see the family dentist on a regular basis

School	Class	Letter A (n)	Letter B (n)	Letter C (n)	Not Inspected (n)
Auchinairn	P1	2	6	13	0
Baldernock	P1	0	0	5	0
Baljaffray	P1	0	3	25	1
Balmuildy	P1	0	10	25	1
Bearsden	P1	0	9	49	2
Castlehill	P1	1	2	15	1
Clober	P1	2	2	36	1
Colquhoun Park	P1	0	8	16	1
Craigdhu	P1	1	7	22	2
Craighead	P1	4	5	23	1
Gartconner	P1	1	5	16	1
Harestanes	P1	2	10	15	2
Hillhead (Kirkintilloch)	P1	5	9	9	0
Holy Family	P1	1	9	35	3
Killermont	P1	4	7	53	2
Lairdsland	P1	2	6	37	2
Lennoxtown	P1	0	2	15	1
Lenzie Meadow	P1	1	9	70	2
Meadowburn	P1	1	3	31	4
Millersneuk	P1	0	2	34	3
Milngavie	P1	2	2	44	0
Mosshead	P1	0	8	39	2
Oxgang	P1	1	10	29	1
St Agatha's	P1	0	0	9	1
St Andrew's (Bearsden)	P1	1	7	32	2
St Flannan's	P1	8	8	19	1
St Helen's	P1	2	6	47	1
St Joseph's (Milngavie)	P1	0	0	7	0
St Machan's	P1	3	2	13	2
St Matthew's	P1	4	8	28	2
Torrance	P1	1	2	15	1
Twechar	P1	2	2	9	2
Wester Cleddens	P1	2	3	27	3
Westerton	P1	2	7	32	2
Woodhill	P1	6	12	33	2
Campsie View	P1	0	0	4	6
Merkland	P1	0	0	0	1

Basic NDIP P1 Schools 2015/6 – 2016/7

	2015/16		2016/17	
Number of NDIP Schools	36		37	
Total number of P1's on Roll	1310		1242	
Total number of P1's not receiving NDIP	85		59	
Number (%) Children Inspected: Letter A	54	4.4%	61	5.2%
Number (%) Children Inspected: Letter B	212	17.3%	191	16.1%
Number (%) Children Inspected: Letter C	959	78.3%	931	78.7%

Summary of Basic P7 NDIP Programme 2016/17

Letter A: should arrange to see the dentist as soon as possible, if the child has not had a recent appointment, on account of severe decay or abscess
Letter B: should arrange to see the dentist in the near future, if the child has not had a recent appointment, on account of evidence of current or previous decay
Letter C: no obvious decay experience but should continue to see the family dentist on a regular basis

School	Class	Letter A (n)	Letter B (n)	Letter C (n)	Not Inspected (n)
Auchinairn	P7	1	5	7	1
Baldernock	P7	0	0	7	1
Baljaffray	P7	1	11	44	4
Balmuildy	P7	0	7	23	0
Bearsden	P7	0	7	50	3
Castlehill	P7	0	3	8	0
Clober	P7	0	4	23	4
Colquhoun Park	P7	0	15	14	0
Craigdhu	P7	0	8	32	2
Craighead	P7	1	7	12	13
Gartconner	P7	0	8	10	1
Harestanes	P7	2	10	14	2
Hillhead (Kirkintilloch)	P7	1	4	15	2
Holy Family	P7	1	10	45	1
Killermont	P7	0	6	35	2
Lairdsland	P7	0	6	32	2
Lennoxtown	P7	0	4	12	2
Lenzie Meadow	P7	1	20	43	1
Meadowburn	P7	0	7	37	0
Millersneuk	P7	0	8	36	0
Milngavie	P7	0	8	37	2
Mosshead	P7	0	10	47	4
Oxgang	P7	0	7	17	1
St Agatha's	P7	0	1	5	0
St Andrew's (Bearsden)	P7	0	4	35	2
St Flannan's	P7	1	18	14	0
St Helen's	P7	0	15	43	7
St Joseph's (Milngavie)	P7	1	3	13	1
St Machan's	P7	0	10	17	5
St Matthew's	P7	2	9	30	5
Torrance	P7	0	6	17	1
Twechar	P7	0	6	5	1
Wester Cleddens	P7	0	3	11	1
Westerton	P7	0	6	21	3
Woodhill	P7	1	16	47	4
Campsie View	P7	0	0	1	1
Merkland	P7	0	1	5	4

Basic NDIP Data P7 Schools 2014-2016

	2015/16		2016/17	
Number of NDIP Schools	36		37	
Total number of P7's on Roll	1191		1233	
Total number of P7's not receiving NDIP	70		83	
Number (%) Children Inspected: Letter A	11	1.0%	13	1.1%
Number (%) Children Inspected: Letter B	256	22.8%	273	23.7%
Number (%) Children Inspected: Letter C	854	76.2%	864	75.1%

The data for Basic NDIP is generally supportive of the Detailed NDIP findings. The percentage of “C” letters (which represents no obvious decay experience) for P7 will always be slightly lower that the Detailed NDIP results due to teeth from both the primary and secondary dentition being included in the Basic but not the Detailed NDIP dataset.

The Basic NDIP results for both P1 and P7 suggest that levels of child dental health in East Dunbartonshire have been static over the past year, with no improvement seen.

Closer examination of the data at a school level suggests whilst the overall picture of oral health in East Dunbartonshire is good, there are areas where oral health is poor. There are a number of schools where higher numbers of category A and B letters were issued. This relates to both P1 and P7 classes. Caution should be used when interpreting this data as the sample sizes are low and comparisons between schools may not be robust. However, the data are suggestive that there are areas of East Dunbartonshire where closer scrutiny of population oral health may be needed. This is agreement with the findings from the latest Detailed NDIP surveys which highlighted no improved in the severity of decay for those with decay experience.

Dental Extraction under General Anaesthetic

The extraction of teeth is an end-point for dental decay experience. For young children this procedure is usually performed under general anaesthetic – a traumatic experience presenting a risk to children, loss of school time (work time for parents) and resource intensive for NHS GG&C. Data are available for the numbers of referrals of children for extraction of teeth under general anaesthetic and can assist in building a more comprehensive knowledge of population oral health. The numbers of referrals of children for dental extractions under general anaesthetic is shown below.

Postcode	2013	2014	2015	2016	Total	Pop^{n} Rate (per 1000) in 2015
G61 1	2	7	4	3	16	
G61 2	3	2	5	4	14	
G61 4	10	3	5	5	23	
G62 7	5	4	7	4	20	
G64 1	**9**	**17**	**15**	**13**	**54**	
G64 2	3	2	9	1	15	
G65 9	4	11	3	5	23	
G66 1	9	1	4	3	17	
G66 2	**13**	**13**	**20**	**22**	**68**	
G66 3	**5**	**7**	**10**	10	32	
G66 4	1	7	5	2	15	
G66 7	**5**	**9**	**12**	**10**	**36**	
G66 8	2	6	7	6	21	
Total East Dun	71	89	106	88	354	7
Total GG&C	2339	2340	2413	2007	9099	15

Referrals for dental extractions under general anaesthetic for children in East Dunbartonshire (rates calculated from mid 2014 population estimates ages 3-16)

As with data for dental caries, the numbers of referrals for extractions under general anaesthetic are lower in East Dunbartonshire than for other localities in GG&C. It should be noted the data rows in the table above are raw data and not weighted by population. Nevertheless, the data illustrates there has been a slight reduction in the number of children referred in East Dunbartonshire between 2015 and 2016. However, numbers of referrals remain higher in certain localities, highlighted in bold text above. The population rate in 2015 for East Dunbartonshire for referrals for extraction under general anaesthetic is 7/1000, compared to 15/1000 for GG&C. This demonstrates the better oral health of children in East Dunbartonshire compared with GG&C as a whole.

The localities with higher numbers of referrals for general anaesthetic extractions demonstrate a correlation with schools and localities where NDIP outcomes are poorer.

Overall, the oral health of children in East Dunbartonshire is better than the average for GG&C and for Scotland. However, it is not without its challenges and is not increasing as well as would be expected for the area. There remain pockets of significant dental decay in some localities. A major challenge in East Dunbartonshire will be to sustain improvements in oral health. The Childsmile programme has contributed to rapid improvements in oral health since 2006. In East Dunbartonshire the baseline for child oral health is high and as a consequence additional improvements will be more difficult to achieve.

Greater use of dental public health intelligence and collaboration is facilitating the development of more effective partnership working for the Oral Health Improvement Team and the HSCPs. Data intelligence is assisting in the targeting of interventions to the most vulnerable groups in East Dunbartonshire in order to improve oral health outcomes.

ORAL HEALTH IMPROVEMENT

The Oral Health Improvement Team will seek to determine if there is a risk that more affluent children are being overlooked in oral health improvement programmes which are targeting more vulnerable, or deprived children.

Childsmile

Childsmile is the National Dental Programme to improve the oral health of Scottish children. The programme has three main components; Childsmile Practice, Childsmile Core, the Toothbrushing Programme and the Childsmile Fluoride Varnish Programme.

Childsmile Practice

An important link is established between Health Visitors and Dental Health Support Workers (DHSW) and dental practices. Assistance is provided in locating and visiting a dentist for new parents. The table below outlines the patient contacts for Childsmile Practice staff providing home visit support.

Children Successfully Contacted and Not Contacted by DHSW, and Families Who Refused Childsmile 2016/2017

SIMD	Children with (at least one) kept DHSW appointment	Children whose families refused Childsmile	'Family could not be contacted'	Families with outcome 'FTA / Not at home' (Further contact required)
1	7	0	0	1
2	23	0	0	6
3	1	0	0	0
4	19	1	0	4
5	34	0	0	2
Total	84	1	0	13

2016/2017 (April/March)

The number of children with (at least one) kept DHSW appointment has fallen this year.

Childsmile Core

Childsmile Core Toothbrushing Programme was established within the East Dunbartonshire area in 2006. There are currently 33/35 mainstream schools and 2 Additional Support Needs schools taking part in the programme. Oral Health Educator's (OHE's) have established effective partnership working with HSCP colleagues in East Dunbartonshire.

The non-participating schools are contacted on a regular basis to review interest in participation and offered support to implement Childsmile. This is done in via email, phone calls and meeting with Education staff.

East Dunbartonshire Establishments Participating in Tooth-brushing 2016/2017

SIMD	Nurseries	Primary Schools	% of Primary Schools Brushing	Additional Support Needs	Overall Total Brushing
1	1	0/1	0%	0	1
2	5	5/6	83%	1	10
3	8	7/7	100%	0	15
4	9	4/4	100%	1	13
5	25	17/17	100%	0	42
Total	48	33/35	94%	2	81

Figures as at as at June 2017

100% of nurseries and Additional Support Needs schools are participating in toothbrushing this has remained stable. The number of schools brushing has increased with 3 additional schools participating in toothbrushing during 2016/2017.

East Dunbartonshire Children with Tooth-brushing Consents 2016/2017

A major change in the Childsmile programme for 2016/17 was a move to negative consent, or parental opt-out instead of a positive consent. This should have the effect of reaching more children in families who have not previously engaged in the tooth brushing programme i.e. they did not provide positive consent.

OHE Activity

The OHE linked to the East Dunbartonshire HSCP attends health events in primary schools, delivers oral health advice related to toothbrushing, diet and dental attendance. The OHE's work with school staff to provide support to families who have received a category A NDIP letter. The support offered includes 1-1 advice to parents to address their individual needs and encourage registration with a dentist. Support is also offered to children who have a fear around going to the dentist by offering acclimatisation sessions before their dental appointment. OHE's have also

followed up all families who contacted NHS 24 for out-of hour's dental care. The follow up of NHS 24 calls commenced in November 2016.

The OHE offers Toothbrushing training to all establishments, this training re-enforces the national toothbrushing standards. The OHE monitor all toothbrushing establishments every term and record data onto HIC (Health Informatics Centre) system hosted by Dundee University. Several parents workshops and one to one oral health advice have been delivered to parents on different occasions e.g. parents evenings, induction days, providing dentists list to encourage dental registration.

The OHE's are also involved in the annual Canal Festival where they promote Childsmile and offer advice and resources alongside the Smoking Cessation, Addictions, and Antenatal and Weight Management teams.

Summary of OHE Activity

Area	Health Days	OH Session/ Monitoring	Induction Days	ED HSCP Events	School Nurse Referral/ School	NSM Talk/ Event	Training
East Dunbartonshire	10	91	09	1	1	7	14

Overall OHE activity increased during 2016/17 with a higher number of OH sessions delivered in this period.

Caring for Smiles

The table below provides data on the number of Care Homes involved in the Caring for Smiles programme in East Dunbartonshire within 2016/2017.

HSCP	Number of Care Homes	Number participating in CFS Training	Number participating in CFS Monitoring	Total number of Residents	Number registered & seen by a dentist within last 12 months	% of residents seen & registered wi a dentist within last 12 months
East Dunbartonshire	13	13	12	496	384	68%

The National standard for training asks that 30% of care home staff have been trained in the caring for smiles dental programme. Between 31st March 2016-30th April 2017 a total of 63 staff have been trained, however, the overall number of staff trained since programme commenced is outlined in table below.

10 staff had attended for SCQF (Foundation) training - 6 completed and 4 failed to complete. A date for SCQF Intermediate training has been offered to those who passed Foundation level.

Buchanan House is below the recommended training of 30% WTE. Training sessions were arranged in-house but there was no uptake. Contact has been made with Care Home Manager to discuss additional training requirements.

Care Home	Total Number of staff	Number of WTE	Number of WTE trained	% of WTE trained	Number of staff trained
Canniesburn Care Home	101	69.0	26.9	38.29%	30
Abbotsford House	20	15.0	7.5	50.2%	10
Buchanan House	80	70.0	15.2	15.1%	13
Buchanan Lodge	30	26.6	22.2	90.8%	36
Mavis Bank	45	35.2	26.6	75.6%	32
Campsie View	125	90.0	31.8	35.3%	47
Campsie House	17	14.0	13.6	96.8%	17
Whitefield Lodge	41	36.0	17.1	47.6%	19
Lillyburn	80	42.3	17.7	41.7%	21
Westerton Care Home	77	66.0	28.79	43.8%	33
Antonine Care Home	70	65.0	42.3	65.1%	51
Whitehill Court Care Home (respite)	8	6.0	5.4	90.6%	11
Mugdock House	54	44.0	24.3	55.1%	28

Key Findings and Recommendations

- There needs to be an increase in activity reported for Childsmile Practice
- There is a need to continue the monitoring and support for Childsmile Core
- Continued support and training are required for Caring for Smiles and other priority groups
- The Oral Health Directorate would be keen to work in partnership with our colleagues in the HSCP to improve the oral health outcomes for their population.
- The Oral Health Improvement team will continue to improve links with General Dental Practices and provide support & training for Childsmile
- The Oral Health Improvement Team will continue to work with partners in the HSCP and education to improve the uptake and delivery of Childsmile Core and the Fluoride Varnish programme

Agenda Item Number: 9

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2017
Subject Title	Annual Chief Social Work Officer Report
Report By	Paolo Mazzoncini, Chief Social Work Officer & Head of Children and Criminal Justice Services.
Contact Officer	Paolo Mazzoncini, Chief Social Work Officer & Head of Children and Criminal Justice Services. 0141 232 8266 Paolo.Mazzoncini@eastdunbarton.gov.uk

Purpose of Report	a. The purpose of this report is to present the Chief Social Work Officer's (CSWO) Annual Report to East Dunbartonshire Council.

Recommendations	It is recommended that the HSCP Board: • Notes the contents of the Report.

Relevance to HSCP Board Strategic Plan	Social Care and Social Work Services support the key priorities of the HSCP Strategic Plan.

Human Resources	None

Equalities:	None

Implications for Health & Social Care Partnership

Financial:	None

Legal:	None

Economic Impact:	None

Sustainability:	None

Risk Implications:	None

Implications for East Dunbartonshire Council:	This report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

Implications for NHS Greater Glasgow & Clyde:	This report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

Direction Required to Council, Health Board or Both	**Direction To:**	**Tick**
	1. No Direction Required	✓
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

1.0 MAIN REPORT

1.1 Each year, the CSWO is required to produce a summary report advising the Council of performance in relation to the discharge of statutory duties and responsibilities, as well as the functions of the CSWO. With the commencement of the Public Bodies (Joint Working) (Scotland) Act 2014, this reporting arrangement was extended to include Integration Joint Boards (IJBs)

1.2 The Chief Social Work Advisor to the Scottish Government developed a standardised framework for reporting in order to ensure consistency across Scotland. This report utilises that framework and provides the annual report for the period 1 April 2016 to 31 March 2017. (**Appendix 1 is the Annual Report which summarises achievements of the East Dunbartonshire Social Work Department 2016/17).**

1.3 Local authorities are legally required to appoint a professionally qualified Chief Social Work Officer under section 3 of the *Social Work (Scotland) Act 1968*. The overall objective of the CSWO is to ensure the provision of effective professional advice to local authorities and Integration Joint Boards (IJBs) in relation to the delivery of social work services as outlined in legislation. The statutory guidance states that the CSWO should assist local authorities, IJBs and their partners in understanding the complexities and cross-cutting nature of social work service delivery, as well as its contribution to local and national outcomes.

Key matters such as child protection, adult protection, corporate parenting and the management of high risk offenders are covered in this report. The report also provides information relating to the following:

- Summary of Performance – Key Challenges, Developments and Improvements;
- Partnership Working - Governance and Accountability Arrangements;
- Social Services Delivery Landscape;
- Resources;
- Service Quality, Performance and Delivery of Statutory Functions;
- Workforce Planning and Development; and
- Improvement Approaches

1.4 The information contained within the report reflects the key matters affecting Social Work Services over the reporting period

1.5 This report was submitted to East Dunbartonshire Council at the Board meeting on the 21st of December.

Appendix 1

sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

East Dunbartonshire
Health & Social Care
Partnership

Annual Chief Social Work Officer Report

1 April 2016 – 31 March 2017

Contents **Page**

1. Introduction

This Chief Social Work Officer Annual Report focuses on the period 1 April 2016 to 31 March 2017 and covers the range of activities undertaken by social care and social work services within East Dunbartonshire Council. The report follows the suggested guidance and format provided by the Office of the Chief Social Work Advisor to the Scottish Government. The report provides the Council, the Health and Social Care Partnership Board, staff, stakeholders and the public with a summary of relevant information relating to social work and social care services: their achievements, the challenges they face; and the plans being made to continue to deliver high quality and effective services to the residents of East Dunbartonshire.

2. Summary of Performance - Key challenges, Developments and Improvements

Social work services dealt with a number of challenges in this last year. Prominent amongst them was attempting to meet an increasing demand for children and adult social work services at a time when public finances had been significantly constrained. Delivering sector-leading, effective and person-centred care in this context was, and remains, a considerable endeavour.

Another key challenge centred on addressing the complexity of service users' personal situations. Many of the individuals with whom we engaged, often presented with numerous needs frequently linked to frailty and infirmity; vulnerability; the breakdown of family relationships; poor mental health; addiction; poverty and deprivation. The services we provided were alert to this complexity. We worked closely with our service users, their carers, a range of partners and local community services to ensure that the right support and advice was available at the right time for our residents.

It is evident that these pressures and their combined effects will continue to pose serious challenges in the coming years. Audit Scotland in its report, *Social Work in Scotland (2016)* echoed these points, noting:

> '*Councils' social work departments are facing significant challenges because of a combination of financial pressures caused by a real-terms reduction in overall council spending, demographic change, and the cost of implementing new legislation and policies. If councils and IJBs* [Integration Joint Boards] *continue to provide services in the same way, we have estimated that these changes require councils' social work spending to increase by between £510 and £667 million by 2020 (16–21 per cent increase)*.'[1]

The integration of health and social care/social work services was also a crucial activity in the last year. The *Public Bodies (Joint Working) (Scotland) Act 2014* focused our attention on integration. The Act was passed by the Scottish Parliament in February 2014 and came into force on 1 April 2016. In East Dunbartonshire this led to the development of an Integration Joint Board (now called East Dunbartonshire's Health and Social Care Partnership), to which the Council and NHS Greater Glasgow and Clyde delegated key functions and responsibilities. Much of our work in 2015/16 was taken up with transition planning and putting in place the supporting structures and processes to make this a successful enterprise.

As I noted in my last Chief Social Work Officer Report 2016, adult social care services were delivered in partnership under the auspices of East Dunbartonshire's Health and Social Care Partnership (HSCP). In May 2016, the decision was taken by the Council and NHS Greater Glasgow and Clyde to delegate respectively Children and Families and Criminal Justice social work

[1] The Report can be found at http://www.audit-scotland.gov.uk/report/social-work-in-scotland

services and NHS Community Children's Services to the HSCP. This was subsequently approved by the Cabinet Secretary for Health and Sport on 5 July 2016 and given effect by the HSCP Board on 11 August 2016. A significant part of our work in this last year therefore focused on bringing these services within the developing panoply of structures and processes in the newly formed HSCP. These arrangements are now working more effectively and we have noted improved professional relationships and communication. Integration has provided an opportunity to cultivate appropriate joint working in order to deliver seamless services and better outcomes for individuals. That said, we recognise that further work will be required over the coming years, particularly in relation to the implementation of the HSCP Strategic Plan, workforce planning, service redesign and engaging service users, carers, staff, stakeholders and others fully in these discussions and planning.

Social work services in East Dunbartonshire met these challenges head-on. There has been progress on a number of practice fronts. Notably we have:

- Worked in partnership with other key agencies to develop a more effective Corporate Parenting approach, which fully engages young people in its design and operation. This included the submission of a proposal to the Life Changes Trust for their assistance in creating a Young Person's Corporate Parenting Champions Board.
- Reviewed our Kinship Care arrangements in order to augment community based familial support for children and young people.
- Reinvigorated our Child Protection Committee to meet the challenges which were expected to flow from the Scottish Government's Child Protection Improvement Programme.
- Commissioned a specialist parenting capacity service to support our fieldwork services in the assessment of familial relationships and also assist practitioners in making robust future plans for children and young people.
- Developed a new Intermediate Care Model (pilot) for those older people who require further assessment on discharge from acute care, prior to longer term plans being made.
- Significantly reduced the number of bed days lost (delayed discharge) by focusing our Hospital Assessment Team on the early identification of need and the appropriate targeting of available resources.
- Initiated preparatory discussions on the impact of the *Carers (Scotland) Act 2016.*
- Took forward initiatives to implement our revised Autism Strategy (published November 2015)
- Contributed to work within the North Strathclyde MAPPA Strategic Oversight Group to plan for the introduction of category three offenders (mainly violent offenders) into the Multi Agency Public Protection Arrangements (MAPPA)
- Completed plans with East Dunbartonshire's Community Planning Service in preparation for the disestablishment of the Community Justice Authorities (on 31 March 2016) and the replacement arrangements for Community Justice, including the development of a local Community Justice Outcomes Improvement Plan.
- Reviewed the learning from inspections carried out by the Care Inspectorate to assess what improvements to services could be made.
- Continued to ensure staff are suitably trained to meet the practice challenges present.

The examples above are a few of our achievements. More information on social work and social care services can be found on the Council and the HSCP website.[2]

[2] For more information on services, reports to Committees and the HSCP Board etc. please see https://www.eastdunbarton.gov.uk/

3. Partnership Working - Governance and Accountability Arrangements

The requirement for every local authority to appoint a professionally qualified Chief Social Work Officer (CSWO) is contained in section 3 of the *Social Work (Scotland) Act 1968*. The overall objective of the CSWO is to ensure the provision of effective professional advice to local authorities in relation to the delivery of social work services. The *Public Bodies (Joint Working) (Scotland) Act 2014* provides for the delegation of certain social work functions by a local authority to an integration authority. The CSWO's responsibilities in relation to local authority social work functions continue to apply to functions which are being delivered by other bodies under integration arrangements. However, the responsibility for appointing a CSWO cannot be delegated and must be exercised directly by the local authority itself.

Within East Dunbartonshire the duties of the Chief Social Work Officer are discharged by the Head of Children and Families and Criminal Justice Services. The CSWO has been able to help shape the broader planning agenda for social work within the Council, the Health and Social Care Partnership and the Community Planning Partnership. The CSWO has had the opportunity to influence budgetary decisions to ensure the needs of vulnerable children and adults are met and resources are deployed effectively.

Within the Council and the Health and Social Care Partnership there are clear structures and processes that have enabled the CSWO to fulfil the role and function. The CSWO attends a range of key internal and external partnership meetings including for example:

- East Dunbartonshire's Health and Social Care Partnership Board – the CSWO is a non-voting member of the HSCP Board.
- East Dunbartonshire's Child Protection Committee – the CSWO is the Chair of the Committee;
- East Dunbartonshire's Adult Protection Committee;
- the Delivering for Children and Young People Partnership (DCYPP);
- the North Strathclyde Multi Agency Public Protection Arrangements Strategic Oversight Group (MAPPA SOG);
- the Community Planning Executive Group - the first part of the CPEG meetings constitutes East Dunbartonshire's Chief Officers Group; and
- the Community Planning Partnership Board.

The CSWO is a member of the HSCP's Clinical and Care Governance Group (CCGG). The Chair of the CCGG is the HSCP's Clinical Director and membership includes the Chief Officer and a range of senior health and social work professionals. The role of the CCGG is to provide the HSCP Board with assurance that services are delivering safe, effective, person-centred care to the residents of East Dunbartonshire. The CCGG group meets on a bi-monthly basis and has covered a variety of diverse issues including: Stress and Distress interventions; falls prevention; the reviewing of significant clinical incidents and complaints, and quality improvements. The CCGG Annual Report 2016-17, which details the range of work undertaken, can be found on the Council and HSCP website[3].

The CSWO is also a member – and Chair – of the HSCP Professional Advisory Group (PAG). Its purpose is to provide a source of expert professional health and social care advice to the HSCP Board, linking the Board to professionals within health and social work, including the General Practitioner (GP) Forum. The PAG provides professional expertise to inform planning, the identification of priorities and the redesign of service provision. The PAG supports the delivery of the national outcomes for health and social care. At the end of reporting period in 2017 there was

[3] Ibid.

discussion within the PAG about the Terms of Reference and group membership. It was agreed that further work should be undertaken to review these and this will continue into 2018.

The CSWO reported to the Strategic Service Committees and Council meetings on key matters affecting social work services. Topics covered included, for example, proposed changes to legislation, policy and procedure, inspection activity as well as performance reporting. Elected members were kept appraised of important developments in social work. The Social Work Committee met on an eight-weekly basis and this provided an important forum for detailed discussion on a range of social work matters. It is worth noting that in April 2017, East Dunbartonshire Council amended the Administrative Scheme, deciding to disestablish the Social Work Committee and to create an Integrated Social Work Services Forum (ISWSF). This was in recognition of the changing face and reality of integration arrangements. The Terms of Reference for the new ISWSF agreed a thirteen member Forum (10 elected members plus three members represented on the HSCP Board) which seeks to shape and influence the strategic direction and agenda for the HSCP Board. This will be covered in more detail in the next CSWO Annual Report 2017/18.

In 2016/17, an area identified for development was the establishment of a Public Protection Working Group. This CSWO-led group would focus on common areas in policy, procedures and practice across child, adult and wider protection areas (i.e. the management of high risk offenders, domestic abuse and addictions). Particular attention would be paid to risk assessment and risk management practices, supported by training and guidance. This group is still developing and initial discussions with key partners are progressing. There is a strong commitment to putting this group on a stronger footing in 2017/18.

As noted earlier, work began in the reporting period to strengthen our approach to Corporate Parenting. The multi-agency Corporate Parenting Steering Group recognised the need to involve more partners in the planning and work associated with this agenda. There was a strong commitment to the involvement of care experienced young people as equal partners in the planning of our approach. Consequently we submitted a proposal to the Life Changes Trust to develop a Young Person's Champions Board and a Peer Mentoring Programme, which would be supported by two Modern Apprenticeships. At the time of writing, I am happy to report that the proposal was successful and that the Life Changes Trust has awarded three years funding to progress this initiative. Further updates will be provided in the future CSWO Annual Reports.

4. Social Services Delivery Landscape

East Dunbartonshire lies to the north of Glasgow and has a population of 106,960. The Council covers a geographical area of 77 square miles and is in the mid-range of Scottish local authorities (i.e. a middle-sized council). East Dunbartonshire is recognised as an excellent place to live based on health, life expectancy and school performance. However, considerable inequalities do exist across the authority with pockets of significant deprivation. Recent analysis of local data confirms a continuing gap in equalities between our most and least deprived communities.

In terms of population in East Dunbartonshire, the mid-2016 population estimates show 61% are of working age, 17.5% under 16 years of age and 22% of pensionable age. Recent projections suggest that the population of East Dunbartonshire Council will increase by 5.9% over the next 25 years. According to National Records of Scotland, the overall population increase is a result from migration alone. The number of children (0-15 years) is projected to increase by 4.4% during this period, whilst the population of pensionable age is expected to rise by 30.4%. The working age population is predicted to decrease by 3.2%. The highest population increase will be seen in those aged 75 and over with a predicted increase of 95%.

The Council has a diverse community, with 4.2% of the population regarding themselves as being from a Black/Minority Ethnic Community (BME) according to figures from the 2011 Census. The

Asian population was the largest minority ethnic group (3.3%) in East Dunbartonshire. Within this, Indian was the largest individual category, accounting for 1.5% of the total population.

East Dunbartonshire is, in the main, a prosperous area where employment rates are high and levels of crime fall significantly below the Scottish average. That said, there are pockets of deprivation where major inequalities exist and the quality of life falls below the national average. Within the authority, seven data zones fall into the top 25% most deprived in Scotland. These data zones are located in Hillhead, Lennoxtown, Auchinairn and Kirkintilloch West. The Scottish Index of Multiple Deprivation (SIMD) ranks in the Hillhead area have improved with two datazones moving out of the 5% most deprived in Scotland and the majority of datazones showing less deprivation than in SIMD 2012. However, Hillhead remains the most deprived area in East Dunbartonshire, with one datazone in the top 10% most deprived in Scotland; the same datazone also appears in the top 5% most deprived in the Health domain. Social care and social work services are working with key partners to ensure that our collective contributions can help tackle inequality and improve the life chances for individuals in these communities.

Social care and social work services support the endeavours of the Council and other community planning partners, which is targeted through *Place* based initiatives. This activity is aimed at strengthening the focus on prevention and targeted support. These principles have underpinned the development of our Place approach to joint resourcing in Hillhead and more recently in Lennoxtown, Auchinairn and Twechar where community planning partners are working together with local people to target interventions and design services aimed at regenerating the area. More can be found on this at https://www.eastdunbarton.gov.uk/our-local-outcomes.

In this reporting period, East Dunbartonshire's social work services operated within a landscape that has been significantly affected by austerity, changing demographics, increasing demand for services, new legislative and policy imperatives and the increasing complexity of risk/need. The economic downturn resulted in financial constraints for East Dunbartonshire Council, as it has done for many other Scottish local authorities and public bodies. In adult services, there was – and continues to be – increasing demand on services for older people, for those individuals with a learning disability and for those people with substance misuse and mental health difficulties. In children services, we saw a rise in the numbers of vulnerable children coming to the attention of social work services. This was demonstrated by high numbers of children on the child protection register, a growth in the numbers of children who require to be looked after and an upsurge in the numbers of vulnerable children in need of social work interventions. In the field of criminal justice, the introduction of Community Payback Orders resulted in initial increases to the number of disposals from Court.

The Social Care/Social Work Marketplace

In the current reporting period, social care service provision continued to be a mixture of in-house delivery and commissioned provision. 70% was provided by the Third and Independent Sectors, with the remainder provided in-house by the Council on behalf of the HSCP. It is important that the market continues to develop and remains flexible and responsive to current and future need. The HSCP is, at the time of writing, developing a three year Business Plan to provide the platform from which a newly commissioned landscape - one which offers more choice and control and is financially sustainable - evolves. All key stakeholders including service users, carer groups, the third and private sectors will be involved in developing and shaping the Business Plan and thereafter, in terms of facilitating market change. The Business Plan underpins the HSCP's Strategic Plan which is currently being updated.

Advocacy

Social work services recognise the importance of independent advocacy for service users and their carers. This is often focused on individuals who require advocacy support in their engagement with public bodies. However advocacy also plays an important part in our engagement with service users and carers in respect of helping shape the social care marketplace. Two examples of current advocacy work are highlighted below.

Ceartas, a local third sector organisation, was commissioned to deliver independent advocacy support to service users (16 years+) across all client groups (e.g. physical disability, sensory impairment, older people, dementia and mental health etc.). Within the context of service provision, Ceartas provided individual support and group work as well as signposting individuals to alternative support/programmes. This was aimed towards helping people improve their self-confidence; reduce isolation; increase support networks; and people's ability to self-advocate.

Ceartas played - and continues to play - an important role in terms of community development and as such, is an active member of various strategic planning groups including: Locality Planning Groups, East Dunbartonshire's Adult Protection Committee, Equality Engagement Group, Empowered, Welfare Reform Group, and Community Planning.

East Dunbartonshire Council also commissioned Who Cares? Scotland to provide advocacy support to Looked After and Accommodated Children. The organisation has helped children and young people to make their voices heard and ensured that their rights are respected. Who Cares? Scotland has assisted in the planning in respect of the Corporate Parenting agenda and will be involved in the development of the Young Person's Champions Board.

5. Resources

As previously noted, managing public sector austerity and reducing financial resources within a climate of increasing demand for services, is a key risk area for the Council and the HSCP. Like other local authorities, East Dunbartonshire Council has faced increasingly difficult financial challenges over recent years, and the reduction in public sector budgets will continue over the next financial planning period (3-5 years). The most significant uncertainties to the delivery of service objectives are:

- The demographics associated with an ageing population – Care budgets face on-going pressure. This still remains a significant challenge to be addressed.
- Complexity of care required – There are numerous areas where complex care packages are required and these are costly to deliver. There are examples in child protection; in working with children/young adults with significant mental health problems and a history of self-harm; and with offenders who pose significant risk of serious harm to the public. Increased child and adult survival rates are also a factor in this area.
- Inflation – Limited provision is available to address price movements. Containing spend pressures will be difficult in areas like care fees, recycling costs and utility costs.
- Future Scottish Government funding – Council specific information on the levels of revenue grant funding is not available beyond 2017/18. This uncertainty is having an impact on future financial planning with anticipated reductions in budget being set against increasing demand for services.
- Welfare reform – Provision has been made for services and income sources related to Welfare Reform. Discretionary Housing Payment and Universal Credit are key factors. The reforms are still being rolled out nationally, although within East

Dunbartonshire full service roll out commenced in November 2016 and rent arrears have increased as a result.

The approved 2017/18 Revenue Budget for East Dunbartonshire Council had to incorporate a range of outcomes, which the Scottish Government wanted to achieve, that included:

- Funding commitments to the Health and Social Care Partnership, and
- Supporting attainment in schools.

Reductions in central government funding are such that there continues to be a financial gap between our projected expenditure commitments and the anticipated budget settlement. Measures to address this financial gap are contained in East Dunbartonshire Council's "*Strategic Planning and Performance Framework 2017/18: Transformational Change and Budget Reduction Strategy*" which considers alternative models of service delivery and workforce planning.[4]

In preparation for integration, financial governance arrangements were developed between the Council and the HSCP to support the latter in the discharge of its business. This included financial scoping, budget preparation, standing orders, financial regulations and the code of corporate governance to support the activities of the HSCP Board and Audit Committee. Such arrangements ensure the adequacy of the arrangements for risk management, governance and the control of the delegated resources.

The activities of the Health & Social Care Partnership were the subject of regular reporting throughout the financial year. There was a year-end underspend of £4.1m on the partnership funding available relating primarily to a favourable position in relation to the Social Care Funding from the Scottish Government (£1.7m). An element of this Social Care funding was provided to meet the costs associated with implementing the Scottish Living Wage across care home, care at home and housing support services from the 1st October 2016. This created an in-year surplus due to the full funding allocation being made available in 2016/17 to meet a part-year requirement. The full cost will become liable during 2017/18.

In addition there were surpluses across Children's Social Work budgets (£460k) as a result of vacancies across the service which off-set pressure on residential school expenditure. There was also a small surplus on adult service budgets (£280k) across learning disability and mental health services, which off-set pressure in relation to older people services. There was some additional surplus in relation to other budgets delegated to the partnership in relation to the Private Sector Housing Grant (PSHG), care & repair and fleet recharges (£242k). NHS Community budgets also delivered a surplus (£1.4m) in relation to delays in filling vacancies across community functions including Oral Health, District Nursing and Rehabilitation Services. There was also a surplus on the Integrated Care Fund which was not fully allocated in year and delayed discharge monies which were directed to fund an Intermediate Care Facility (part year costs only). The surplus generated during 2016/17 furthered the Partnership's reserves position and provided some resilience for future year financial pressures and any slippage in savings targets. In the reporting period, the HSCP ear-marked an element of these reserves for potential service re-design in pursuit of the expected priorities, which would be set out in the forthcoming Strategic Plan. It is worth noting too that the reserves available in the period were exceptional and are not expected to be replicated in the future.

Looking Ahead

The HSCP continues to face significant financial pressures from demographic growth particularly amongst the elderly population, which is expected to generate demand and increased costs across a range of adult care services. There are different but similarly concerning pressures in children and criminal justice services.

[4] Ibid.

Both the Council and NHS GGC continue to face significant financial challenges. The NHS Greater Glasgow & Clyde Health Board has savings of +£100m to secure during 2017/18 with a number of initiatives underway to deliver on this challenge. Of the circa. £95m savings target, £16.6m relates to the six Health & Social Care Partnerships operating within the Board area, of which £1.5m relates to East Dunbartonshire with potential for a further share of £3.6m (ED - £0.5m share) relating to un-achieved savings dating back to 2015/16 for Community Health Partnerships.

East Dunbartonshire Council is facing significant challenges with £11.7m required to close the funding gap during 2017/18. This will predominantly be delivered through the Council's transformation and budget reduction programme with the aim of protecting the provision of frontline service delivery. The financial settlement to the Partnership is particularly challenging with a further £3.6m of savings to be delivered during 2017/18.

In total, the level of savings on the HSCP is £5.1m for 2017/18 and it is expected that this position will continue for future years given the challenging financial settlements expected to both the Council and NHSGGC. There is some recurring funding available to Health & Social Care Partnerships from the Scottish Government.

In short, the financial outlook remains challenging. New imaginative, effective and efficient solutions will be required as we attempt to meet the financial and demand challenges, and the expectations of our communities about what services should and could be provided. There is a need to refocus our attention on preventative, early intervention and more community-based services whilst simultaneously ensuring specialist and targeted services are available when required.

6. Service Quality, Performance and Delivery of Statutory Functions

East Dunbartonshire Council and the Health and Social Care Partnership have robust performance monitoring, management and quality assurance systems in place. Social work services reported on a monthly, quarterly, six monthly and annual bases. There are a range of fora within which performance data or management information was reported or discussed in 2016/17. These included:

- The HSCP Senior Management Team and the Board;
- The Social Work Committee and full Council;
- The Community Planning Executive Group (Chief Officer's Group: COG);
- The Delivering for Children and Young People's Partnership (DCYPP);
- The Child Protection Committee (CPC);
- The Adult Protection Committee (APC);
- The MAPPA Strategic Oversight Group (SOG); and
- NHS Greater Glasgow and Clyde Heads of Children's Services Group.

Performance management systems utilised a range of data that informed the deployment of resources and the development of services. This included:

- statistical data highlighting patterns and trends
- outcomes from quality assurance activity
- the outcome of case file audits – both thematic and case specific
- consultation activity involving service users and carers
- benchmarking activity
- the outcome of external inspection by the Care Inspectorate

A culture of self-evaluation and continuous improvement has been embedded across all services. A coordinated approach has seen the implementation of outcome-focused assessment and care planning. A programme of systematic case file audits has been one of a number of tools which have secured improved standards. Supervision and training remains a key priority to ensure our staff are supported to maintain the knowledge and understanding required to deliver on our statutory functions.

Detailed below are a number of tables showing performance data (both local and national) for the reporting period 2016/17. These are set within the context of Local Outcomes. A brief commentary is also provided, as required.

It should be noted that as the delegation of Children and Criminal Justice functions from the Council to the HSCP took place in August 2016, the reporting of outcomes has not been aligned in this reporting period, though will be in the next CSWO Annual Report. The information relating to adult services and those of children and criminal justice are therefore reported separately below, as are the outcomes they are linked to (Health and Council ones).

Adult Services

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

National Core Indicator	2015/16	2016/17
Percentage of adults able to look after their health very well or quite well	95.1%	95.1%

HSCP Performance Measure	Target 2016/17	2016/17
Number of alcohol brief interventions delivered	366	487
Percentage of clients will wait no longer than 3 weeks from referral to alcohol and drug treatment	91.5%	88.2%
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	85%	92.5%

- The number of Alcohol Brief Interventions (ABI's) completed for 2016/17 was 33% above target. The uptake of ABI's within the wider community setting was very positive, but there was a low uptake within the primary care setting. The annual performance plan for ABI's will reflect actions to encourage and support uptake within primary care.
- The integrated East Dunbartonshire Drugs & Alcohol Service (EDADS) is working to improve the waiting times from referral to alcohol and drug treatment. The team has begun to redesign the referral process, integrate health and social work administration processes, and ensure senior staff within the team are overseeing the recording processes for waiting times.
- The Psychological therapies 18 week target remained above target for 2016/17. Evening appointments and localised clinic have been introduced to further improve access to early intervention and support for those with mental health issues.

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

National Core Indicators	2015/16	2016/17
Emergency admission rate (per 100,000 population)	13,258	12,136
Emergency bed day rate (per 100,000 population)	133,667	120,348
Readmission to hospital within 28 days (per 1,000 population)	79	78
Proportion of last 6 months of life spent at home or in a community setting	86%	86%
Percentage of adults with intensive care needs receiving care at home	67%	67%
Number of days people spent in hospital when they are ready to be discharged (per 1,000 population)	379	186

HSCP Performance Measure	Target 2016/17	2016/17
Rate of unplanned acute bed days 75+ (per 1,000 pop)	345	364
Number of emergency admissions 75+ rate (per 1,000 pop)	29	28
Number of acute bed days lost to delayed discharges for Adults with Incapacity (aged 65+)	0	0
Number of people 65+ with anticipatory care plans in place (District Nursing only)	70	67
Number of people aged 65+ in permanent care home placement	640	681
Percentage of people 65 or over with intensive needs receiving care at home	32%	38.4%
Percentage of EDC homecare customers 65+ receiving a service during the evenings or overnight	50%	52.9%
Percentage of EDC homecare customers 65+ receiving service at weekends	84%	93.3%

- The reduction in delayed discharges was achieved over a sustained period. A range of activities contributed to this success including:

    - Weekly delayed discharge meetings enabled early identification of people admitted to hospital who potentially require complex discharge planning. This included consideration of those suitable for intermediate care;
    - Eight intermediate care beds were commissioned within a local Care Home and have been operational since November 2016. The inter agency approach is undergoing a formal evaluation, but early indicators suggest that over 30% of those transferred to this facility are able to return to their own homes after a short period of rehabilitation; and
    - Access to services has been improved including self referral to the Community Rehabilitation Team (CRT). A single point of access for all weekend calls from acute services to nursing and CRT is now being coordinated through the Homecare Team to enable people to be discharged from hospital at the weekends.

- Building on the success in reducing the number of delayed discharge bed days, emergency admissions and the emergency bed days rate, the focus will remain on reducing our hospital emergency admissions and bed days rates which remain above the Scottish average.

- The Rapid Assessment Link team provides GPs with a rapid response service for people who are at potential risk of hospital admission. During 2016/17, the team received 264 referrals of which 202 (76.5%) people avoided the requirement for a hospital admission by receiving appropriate care in their own home.
- The Red Cross, funded through the Integrated Care Fund, provide transport home for older people who are discharged from A&E. This involves taking the patient home and helping settle them back into their homes. During 2016, 118 East Dunbartonshire residents benefitted from this service and avoided unnecessary hospital admission.
- The Community Mental Health Team meets weekly with Secondary Care and Crisis Team colleagues to review hospital admissions and repeat A&E attendees, and discuss if they could have been avoided. Each person's individual care and treatment plan is reviewed to ensure they receive the correct treatment and support in the community to prevent hospital attendance.

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

National Core Indicator	2015/16	2016/17
Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	75%	75%
Percentage of adults receiving any care or support who rate it as excellent or good	82%	84%
Percentage of people with positive experience of care at their GP Practice	91%	91%

HSCP Performance Measure	Target 2016/17	2016/17
Percentage of people 65+ indicating satisfaction with their social interaction opportunities	100%	95%
Percentage of service users satisfied with their involvement in the design of their care packages	100%	95%
Percentage of service users satisfied with the quality of social care provided	100%	99%

- The national Health & Social Care Experience survey, which is undertaken ever two years, focussed on the importance of a personal outcomes approach. The HSCP improved performance against all these outcomes in 2015/16. A working group has been established to develop a tool which will collate service user data on a more regular basis to ensure personalised care is at the centre of service delivery. This will build on the service user Reflective Questionnaire developed by the Community Rehabilitation Team, and the 'How Are We Doing' methodology introduced by Community Nursing.
- HSCP Mental Health staff and East Dunbartonshire Alcohol & Drug Services (EDADS) undertook trauma awareness training, and have worked with service users who have experienced trauma. This model is encouraging service users to attend the clinic sessions which have been designed to provide a more positive experience and environment for those attending.

- ***Local Outcome 4 - Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services***

National Core Indicator	2015/16	2016/17
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	83%	86%

HSCP Performance Measure	Target 2016/17	2016/17
Number of newly diagnosed people with Dementia in receipt of one year's post diagnostic support	100%	18%

- Maintaining quality of life for those with a diagnosis of dementia, and their carers, continues to be a priority. In partnership with third sector organisations, a range of initiatives have been established to support those impacted by dementia including:

  - Dementia website now live: **www.eddn.org.uk**
  - Intergenerational café supported by 48 secondary 6 school pupils
  - People with dementia are contributing to the quality of their life through introduction of PRESENT Charter and local Dementia Voices group
  - Dementia friendly sites established in supermarkets and golf clubs.
  - 4 weekly supported walks
  - Music Network

- The Joint Learning Disability Team (JLDT) provides specialist assessment, advice, treatment and support services for adults with a learning disability and their carers. Our service helped individuals to live as independently as possible with the right level of support they needed. We also developed a new local, residential intensive support facility for three adults with complex learning disabilities and autism. Prior to its development, individuals requiring this type of support would have been placed outwith East Dunbartonshire.

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

National Core Indicator	2015/16	2016/17
Percentage of carers who feel supported to continue in their caring role	39%	45%

HSCP Performance Measure	Target 2016/17	2016/17
Number of carers who feel supported and capable of continuing in a caring role	94%	97%

- The social care service user feedback demonstrated high level performance which exceeded the local target in relation to supporting carers to continue in their caring role.
- Our local (commissioned) third sector organisation, Carer's Link, provides support, information and advocacy to carers. Carers Link had direct or telephone contact with 1153 carers during 2016/17, of which 393 were new contacts.
- The Carer Information Strategy fund provided the opportunity to support the provision of the '*Caring with Confidence'* programme aimed to increase the resilience of carers. This programme, developed and provided by Carer's Link, supported 187 carers through one or

more of training sessions offered during 2016/17. Carer feedback reported that 98% agreed or strongly agreed that the session they attended made them feel more confident, less stressed and better informed in their caring role.

- ***Local Outcome 7 – People who use health and social care services are safe from harm***

National Core Indicator	2015/16	2016/17
Percentage of adults supported at home who agree they felt safe	83%	86%

HSCP Performance Measure	2015/16	2016/17
Falls rate per 1,000 population aged 65+	21	21
Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	83%	83%

- The East Dunbartonshire Falls Pathways was implemented in partnership with Care Homes and the Scottish Ambulance Service to support the identification of people who are at risk of falling, and take action to prevent further falls. This has led to a reduction in the number of falls admissions to hospital.

- The Care and Repair service, which undertakes small repairs and adaptations to keep older people safe in their homes, received Integrated Care Funding to provide a home safety advice and information service to older people. Over 100 older people benefitted from this advice, helping to keep them safe in their own homes.

- A Scottish Patient Safety Programme pilot was commenced in 5 care homes within East Dunbartonshire. The programme was particularly focused on reducing pressure ulcers and the introduction of insulin management plans for appropriate individuals. The peer grading of pressure ulcers and review of record keeping was introduced and pressure ulcer data collection commenced in November 2016, with the 5 Homes submitting results monthly.

- A number of interventions have been introduced to support vulnerable adults including:

    - Introducing a thresholds framework to improve the consistency of adult support and protection referrals made by care providers and other partners.
    - Developing effective policy and practice for young adults in transition between children's and adult services.
    - Providing a professional seminar and staff guidance on Sexual Harm; identified by a multi-agency case file audit as an area for improved practice, particularly around recognition and response.
    - Improving staff knowledge and understanding on the impact of both alcohol misuse and domestic abuse in older age
    - Continuing to develop policy and raise employee and public awareness about a range of inter-sectional violence issues including Female Genital Mutilation; Human Trafficking and Exploitation, and Hate Crime.
    - Preparing for the arrival of unaccompanied asylum-seeking children, and refugee families resettling in East Dunbartonshire under the Syrian Resettlement Programme.

- In East Dunbartonshire, 5 services were inspected by the Care Inspectorate in the last year and the findings were extremely positive and provide an indication of the quality of services delivered. Plans are in development to progress areas for improvement.

Children's services

- **Outcome 3 - Our children and young people are safe, healthy and ready to learn**

Code	PI Title	2016/17 Target	2016/17 Value
ECS-01-BIP-3	% of child care Integrated Comprehensive Assessments (ICA) for Scottish Children's Reporter Administration (SCRA) completed within target timescales (20 days), as per national target	**75%**	**94%**
ECS-02-BIP-3	% of first Child Protection review case conferences taking place within 3 months of registration	**95%**	**100%**
ECS-04-BIP-3	% of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated	**100%**	**96%**
IHSC-SOL-CHN9	Balance of Care for looked after children: % of children being looked after in the Community	**86%**	**89%**

- There was consistently strong performance in ensuring that ICAs were completed in line with the national target of 20 days. Ensuring that reports are available to SCRA on time means that children and young people's needs are addressed quickly and that they have access to the right support at the right time.
- All Child Protection Review Case Conferences took place within three months throughout the reporting period. This ensured that the plans made to protect young people at risk were regularly reviewed and adapted as required to keep them safe and healthy.
- With the exception of the first quarter of 206/17, all Looked After and Accommodated Review meetings took place within 4 weeks. Whilst performance was slightly below our target overall, it should be noted that the number of cases where the target was not met was small.
- In the reporting period, we exceeded our target of maintaining a high percentage of looked after children in the community rather than in residential care settings. However, as the table below shows, there has been a 16% increase in the number of residential placements being used over the last five years.

Looked After children: Balance of Care

Placement Type	31 Mar 2013	31 Mar 2014	31 Mar 2015	31 Mar 2016	31 Mar 2017	% over 5 years
At Home with Parents	64	44	65	51	47	**-27%**
Semi-Independent Living / Supported Accommodation	0	0	4	1	0	
With Friends/Relatives	48	52	47	54	52	
With Foster Carers	28	29	41	40	43	
With Prospective Adopters	2	1	0	1	0	
Total Community	**142**	**126**	**157**	**147**	**142**	**0% change**
Hospital	0	0	1	1	0	
LA Children's Home	6	7	9	10	6	
Residential School	6	6	2	3	4	
Secure Accommodation	2	2	0	0	1	
Voluntary Children's	5	7	4	8	11	

Home						
Close Support Unit	0	1	0	0	0	
In Custody	0	0	0	1	0	
Total Residential	**19**	**23**	**16**	**23**	**22**	**+16%**
% COMMUNITY PLACEMENTS	**88%**	**85%**	**91%**	**86%**	**87%**	

Criminal Justice Services

- **Outcome 4 - East Dunbartonshire is a safe sustainable environment in which to live, work & visit**

Code	PI Title	2016/17 Target	2016/17 Value
ECS-07-BIP-6	% of CJSW Reports submitted to court by due date	**95%**	**100%**
ECS-08-BIP-6	The % of individuals beginning a work placement within 7 working days of receiving a Community Payback Order	**80%**	**72%**

- Criminal Justice Services provide reports to Court to assist the sentencing process. Our reports provide Sheriffs and Judges with a range of information, for example, on an individual's background, their health and personal situation etc. Importantly, they also cover information pertaining to the assessed level of risk the person may pose to individuals and the wider community, as well as an assessment of the suitability of the options available to the Court in dealing with the matter at hand. In meeting the target set, criminal justice services have been able to support the efficient use of the Court's resources and also helped ensure that East Dunbartonshire is a safe place to live and visit.
- Community Payback Orders allow individuals to make amends to the community for their wrongdoing. It is vitally important that a CPO placement begins shortly after the offender's Court appearance in order to maintain the connections between the crime, the Court's finding and the *punishment*. The trend of unpaid work hours imposed by the Courts has steadily increased, showing an overall increase of 65% since Community Payback Orders were introduced in 2011. Our performance in arranging CPO placements has been below our target in this period. However, this has overwhelmingly been as a result of factors outwith the service's control: for example, an offender's failure to attend; their ill-health; or their employment impinging on the Court Order's requirement. Plans are in place to ensure that we address this as far as is possible in the future. Noted below are some of the activities undertaken in the community by those on CPO placements.

    - Lennoxtown community council - gardening, fencing, tidy of public areas
    - Harestanes community council - painting and general handyman jobs
    - Campsie community council - clearing railway walkway
    - Hillhead housing 2000 - removal of fly tipping
    - Mugdock country rangers - ground and park maintenance
    - Scottish canals - bridge painting and litter picking
    - Caurnie angling club - ground maintenance
    - Milngavie in Bloom - leaf clearing
    - St Margaret's hospice - uplift and delivery of sold goods and disposing of unsold goods
    - St Cyprian's Church - setting up polling station
    - St John of the Cross Church - fence building and painting
    - Abbyfield nursing home, Lenzie - garden landscaping and building of greenhouse

- A local gritting service is available in winter to help vulnerable people in the community

- Unpaid work projects in 2016/17 in East Dunbartonshire completed 17,654 hours of unpaid work. This equates to approx £127,100 of unpaid work in the community (based on current levels of the National Living Wage)
- Criminal justice services continued to fulfil their responsibilities with respect to the Multi Agency Public Protection Arrangements (MAPPA). There are three risk management *levels* in the MAPPA. These are designed to ensure that resources are focused upon the cases where they are most needed, i.e. targeted generally at those individuals assessed as posing higher risks of serious harm. The levels are described as follows:

    - Level 1: routine risk management – where the risks can be managed by a single agency or multi-agency but do not require the attendance or commitment of resources at a senior level.
    - Level 2: multi-agency risk management – where the risks require multi-agency involvement and management oversight along with the resource input of senior management.
    - Level 3: Multi Agency Public Protection Panels (MAPPP) – For the critical few where the risk presented can only be managed by a plan which requires close co-operation at a senior level. This would be due to the complexity of the case and/or because of the unusual resource commitments required. This also applies to those cases where there may be high levels of media scrutiny and/or public interest in the management of the case.

- In the reporting period, on average 41 individuals were being managed each quarter by the responsible authorities. The overwhelming majority were managed at Level 1, with approx three individuals managed at Level 2 and no offenders being managed at Level 3.
- To prepare for the MAPPA expansion to include all category 3 offenders (mainly violent), all criminal justice social workers were trained by the Risk Management Authority to use their specialist Risk Management and Contingency Planning framework.
- In the reporting period, East Dunbartonshire Council/HSCP continued to benefit from an effective working partnership with the Scottish Prison Service via HMP Low Moss, providing around 110 reports to the Parole Board and the SPS. The prison based social work team played a key role in working with a range of partners in a coordinated multi agency approach by contributing to over 400 Integrated Case Management meetings. The focus of these meetings is on public protection alongside rehabilitation and reintegration to promote safe and positive outcomes for those returning home to their communities.

Child and Adult Protection

Child Protection Committee (CPC)

As noted earlier, the CSWO chairs East Dunbartonshire's Child Protection Committee. The Committee consists of representatives from a range of agencies including education, social work and housing services, Police Scotland, NHS Greater Glasgow and Clyde, the Scottish Children's Reporter's Administration and the third sector. The Chair and Committee are supported by the Council's Child Protection Lead Officer. Working in partnership, these representatives carry out the core functions of the CPC, which the National Guidance for Child Protection in Scotland (2014) specifies as continuous improvement, strategic planning and public information & communication. The multi-agency Committee produces an annual business plan and manages the required work through three standing sub-groups:-

- Management Information & Self-evaluation
- Learning & Development
- Public Information & Communication

In additional, in 2016/17, short life working groups were formed to undertake specific pieces of work. This included, for example, a group looking at the recommendations emanating from the Bailey Gwynne Significant Case Review and what lessons could be learned for East Dunbartonshire. This led to the development and introduction of Anti-Knife and Weapon Guidance for staff.

Key Developments in Child Protection

The Committee was reinvigorated in October 2016 and agreed new Terms of Reference. This included reviewing the structure of the CPC and subgroups described above. This was a key development that enabled the functions of the Committee to be discharged in an effective manner and provided the CPC with clear, structured information from sub-groups on their specific focus areas. All subgroups carried out a process of self-evaluation in relation to their specific area of focus and agreed revised plans for 2017/18.

The Public Information and Communication Subgroup publicised and supported Safer Internet Day on 7th February 2017. This was complemented by joint work with Police Scotland and schools working together to provide awareness raising sessions for children and supporting schools to build the capacity of teachers to address internet safety within the curriculum. A baseline sample audit of the awareness level of children was carried out prior to Internet Safety Day and this was repeated in June 2017 to measure impact.

It should be noted that the Scottish Government published two key reports on child protection in March 2017: The *Child Protection Improvement Programme Report* and *Protecting Scotland's Children and Young People: It is Still Everyone's Job*. These reports can be found at http://www.gov.scot/Topics/People/Young-People/protecting/child-protection.

There are nine interconnected work strands within the reports, which are helping to deliver an improved child protection system, focusing on:

1. Child Protection Systems Review;
2. Neglect;
3. Child Sexual Exploitation;
4. Child Trafficking;
5. Child Internet Safety;
6. Children's Hearings;
7. Inspections;
8. Leadership; and,
9. Data and Evidence

Thirty five Action Points and 12 key recommendations emanate from the reports. The Child Protection Committee, the Chief Officers Group, the HSCP Board and the Integrated Social Work Services Forum have all been advised of this work and the implications this will have on the future work of the Committee and other partners. Progress against our business plan will be reported in the next CSWO Annual Report.

Child Protection Services

The tables below provide a broad overview on the number of children and young people with whom East Dunbartonshire's Child Protection Services have had contact over the past five reporting periods. The figures indicate that the number of children coming to our attention has grown significantly: a 30% increase in the number of child protection investigations since 2012/13.

	2012/13	2013/14	2014/15	2015/16	2016/17
CP Investigations	142	171	154	171	185
CP Conferences	212	265	301	313	294
CP Registrations	42	80	69	83	73
CP De-registrations	56	68	73	73	83
Total on CP Register at Year End	**32**	**44**	**40**	**50**	**42**

Type of Case Conference	**Number of Children Subject to Case Conference**
Pre-birth	5
Initial	69
Review	219
Transfer In	1
TOTAL	**294**

No. of De-registrations by length of Registration	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Less than 6 months	36	39	41	38	45
6 months to under 1 year	14	21	23	28	21
1 year to under 18 months	6	5	9	6	16
18 months to under 2 years	0	3	0	1	1
TOTAL	**56**	**68**	**73**	**73**	**83**

Re-registrations by length of time since last de-registered	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Less than 6 months	3	1	4	0	7
6 months to under 1 year	4	0	0	0	2
1 year to under 18 months	0	0	0	0	3
18 months to under 2 years	0	0	0	3	0
2 years or more	0	6	10	11	12
TOTAL	**7**	**7**	**14**	**14**	**24**

Adult Support & Protection

The Council is designated as lead agency for Adult Support and Protection (ASP) by the 2007 Act of the same name. The Council has statutory duties to set up and support East Dunbartonshire's Adult Protection Committee; to make inquiries where an adult is suspected to be at risk of harm; and to apply for protection orders where these are required to safeguard the adult. The Council's duties were delegated to the Health and Social Care Partnership with the establishment of East Dunbartonshire Integration Joint Board. Qualified social workers continue to be trained and authorised to carry out "Council Officer" duties in East Dunbartonshire, as required by the legislation.

The Adult Protection Committee is independently chaired and has representation from all key agencies. The convenor and Committee are supported by the Council's Adult Protection Coordinator. A report on the Committee's activity is submitted to the Scottish Government on a biennial basis, most recently on 31 October 2016[5].

[5] For further info, please see https://www.eastdunbarton.gov.uk/health-and-social-care/services-adults-and-older-people/adult-protection.

Key Developments in Adult Protection

The Committee has established an annual multi-agency case file audit, and sponsors annual multi-agency learning events. Amongst the findings from the 2016 audit was the need to strengthen practitioner understanding and confidence in responding to sexual relationships and sexual harm. This led to the development of Health & Social Care practice guidance which was launched at a professional seminar in February 2017. The 2017 audit has identified the need for Social Work to improve arrangements to support and protect young adults in transition between children's and adult services. This work will be taken forward by the HSCP.

On 1 April 2016, recording of all ASP activity undertaken by Social Work (bar minuted meetings) was switched to the Carefirst electronic database. This positive development supported the out of hours services, including East Dunbartonshire Home Care and Glasgow & Partners Emergency Social Work Services, to access comprehensive, up-to-date service user information and so improved our ability to respond and protect adults at acute risk on a 24 hour basis.

The performance of the social work service in respect of ASP activity is reported regularly via internal and Community Planning structures, providing a reliable indicator of the efficiency of our systems and processes. A significant trend in 2016 was a reduction in the percentage of ASP referrals which were progressed to inquiry within local timescales. This trend was associated with a 36% increase in the volume of ASP referrals and inquiries undertaken by Adult Social Work during 2016/17.

The substantial increase in the use of the Section 4 *duty to inquire* provision in 2016/17 did not result in an equivalent rise in the use of the Council's other safeguarding powers and duties. This can be explained by the significant number of adults referred who were not assessed as an adult at risk of harm, or because appropriate action had already been taken to reduce the risk. East Dunbartonshire's intervention framework offers less restrictive options, including a repeat referrals protocol and risk assessment & management procedures (RAMP), which can prevent escalation of harm.

Provision of Adult Support and Protection Services in 2016-17:

Nature of Activity	Number
Duty to Inquire	550
Planning meetings (including those convened under the Repeat Referrals Protocol)	16
Investigations	22
Case conferences	24
Review case conferences	20
Protection plans initiated in 2015-16	7
Temporary Banning Orders	0
Banning Orders	1

Service User Feedback

The Adult Protection Committee has an established Service User and Carer consultation sub-group. The group contributed to the launch of a new feedback system for adults subject of ASP protection plans during 2016-17. Additionally, as part of the Community Care case file audit, the Ceartas Advocacy service was commissioned to interview service users, including some adults who had received ASP services, about the impact of social work intervention. The feedback received helped shape service activity.

Carers

The *Carers (Scotland) Act 2016* was passed by the Scottish Parliament on 4 February 2016 and received Royal Assent on 9th March 2016. It is due to come into force on 1 April 2018. East Dunbartonshire's Health and Social Care Partnership has been preparing for this and is in the process of completing the 'Readiness toolkit for the Carers Act'. There are 15 areas to be completed:

- Programme Management and Governance,
- Workforce Support and Development,
- Role of the Third Sector,
- Communications and Public Awareness,
- Providing real choice / Commissioning,
- Information and Systems,
- Finance and Demand,
- Monitoring and Evaluation,
- Adult carer support plans,
- Young carer statements,
- Local eligibility criteria,
- Duty to provide support to carers,
- Carer involvement,
- Local Carer Strategies and,
- Information and advice service for carers

Some early work on the implications of the Act for East Dunbartonshire began in the reporting period and this has carried on since then. Further information will be reported in the next CSWO Annual Report.

7. Workforce Planning and Development

East Dunbartonshire Council and NHS Greater Glasgow and Clyde have systems for staff performance appraisals: respectively Personal Development Reviews (PDRs) and Employee – Skills and Knowledge Framework (e-SKF). These are important processes for ensuring that staff are supported in maintaining their skills and knowledge to effectively undertake their roles.

With respect to training, the CSWO Chairs the Social Work Training Sub Group, which considers the training requirements of staff and sets out the training plan to meet existing and future demands. This plan serves as a focus for planning with colleagues in human resources and finance.

In 2016/17, Adult services reorganised their senior management team to ensure that it reflected the integration priorities. That same approach will be considered in 2017/18 for Children's services given the delegation of NHS Community Health Services under the management of the Head of Children and Criminal Justice Services.

8. Improvement Approaches

There are a number of the Improvement Approaches we intend to take forward in 2017/18. Highlighted below are three key ones.

Self Directed Support (SDS)
We will explore and develop pilot projects within our children and families, mental health, and addiction recovery services in order to continue our efforts to raise awareness, build capacity and increase the uptake of Self Directed Support options amongst these customer groups.

We have seen a steady increase in customers choosing Self Directed Support Option 2 which has encouraged us to work closely with support provider organisations, finance and procurement colleagues to ensure that this option is being utilised in the spirit intended by the legislation.

Over the course of the next year, we plan to:

- Evaluate the one year brokerage pilot that we established for customers with a mental health illness.
- Consult on and review the local Self Directed Support Strategy incorporating the four national outcomes identified in the national Self Directed Support Implementation Plan for 2016 – 2018;
- Host a local 'Sharing the Self Directed Support Stories' event for all stakeholders where customers and carers share their own experiences of managing their own support packages;
- Explore the development of a local Framework that will support customers who utilise any of the Self Directed Support options.

Autism
The East Dunbartonshire Autism Strategy (ten year strategy) was launched in November 2015 and four priority themes were agreed; mainstreaming, training, pathways and transitions. Bishopbriggs Leisuredrome has been going through the process to gain an 'Autism friendly award'. The award criteria looks at five areas; customer information, staff awareness, physical environment, customer experience and promoting understanding. An autism friendly floor plan is being developed that will be accessible on the Leisure and Culture website. A range of basic awareness training and advanced training took place over 2016; a training needs analysis will be taking place to address any training gaps.

Work will be commencing to scope out and develop current autism pathways, from diagnosis into services for all age groups; particularly for individuals who do not fit neatly within social work or health services. Eligibility criteria and transitions need to be part of the pathway mapping.

Autism advisers are being developed across nursery, primary and secondary schools. The aim of the Autism Advisers initiative is to support the development of autism friendly educational establishments across East Dunbartonshire. The Autism Advisers will not replace any existing external services and supports who currently work in mainstream contexts e.g. speech and language therapy, educational psychology, education support teachers or language and communication outreach teacher. These services and supports will continue to work in partnership with nurseries and schools to support individual pupils and their families, and to support whole nursery/school developments. An 'Autism Friendly Nursery in East Dunbartonshire Council: Audit toolkit (2017)', 'Autism Adviser Collaborative Practitioner Enquiry Workbook' and the 'School Autism Adviser implementation guide has been developed' to support the advisers.

Transitions
Transitions for young people moving from children's services into adult services has been raised as an area that requires development. The *Principles of Good Transitions 3*[6] was recently launched to provide a framework and structure around the improvement of support for young people with additional needs between the ages of 14 and 25 who are making the transition to adult services. The Principles of Good Transitions 3 is divided into 8 parts: the seven principles of good transitions and the autism supplement. The Autism Steering group has made a commitment to adopt the principles as part of the transitions process to ensure an earlier more supported transition.

[6] See https://scottishtransitions.org.uk/7-principles-of-good-transitions/

Agenda Item Number: 10

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	Public, Service User & Carer Representative Support Group
Report By	Martin Brickley (Service User Representative) / Jenny Proctor (Carers Representative)
Contact Officer	David Radford Health Improvement & Inequalities Manager David.radford@ggc.scot.nhs.uk 0141 355 2391

Purpose of Report	The report describes the discussions and actions following the latest meeting of the Public, Service User & Carer Representatives Support Group (PSUCRSG)

Recommendations	It is recommended that the HSCP Board note the progress of the Public, Service User & Carer Representatives Support Group.

Relevance to HSCP Board Strategic Plan	The report supports the ongoing commitment to engage with the Service Users and Carers in shaping the delivery of the HSCP priorities as detailed within the Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

Financial:	None

Legal:	None

Economic Impact:	None

Sustainability:	None

Risk Implications:	None

Implications for East Dunbartonshire Council:	None

Implications for NHS Greater Glasgow & Clyde:	None

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	**x**
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☐
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

1.0	**PURPOSE OF REPORT**
1.1	The attached report details the actions and progress of the PSUCRSG, following their latest meeting, highlighting their progress as detailed in **Appendix 1**.
2.0	**SUMMARY**
2.1	In total 9 meetings have taken place, the most recent was on the 4th December 2017.
2.2	Two new service users / carers attended the meeting, with a view to their future involvement with the West locality Group and the HSCP Strategic Group.
2.3	Members continue to develop their awareness and knowledge to the role and function of the Health & Social Care Partnership (HSCP), with the HSCP Planning and Information Officer providing an overview of the data pertaining to residents requiring admission to hospital and on hospital bed stays.
2.4	The group has invited the Clinical Pharmacy and Prescribing Lead Officer, to present at a future meeting with additional invitations extended to, and accepted by, the Joint Adult Services Managers for the March and May meetings.
2.5	Members are looking forward to receiving the HSCP Engagement Report and supporting the HSCP with the consultation of the Strategic Plan.
2.6	The group has agreed to develop succession planning for their group, considering the options towards the development of a process to support wider engagement with interested East Dunbartonshire service users and carers.
3.1	It is recommended that the HSCP Board: Note the progress of the Public, Service User & Carer Representatives Support Group.

Appendix 1

Public Service User and Carer Support Group / 4th December 2017 – Room G34, KHCC.

Attending: Gordon Cox, David Bain, Martin Brickley, Sandra Docherty, Avril Jamieson, Marion Menzies, Mary McKenzie, Jenny Proctor, Isobel Twaddle and Linda Jolly

Apologies: Susan Manion, Claire Taylor

HSCP Staff in attendance; David Radford, Dianne Rice, Anthony Craig

Action points agreed at meeting;

Action	By who	When	G	A	R
Feedback from SMT on options paper to PSUC group by next meeting.	DR	Before next meeting 05/02/18			
J Campbell (HSCP Head of Finance) presentation to be re-sent to the group.	AC	By 10/12/17			
PSUC group will collate hospital discharge case studies/stories.	PSUC members	By next meeting 05/02/18			
PSUC group will collate Dementia review meetings with service users attending Woodlands.	PSUC members	By next meeting 05/02/18			
PSUC group action plan for 2018/19, to be made available in easy read format and shared.	AC	By next meeting 05/02/18			
2018 meeting dates and venue to be shared with group.	AC	By 010/12/17			
Group requested an update on the timings of the locality group meetings and for the dates of future meetings to be circulated to the relevant service users & carers.	DR	By next meeting 05/02/18			
Request made to AC to update members on the MIU's (opening and	AC	By 10/12/17			

closing times).					
PSUC requested that engagement event(s) report to be circulated to group following sign off from SMT	DR	By 15/01/18			
PSUC requested that draft Strategic Plan is distributed in line with consultation time lines.	DR	By 15/01/18			
Carers Strategy - Eligibility Criteria consultation info and link to be shared with group	AC	By 10/12/17			
PSUC requested that AC extend an invite to the improvement service, request that a staff member provide training on the 'Knowledge hub'	AC	By next meeting 05/02/18			

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Susan Manion

Agenda Item Number: 11

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2017
Subject Title	East Dunbartonshire HSCP Clinical & Care Governance minutes of meeting on 5th September and 22nd November 2017
Report By	Lisa Williams, Clinical Director, Tel: 0141 304 7425
Contact Officer	Lisa Williams, Clinical Director, Tel: 0141 304 7425

Purpose of Report	To provide the Board with an update of the work of the Clinical & Care Governance Sub Group.

Recommendations	The Integration Joint Board is asked to: a. Note the contents of the minute of the Clinical & Care Governance Sub Group held on the 5th September 2017 (ratified) & 22nd November 2017 (draft)

Relevance to HSCP Board Strategic Plan	This group support the clinical & care delivery aspects of the Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	None
Equalities:	To oversee clinical & care services provided to service users and carers of East Dunbartonshire and ensure all are treated fairly and equally.
Financial:	None.
Legal:	None.
Economic Impact:	None
Sustainability:	None
Risk Implications:	Group has a responsibility to review complaints received and manage any appropriate outcomes, review all incidents to ensure learning and change is taken forward to manage risk and maintain proper governance arrangements.
Implications for East Dunbartonshire	N/A

Council:	

Implications for NHS Greater Glasgow & Clyde:	N/A

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	**x**
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

Chief Officer: Susan Manion

Clinical & Care Governance Sub Group
22nd November 2017, 2.30pm
F33A, Kirkintilloch Health & Care Centre

Members Present

Name	Designation
Lisa Williams	Clinical Director
Alex O'Donnell	Criminal Justice Service Manager
Gillian Notman	Change & Redesign Manager
Fiona Munro	Manager, Rehab & Older Peoples Services
Lorna Hood	Senior Nurse, Children & Families
Carolyn Fitzpatrick	Lead for Clinical Pharmacy and Prescribing
Lorraine Currie	Operations Manager, Mental Health
Andrew Millar	Clinical Effectiveness Co-ordinator
Fraser Sloan	Clinical Risk Analysis

In Attendance

Name	Designation
Dianne Rice	Clinical Governance Support Officer
Katherine Turnbull	Management Trainee
Cara Bottomley	Specialist Physiotherapist
Tracey Welbury	Assistant Clinical Director

Apologies

Name	Designation
Paolo Mazzoncini	Head of Children's Services / Chief Social Work Officer
Wilma Hepburn	Professional Nurse Advisor
David Aitken	Joint Adult Services Manager
Michael McGrady	Consultant in Dental Public Health Clinical Effectiveness Co-ordinator
Claire Carthy	Fieldwork Manager
Fraser Sloan	Clinical Risk Co-ordinator

No.	Topic	Action
1.	**Apologies and attendance**	
	Apologies and attendance are detailed on page 1 Lisa Williams welcomed all attendees to the group.	
2.	**Minutes of Previous Meeting – 5th September 2017**	
	One change was requested in relation to Lisa Williams designation. DR will update the minutes. The remainder of the minutes were agreed as an accurate reflection.	**DR**
3.	**Matters Arising**	
	Core Audit Report – Community Nursing Wilma Hepburn was unavailable to attend the meeting today; however, Lisa Williams advised that Wilma had discussed the recording of medications noted in the previous core audit report with the Practice Development Nurse. **Health & Safety Report on Falls** Dianne Rice will contact Wilma Hepburn requesting the above document and will then circulate the report to the members of the group. **QI Update on "abandoned" project** At the meeting on the 5th September, it was noted that within the QI update that an LD pilot had been "abandoned". Members of the group asked Dianne to find out the reason for this as the outcomes / learning of this pilot could have been used for East Dunbartonshire HSCP LD Review. Dianne Rice contact the Clinical Effectiveness Team who advised that the pilot was not abandoned in the sense that it had not taken place, that the term "abandoned" only meant that this pilot was not supported by the Clinical Effectiveness Team.	**DR**
4.	**Governance Leads Update / Reports**	
(a)	Core Audit Reports All Core Audit Reports received for inclusion in the agenda highlighted no concerns with the exception of Community Nursing. The core audit report for Community Nursing showed 97% within medication report. As this was an issue that was noted at the previous meeting Lisa Williams will speak to Wilma Hepburn in relation to this to ensure staff are recording medication information correctly as there is clinical risk attached to this. Fraser Sloan advised that if a trend noticed within the core audits, that this should be noted on Datix and if appropriate an action plan and PDSA should be developed.	**LW/ WH**
(b)	Safety Cross Report – 01/06/17 – 30/07/17 The group reviewed the safety cross report. There were no concerns to note.	

(c)	LD Governance David Aitken was unavailable to attend the meeting today. This item will remain on the agenda as a standing item and an update will be given at the next meeting.	**DA**
(d)	Mental Health Governance David Aitken was unavailable to attend the meeting today. This item will remain on the agenda as a standing item and an update will be given at the next meeting.	**DA**
(e)	Primary Care & Community Partnerships Governance Group update (PCCPG) – 21st September 2017 An update for this meeting was circulation previously with the agenda. Lisa Williams highlighted a key success which was included within the update relating to Clozapine and outside medication being recorded in Primary Care notes. Letters will be shared with all GP surgeries to ensure that they have an up to date record of which of their patients are being prescribed clozapine. This will reduce the risk of missed drug interactions and alert primary care staff to consider symptoms and results of investigations in the context of the individual being on clozapine."	
(f)	Board Clinical Governance Forum update Lisa Williams provided an update from the above group which was circulated previously with the agenda. Lisa asked that the members to particular attention to the Duty of Candour update. Lisa also advised that there are factsheets available on Staffnet in relation to this. Dianne Rice will circulate these factsheets to the members for their information and action.	**DR**
5.	**Risk Management**	
(a)	Care Home Update A concern was raised by the Care Commission in relation to a care home within Lennoxtown having issues retaining and training staff. The GP Practice provided medical support to this care home through a LES has requested to withdraw due to the concerns raised. The HSCP have arranged to meet with the care home managers on a monthly basis with the intention to support them improve the standards. Lisa Williams also raised the concern around 3 new care homes in the process of being developed within East Dunbartonshire. One care home in Milngavie (45 bed unit), 1 in Bearsden and 1 in Bishopbriggs. There has been no agreement for a LES for these new care homes from NHSGG&C Board which means responsibility would fall to the HSCP. Concerns were noted around medical GP Cover and financial costs to the HSCP.	
(b)	Clinical Risk Update Fraser Sloan ran through the update with the group. He noted that there were a number of outstanding SCI actions. All members were asked to investigate and sign off all complete actions. Within the update it was noted that members noted as the owner of the actions were staff that were no longer employed by the HSCP. Dianne Rice advised that an updated reviewer and approver list had been sent to the Datix team for updating the system. Incident No. 478286 – Dianne to find out which service raised this incident.	**DR**

(c)	Incident Report – 23/08/17 – 08/11/17 The group reviewed the incident report. Lisa Williams noted that there were confidential details used within some incidents. Members were asked to remind staff that patient identifiable should be included within the correct section of the Datix system and not to be used within the main description of the incidents.	
(d)	Outstanding Incident Report as at 26/10/17 Dianne Rice noted that there as of the 26/10/17 there were 45 incidents outstanding. All members were asked to review and sign off incidents when appropriate to do so.	**ALL**
(e)	SCI Update – Mental Health Incident Lorraine Currie, Operations Manager Mental Health attended the group today to update the group on an incident which had taken place in mental health and the progress of this. Lorraine advised that group that they had developed a template, which is updated on a monthly basis. This template shows the progress of actions raised within the incident. This includes areas detailing persons responsible for carrying out actions, progress and any complaints made in relation to the incident. Lisa Williams thanked Lorraine for the update and agreed that the template used was very clear to follow. The group agreed that this would be a useful template to use with future incidents.	
6.	**Public Health Reports / Prescribing Updates**	
	There were no reports to note.	
7.	**Clinical Effectiveness / Quality Improvement**	
(a)	Quality Improvement Workplan Andrew Millar updated the group on the new projects, progress against current pilots and completed projects made within the QI Workplan.	
(b)	Clinical Effectiveness Update Andrew advised that the clinical Effectiveness Team are now able to provide an update. This update provides information on: • Quality Improvement (QI) Projects • NHSGGC Clinical Governance Related Guidance • National Guidance • SIGN / NICE Guidelines • Developing Quality Improvement Capability • Assurance	
8.	**Scottish Patient Safety Programme**	
(a)	Scottish Patient Safety Programme (SPSP) The report was circulated previously with the agenda for information.	
(b)	Clinical Governance Related Guidance Newsletter The newsletter was circulated previously with the agenda for information.	
(c)	SPSO Update – October 2017 The October update was circulated previously with the agenda. The November update will be circulated to the members.	**DR**

9.	**Enabled to Deliver Person Centred Care**	
(a)	Complaints Report There were no Health complaints to note. A new system is in the process of being implemented to allow a report showing all Social Care complaints received. Unfortunately since it has not been fully implemented a report was not available for this meeting.	
(b)	GP Complaints Report There was no update available for the meeting.	
(d)	Pharmacy Complaints Report Complaint reports for Pharmacy are now available on an annual basis but will remain on the agenda.	
(e)	Optometry Complaints Report There was no update available for the meeting.	
10.	**Vulnerable Children and Adults**	
(a)	Child Protection Claire Carthy was unfortunately unavailable to attend the meeting. Lorna Hood that there will be a new Child Protection Advisor in post by the 4th December 2017.	
(b)	Child Protection Case Conference Attendance – Q1 An update on both Q1 and Q2 was given to the group. Dianne advised that GP attendance was still low and that the School Nursing services also had low attendance rates in both quarters. Lorna Hood advised that due to staffing issues it was agreed that School Nursing staff would only attend Initial Case Conferences until they are back to a full complement of staff.	
(c)	Looked After & Accommodated Children Claire Carthy was unfortunately unavailable to attend the meeting.	
(d)	Child protection Forum Minutes – 01/08/17 The minutes were circulated previously with the agenda for information.	
(e)	Child Sexual Exploitation – Practitioner Guidance The above guidance was circulated previously with the agenda for noting.	
(f)	MAPPA ICR Alex O'Donnell attended the meeting to update on the above multi-agency initial case review (ICR). Multi agency ICR completed which concluded all reasonable steps had been taken. Learning point: Health to provide an input on the effects of medication and reiterate the details of the STAD service which provides consultancy to agencies working with individuals with harmful behaviour	
(g)	Child Protection ICR On behalf Deborah Blackhurst who was unable to attend the meeting, Alex O'Donnell updated the group on the above review. Alex advised that group that the named individual was not known to any services and that the review was closed with no actions to note.	

(h)	Adult Protection Lisa updated the group that the multi-agency case file audit was now complete. This took place within the HSCP where 50 adult case files were scrutinised to ensure all relevant information and details were included. Although the HSCP is awaiting the final report initial feedback was positive.	
11.	**Infection Control Minutes**	
	There were no minutes available for this meeting.	
	General Business	
12.	CMHT – Stalking Incident – For Information Lorraine Currie updated the group on the above incident and progress made with this incident. This highlighted the importance of staff managing personal social media accounts in order to maintain privacy & professionalism. Members were asked to circulate Social Media Use document to their staff for information.	
13.	How well are we doing Audit The audit results were circulated previously with the agenda for noting. This audit is carried out by the District Nursing Service and gathers feedback from carers whose relatives have received end of life care. All feedback is welcomed by the team and is used to improve the service.	
14.	Exception Report for Primary Care & Community Partnership Governance Forum Lisa Williams advised the group that she is required to provide an exception report to the above Board wide group with relevant points from the local Clinical & Care Governance Forum. The exception report from the previous meeting on the 5th September was circulated prior to the meeting with the agenda for information. Lisa explained that she and Dianne Rice would complete the exception report detailing highlights from today's meeting. All members are welcome to contribute and any comments can be sent to Lisa or Dianne for inclusion.	
15.	Datix Bulletin – October 2017 The bulletin was attached previously with the agenda for information.	
16.	Any other business There was no other competent business to note	
17.	**Date and time of next meeting** **Wednesday 31st January 2018, 2pm, Room F33A, KHCC**	

Chief Officer: Susan Manion

Clinical & Care Governance Sub Group
5th September 2017, 2.30pm
F33A, Kirkintilloch Health & Care Centre

Members Present

Name	Designation
Lisa Williams	Clinical Director
Andy Martin	Head of Adult and Primary Care Services
Michael McGrady	Consultant in Dental Public Health
Paolo Mazzoncini	Head of Children's Services / Chief Social Work Officer
David Aitken	Joint Adult Services Manager
Carolyn Fitzpatrick	Lead for Clinical Pharmacy and Prescribing
Lorraine Currie	Operations Manager, Mental Health
Wilma Hepburn	Professional Nurse Advisor
Fiona Munro	Manager, Rehab & Older Peoples Services

In Attendance

Name	Designation
Dianne Rice	Clinical Governance Support Officer

Apologies

Name	Designation
Andrew Millar	Clinical Effectiveness Co-ordinator
Claire Carthy	Fieldwork Manager
Fraser Sloan	Clinical Risk Co-ordinator
Lorna Hood	Senior Nurse, Children & Families
Gillian Notman	Change & Redesign Manager
Alex O'Donnell	Criminal Justice Service Manager

No.	Topic	Action
1.	**Apologies and attendance**	
	Apologies and attendance are detailed on page 1 Lisa Williams welcomed all attendees to the group.	
2.	**Minutes of Previous Meeting – 26th July 2017**	
	The minutes of the meeting on 26th July 2017 were agreed as an accurate reflection.	
3.	**Matters Arising**	
	Terms of Reference / Reporting Structure Prior to the meeting, the Terms of Reference and Reporting Structure were circulated to the members for comments. Lisa Williams thanked all members for their contributions and advised that the documents were now finalised. Both documents will be reviewed in 6 months.	**DR**
4.	**Governance Leads Update / Reports**	
(a)	Core Audit Reports All Core Audit Reports received for inclusion in the agenda highlighted no concerns with the exception of Community Nursing. The core audit report for Community Nursing showed 97% within medication report. Wilma Hepburn will take this forward with the Practice Development Nurse.	**WM**
(b)	Safety Cross Report – 01/06/17 – 30/07/17 Wilma Hepburn provided an overview of the safety cross report. During the month of June there were a total of 16 pressure ulcers noted. 18.75% (3) were new within caseload, 56.25% (9) were inherited from community referral and 25% (4) were inherited from hospital discharge.	
(c)	LD Governance A post was created and filled to take the LD Redesign forward. David Aitken advised that there may be action from the redesign that will be the responsibility of the Clinical & Care Governance group to take forward. David will keep the group updated.	
(d)	Mental Health Governance Lorraine Currie advised that the Mental Health Governance group has recently been restructured and that she is a member of this group. Lorraine will keep the group updated with all relevant information / action required from the Clinical & Care Governance group.	

(e)	Primary Care & Community Partnerships Governance Group update (PCCPG) Lisa Williams advised that the next meeting of the Primary Care & Community Partnerships Governance group would take place on the 14th September. Governance Leads from Scottish Ambulance Service will be in attendance to discuss concerns around incidents. Lisa also advised that she and Stuart Sutton, Chair of PCCPG group has a meeting arranged with Jennifer Armstrong, Medical Director to discuss local governance groups incorporating all areas of governance e.g. LD, MH, OHD etc. Stuart and Lisa will be doing some work around this. Lisa will keep the group updated. Discussion took place around SCIs and cross boundary learning. It was agreed that all learning for the HSCP should be brought to the Clinical & Care Governance group. Michael McGready advised that he will bring exception reports for Primary Care section of Oral Health to the group.	**All**
(f)	Board Clinical Governance Forum update For the member's information, Lisa advised that Stuart Sutton currently attends this group and will feedback any issues to Lisa. There were no current updates.	
5.	**Risk Management**	
(a)	Care Home Update Wilma Hepburn advised that due to sickness and training that the Care Home Liaison service is short staffed. Wilma also informed the group that Care Homes have engaged with the FALLS service. A Health & Safety report on FALLS has been produced. Wilma will circulate this to members for their information.	**WH**
(b)	Clinical Risk Update Fraser Sloan submitted apologies for this meeting. Fraser advised that the meeting fell out with reporting timeframe and that there was no current update.	
(c)	Incident Report – 15/07/17 – 23/08/17 The group reviewed the report. The following incidents were discussed Wilma advised that there was an SCI for a pressure ulcer and this is almost concluded with no other concerns to note. Lisa noted that there had been a noticeable decrease in violence & aggression incidents being reported. This category of incidents has been within the top number of incidents reported within the HSCP over the past 4 years. Lisa Williams expressed concern that staff may be normalising unacceptable behaviours. The group agreed that all members will remind staff of the importance of reporting incidents through the Datix system.	**All**

6.	**Service Risk Registers**	
	The service risk registers were circulated with the agenda prior to the meeting. Discussion took place around mis-categorisation and not including "low risk" items on the register. All actions for members are detailed within internal action note.	
7.	**Public Health Reports / Prescribing Updates**	
	There were no reports to note.	
8.	**Clinical Effectiveness / Quality Improvement**	
	The group reviewed the QI Workplan. The group noted that PAT/EB/009 – Baseline audit of current transition activity within LD services status was "abandoned". Discussion took place around the growing number of individuals with LD and that more placements / services are needed. Dianne Rice will ask the Clinical Effectiveness representative why this project was abandoned.	**DR**
9.	**Scottish Patient Safety Programme**	
(a)	Scottish Patient Safety Programme Out with reporting timeframe. Not report to note.	
(b)	Clinical Governance Related Guidance Newsletter Out with reporting timeframe. Not report to note.	
(c)	SPSO Update – July 2017 The above report was circulated previously with the agenda for information and learning.	
10.	**Enabled to Deliver Person Centred Care**	
(a)	Complaints Report There were no Health complaints to note. Dianne Rice to speak to Dee Horne in relation to reporting Social Care complaints.	**DR**
(b)	GP Complaints Report Quarter 4 GP complaints summary report was circulated previously with the agenda for information. Lisa advised that the main reason for complaints within GP Practices are around access and attitude of staff.	
(d)	Pharmacy Complaints Report Carolyn Fitzpatrick advised that the complaints report for Pharmacy will be done on an annual basis.	
(e)	Optometry Complaints Report There was no update available for the meeting.	

11.	**PCMHT Survey**	
	Lorraine Currie advised that PCMHT carry out a service user survey which is repeated after every discharge. The findings from the survey are compiled into a report on a bi-annual basis. Lorraine reported that some of the outcomes from the report have been to change the service to suit the service users e.g. providing appointments after 5pm to accommodate people in full time employment. PCMHT are also piloting a CBT telephone line. Lorraine will keep the group updated.	
12.	**Vulnerable Children and Adults**	
(a)	Child Protection Claire Carthy was unfortunately unavailable to attend the meeting, however, had advised that there were 47 children currently on the Child Protection register.	
(b)	Child Protection Case Conference Attendance – Q4 Out with reporting timeframe.	
(c)	Looked After & Accommodated Children It was agreed that the Child Protection lead would be invited to a future meeting to give an overview of Looked After & Accommodated Children within East Dunbartonshire.	**LW**
(d)	Child protection Forum Minutes – 25/04/17 The minutes were circulated previously with the agenda for information.	
(e)	Adult Protection David Aitken advised that group that the Care Inspectorate will be carrying out a Multi-Agency inspection on the 30th October 2017. There will be 50 cases / interventions inspected. David will feedback results of inspection once available.	
13.	**Infection Control Minutes – 13/07/17**	
	The minutes were circulated previously with the agenda for information.	
14.	**Regent Gardens Medical Practice – Chaplaincy Evaluation Proposal**	
	Regent Gardens Medical Practice asked the Clinical & Care Governance group to consider their proposal to carry out a service evaluation and publish the findings for this evaluation. The group agreed the proposal. Lisa Williams will contact the Practice to confirm agreement.	
15.	**AOCB**	
	Care Quality Bundles for PDS Fiona Munro advised that Health Improvement Scotland (HIS) had identified Woodlands Resource Centre as a test site for the Care Quality Bundles for Post Diagnostic Support (PDS). Fiona will keep the group updated on progress. Acknowledgement Andy Martin, Head of Adult & Primary Care Services retires on the 20th September. On behalf of the members, Lisa Williams noted their thanks and	

	appreciation to Andy for his participation and valuable contributions within the group.	
16.	**Date and time of next meeting** **Wednesday 31st January 2018, 2pm, Room F33A, KHCC**	

Agenda Item Number: 12

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11 January 2018
Subject Title	East Dunbartonshire HSCP Staff Partnership Forum minutes of 27 November 2017
Report By	Tom Quinn, Head of People & Change, Tom.Quinn@ggc.scot.nhs.uk 0141 232 8227
Contact Officer	Tom Quinn, Head of People & Change

Purpose of Report	To provide the re-assurance that Staff Governance is monitored and reviewed within the HSCP.

Recommendations	Note for information

Relevance to HSCP Board Strategic Plan	This group supports the workforce planning and delivery aspects of the Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	Information is cascaded to staff through the partnership via Our News

Equalities:	N/A

Financial:	N/A

Legal:	Meets the requirements set out in the 2004 NHS Reform legislation with regard to Staff Governance

Economic Impact:	N/A

Sustainability:	N/A

Risk Implications:	N/A

Implications for East Dunbartonshire Council:	N/A

Implications for NHS Greater Glasgow & Clyde:	Included within the overall Staff Governance Framework

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	**X**
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☐
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

1.0 MAIN REPORT

1.1 Minute of meeting of 27 November 2017 attached.

1.2 Key topics covered within the minute include:

- We highlighted the success of our Modern Apprentices in both the HSCP and Oral Health, with a focus on Sarah Hogg our administration Modern Apprentice who was a finalist in the Skills Development for Scotland awards.
- Paolo Mazzoncini gave an update on some recent inspections in Adult Support & protection and in our Fostering & Adoption services, Paolo thanked staff for their support and sited positive feedback with the formal reports due in 2018.
- David Radford spoke about the planning to undertake a HSCP wide stress audit as part of our on-going commitment to Health Working lives.

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Mrs Susan Manion

Minutes of East Dunbartonshire Staff Forum Meeting
Monday 27 November 2017 at 2pm in F33A&B, Kirkintilloch Health & Care Centre

PRESENT

Susan Manion (SM)	**Chief Officer (Chair)**
David Radford (DR)	**Health Improvement & Inequalities Manager**
Stephen McDonald (SMc)	**Joint Service Manager Older People**
Robert McIlreavy	**Senior Learning and Education Advisor**
Margaret Hopkirk (MK)	**People & Change Manager**
Gillian Notman (GN)	**Change and Redesign Manager/Lead OT**
Lyndsay Ovenstone (LO)	**British Dental Association Area Representative**
Andrew McCready (AMC)	**Unite Oral Health (Co Chair) Chairing**
Sandra Cairney (SC)	**Head of Planning & Health Improvement**
Linda Tindall (LT)	**Senior Organisational Development Advisor**
Diana McCrone (DMc)	**British Association of Occupational Therapists**
Simon McFarlane (SMc)	**Unison**
Tommy Robertson (TR)	**Unison (part of meeting)**
Jamie Carrick (JC)	**Unison (Co-Chair) Chairing**
Michael Crainey (MC)	**Unison H&S Rep**
Anne McDaid (AMc)	**RCN SPF Joint Secretary**
Paolo Mazzoncini (PM)	**Head of Children's Services**
David Aitken (DA)	**Joint Service Manager Adult Services**
Tom Quinn (TQ)	**Head of People & Change**
Frances Mclinden (FMc)	**General Manager Oral Health**
Jean Campbell (JCa)	**Chief Finance & Resource Officer**
Lorna Hood (LH)	**Senior Nurse – Children & Families**
Karen Gillespie (KG)	**HSCP Administrator – Minute Taker**

ITEM	SUBJECT	ACTION
1.	**Welcome & Apologies** Apologies were submitted on behalf of Caroline Smith, Margaret McCarthy, Sharon Bradshaw and Wilma Hepburn.	
2.	**Minutes of previous meeting** Minutes of meeting held on 18 September 2017 were agreed as an accurate reflection of discussions; with the following exception Unison Care Charter – SMC requested update on the HSCP stance on this charter. SM advised that the previous minutes should have read that the sign off of the Charter sits with East Dunbartonshire Council and not with the HSCP. SMc took opportunity to advise everyone that the Charter was looked at by EDC a few years ago and it was felt that that council comes in line higher than the charter requires, therefore there was no need to sign. JC will clarify EDC position and feedback at next meeting.	**Jean Campbell**

3.	**Matters Arising** School Nursing – DM asked for clarification on school nursing review. SM gave overview of the work currently being undertaken by the Heads of Services to establish priorities within their area: once this has been completed by the each HSCP and will be agreed by each HSCP LH advises that she currently meets with the school nurses locally within her remit ensuring that they are supported and informed throughout the process. Winter Plan – Staff Flu Immunisation – TQ advised there was a 40% uptake of the free vaccine from staff across the HSCP and this is an excellent base to improve on from in coming years. Management Structure – Interviews will take place on 11 December 2017 for the post of Head of Mental Health, LD & Addictions and Head of Community Health & Care. SM confirmed that this was an open advert and the successful candidate will have the option regarding whether the Council or NHS will be their employer.. Pre-5 Immunisation – LH informed that GGC are ordering the vaccine fridges in bulk to ensure cost effectiveness. Accommodation has been arranged within the Kirkintilloch and Milngavie area to house the immunisation clinics however there are still some issues with the Bishopbriggs area – LH will progress talks with a GP Practice and feedback at next meeting. HSCP Staff Awards – LT advised that the overall HSCP winner from the local awards ceremony was the Children and Families First Steps project. LT highlighted the standard of nominations submitted this year and this gave an excellent marker for next year. SM took opportunity to echo LTs remarks and stated that staff should be highlighting good practice and not necessarily thinking about only new projects. SSSC Awards – PM asked everyone to look at the criteria for these awards and consider a submission to recognise work within the HSCP. Modern Apprentice Awards – FMc commented on the standard demonstrated at the recent MA awards ceremony where both the HSCP and Oral Health has apprentices graduating. Skills Development for Scotland Awards – LT advised that Sarah Hogg, Administration Modern Apprentice had been a finalist in her category at the recent events. Sarah was the first modern apprentice from GGC to reach this stage and although she wasn't the category winner she did well to get to this point. H&S Group – unfortunately due to number of apologies the meeting scheduled for 15 November has been rescheduled to 28 November 2017.	

	KHCC – GN gave an update on the work that took place on the top floor of KHCC and the teams that are now based there. A number of issues around IT had to be resolved prior to the team moves being finalised but these have been resolved and all staff should be insitu this week. SM thanked all staff affected by the redesign for their patience and understanding during the works and added this new environment would go a long way towards encouraging co-location of teams.	
4.	Care Inspection of Adult Support & Protection Inspection took place during week of 30 October 2017 and initially feedback is positive although formal feedback is not expected until early in 2018. Fostering & Adoption Service Two week inspection is now half way through and feedback will be received early 2018. Ferndale Children's Home – Inspection will take place during 2018 and in preparation staff have been issued with questionnaires. Children's Service will also be responsible for the distribution of questionnaires to users of the service.	
5.	iMatter Oral Health Directorate – 100% upload of action plans with updated due 23 December 2017. HSCP – still some work to be done to encourage team leads to complete the outstanding action plans. LT advised that 3-monthly meetings have been set up in both HSCP & Oral health to encourage ownership of iMatter and sharing of good practice. Homecare Services have been asked to submit and article on their iMatter journey for a national journal.	
6.	Staff Governance Group Minutes of meeting held on 26 October 2017 were circulated with the agenda. TQ advised that the action plan is on target with two areas to be updated on the development; Team Lead briefing sessions and development of an annual learning plan.	
7.	OOH Update FMc will represent both the HSCP and Oral Health at these meetings. Initial meetings are being used to establish if the correct representation is around the table. FMc will bring updates to future meetings. FMc confirmed there is Staffside representation in the group but could not advise names at this time.	

8.	Finance JC gave a summary of the HSCP Financial Performance report that was submitted to the IJB Board at the meeting on 9 November 2017. The paper updated the Board on the financial performance as at period 6 and gave an update on the finalised budget for 2017/2018. JC spoke about the significant challenges ahead once the financial position for both the HSCP and EDC has been finalised.	
9.	Oral Health Workforce Plan FMc gave an update on the progress of this plan and advised that the last meeting has had to be rescheduled until January 2018 and all progress will be brought to the forum.	
10.	HR Update MH spoke to the paper that was previously circulated with the agenda and advised the report focussed on the activity during September 2017. TQ took opportunity to highlight that although the report shows that there is only 67% PDR completion rate; this is not necessarily the case as there have been issues getting the information uploaded; the PDRs may have taken place just not uploaded onto system as yet.	
11.	TURAS Paper was previously circulated advising that from April 2018 the current E-KSF system will be replaced with TURAS. The paper outlined the process for the change over. TQ advised that the message to be sent to staff is that the PDP/review process will remain only the recoding platform will change. Staff should be encouraged to ensure all reviews are up to date to ensure they are migrated to new system in new year.	
12.	Strategic Plan SC gave feedback from the recent engagement events and advised the plan should be ready to for consultation purposes by end of the month. Timescale for approval should be with the IJB in march with implementation in April 2018.	
13.	Workforce Planning Update TQ advised that there are plans to hold further session in new year and a skeleton workforce plan to be submitted to SPF in January 2018 before presentation at IJB in March.	

14.	NHS GG&C Health & Social Care Transformational Strategy Programme SM gave overview of paper that was submitted to GGC Board meeting in October 2017; paper requested the approval of the transformational strategic programme which should ensure that local strategic plans align themselves to the NHS overall plan. FMc requested clarification on who represents Oral Health in the forum; SM & FMc will discuss further to ensure appropriate representation is made.	
15.	Review of NHS GG&C Smoking Cessation Services DR advised that although the smoking cessation services throughout GG&C are currently managed at a local level, the paper is proposing to create a single smoking cessation service that would standardise services across pharmacies, community, maternity, acute, prison and mental health services. The board wide service would be managed by the Board Public Health Team. Currently there is only one member of staff within the HSCP who would be affected and they have been kept informed and supported.	
16.	Unscheduled Care Review Mental Health – newsletter Newsletter circulated for information only	
17.	Healthy Working lives – Staff Stress Audit The audit takes place every 3 years as part of the HWL Gold revalidation. The content of the audit has been approved by the SMT and will be passed through H&S Sub group next meeting. SC informed that the current audit is a validated tool and if changed can no longer be classed as such.	
18.	Dignity at work Survey – NHS Scotland TQ advised the closing date for this survey is today and findings will be issue in new year. TR asked for clarification on survey being for NHS staff and how this could be related to EDC staff. TQ suggested that one of the recommendations would be better use of iMatters which relates to all staff within the HSCP.	
19.	A.O.C.B. Future papers – request by Staff side reps that rather than verbal updates a short note is circulated with the agenda giving brief overview/update of topic Values & Behaviours - LT advised that the recent process to identify HSCP values had resulted in 6 values being identified and staff were asked at the staff awards ceremony what behaviours they felt underpinned these values. Further staff focus events are planned for the coming weeks prior to bringing set back to SMT & SPF. Communication Log – SC reminded everyone of the communication log that is held by the Corporate Admin team within KHCC to record any staff or public partnership engagement events.	

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	East Dunbartonshire HSCP Draft Strategic Plan.
Report By	Sandra Cairney – Head of Strategy, Planning & Health Improvement
Contact Officer	Sandra Cairney – Head of Strategy, Planning & Health Improvement Sandra.cairney@ggc.scot.nhs.uk 0141 232 8224

Purpose of Report	To present for approval, the HSCP Strategic Plan 2018-21Draft Consultative Document which will be subject to a wide ranging consultation to inform the final Strategic Plan 2018/21.

Recommendations	The HSCP Board is asked to: ▪ approve the HSCP Strategic Plan 2018-21Draft Consultative Document; and ▪ Approve commencement of a formal consultation process to inform the final Strategic Plan which will be presented back to the HSCP in March 2018 for approval.

Relevance to HSCP Board Strategic Plan	This document is a consultative draft Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	Nil

Equalities:	Following the consultation period the final Strategic Plan will be subject to an Equality Impact Assessment

Financial:	Nil

Legal:	Nil

Economic Impact:	Nil

Sustainability:	Nil

Risk Implications:	Nil

Implications for East Dunbartonshire Council:	East Dunbartonshire Council will be consulted on the draft Strategic Plan

Implications for NHS Greater Glasgow & Clyde:	NHSGGC will be consulted on the draft Strategic Plan

Direction Required to Council, Health Board or Both	**Direction To:**	
	No Direction Required	**X**
	East Dunbartonshire Council	☐
	NHS Greater Glasgow & Clyde	☐
	East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

1.0 MAIN REPORT

1.1 This will be the second Strategic Plan for East Dunbartonshire Health & Social Care Partnership.

1.2 The three year Plan will outline the HSCP ambitions to further improve the opportunities for people to live a long and healthy life, provide early support to families and young children and provide specific and personalised support to those most vulnerable in our communities

1.3 This Draft Consultative Document **[Appendix A]** has been informed by the views of service users, local communities, partners and staff obtained through a series of community and staff engagement events.

1.4 The next stage is to commence a formal consultation process, disseminating this document widely, seeking further views to inform the final iteration of the three year Strategic Plan 2018-21.

East Dunbartonshire
Health & Social Care
Partnership




Health and Social Care Partnership Strategic Plan 2018 – 2021 Draft Consultative Document

CONTENTS

FOREWORD

This is the second Strategic Plan for East Dunbartonshire Health & Social Care Partnership (HSCP). This outlines our ambition to further improve the opportunities for people to live a long and healthy life. We aim to provide early support to families and young children. We also want to focus on those most vulnerable in our communities.

There have been significant improvements in many of our services in the last three years but there is still much to do. In this draft plan for 2018/21 we will outline the next steps.

The previous plan related only to adult services. This draft outlines our plans for child health and social care services as well as criminal justice. These services are now part of the Health and Social Care Partnership. This enables us to consider the needs of, and plan for, services through a life span. It allows us to plan for the needs of children in the context of their families and, particularly for more vulnerable children, helping the transition to adulthood. It is even more crucial we work together in East Dunbartonshire in the increasingly challenging and uncertain financial environment.

In the preparation of our draft Plan we have engaged with our staff, service users, local communities and our partners in the Council, NHS and third sector. We want to hear your views at the next stage of formal consultation so we can truly reflect the views of our staff, stakeholder organisations and local communities.

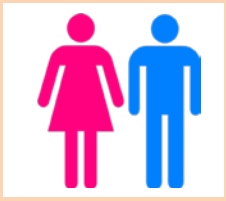
EAST DUNBARTONSHIRE PROFILE

An understanding of communities and people across the HSCP population is vital in the planning and provision of health and social care services. This section provides a summary of the population structure, age profile, characteristics and potential impact on health and social care services and highlights the challenges to be addressed. Detailed and more extensive information is provided in the East Dunbartonshire HSCP Joint Strategic Needs Assessment (2016).

The estimated population of East Dunbartonshire in 2018 predicts a higher proportion of older people than the Scottish average.

Figure 1 - Estimated Population in 2018

All People
107,431

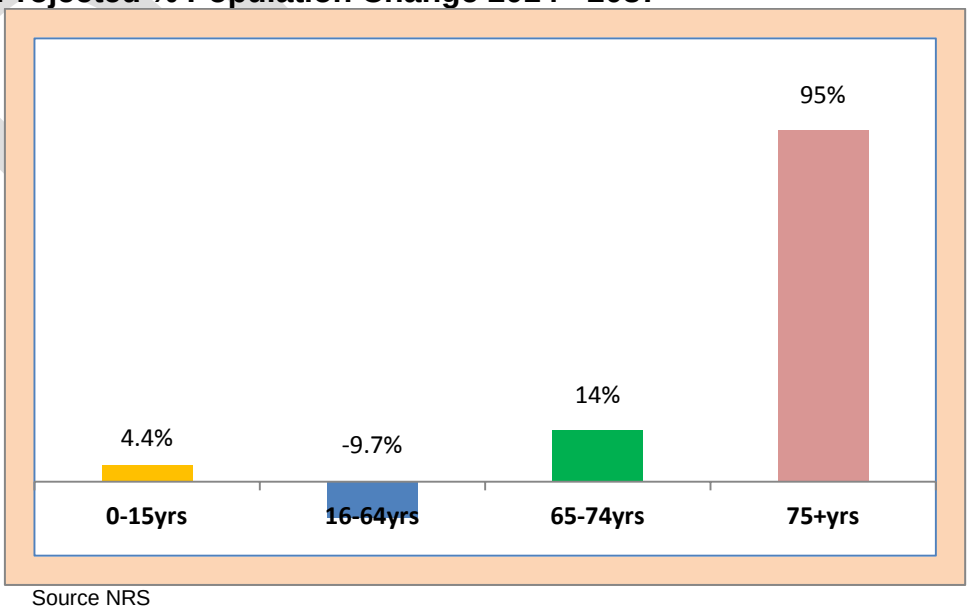


Age	No.	Percent	*Scotland*
0-15	18,361	17.1%	*16.9%*
16-44	32,748	30.5%	*36.3%*
45-64	31,871	29.6%	*27.7%*
65-74	12,646	11.8%	*10.6%*
75-84	8,360	7.8%	*6.2%*
85+	3,445	3.2%	*2.3%*

Source NRS

Over the 25 years 2014-2037, there is a projected increase of 95% in the number of people aged 75+yrs. During the same period, the number of children aged 0-15yrs is projected to increase by 4.4%.

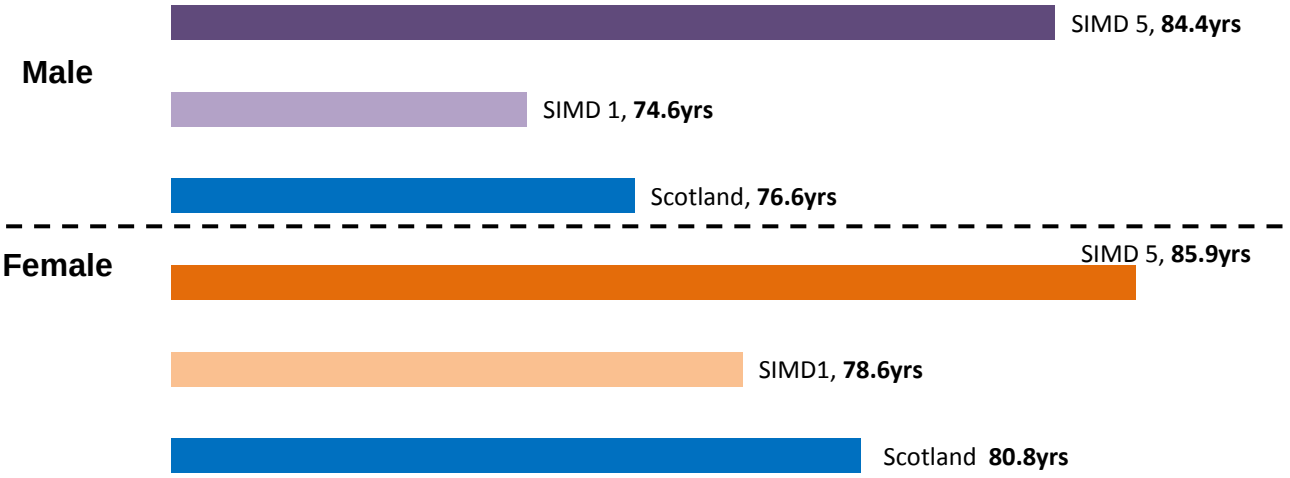
Figure 2 - Projected % Population Change 2014 - 2037



Source NRS

Whilst East Dunbartonshire has the highest life expectancy in Scotland at 83.5yrs for females and 80.5yrs for males (Scotland: 81.1yrs and 77.1yrs respectively), there is a demonstrable variance in life expectancy between the most deprived communities (SIMD 1) and the least deprived communities (SIMD 5)

Figure 3 - Life Expectancy for our most deprived (SIMD 1) and least deprived (SIMD 5) populations in comparison to Scotland

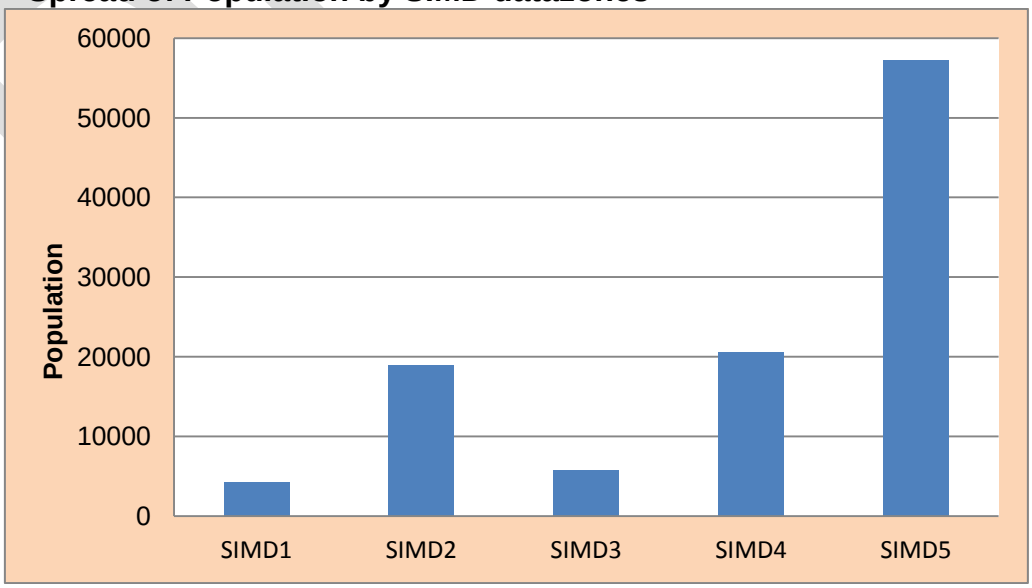


Source ScotPho

Deprivation

There are five datazones within the 20% *most* deprived in Scotland: Two are in Hillhead, while Auchinairn, Kirkintilloch West, and Lennoxtown each have one most deprived datazone. The majority of East Dunbartonshire's residents live within the 20% *least* deprived datazones.

Figure 4 - Spread of Population by SIMD datazones



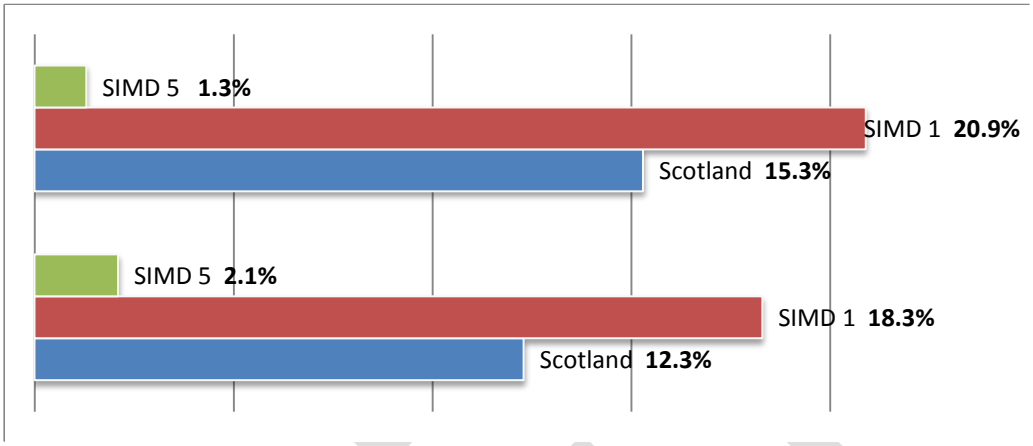
Source ScotPho

Almost 18% of children in East Dunbartonshire are living in the three most deprived datazones which are areas of multiple deprivation with poor health outcomes and reduced life expectancy.

Figure 5 - Comparison of Poverty in East Dunbartonshire SIMD 5 and SIMD 1 datazones compared to national average

Population Income Deprived *(2015)*

Children Living in Poverty *(2012)*



Source ScotPho

WHAT THIS MEANS Focussing on closing the gap between the most deprived and least deprived populations, reducing income deprivation and enabling people to keep well as long as possible.

Healthy Lifestyles

The 2014 Health & Wellbeing Survey showed that in general, the population is healthy with 84.9% of residents describing their health as good or very good. Between 2011-2014, there has been a significant shift towards adopting more of the five positive health behaviours (physical activity, not smoking, not binge drinking, meeting fruit and vegetable target and BMI less than 25).

The Secondary Schools Health and Wellbeing Survey (2014/15) found that, overall, young people are adopting positive behaviours: 87% clean their teeth at least twice a day; 52% walk or cycle to school; 48% eat five portions of fruit or vegetables a day; 92% don't currently smoke.

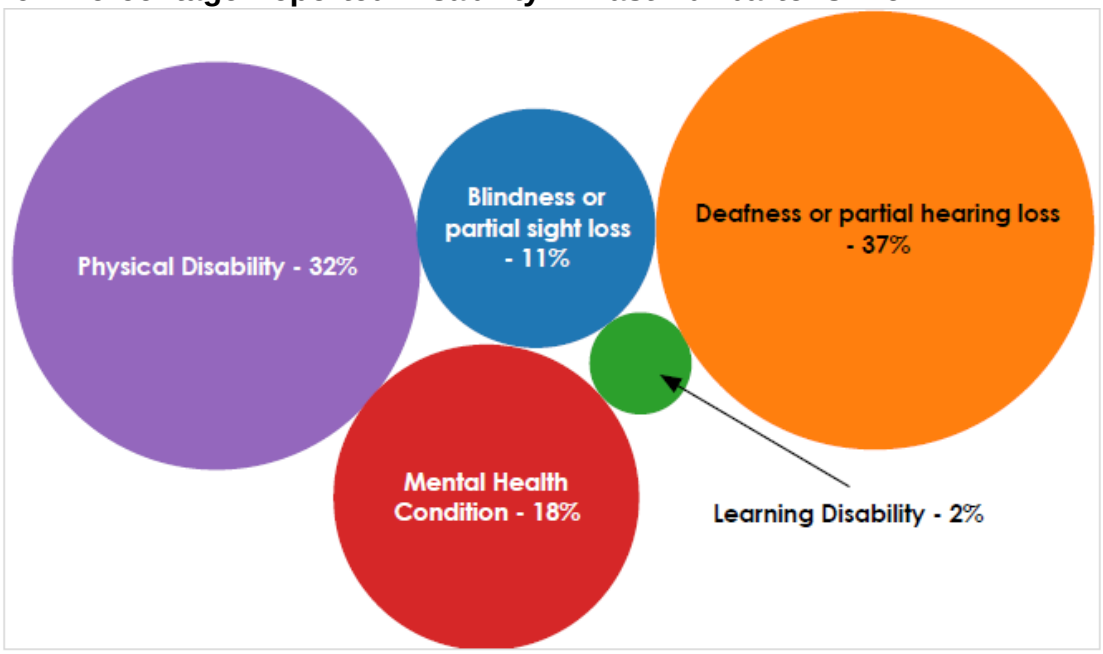
WHAT THIS MEANS

Services need to encourage and support more of the population, particularly children and young people, to adopt healthy lifestyles.

Disability

In the 2011 Census, 5.6% of the adult population in East Dunbartonshire reported a disability, with hearing impairments and/or physical disability being the main disabilities reported.

Figure 6 – Percentage Reported Disability in East Dunbartonshire

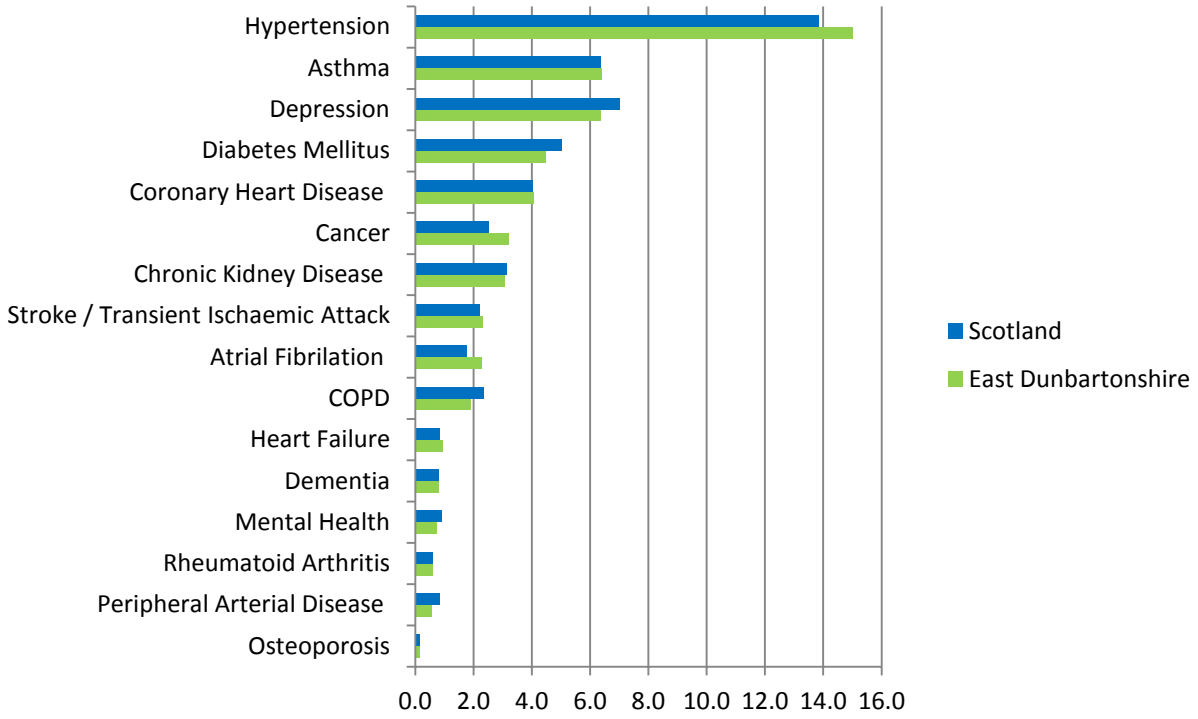


Source: Scotland Census 2011 *(N.B. data does not indicate if people reported more than one disability).*

Long Term Conditions

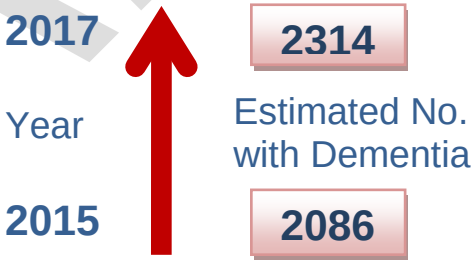
Many people live with one or more long term condition. The number of long term conditions rises with age and we need to support those with complex needs so that they may manage their conditions and lead an active, healthy life. The most diagnosed long term condition in East Dunbartonshire is hypertension. The prevalence for this condition, cancer and atrial fibrillation, are all notably higher than the rate for Scotland.

Figure 7 - Disease Prevalence



Source ISD

Between 2015 -17 there was an estimated 11% rise on the number of people with dementia. This number will continue to rise with the growing older population.



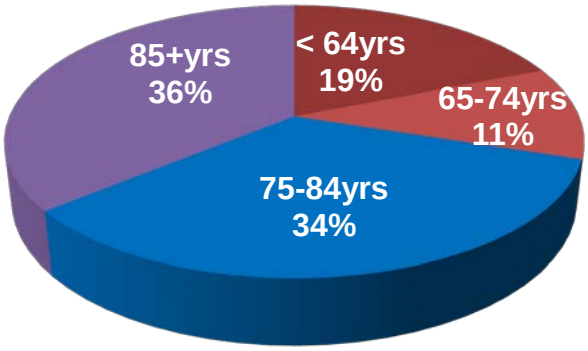
WHAT THIS MEANS

Prioritising the early detection of disease, supporting people to recover or manage their own conditions, and providing a range of supports, particularly for those with dementia and their carers.

Home Care

In 2016, there were 1,325 people in receipt of home care in East Dunbartonshire, 70% of whom were aged 75yrs and over.

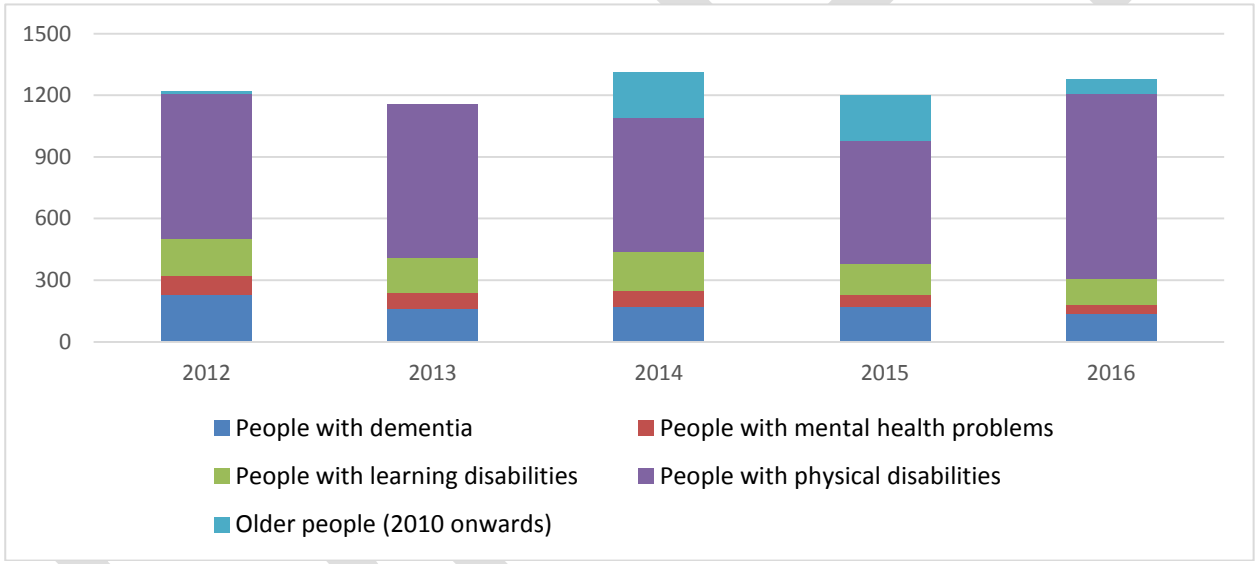
Figure 8 - Age Breakdown of HSCP Home Care Clients



Source Social Care Survey

Home care supports people to remain in their own homes across a range of client groups, particularly those with a physical disability.

Figure 9 - Home Care Client Breakdown 2012-16



Source Social Care Survey

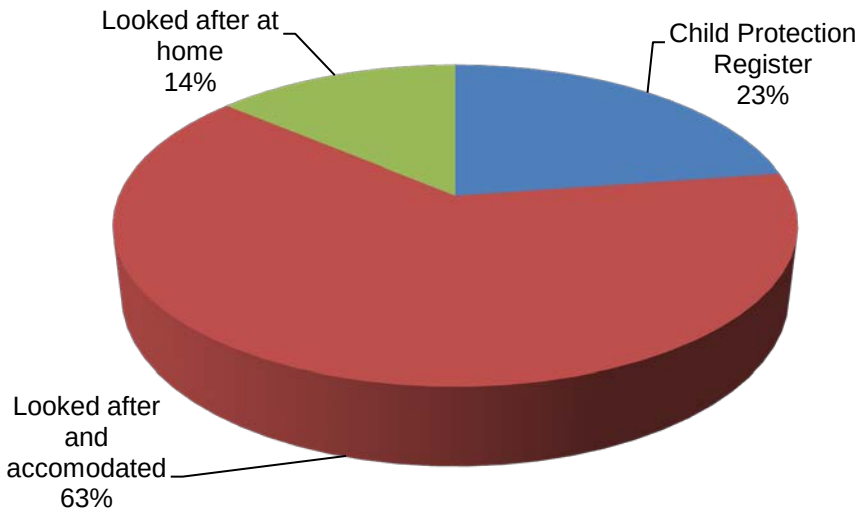
Unpaid Carers

The 2011 Census identified 11,164 carers in East Dunbartonshire. There are 572 carers known to social work. Health and Social Care services work in partnership with carers, and are dependent on the care they provide. Easily accessible information and appropriate support help to ensure the wellbeing of carers and enable them to feel supported in continuing their caring role.

Child Protection

East Dunbartonshire mirrors the national trend of identifying more vulnerable children who may be at risk of harm and therefore in need of statutory interventions in order to keep them safe. In November 2017 there were 203 children on the Child Protection Register or Looked After and accommodated in safe places.

Figure 10 - Placement of Children Looked After and Accommodated (Nov 2017)



Unscheduled Hospital Care

People should only remain in hospital for as long as necessary and receive more appropriate care at home or in a homely setting. There has been significant progress in reducing delayed discharges and unscheduled bed days over the last three years but we need to ensure more people are getting the right care in the right place and at the right time. The aim is to reduce unplanned hospital care by 10% by the year 2021.

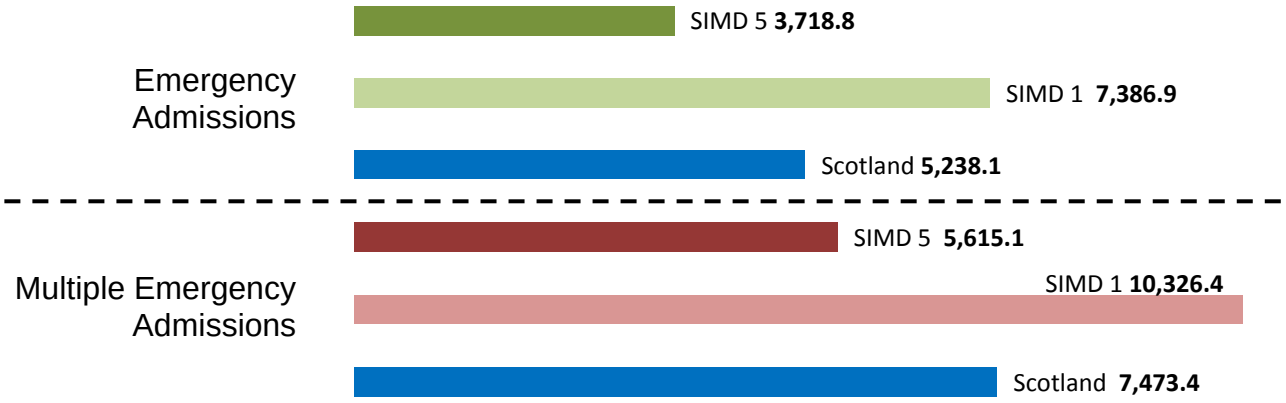
The HSCP has made significant progress in reducing delayed discharges and unscheduled bed days over the last three years, but further improvements are required to ensure people are getting the right care in the right place and at the right time. Therefore the HSCP aims to reduce unplanned hospital care by 10% from 2016/17 to 2021, and the current status demonstrates a downward trend towards achieving this goal.

Figure 11 - Projected Unplanned Hospital Episodes 2016/17 to 2020/21

	2016/17		2020/21	Current Status
 **A&E attendance**	27289		24409	
 **Unscheduled Admissions**	11308		10177	
 **Unscheduled Bed Days**	78260		70434	
 **Delayed Discharges**	3119		2807	

There is a significant variance in unplanned hospital care between the most deprived population (SIMD 1) and the least deprived population (SIMD 5) in East Dunbartonshire. The rate of emergency admissions is greater amongst our more deprived populations.

Figure 12 Emergency Admissions for our most deprived and least deprived populations



SR4 2014 standardised rate per 100,000

WHAT THIS MEANS

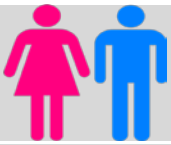
Prioritising the prevention of unplanned hospital admission through supporting people to remain in their own home, supporting timeous discharge, and providing specifically targeted, alternative, models of care.

LOCALITY PLANNING

The HSCP established two Locality Planning groups during 2015/16 to support the understanding, planning and delivery of services around communities within these localities. These locality areas related to natural communities. They consisted of:-

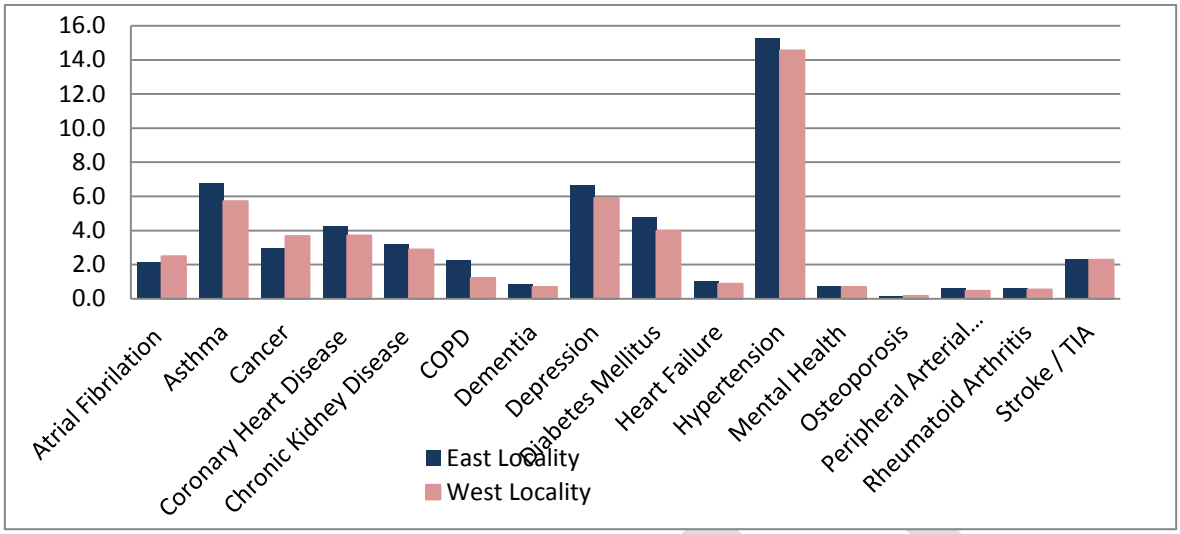
- The east of East Dunbartonshire (Bishopbriggs, Torrance, Lenzie, Lennoxtown, and Kirkintilloch).
- The west of East Dunbartonshire (Bearsden and Milngavie)

Figure 13 - Percentage Population by age group within each Locality.

	East Locality	West Locality
0-15 years	17%	18%
16-49 years	40%	36%
50-64 years	22%	22%
65-74 years	11%	12%
75-84 years	7%	8%
85+ years	2%	4%
% of all East Dunbartonshire residents aged 75+yrs	55.5%	44.5%

The Locality Groups have brought together a range of stakeholders including GPs, acute clinicians, social workers, carers and service users to facilitate an active role in, and to provide leadership for local planning of service provision. The groups commenced by undertaking an assessment of need which explored service and community strengths, potential gaps in service delivery and issues of inequality. Disease prevalence assisted in the identification of health conditions which affected people living in each locality.

Figure 14 - Disease Prevalence by Locality



This information formed the baseline for discussions within each locality group to help prioritise the areas they wanted to focus on and help make a difference within their community. Each group will develop a locality plan for their area involving key local groups and communities, linking to local services. These plans will align with priorities outlined in the Community Planning Partnership Local Outcomes Improvement Plan.

Each group has agreed the following priorities for 2018-19:

East Locality Group

- Cancer screening - Care after cancer treatment has been a theme with emphases on using social prescribing as a means of supporting wider rehabilitation. Establishing links with the local cancer prevention group are underway.
- Housebound – This has raised some inequalities and is an ongoing theme. Examples on how some voluntary services have dealt with isolation and loneliness have been circulated to the group.
- Acute/primary care interface - Developing positive dialogue with acute consultants has begun with our shared experiences of intermediate and continuing care.

West Locality Group

- Dementia - The emphases on linking in with current services, particularly those who have a strong self management approach has been highlighted as a useful model to help support clients and their carers.
- Day care services - Moving away from the traditional model towards day care services that focus on matching individuals to a wider range of HSCP and other third and independent sector services
- Housing - Tentative links with housing to have active dialogue with planners, particularly around local developments of care homes. Influencing their local development plan would be welcomed.

.

HEALTH & SOCIAL CARE SPENDING

The Long Term Financial Landscape

In December 2016, the Scottish Government published the Health & Social Care Delivery Plan which sets out the programme for further enhancing health and social care services. Critical to this is shifting the balance of where care and support is delivered from hospital to community care settings, and to support individuals at home where appropriate. This furthers the Scottish Government's wider goal, to shift the balance of care from the acute hospital sector to community care by 2021.

It is anticipated that the public sector in Scotland will continue to face a challenging medium term financial outlook. Looking forward to 2018/19 and beyond, it is important that this context is understood and planned for in support of the delivery of the HSCP Strategic Plan, and adjusted on a year on year basis dependant on the allocation available.

In addition, subsequent Audit Scotland Reports on both NHS and Social Work in Scotland set out the real delivery challenges facing IJBs. These include:

- Social care faces growing demographic demand pressures which are unsustainable within existing service models and resources; and
- The NHS is facing a combination of increasing costs, staffing pressures which challenge how NHS boards balance demand for hospital care with investing in community-based services to meet future need.

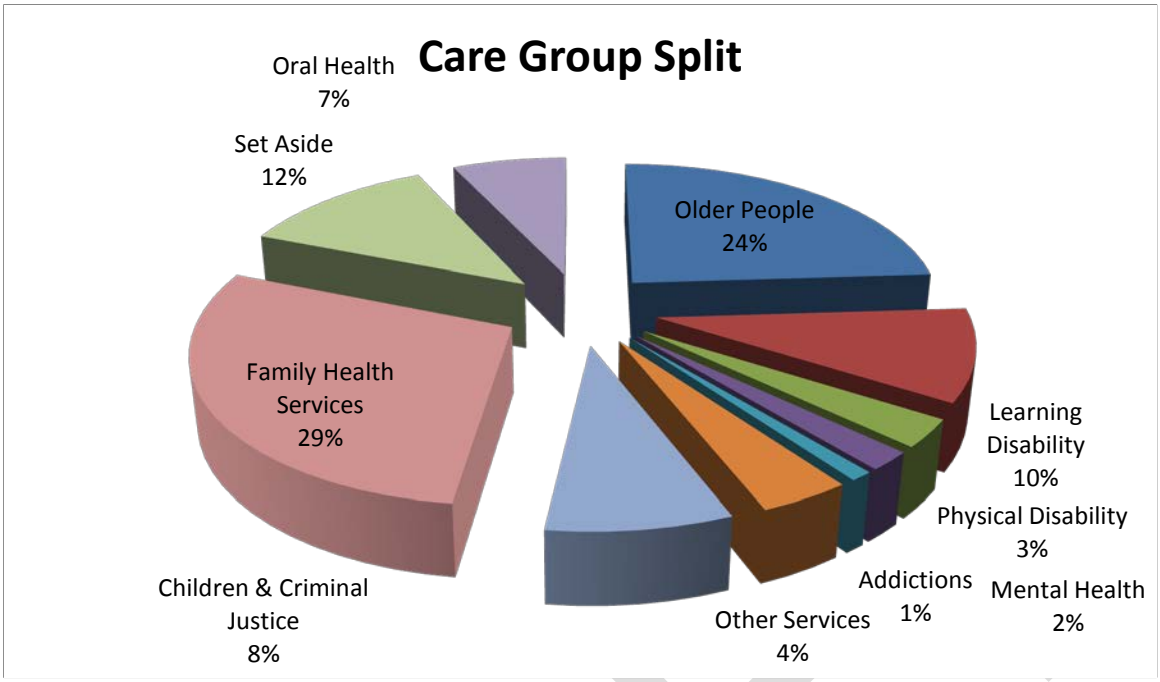
Currently the Scottish Government is carrying out a number of consultations which may have a direct impact on the 2018/19 budget allocations for IJB's. These include:

- Living wage and sleepover costs and implications;
- Impact of the carers legislation; and
- Impact of the proposal to extend free personal care to the under 65's.

East Dunbartonshire Financial Landscape

The total budget for East Dunbartonshire HSCP for 2017/18 was £150.4m which includes £17.4m set aside (an allocation reflecting the usage of certain prescribed acute services including A&E Inpatient and Outpatient, general medicine, Rehab medicine, Respiratory medicine and geriatric medicine).

This is split across a range of services and care groups as follows:-



The current financial position (as at December2017) for East Dunbartonshire HSCP is indicating significant cost pressures in the areas of care at home services for older people, day care supports/supported living for young people transitioning through to learning disability and mental health services and residential placements for Children.

In terms of medium term financial planning, a detailed analysis of costs and demands has been undertaken for the partnership and assuming nothing else changes an additional £11.4m would be required to meet current and anticipated costs for the three years of the Strategic Plan, therefore significant change is required to ensure the sustainability of services and development required within this Strategic Plan.

The areas of key uncertainty for the HSCP include:-

- Impact of future Scottish Government funding levels on both the NHS and Local Authority;
- Pay Settlements and the impact of the decision to lift the pay cap on public sector pay;
- Demand led pressures particularly in the area of older people services but also for learning disability and children's Services;
- Prescribing costs as a consequence of rising costs and short supply of drugs.

The main areas of cost pressure relate to:

- Pay Inflation
  It is expected that pay increases will remain a recurring pressure for partnerships and current assumptions provide for 1.5% - 2% increase each year for both health and social work staff. This may be subject to a degree of variation given the decision to lift the pay cap for public sector pay. Assumptions also reflect the costs associated with the apprenticeship levy and increments for staff moving through the salary grades.
- Demographic and Volume
  This reflects increases anticipated across older people care at home services (assumed 6% increase year on year based on previous year trends), transitions from children's services to adult learning disability and mental health (assumed 10 – 15

cases transferring each year) and demands on residential school placements for children.

- Prescribing Costs
  Costs reflect current demand and cost pressures based on previous years' experience and analysis.
- Inflationary Pressures
  These reflect anticipated annual increases in payments to third parties and in the main reflect expected increases to the National Care Home Contract, fees for fostering, adoption and kinship care.
- Living Wage
  There were increases to the living wage in 2016/17 and then again in 2017/18 with an expectation that this will increase further to meet the Government's commitment to reach a national living wage of £9 by 2020. As in previous years it is expected that any increase will be funded by the Scottish Government through additional social care funding.

One of the Scottish Government's key policy commitments over the course of the parliament is to increase health spending by £500m above real term growth. Given the limited growth prospects for the Scottish Government budget, this commitment is likely to continue to have a challenging impact on respective partner agency budgets which are anticipated to be subject to sustained reductions over the coming years.

In addition to the delivery of key strategic priorities, it is expected that the HSCP will deliver significant year on year savings to address the financial challenges of reducing resources set against increasing cost and demand pressures. The partnership is therefore planning for the period 2018/19 to 2021/22 for a potential funding gap of £11.4m to £18.8m.

Medium Term Financial Strategy

In order to address the financial challenges over the medium term, the HSCP will need to develop plans to bridge the financial gap and focus spending on the areas which will deliver our strategic priorities. A medium term strategy will focus on a number of themes:-

- Maximise Efficiencies
  The HSCP will maximise opportunities to deliver services in the most efficient manner which seeks to protect frontline service delivery as much as possible.
- Strategic Planning and Commissioning
  The HSCP has strong links with the Third and Independent Sector and engage with them in a range of forums and we will work with them to ensure we are collectively agreeing plans for services and workforce. These arrangements inform service development and advise on direction of travel in progressing HSCP priorities. The Strategic Needs Assessment will inform the needs of the population and where resources should to be targeted, supplemented by a workforce strategy aligned to service redesign and commissioning intentions.
- Service Redesign and Transformation
  The underlying principle of integration is to shift the balance of care to enable individuals to live within their own home for as long as possible. To achieve this a shift in funding will also be required. This will require us to match service delivery with financial plans and consider responsibility in relation to acute / set budgets.

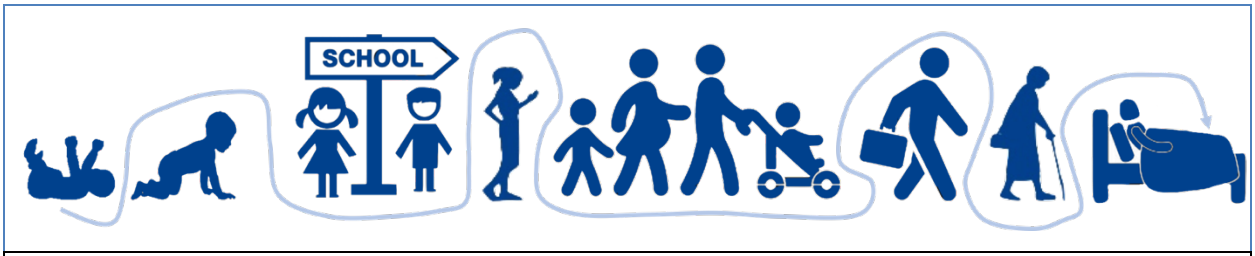
- Prevention and Early Intervention
  This is an essential element of service changes and will have an impact on our financial position. We will need to consider the thresholds as part of our planning to ensure those on low incomes or minimum benefit levels are protected and there is equity of entitlement.

- Review of Eligibility and Charging
  The threshold for access to services is currently for those at critical or substantial risk and this is applied fairly and consistently across the HSCP. Equally there are opportunities for the HSCP to maximise income generation for the services it provides which ensures that those on low incomes or minimum benefit levels are protected from any charging as much as possible. This is set in the context of financial inclusion and ensuring that individuals are in receipt of all the benefits to which they are entitled through an income maximisation assessment.

- Service Reduction/Cessation
  As part of service redesign there will be a review of the range of services delivered across the HSCP which will inform not just areas which require expansion and investment but also areas where the HSCP will disinvest in line with the Strategic Plan.

WHAT WE PLAN TO DO

The Strategic Plan emphasises the need to plan and deliver services that contribute to the health and wellbeing throughout people's lives. This approach focuses on a healthy start to life and targets the needs of people at critical periods throughout their lifetime. It promotes timely effective interventions that address the causes, not just the consequences, of ill health, deprivation and a range of other life circumstances.



Engaging and listening to communities, staff and partners about what matters to them was central to determining the HSCP's key priorities. Six engagement workshops were held across East Dunbartonshire involving members of the public, community organisations, partners organisations; and health and social care practitioners. These events focussed on the participants' perspective of what the priorities should be for the HSCP. Four themes emerged from the wide ranging discussions (a full report is available):

- Theme 1 : Keeping people healthy
- Theme 2 : Improving access to services.
- Theme 3 : Reducing unnecessary hospital admissions and supporting people to live at home or in a homely setting.
- Theme 4 : Supporting carers.

Service user and carer feedback and involvement will be a continuous process to ensure views from all sectors of the community are captured and shared to influence decisions made. Mechanisms for capturing this include:

- proactive feedback from service user and carers via face to face contact with practitioners; real-time independent patient surveys; national patient experience surveys
- reactive feedback in the form of complaints, comments and reported safety incidents;
- support the Service User & Carer Representative Group to ensure that service user experience is at the centre of everything the HSCP does; and
- regular stakeholder/community engagement events.

The Strategic Plan outlines eight key priorities to be delivered over the next three years.

Examples are given on what is already being delivered, what still needs to be delivered and what measures are in place to monitor performance. The eight priorities are:

PRIORITY 1. Promote positive health and wellbeing, preventing ill-health, and building strong communities	**PRIORITY 2.** Enhance the quality of life and supporting independence for people, particularly those with long-term conditions	**PRIORITY 3.** Keep people out of hospital when care can be delivered closer to home	**PRIORITY 4.** Address inequalities and support people to have more choice and control
PRIORITY 5. People have a positive experience of health and social care services	**PRIORITY 6.** Promote independent living through the provision of suitable housing accommodation and support.	**PRIORITY 7.** Improve support for Carers enabling them to continue in their caring role	**PRIORITY 8.** Optimise efficiency, effectiveness and flexibility

The development of commissioning priorities is an ongoing process and progress will be captured within HSCP Business Plans and reported through the Annual Performance Report.

Equality Duties

Health and Social Care Partnerships, as Public Sector Organisations, have specific legal duties applied to them under the Equality Act (2010) which are to:

Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Equality Act 2010.
Advance equality of opportunity between people who share a relevant protected characteristic that is protected under the Act, and those who do not.
Foster good relations between people who share a characteristic and those who do not.

East Dunbartonshire HSCP's Equality Outcomes and Performance Measures were intimated in the Equality and Diversity Mainstream Report 2017–2021. Some of the identified activities that will take place during that period include:

- Engage with HSCP service users and particularly those with a disability to assess accessibility and work with East Dunbartonshire Council (EDC) and NHS Greater Glasgow & Clyde (NHSGG&C) to make all reasonable adjustments to Health and Social Care Services.
- Review services to ensure that they are based on biological rather than chronological access unless objectively justified.

- EDC and NHSGG&C employees are trained to use homelessness risk assessment tools and address need more effectively.
- Engage service users and carers to implement the engagement model as approved by East Dunbartonshire HSCP Board.
- Equality Impact Assessment is further developed as an online tool; training delivered to managers/lead reviewers and the process is embedded in practice.
- Set out mechanisms that enable service users and carers to have a voice in service planning and development.
- Develop and deliver health & wellbeing interventions through PLACE approach.
- Monitor participation levels for people with different characteristics through commissioned services.

The protected characteristics under the Equality Act 2010 are:

AGE all ages	**DISABILITY** all disabilities and health conditions	**GENDER** male, female and transgender
MARRIAGE and CIVIL PARTNERSHIP single, divorced, married, separated and civil partnership	**PREGNANCY and MATERNITY** work, services, education, breastfeeding, premises etc	**RACE** colour, nationality, ethnic, and national origins
RELIGION or BELIEF All religions including no religious beliefs	**SEXUAL ORIENTATION** bisexual, gay, heterosexual and lesbian	**CARERS** All carers including formal and informal carers

STRATEGIC PRIORITIES

STRATEGIC PRIORITY 1.

Promote positive health and wellbeing, preventing ill-health, and building strong communities

What are we already doing?

- Continuing to implement a successful 'WALK East Dunbartonshire' programme in partnership with the Leisure Trust that delivers appropriately graded supported walks for all ages.
- Supporting efforts to identify and increase employability opportunities, in particular, working with local employers and higher educational establishments to develop more opportunities for people with Autism/Aspergers.
- Developing the Community Assets map to help people to identify services and supports available to them
- Improving child health through the delivery of breastfeeding support; promoting good oral health and family registration with a dentist; delivering parenting programmes, and delivering childhood and school immunisation programmes.
- Implementing the Community Justice Local Outcome Plan and continuing to take forward the new Community Justice priorities.
- Criminal Justice Unpaid Work Service delivering community benefit activity for older and vulnerable people.
- Increasing access to leisure and culture services for children through the Corporate Parenting support.

What matters to our residents, partners and staff?

- The HSCP should help people to improve their health through activities such as walking, gardening and other social activities.
- Working with communities and partners to help people access the services they need whether or not it is a Council, Health or third sector service..
- Working with other organisations to promote and deliver a wide range of services that promote positive health, such as help to stop smoking; physical activity opportunities; healthy weight support; and promoting positive mental health.
- Social isolation has been highlighted as a significant issue for many in our communities. Loneliness can have an adverse impact on our health and well being should be addressed.

What do we intend to do?

- Address issues relating to loneliness including facilitating the development of befriending services; promoting social activities; developing intergenerational activities; and volunteering opportunities
- Further develop our successful model of Local area coordination in partnership with third sector organisations which improves access to services and decreases social isolation for vulnerable groups.
- Revise and improve our services to those suffering harm through alcohol and substance abuse
- Revise and update our Stop Smoking Services.
- Support people to better connect to their communities, for example development of the Community Asset Map, and utilising Self Directed Support to access a range of services provided by the community.
- Deliver a core programme of visits to all children from birth to 5yrs, to assess need, monitor development, promote positive health and support parenting (the Universal Pathway).
- Support free access to leisure facilities for looked after and accommodated children (LAAC) and care leavers.
- Improve access to welfare, health and wellbeing, housing and employability for people with convictions.
- Develop pathways within community payback orders to increase the use of specific alcohol, drug and mental health requirements and interventions to promote healthy living and risk reduction.
- Revise and update our Child Protection arrangement in line with national recommendation. Develop and implement the national child protection improvement programme.

How we will measure our success?

The HSCP aims to:

- Reduce smoking prevalence
- Increase the number of people meeting the national recommendation for physical activity, healthy eating and safer consumption of alcohol
- Increase levels of Breastfeeding rates
- Improve dental health and increase Child Smile registrations
- Maintain percentage of childhood immunisation uptake
- Increase community payback orders with alcohol, drug and mental health requirements to promote healthy living and risk reduction.

STRATEGIC PRIORITY 2.

Enhance the quality of life and supporting independence, particularly for those with long-term conditions

What are we already doing?

- Implementing the learning from the 'Wellbeing Workers' pilot programme, that supports people to access a range of social and community groups.
- Supporting people in recovery from alcohol and substance misuse by adopting a Peer Support approach.
- Ensuring full utilisation of the Intermediate Care facilities for service users being discharged from hospital.
- Providing demonstration visits to the Assisted Living Show Flat ensuring stakeholders are familiar with available technology.
- Delivering activities aimed at young people with learning disabilities via the Local Area Co-ordination Programme, for example, Music Group and Tennis Aces.
- Providing community payback orders with multi agency and third sector involvement.

What matters to our residents, partners and staff?

- Health and social care staff should be equipped to signpost people to services through routes into communities that have not been traditionally considered.
- Self management should be a partnership between people and the services that support them.
- Peer support approaches can play an important role in supporting people to self manage their health, providing information, support and sharing experiences.
- There needs to be care pathways to address relapse, ensuring people whose condition worsens find their way to the right service when they most need them.
- A range of effective early intervention services need to be in place to support more vulnerable people.

What do we intend to do?

- Re-orientate health services toward prevention of illness and promotion of health for our older and more vulnerable population so that they are supported by effective care and support services that enable them to maintain their independence and enjoy a high quality of life. This includes developing social prescribing approaches within all primary care settings.
- Develop and promote a range of sustainable approaches to self-management, early intervention and anticipatory care for people with long term conditions, including building on the learning from our 'House of Care' and 'Transforming Cancer After Treatment' (TCAT) pilot programmes.
- Identify and develop evidence based approaches to support people to better manage their long term health conditions including providing information to help

people connect people to a wide range of services in their community.

- Review and update our Older People Day Care services to deliver early a variety of services helping people live an active life
- Focus on improving our services for those people with dementia, and their carers, enhancing Dementia Post Diagnostic Support services, and further develop ‘Dementia Friendly Communities’.
- Roll out our Recovery Orientated System of Care (ROSC) service model which establishes closer links to communities for individuals with Alcohol & Drugs and/or Mental Health issues.
- Promote independent living through the uptake of telecare and telehealth solutions through the implementation of the Assisted Living Technology Strategy 2018-2023, and the development of E-frailty project and advancement of e-self solutions.
- Review and redesign service provision of both Learning Disability and Mental Health services to create modernised, sustainable and flexible service delivery models for service users, including developing community supports with the third sector.
- Review complex and non-complex care requirements and redesign Care at Home Services to ensure a balanced provision of in house/external services.
- Promote effective and efficient prescribing to minimise medicines waste, reduce prescribing costs and achieve a more consistent prescribing service across all GP practices.
- Review and improve services and interventions to support children who have long term conditions.
- Review and improve transition pathways for children and young people moving into adult services across all care groups.
- Improve access to health service interventions for the ageing population in custody.
- Implement an alcohol intervention and education programme, establishing closer links to partners and communities to raise awareness and reduce alcohol related harm.

How we will measure our success?

The HSCP aims to:

- Increase uptake of a variety of telecare/telehealth care solutions
- Improve drug and alcohol referral to treatment waiting times
- Improve psychological therapies referral to treatment waiting times
- Improve percentage of people newly diagnosed with dementia accessing post diagnostic support

STRATEGIC PRIORITY 3.

Keep people out of hospital when care can be delivered closer to home.

What are we already doing?

- Providing a seven day community nursing service including evening and overnight access to respond to unplanned care requirements in a timely manner through direct contact and single point of access at weekends.
- Reduced admissions through the Rapid Response service and established pathway between A&E and Community Rehabilitation Team to provide next day response.
- Working with care homes to introduce a falls pathway, reduce pressure ulcers and provide '*Stress and Distress'* training.
- Established pathways with Scottish Ambulance service to provide an alternative to hospital admission for non-injured people who fall.
- Reduced delayed discharges through the provision of intermediate care providing opportunity for full assessment and return home to the community.

What matters to our residents, partners and staff?

- Services should move beyond operating in a Monday to Friday, nine to five culture.
- Need to maximise the potential of telecare and access to services to support people in their own homes.
- Community rehabilitation is vital in returning people to independence.
- Services should incorporate different approaches to prevent people going into hospital and help them to be discharged quicker.
- Support needs to be in place before peoples' conditions reach crisis, meaning hospital admission becomes the last resort.
- Need to promote 'Advanced Statements' and 'power of attorney' to plan for future care needs.
- Care homes should integrate more with the local community for example encouraging intergenerational and befriending activities.
- Care home residents should be able to contribute to aspects of the care home life based on their skills and interests such as baking and organising activities.

What do we intend to do?

- Develop and commission recovery orientated care service provision for adults with complex mental health needs to provide alternative to long term hospital care. This will consider future models of care and support ensuring that the third sector is a key partner in our approach.
- Reshape and redesign community based rehabilitation services to avoid admission to hospital and facilitate discharge

- Contribute to NHS Greater Glasgow & Clyde Out of Hours (OOH) service review to support better access to services at different times and settings.
- Reduce unplanned hospital admission through the development of models to support people to receive the necessary care within their community, including the introduction of a Single Point of Access across health and social care services.
- Develop a joint approach with GP's and stakeholders to anticipate and respond to changes in those with life limiting conditions that require palliative care so that support can be provided at an early stage to enable people to remain at home.
- Develop the Care Home Liaison Nurse service to provide support and advice to care homes to enable them to care for residents with complex needs and prevent unplanned hospital admission.
- Support people who require end of life care in a homely setting to ensure their preferred place of death is met.
- Facilitate prompt discharge from hospital through working with hospital services to identify the needs of patients at an earlier stage.
- Utilise the opportunities which will come from the new GP Contract to improve local services and increase access to treatment and care in a local setting.

How we will measure our success?

The HSCP aims to:

- Reduce unplanned hospital admissions
- Reduce occupied bed days for unscheduled care
- Reduce A&E attendances
- Reduce bed days lost to discharges delayed
- Increase the percentage of last 6 months of life spent in the community

STRATEGIC PRIORITY 4.

Address inequalities and support people to have more choice and control.

What are we already doing?

- Increasing the number of early intervention/prevention and community assets available to all service user groups in partnership with the third sector.
- Delivering self directed support options to all service user groups and reviewing of local independent Self Directed Support information, advice and support.
- Increase accessibility; and support vulnerable and hard-to-reach individuals and groups access appropriate financial support services.
- Promoting and supporting the uptake of income maximisation services to increase financial benefit for children and their families and our older populations.
- Promoting and supporting the uptake of Healthy Start programme enabling families to access free vouchers every week to spend on milk, fruit, vegetables, infant formula milk and free vitamins.
- Work with families to enable them to appropriately access the Early Learning & Childcare entitlement.
- Deliver with Peer Volunteers, the Baby Café breastfeeding support within Hillhead PLACE community.
- Supporting people living in Hillhead & Harestanes, Lennoxtown and Auchinairn (PLACE communities) to establish or create new activities and strengthen community capacity through co-production and involving local residents and partners.

What matters to our residents, partners and staff?

- Remove barriers that prevent people taking action to maintain and improve their health and wellbeing, particularly for those people with mental health conditions; those fearing being a victim of crime; and children being bullied.
- The health and social care system is highly complex and is often difficult for people to understand and navigate easily.
- Waiting lists can create barriers to access and may prevent people getting the appropriate help when they most need it.
- Health and social care services should work with the voluntary sector to maximise financial advice and support advocacy for their service users in greatest need.
- Domestic violence has a negative impact on the physical and mental wellbeing of women and children.

What do we intend to do?

- Focus on Identifying where hidden health inequalities and poverty exist outwith areas of deprivation, particularly employability, fuel poverty and family income.
- Promote choice and control across all care groups through the implementation of the Self Directed Support Strategy 2018-21.
- Tackle child poverty, its cause and effects through working with our community planning partners and in line with the emerging Child Poverty Act
- Improve services for people with Autism by implementing a series of key community based actions
- Improving the health and well being of people subject to community orders and those leaving custody and returning to the community by improving access to local health services
- Deliver high quality health information, assessment and treatment to all prisoners.
- Provide health information, assessment and treatment for children who are looked after and accommodated.

How we will measure our success?

The HSCP aims to:

- Increase the number of service users utilising self directed support options.
- Increase the uptake of the income maximisation service.
- Monitor the uptake of Healthy Start programme.
- Increase the breastfeeding rates in deprived communities.
- Increase % of people released from a custodial sentence who are:
  - registered with a GP
  - have suitable accommodation
  - have had a benefits eligibility check

STRATEGIC PRIORITY 5.

People have a positive experience of health and social care services

What are we already doing?

- Service users and carers inform key HSCP decisions through their active representative on the HSCP Board, Strategic Planning Group and Locality Planning Groups.
- Service user feedback is being captured and acted upon through service user satisfaction surveys; service comments, complaints; and engagement events
- In partnership with Education, the HSCP has adopted an Alternative and Augmented Communication Protocol for young people with sensory impairment and provided AAC equipment
- Regularly reviewing the views of service users, family and partner agencies regarding the delivery of Justice Services.

What matters to our residents, partners and staff?

- People should experience their journey through the health and social care system as holistic and seamless.
- There needs to be more information about the transition from children's to adult services.
- Effective links between hospital services and community support will improve the experience of people, particularly those with dementia.
- The quality of the care provided could be improved through preventing duplication of assessments that just cover the same ground, as well as continuity of care delivered by those providing care.
- There should be better use of local pharmacies and promotion of the minor ailments service
- Joint working across health and social care teams and other organisations is more likely to enhance service provision.

What do we intend to do?

- Provide forums and opportunities for service users and carers to meet, discuss health and social care issues affecting local people and contribute to plans to reshape care locally.
- Establish more effective and consistent mechanisms to capture service user and carer feedback about the services they receive in order to inform service improvement.
- Improve transitional planning arrangements for young people, young carers and families who are approaching entry into adult health and social care services.
- Improve the effectiveness and efficiency of services by maximising opportunities for integrated service delivery including, reviewing referral pathways across care groups; implementing an Information Technology plan to promote information

sharing; and improving information systems.

- Develop a Community Justice Plan to improve supervision and services for people who have committed offences, from the point of arrest, through prosecution, community disposal or custody and alternatives to these, until they are reintegrated into the community.
- Increase the accessibility and availability of public information regarding Children's resources and eligibility criteria, including transitional arrangements between children and adult services.

How we will measure our success?

The HSCP aims to:

- Monitor the number of complaints and comments.
- Increase the percentage of service users satisfied with the quality of care provided
- Increase the percentage of service users satisfied with their involvement in the design of their care provided
- Increase the percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided

STRATEGIC PRIORITY 6.

Promote independent living through the provision of suitable housing accommodation and support.

What are we already doing?

- Building all new properties to meet the varying standards of need.
- Providing housing adaptations for residents in all tenures through the Care and Repair Scheme.
- Providing Telecare packages to existing residents.
- Utilise a 'Smart Flat' to demonstrate new technologies assisting older people to live in their home for longer.
- Providing a Care of Gardens scheme.

What matters to our residents, partners and staff?

- Suitable accommodation is available for vulnerable people within the communities in which they live at present.
- Many older people occupy homes unsuitable for their needs in terms of size or adaptation.
- People should have a range of housing options available to them to help match needs; there is no 'one size fits all' model.
- Support should be available for people to help assess available housing options.

What do we intend to do?

- Deliver the Affordable Housing Investment Programme, providing a percentage of amenity housing within larger development sites.
- Review our present older people's housing model and service provision to inform the development of a new generation of sheltered or extra care housing for rent that suits the needs of older tenants within their own communities.
- Actively pursue opportunities with the Registered Social Landlord sector to enable older people to continue as homeowners in accommodation more suitable to their needs.
- Establish the level and location of demand for housing for older people, particularly within the private sector, through a facilitated research study.
- Renew the commitment to the Care & Repair Scheme through new partnership working.
- Evaluate the Council's allocations policy to ensure that older people are being given an equitable opportunity to access the housing they need.

How we will measure our success?

The HSCP aims to:

- Increase the number of people receiving the ‘Care of Gardens’ Scheme.
- Increase the number of people accessing the Care and Repair Service.
- Increase the percentage of our housing for Specialist Needs with Community Alarm or Telecare systems to 65% by 2021.

STRATEGIC PRIORITY 7.

Improve support for Carers enabling them to continue in their caring role.

What are we already doing?

- Established a multi-disciplinary Carers Working group whose membership includes HSCP, Education, Carers Link, the third sector, and carers to inform the development of the new local Carers Strategy.
- Continue to involve carers in the planning of services at a strategic level through their representation on HSCP strategic groups.
- Eligibility criteria for carers published following consultation with carers.
- Identified Adult Support Plans and Young Carers Statements for identifying carers needs.
- Providing short breaks and respite for carers based on assessed need.
- Supporting raising the knowledge and awareness of carers about the Carers Act and the Adult Support Plans and Young Person Statement.

What matters to our residents, partners and staff?

- People should be supported to identify themselves as carers so that their needs can be assessed and supported.
- Carers' knowledge and understanding of the cared for person's situation needs to be better taken into account.
- More information about the services available and flexible respite is critical for carers to support them in their caring role.
- Young carers require support so that they can study and socialise.

What do we intend to do?

- Prepare and publish a local Carers Strategy with an accompanying action plan and performance framework which will embed the legislation into practice.
- Prepare and publish a Short Breaks Statement.
- Develop mechanisms to better identify adult carers and young carers in order to assess and monitor the impact of their caring role.
- Develop a system to harmonise the monitoring of carers identified and assessed carers across relevant disciplines and agencies.
- Work in partnership with carers organisations and other third sector organisations to raise awareness about the Act and carers rights, and develop services that support carers to continue in their caring role.
- Establish and maintain an accessible information and advice service for carers.

How we will measure our success?

The HSCP aims to:

- Increase number of adult carers identified and completing an Adult Support Plan
- Increase number of young carers identified and completing a Young Persons Statement
- Increase number of carers who feel supported to continue in their caring role

STRATEGIC PRIORITY 8.

Optimise efficiency, effectiveness and flexibility

What are we already doing?

- Developing HSCP and service area business plans outlining priorities and progress measures.
- Developing a Market Facilitation Plan to ensure there is diverse appropriate and affordable provision of available service providers across sectors to meet local needs and deliver effective outcomes both now and in the future.
- Co-located health and social care staff to achieve effective integrated communication and joint working.
- Involving staff in the development of a workforce plan to ensure organisational skills and capacity is fit for the future.
- Established a suite of governance arrangements to ensure the provision of safe, effective and efficient services
- Delivering Multi-Agency Protection Arrangements (MAPPA) bringing together the Police, Scottish Prison Service (SPS), Health and the Local Authorities, in partnership as the Responsible Authorities, to assess and manage the risk posed for certain categories of offender.

What matters to our residents, partners and staff?

- Local Hubs, libraries and community facilities should be better recognised and used as community resources.
- Build relationships with the third and voluntary sector who have critical knowledge, skills and capacity.
- Services should be redesigned to improve responseto meet need.

What do we intend to do?

- Enhancing contract management arrangements to ensure services are compliant, outcomes focussed and deliver best value. Implement a Market Facilitation Plan to effect market change.
- Implement an Accommodation Plan to enable health and social care teams to work in an integrated way across both localities. This will mean completing our refurbishment of Kirkintilloch Health and Care Centre and review our accommodation arrangements in the Milngavie/Bearsden area
- Review and assess the impact of private sector care home developments across geographical areas.
- Engage and action feedback from the workforce through further embedding of iMatter staff survey across health and social care.
- Support the national priority for the implementation of the rollout of the Drugs & Alcohol Information System (DAISy) across alcohol and drugs services.

How we will measure our success?

The HSCP aims to:

- Monitor Adult and Child protection measures
- Reduction of re-offending
- Analyse and measure the impact and outcomes associated with the review and redesign learning disability and mental health services
- Monitor providers' compliance with contract monitoring framework

APPENDIX A

The National Health and Wellbeing Outcomes are high-level statements of what the HSCP aims to achieve through improving quality across integrated health and social care services

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

Agenda Item Number: 14

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	Learning Disability Strategy and Implementation Plan
Report By	Susan Manion, Chief Officer
Contact Officer	Alan Cairns, Service Redesign Officer Alan.cairns2@ggc.scot.nhs.uk

Purpose of Report	The purpose of this report is to provide the HSCP Board with an update on the preparation of an Adult Learning Disability Strategy and Implementation Plan, with reference also to the Learning Disability Review and Redesign Project.

Recommendations	It is recommended that the HSCP Board: i. notes the contents of this report ii. requests regular updates on the progress of this work

Relevance to HSCP Board Strategic Plan	The development of an Adult Learning Disability Strategy and associated review and redesign work are identified as key activities in the draft Strategic Plan 2018-21.

Implications for Health & Social Care Partnership

Human Resources:	There may be HR implications as the Strategy's Implementation Plan is taken forward. These will be the subject of separate reports.

Equalities:	A full Equality Impact Assessment report will be presented in due course to the HSCPB on the Adult Learning Disability Strategy and as appropriate on substantive aspects of redesign work undertaken as part of the associated Implementation Plan.

Financial:	The implementation of the Strategy will operate within existing financial parameters.

Legal:	There may be Legal implications as the Strategy's Implementation Plan is taken forward. These will be the subject of separate reports.

Economic Impact:	A Strategic Environmental Impact Assessment will be presented in due course to the HSCPB on the Adult Learning Disability Strategy and as appropriate on substantive aspects of redesign work undertaken as part of the associated Implementation Plan.

Sustainability:	Financial and qualitative sustainability is at the heart of the draft Adult Services Strategy and so will inform all aspects of the associated Implementation Plan.

Risk Implications:	A Strategic Environmental Impact Assessment will be presented in due course to the HSCPB on the Adult Learning Disability Strategy and as appropriate on substantive aspects of redesign work undertaken as part of the associated Implementation Plan.

Implications for East Dunbartonshire Council:	As the provider and contractor of learning disability services and employer of staff delivering in-house social care services, the Council has significant interests in the Adult Learning Disability Strategy and associated Implementation Plan. The Learning Disability Review and Redesign Project is included in the Council's Transformation Programme, so its progress will be overseen through these mechanisms. When approved, this strategy will inform the Directions to the Council.

Implications for NHS Greater Glasgow & Clyde:	NHSGGC will be a key stakeholder and has its own specialist NHS learning disability strategy "A Strategy for the Future" at the heart of the document, together with the national strategy "Keys to Life", which has a significant NHS dimension. When approved, this strategy will inform the Directions to NHSGGC.

Direction Required to Council, Health Board or Both	**Direction To:**	**Tick**
	1. No Direction Required	
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	**X**

1.0 MAIN REPORT

1.1 National statistics demonstrate that in East Dunbartonshire:

- Prevalence of adult learning disability in East Dunbartonshire is in line with the Scottish average;
- We spend approximately 8% more than the Scottish average on learning disability services, but we are not in the highest spending quartile of Partnerships;
- Our configuration of accommodation and support arrangements is closely aligned with arrangements across Scotland as a whole;
- We have more people with learning disabilities engaged in supported employment and day centre services than is the case in most Partnership areas.

1.2 We know from the expressed and reflected views of service-users, their families, staff and other stakeholders that there are important service areas and processes that would benefit from improvement, including: transitions, modernisation of day services, better co-ordination between services, more personalisation and self-directed support, better support for carers and continued development of specialist NHS services in line with *A Strategy for the Future*. It has also been identified that our various accommodation and support options could, in some areas, operate more effectively and efficiently.

1.3 The Health and Social Care Partnership inherited from East Dunbartonshire a commitment to undertake a review and redesign of adult learning disability services. This review was aimed at addressing some of the redesign priorities around certain procedural processes, day services and accommodation based services. A Redesign Officer was appointed in mid-November 2017, who has commenced the process of scoping the project's terms of reference and prioritising actions.

1.4 It was identified on commencement that the learning disability review and redesign project could not operate in isolation from a wider strategic framework for learning disability. A draft Adult Learning Disability Strategy has consequently now been prepared for consultation. This draft strategy proposes 6 improvement themes:

1. To improve the planning for young people with learning disabilities transitioning from childhood to adulthood, with early involvement of parents, carers and the young people themselves;

2. To review and redesign residential and day support services, to modernise them, provide them locally wherever possible, make them fit for purpose for the people who need them and ensure they are sustainable for the future;

3. To ensure that specialist NHS services for people with learning disabilities are improved and developed in line with the Health Board's improvement programme "A Strategy for the Future";

4. To continue to embed the principles of personalisation and Self-Directed Support, to encourage choice and independence within a framework that ensures fairness and consistency;

5. To continue to follow the principles and recommendations set out in "Keys to Life", to ensure that the best possible outcomes are being met for people with learning disabilities, their families and carers, within the resources available.

6. To ensure that our resource allocation processes are fair and consistent, and that we maximise efficiencies to secure Best Value for the people we support and the

wider community.

1.5 The Learning Disability Review and Redesign Project will then be responsible for taking forward a number of these improvement themes, within an overall Improvement Plan.

1.6 The draft Adult Learning Disability Strategy will be considered by the Strategic Planning Group at its next meeting and is also scheduled to be considered by the Public, Service User and Carer Group at its next meeting on 5 February. It will be important to ensure that the over-arching improvement themes reflect collective stakeholder priorities. The substantive elements of the Review and Redesign Project will then be subject to more thorough consultation processes as they move forwards.

1.7 After due consultation and consideration by the above groups, the draft Adult Learning Disability Strategy will be presented to the HSCP Board for consideration and approval.

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Susan Manion

Agenda Item Number: 15

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	East Dunbartonshire Local Outcomes Improvement Plan 2017-27
Report By	Sandra Cairney – Head of Strategy, Planning & Health Improvement
Contact Officer	Sandra Cairney – Head of Strategy, Planning & Health Improvement Sandra.cairney@ggc.scot.nhs.uk 0141 232 8224

Purpose of Report	To provide the HSCP Board with information regarding the: ▪ the Community Planning Partnership Local Outcomes Improvement Plan, 2017-2027 (LOIP) approved by the Community Planning Partnership Board on the 7th December 2017; and ▪ the ongoing development of PLACE Plans within the targeted PLACE communities of Hillhead & Harestanes, Lennoxtown, Auchinairn and Twechar

Recommendations	The HSCP Board is asked to note the: ▪ information regarding the approved Community Planning Partnership Local Outcomes Improvement Plan, 2017-2027 (LOIP); and ▪ note the progress in the development of Place Plans for Hillhead & Harestanes, Lennoxtown, Auchinairn and Twechar.

Relevance to HSCP Board Strategic Plan	Relates to key priorities which are agreed and delivered jointly with Community Planning Partners.

Implications for Health & Social Care Partnership

Human Resources	Nil

Equalities:	EQIA undertaken to evidence positive impacts on targeted groups and individuals.

Financial:	Nil

Legal:	Nil

Economic Impact:	Nil

Sustainability:	Nil

Risk Implications:	Nil

Implications for East Dunbartonshire Council:	Nil

Implications for NHS Greater Glasgow & Clyde:	Nil

Direction Required to Council, Health Board or Both	**Direction To:**	
	No Direction Required	**X**
	East Dunbartonshire Council	☐
	NHS Greater Glasgow & Clyde	☐
	East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

1.0 MAIN REPORT

1.1 The Community Empowerment (Scotland) Act 2015 requires community planning partnerships to prepare a Local Outcomes Improvement Plan (LOIP) and produce individual plans for communities who experience poorer outcomes where compared locally or nationally (PLACE Plans).

1.2 PLACE Plans will provide bespoke plans for the four geographic communities in East Dunbartonshire, which have been identified and agreed as experiencing the greatest inequality. The developing PLACE Plans have been informed by a range of research, data, analysis and engagement during 2016 and 2017. They have been developed alongside the LOIP illustrating how inequality is experienced in the context of the new local outcomes and demonstrating the Community Planning Partnership's commitment to tackling this.

1.3 Due to their size, the following link has been provided to avoid printing a large volume of paper. A limited number of hard copies are available on request to East Dunbartonshire Community Planning Team.

'eastdunbarton.gov.uk/our-local-outcomes'

2 BACKGROUND

2.1 The Local Outcomes Improvement Plan (LOIP) replaces the Single Outcome Agreement (SOA) as the high level strategic document, outlining the overarching strategic priorities for the Community Planning Partnership's (CPP) business.

2.2 The LOIP is similar to the SOA, with a few crucial differences. SOAs were agreements drawn up between the Scottish Government and local partners delivering services in East Dunbartonshire, whereas the LOIP and PlACE Plans are developed between the various partners and communities. The LOIP is specifically designed to bring together the efforts of community planning partners to address inequalities, both in East Dunbartonshire as a whole and in communities that are particularly disadvantaged. The LOIP is the result of analysis carried out in partnership of local circumstances, needs, and aspirations. The LOIP demonstrates a clear focus on outcomes and sets out the delivery and accountability processes which will support the CPP to achieve its ambitions.

2.3 CPPs are required to prepare these plans as per the guidance provided in the Community Empowerment (Scotland) Act 2015. A further requirement of the Act is to identify and produce individual plans for those communities who experience poorer outcomes where compared locally or nationally. In East Dunbartonshire these have been defined as Hillhead and Harestanes, Lennoxtown, Auchinairn and Twechar, and for each a Place Plan will be produced.

2.4 The vision and themes of the proposed outcomes have been reviewed collectively by partners and informed by a range of consultations/engagements.. The themes of the LOIP remain broadly similar to those in previous Single Outcome Agreements and any changes have been considered in light of partner knowledge, up to date data and engagement evidence.

2.5 The full LOIP is available at www.eastdunbarton.gov.uk/our-local-outcomes

3 LOIP EXECUTIVE SUMMARY

3.1 The vision and the six themes are:

Working together to achieve the best with the people of East Dunbartonshire'

1. Economic growth and recovery
2. Employment and skills
3. Children and young people's wellbeing
4. Safer and stronger communities
5. Adult health and wellbeing
6. Older Adults, vulnerable people and carers

3.2 For each of the local outcomes there is an established a multi-agency group of service representatives who work together regularly. These are known as local outcome delivery groups and are overseen by the Community Planning Partnership Board. These groups have delegated responsibility to plan for and deliver improvements through partnership actions.

3.3 Within the LOIP each local outcome is presented with; the key facts and issues; who the key partners are; what the priorities within each outcome are; and what the high level indicators are. All detail about planned actions and delivery is retained within individual strategic plans and associated action plans for each local outcome delivery group. These are at various stages of development and are anticipated to be in presented for approval by CPP Board in spring 2018.

3.4 The table below sets out the current and new outcomes together with the strategies and action plans for each local outcome delivery group

Current Outcomes	Outcomes for 2017-2027	Delivery plans
East Dunbartonshire has an expanding economy with a competitive and diverse business and retail base.	East Dunbartonshire has a sustainable and resilient economy with busy town and village centres, a growing business base and is an attractive place in which to visit and invest.	Economic Development Strategy and Action Plan
Our people are equipped with knowledge, skills and training to enable them to progress to employment.	Our people are equipped with knowledge and skills for learning, life and work.	Employability Strategy and Action Plan
Our children and young people are safe, healthy and ready to learn.	Our children and young people are safe, healthy and ready to learn.	Integrated Children's Services Plan (inclusive of Action Plans for each priority)
East Dunbartonshire is a safe and sustainable environment in which to live, work and visit.	East Dunbartonshire is a safe place in which to live, work and visit.	Safer and Stronger Together Framework (inclusive of Community Safety and Antisocial Behaviour Strategy, Violence Against Women Strategy and Community Justice Outcomes Improvement Plan)
Our people and communities enjoy increased physical and mental wellbeing and health inequalities are reduced.	Our people experience good physical and mental health and wellbeing with access to a quality built and natural environment in which to lead healthier and more active lifestyles.	Joint Health and Wellbeing Strategy (inclusive of Action Plans for each priority)
Our older population are supported to enjoy a high quality of life and our more vulnerable citizens, their families and carers benefit from effective care and support services.	Our older population and more vulnerable citizens are supported to maintain their independence and enjoy a high quality of life, and they, their families and carers benefit from effective care and support services.	Health and Social Care Strategic Plan (inclusive of a partnership work Action Plan for older adults, vulnerable people and carers)

3.5 Performance Management arrangements have been an integral part of the development of the new LOIP. There has been on-going work with all local outcome delivery groups to assess the suitability of current indicators, and update these for 2017-2027 to ensure they reflect changes in priorities within each outcome; can be collected over the next ten years; and are accurate and reliable indicators of change which have come about as a result of the interventions by local outcome delivery groups.

3.6 A notable development from previous SOAs is in the inclusion of seven guiding principles. In order to achieve the vision for the LOIP a range of principles are included which should underpin the planning and delivering of services under all of the local outcomes. These include:

- Coproduction and engagement;
- Evidence based planning;
- Fair and equitable services;
- Sustainability;
- Prevention and early intervention
- Planning for Place;
- Best Value.

3.7 These have been agreed by partners and reflect many of the themes within the new Community Empowerment Act. The alignment to these principles is the responsibility of all local outcome delivery groups, and will help inform the local outcomes activity. The LOIP details how the CPP will embed and monitor the guiding principles

3.8 There has been extensive stakeholder engagement to inform these authority wide local outcomes, but also to inform needs and aspirations in our communities that experience the poorest outcomes. This information has been used to help develop the new LOIP. PLACE based engagement in the four identified 'PLACE' areas involved partners providing local knowledge from a range of data sources and single partner engagement in these areas. Additionally there was a large scale partnership engagement exercise undertaken in each of these areas using the Place Standard tool.

3.9 More widely, the development of the LOIP has been underpinned by continuous engagement by all of the partners over the last two years, which is shared through the Community Planning Improvement Group (CPIG) and individual local outcome delivery groups. The LOIP explains this further, giving examples of various conversations, surveying, forums and groups, targeted work and public meetings.

3.10 The process to develop the LOIP has also drawn on the knowledge from several other engagement processes including the Joint Health and Social Care Strategic Needs Assessment 2016, Active Travel Strategy Engagement and EDVA Services and Facilities Investigation Reports.

3.11 During June and July 2017 a public online survey sought views on the LOIP outcome themes, the priorities within them and the means to track success over the next ten years. This survey attracted over 300 responses. This also provided an opportunity for respondents to leave their contact details if they were interested in being consulted on one or more of the themes in the future. This information will provide the basis on which all of the local outcome delivery groups can coordinate community engagement

specific to their outcome.

3.12 The draft LOIP was published for consultation for six weeks following the Community Planning Partnership Board meeting of 7th September 2017 and feedback has been sought through use of a structured public online questionnaire. The statutory process for consultation in relation to the SEA required an Environmental Report to be published which presents an assessment of the process to prepare the LOIP and the options for outcomes considered. This process has run alongside the questionnaire.

3.13 As part of the LOIP development, and in response to the Community Empowerment (Scotland) Act, a review of the CPP governance structure has been undertaken.

3.14 As part of the structure review, partners are considering how the reporting cycle and formats can best meet the needs of the statutory guidance to ensure regular, rigorous and transparent reporting is undertaken. This first annual LOIP report will be due in summer 2019 and will cover the period December 2017- March 2019. Thereafter annual reporting will cover the financial year just ended. In addition, local outcome delivery groups will report on a rolling basis on the implementation of their strategies and action plans, bringing to life their work in through case studies and presentations.

4 PLACE PLANS

4.1 The PLACE Plans will provide bespoke plans for the four geographic communities in East Dunbartonshire, which have been identified and agreed as experiencing the most inequality. The PLACE Plans are informed by a range of engagement, research and analysis over 2016 and 2017. They have been developed alongside the LOIP showing how inequality is experienced in the context of the new local outcomes and demonstrating the partnership commitment to tackling this.

4.2 It is the intention these plans will be holistic, considering the social, economic, health and the physical built environment dimensions of each PLACE. Each of these plans will provide a profile of the area derived from the various research and engagement work, and set out key issues and a range of proposed actions. Some of the actions identified will be existing programmes or initiatives of work which are already underway in these areas, others will require development and further consultation.

4.3 The delivery of the PLACE Plans will be undertaken across the partnership through vehicles such as local outcome delivery groups with many issues and actions relating to local outcomes identified in the LOIP. Other actions will be delivered through single partner agencies or by local communities themselves.

4.4 Further work within local communities, with local groups and across the CPP will be required over the long term to develop community capacity and certain actions identified in the Place plans. Importantly local communities will continue to be involved in their development and will be further consulted in the preparation of final drafts.

4.5 The Lennoxtown PLACE Plan will be the most advanced and detailed plan having benefitted from a Charrette carried out in early 2016. This condensed approach to analysing this area together with the local community has produced a range of actions and interventions, including many which focus on the physical environment. The findings from the Charrette and proposed actions developed with the community, together with more recent analysis via community planning partners, will all form part of the one PLACE Plan for the village.

4.6 Twechar PLACE Plan is proposed to be light touch in comparison to the others due to the strong community led approach already prevalent in this locality. The plan for Twechar will instead set out a commitment to a partnership approach to support Twechar Community Action to realise ambitions in their own community action plan

developed earlier in 2017. The plan will be structured around the existing Twechar Community Action Plan and will highlight support from the CPP where required and where possible to achieve ambitions. This plan will also be cognisant of the existing Twechar Masterplan as a key document which sets land use priorities for action in this area.

4.7 The Auchinairn PLACE Plan and Hillhead & Harestanes PLACE Plans will be more similar in the level of detail, but each presenting a distinct set of actions developed with partners and the local community to meet the needs of each place. The new community facility in Hillhead is an example of recent Council investment to support service delivery in the area, as well as provide a space for community initiatives to develop. As part of the PLACE Plan process there will be ongoing community capacity building work to ensure the best utilisation of new community infrastructure such as the centre and support to new and existing groups.

4.8 Alongside the development of the PLACE Plan with the local community, there is ongoing community capacity building work in preparation for the new Auchinairn PLACE facility, for example the work with the social enterprise who will run the café. The Auchinairn PLACE facility is currently on-site and due for completion in 2018. It has been developed through ongoing work with the local community and relevant stakeholders, and as with Hillhead will provide a modern community space to support service provision, locally based activity and community development.

4.9 The PLACE Plans continue to be developed and discussions with local communities will continue, with a programme of consultation work ongoing running and into early 2018. Community planning partners will continue to work with local communities to develop final versions of the PLACE Plans for presentation to Community Planning Partnership Board in the spring/early summer 2018.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	Carers (Scotland) Act 2016 Implementation
Report By	Fiona McCulloch Planning, Performance and Quality Manager
Contact Officer	Fiona McCulloch Planning, Performance and Quality Manager Fiona.mcculloch@ggc.scot.nhs.uk 0141 355 2395

Purpose of Report	The purpose of this report is to provide an update on the range and provisions to be delivered under the Act and the preparations underway including: • Local governance arrangements in place and implementation approach; • Draft Local Eligibility Criteria and Management of the key risks identified

Recommendations	It is recommended that the HSCP Board note the progress preparations for the implementation of the Carers Act

Relevance to HSCP Board Strategic Plan	The implementation requirements for the Carers Act are included in the draft Strategic Plan 2018-21, and will be further detailed within the Carers Strategy.

Implications for Health & Social Care Partnership

Human Resources	N/A

Equalities:	N/A

Financial:	Scottish Government has indicated that this will be the final year of Carer Information Strategy Fund to be replaced by a Financial Framework of Carer Scotland Act.

Legal:	N/A

Economic Impact:	N/A

Sustainability:	N/A

Risk Implications:	Potential risks are highlighted within the report

Implications for East Dunbartonshire Council:	N/A

Implications for NHS Greater Glasgow & Clyde:	N/A

Direction Required to Council, Health Board or Both	**Direction To:**	**Tick**
	1. No Direction Required	
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

1.0 MAIN REPORT

Background

1. The Carers (Scotland) Act 2016 will be implemented on 1 April 2018. The Act relates to both adult and young carers, defining a carer as "an individual who provides or intends to provide care for another individual (the 'cared for person')".

   The intention of the Act is to ensure that carers of any age are supported to continue with their caring role, are able to have a life and access to support alongside their caring responsibilities. For young carers the Act intends to ensure that they are supported to enable them to have a childhood similar to their non-carer peers.

   The Act introduces a universal entitlement to assessment for carers, regardless of the level or frequency of care they provide. It also includes prescriptive processes around carer assessment, support planning and review.

2. National Policy Context

The provisions set out in the Act are as follows:

- a duty to prepare a local carer strategy;
- a statutory duty to offer and prepare an Adult Care Support Plan (ACSP) and a Young Carer Statement (YCS) for anyone identified as a carer, or for any carer who requests an assessment and appears to be a carer;
- a requirement for an adult carer support plan or young carer statement to include emergency plans;
- a requirement for a timescale for preparing a support plan for the carer of a terminally ill person;
- a duty to set and publish local eligibility criteria;
- a duty to provide support to carers whose needs meet the local eligibility criteria. Within this consideration must be given to whether the support should take the form of, or include, a break from caring;
- a duty to involve carers in carers service design and delivery;
- a requirement for carers to be involved in the hospital discharge procedures of the person they care for;
- a requirement to provide an advice and information service for carers;
- a requirement to prepare and publish a short breaks statement.

An accompanying suite of regulations are being produced by the Scottish Government, including an amendment through the *Public Bodies (Joint Working) (Prescribed Local Authority Functions etc) (Scotland) Amendment Regulations 2017,* which places a duty on Integration Authorities to set local eligibility criteria for carer support. A further two statutory instruments identify a number of functions that ***must*** be delegated and that ***may*** be delegated to the integration authorities.

The Scottish Government is also producing statutory guidance on the Carers' Act. Rather than waiting until all of the guidance has been prepared, it will be distributed as and when available. The statutory guidance relating to eligibility criteria, and the draft statutory guidance relating to the local carers' strategy have been made available. The remaining guidelines will be made available in January 2018.

3. Eligibility Criteria

Whilst the Scottish Government has decided against setting national eligibility criteria, it is desirable for local eligibility criteria to reflect nationally agreed definitions of levels of need/risk, in order to promote consistency of response across Scotland. The Carers' Act does not preclude the use of different eligibility criteria in relation to young carers.

The key provisions relating to setting local eligibility criteria are :

- Duty to provide support for eligible carers and deem what needs are eligible
- Power for establishing and maintaining the information and advice services for those not eligible
- Where a carer is deemed eligible for support, this may take the form of a personal budget and offer of self-directed support options

- The local authority must deem eligible needs according to local eligibility criteria
- Provision and levels of support to carers through breaks from caring
- Waiving of Charging for support provided to carers

There are three aspects to setting an eligibility framework:

- the criteria that determine it;
- the thresholds that must be passed to trigger it; and
- the services that follow it.

There are three aspects to setting an eligibility framework:

- the criteria that determine it;
- the thresholds that must be passed to trigger it; and
- the services that follow it.

Draft eligibility criteria has been developed (Appendix 2), and the consultation questions and process were agreed at the Strategic Planning Group. The consultation was supported by Carers Link and included an electronic survey, and two events with local carers. In line with Scottish Government guidance, the findings of the consultation and final drafts of the East Dunbartonshire Carers Eligibility Criteria will be presented to HSCP Board for approval in March 2018. Subject to approval, local carers' eligibility criteria will be published, and subject to regular review, as required under Section 22 of the Act

4. Financial Framework

East Dunbartonshire HSCP has been allocated funding by the Scottish Government to support the required work to be done in preparation for the Act's commencement over the coming year.

5. Risks

There are a number of risks which may impact on the successful implementation of the Carers (Scotland) Act. These are detailed in the table below with supporting mitigation activities identified by the Strategic Steering Group.

Risk	Mitigation Activities
Delays in receiving guidance could negatively on impact on planning activity	East Dunbartonshire HSCP has representation on national groups and has an early indication on direction of travel, in advance of formal guidance being issued.
The financial impact of waiving of charges for carers has not been quantified.	The HSCP Implementation Group will explore the potential financial impact of waiving of charges
Additional resources required to undertake carers' assessments, Self-Directed Support and care management.	This will be regularly monitored by the HSCP Implementation Group who will identify any additional capacity requirements.
The expectations of carers around eligibility criteria cannot be supported by available resources and / or allocated funding.	There will be ongoing engagement with carers on the eligibility criteria to create a greater shared understanding on how their needs can be best met.
Scottish Government has indicated that this will be the final year of the Carers' Information Strategy Fund to be replaced by Financial Framework	This will be modelled by the Implementation Group to create a better understanding of how this change could impact the current planned commitments.

6. Timeline and Work Plan for Implementation

Up to Oct 2017	• Establish and HSCP Carers Act Implementation Group • Agreement that existing Carers Working Group act as a reference and engagement group • Establish eligibility criteria for carers, • Review any existing criteria, consider relationship to current eligibility criteria for adult social care and children with disabilities • Consider government guidance as made available • Plan the local timetable for the work on eligibility, including the consultation, and the involvement of people and bodies representing carers • Consider any changes required to information systems to collect better data on carers

November 2017	• Finalise draft carers' eligibility criteria ready for consultation, • Plan consultation process including resources for receiving and analysing the responses. • Plan and organise range of methods for consultation with carers, their organisations and wider stakeholders
December 2017	• Consultation on carers' eligibility criteria completed • Complete analysis of consultation responses
January – February 2018	• Report to IJB and Council on consultation responses and proposed draft carers' eligibility criteria • IJB and Council agree final first Adult and Young Carers eligibility criteria, taking into account consultation responses • Draft carers' strategies prepared consulted on. • Agree and finalise local ASCP and YCS • Develop Operational Guidance, • Plan and deliver communications and training to staff, • Develop public information including FAQs
March 2018	Draft eligibility criteria presented to HSCP Board for approval
April 2018	• Commencement of Act in line with eligibility criteria • Eligibility criteria published • Draft carers' strategies prepared consulted on
June 2018	• Draft East Dunbartonshire HSCP Carers' Strategy presented the HSCP Board for approval
July 2018	• East Dunbartonshire HSCP Carers' strategy published
December 2018	• Publish Short Breaks Statement

Draft Eligibility Criteria for Adults and Young Carers for Social Care Support in East Dunbartonshire Health and Social Care Partnership

November 2017

Lead Officer:	
Policy Approved By:	
Date Approved:	
Implementation Date:	
Review Date:	

Contents

PART A – Policy and Background

Section 1: Purpose

The Carers (Scotland) Act 2016, which is due to be enacted on 1st April 2018, places legal duties on each local authority to set local eligibility criteria. It defines this as *"local eligibility criteria are the criteria by which the local authority must determine whether it is required to provide support to carers to meet carers' identified needs"*. The legislation also sets out a duty on each local authority to publish its local eligibility criteria.

The purpose of this policy is to set out clear guidelines that aim to ensure the equitable allocation of social care resources to the adult and young carers of service users living in East Dunbartonshire. The policy aims to serve as a procedure for staff and as a reference document for elected members, carers, service users, members of the public and other stakeholders.

Section 2: Scope and Aims of the Policy

East Dunbartonshire HSCP has a statutory responsibility to assess for and where eligible provide support to adult and young carers to meet those needs.

The support that is required to meet carers' needs can vary enormously; from information and advice services; to advocacy services; income maximisation services; technology enabled care; local community assets; through to home based social care support; to centred-based support; short breaks and equipment and adaptations. Through the use of self directed support options, some support can be provided by the HSCP directly, either provided by in-house or externally commissioned services; some support can be provided from the independent sector and some support services may be organised directly by the carer, depending on the self directed support option chosen.

Eligibility criteria recognise 'urgency' and 'risk' as factors in the determination of eligibility for social care support services. Where a carer is eligible, the urgency of that individual's needs should be kept in focus in determining how to respond to their support needs.

Eligibility criteria are a method for deploying limited resources in a way that ensures that resources are targeted to those in greatest need, while also recognising the types of low-level intervention that can be made to halt the deterioration of people in less urgent need of support. This must be applied strictly in line with risk and need and cannot be simply based against wishes, preferences or quality of life elements.

The policy set out below considers both (a) the severity of the risks and (b) the urgency for intervention to respond to the risks. Some levels of risk will call for the provision of support as a high priority whilst others may call for some support provision, not as a high priority but managed and prioritised on an on-going basis. Some may not call for any paid social care support at all as resources using other assets or universal services may be the most appropriate way of addressing the need. In other circumstances, the assessment may indicate a potential requirement for support provision in the longer term, which requires regular review. As part of the process for assessment and considering whether a carer's needs call for the provision of support, practitioners will consider how each individual's needs match against eligibility criteria in terms of severity of risk and urgency for intervention.

Section 3: To Whom Does the Policy Apply?

The policy applies to all carers including young people identified as carers

The assessment of the carer's needs are clearly distinguished from any consideration of available resources for the implementation of the support plan. After the assessment and application of eligibility criteria, full account should be taken of the Partnership's cost limitations when developing the Support Plan. Consideration should be given to best value and other assets i.e. Personal Assets (personal finances, skills and experiences); Community Assets (clubs, groups, forums); and Carer Assets (family, friends and peer support) when support planning to ensure that we consider the most economic way of meeting eligible needs.

Practitioners, as well as following the priority/risk matrix when applying eligibility criteria, also need to follow this policy in relation to cost limitations.

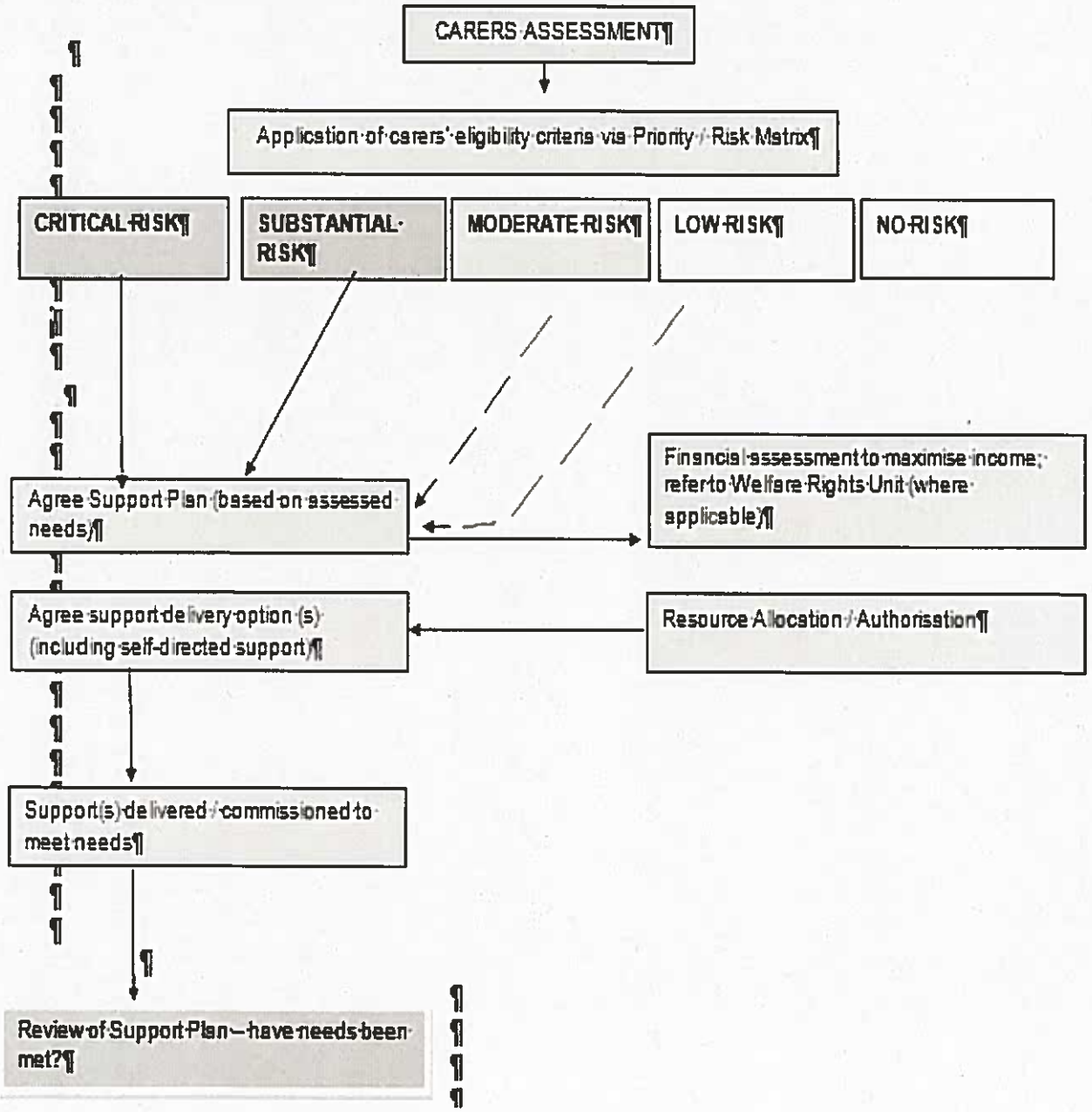
The need to consider whether a limitation will apply on the cost of a carer's support package will include consideration of:

- An assessment of need via the Carer's Assessment and Support Plan/Young Carer's Statement;
- Determining whether the Carer is eligible for support, with reference to the eligibility criteria outlined in this policy;
- Prioritisation of need;
- Identification and costing of support packages to meet assessed needs;
- Calculation on an on-going basis as to whether the total cost of the support package provided exceeds the cost limitations based on equivalency model.

PART B – Eligibility Criteria

Section 4: Assessment Progression Flow Chart

The following chart indicates the progression from assessment to the potential provision of support. It illustrates the process of determining eligibility and how the intensity of risk and potential access to support services is determined using this criteria.



Section 5: Priority Risk Matrix

This policy makes use of the five categories of risk within the Scottish Government's National Eligibility Framework and in line with East Dunbartonshire HSCP's '*Eligibility Criteria Policy for Adults and Community Care Services*'.

Critical risk: Indicates that there are critical risks to the carer's ability to continue in the caring role and likely to call for immediate or imminent intervention and/or provision of social care support for example: health breakdown requiring hospital admission, risks to the health and safety of the carer and/or cared for person.

Substantial risk: Indicates there are significant risks to the carer's ability to continue in the caring role with a likely call for immediate or imminent intervention and/or provision of social care support for example: relationship between carer and cared for person at serious risk of breakdown.

Moderate risk: Indicates there are moderate risks to the carer's ability to continue in the caring role, which may call upon the legal power for the provision of some social care support (in exceptional circumstances), or the provision of and signposting to other services (e.g. Voluntary Organisations, and Community Groups).

Low risk: Some quality of life issues but low risks to the carer's ability to continue in the caring role. There may be some need for alternative support, advice or referral to other services (e.g. Voluntary Organisations, and Community Groups).

No risk: No risks identified to carer's ability to continue in the caring role. No further action or advice, information, simple services arranged or facilitated; referral to other services (e.g. Voluntary Organisations, Community Groups).

The framework acknowledges that, in managing access to finite resources, local authorities; health and social care partnerships and their partners focus first on those carers assessed as having the most significant risks to their continued ability to undertake the caring role and impact on the carer's own health and wellbeing. Where carers are assessed as being in the 'critical' or 'substantial' risk categories their needs will generally call for the provision of support although this may not always equate to paid social care support depending upon the assessed need and outcome.

Section 6: Table of Domains and Indicators

The following table provides definitions of risk factors for each of the domains in the national eligibility framework adopted by the Partnership.

Health and Wellbeing:			
Critical Risk	**Substantial Risk**	**Moderate Risk**	**Low Risk**
Carer's health is breaking/has broken down. Carer's emotional wellbeing is breaking/has broken down.	Carer has health need that requires attention. Significant impact on carer's emotional wellbeing.	Carer's health at risk without intervention. Some impact on carer's emotional wellbeing.	Carer's health beginning to be affected. Caring role beginning to have an impact on emotional wellbeing.

Relationships:			
Critical Risk	**Substantial Risk**	**Moderate Risk**	**Low Risk**
The carer's relationship with the person they care for has broken down and their caring role is no longer sustainable	The carer's relationship with the person they care for is in danger of breaking down and/or they no longer are	Carer has identified issues with their relationship with the person they care for that need to be addressed and/or	Carer has some concerns about their relationship with the person they care for and/or their ability to maintain relationships

and/or they have lost touch with other key people in their life.	able to maintain relationships with other key people in their life.	they find it difficult to maintain relationships with other key people in their life.	with other key people in their life.

Living Environment:			
Critical Risk	**Substantial Risk**	**Moderate Risk**	**Low Risk**
Carer's living environment is unsuitable and there are immediate and critical risks to the health and safety of the carer and/or cared for person.	Carer's living environment is unsuitable and poses an immediate risk to the health and safety of the carer and/or cared for person.	Carer's living environment is unsuitable but poses no immediate risk.	Carer's living environment is mostly suitable but could pose a risk to the health and safety of the carer and cared for person in the longer term.

Finance			
Critical Risk	**Substantial Risk**	**Moderate Risk**	**Low Risk**
Caring is causing severe financial hardship e.g., carer cannot afford household essentials and utilities, not meeting housing payments.	Caring is having a significant impact on finances e.g. difficulty meeting housing costs AND utilities.	Caring is causing some detrimental impact on finances e.g. difficulty meeting either housing costs OR utilities.	Caring is causing a risk of financial hardship e.g. some difficulty meeting housing costs and utilities.

Access to Breaks/Life Balance:			
Critical Risk	**Substantial Risk**	**Moderate Risk**	**Low Risk**
They have no access to breaks and activities, which promote physical, mental, emotional wellbeing or life balance, without which there will be a critical risk to the carer's physical, emotional and wellbeing	They have little access to breaks and activities, which promote physical, mental and emotional wellbeing or life balance, without which there will be a substantial risk to the carer's physical, emotional and wellbeing	They have access to a few breaks and activities, which promote physical, mental and emotional wellbeing.	They have access to a choice of breaks and activities, which promote physical, mental, and emotional wellbeing.

Future Planning:			
Critical Risk	**Substantial Risk**	**Moderate Risk**	**Low Risk**
Carer is very anxious about planning and has severe concerns about managing caring.	Carer is anxious about planning and has significant concerns about managing caring.	Carer is not confident about planning and has some concerns about managing caring.	Carer is largely confident about planning but has minor concerns about managing caring.

Section 7: 'No Risk' Definitions

Where a carer has been identified as having 'No Risks' in any of the domains this will result in no further action being taken or the carer will be provided with advice, information, or referral to other universal services (e.g. Health, Voluntary Organisations, Community Groups).

DOMAIN:	NO RISK:
Health and Wellbeing	Carer is in good health; Carer has good emotional wellbeing.
Relationships	Carer has a good relationship with the person they care for and is able to maintain relationships with other key people in their life.
Living Environment	Carer's living environment is suitable posing no risk to the physical health and safety of the carer and cared for person.
Finance	Caring is not causing financial hardship e.g., carer can afford housing cost and utilities.
Access to Breaks/Life Balance	Carer has regular opportunities to achieve the balance they want in their life; they have a broad choice of breaks and activities, which promote physical, mental and emotional wellbeing.
Future Planning	Carer is confident about planning and has no concerns about managing caring.

Section 8: Review of Circumstances

A process of monitoring and review will be undertaken as required in response to changing circumstances e.g. changing needs as a carer's circumstances change or the cared for person's circumstances change which impact on the carer's role. During the process of review, the eligibility criteria will still apply to identified needs: new and current.

Section 9: Ineligible Needs

The eligibility criteria policy is seeks to ensure that existing resources are allocated on a fairer and more equitable basis. It is equally important to recognise that certain needs will continue to be ineligible. All needs for support services should be recorded following assessments and reviews, and a proper note kept of needs which are ineligible in line with the policy outlined above and the level of current resources. The information gathered from recording ineligible needs will inform future planning and development activities.

Section 10: Personalisation and Self Directed Support

"Personalisation enables the individual alone, or in groups, to find the right solution for them and to participate in the delivery of a service. From being a recipient of services, citizens can become actively involved in selecting and shaping the service they receive" (Scottish Government, 2009).

Self Directed Support is about making sure that people (carers and cared for persons) with health or social care needs are helped to find support to live the way they wish to lead their lives. Carers, cared for persons and their families can make informed choices. Most people who have social care needs will be able to receive an 'Individual Budget' so that they know what the cost of their support package is and can make the appropriate arrangements to purchase their support depending on the Self Directed Support option(s) chosen by the carer. Carers will have control over the way the money is spent and will receive as much or as little support to manage their budget, as they need.

The support is person centred and works towards the achievement of the carer's individual outcomes. While the supports considered and agreed within the carer's support plan/young carer's statement will be personalised to them as an individual, the service descriptors below provide information on the most commonly used support services. The majority of these support services can be arranged using any of the self-directed support options (with the exception of re-ablement, intermediate care, long term residential or nursing home care and continuing in-patient health care).

Section 11: Young Carers

All of the indicators set out in the eligibility criteria applies to young carers although some of the descriptions would change from those provided. The domains and indicators are linked to the eight wellbeing indicators of **S**afe, **H**ealthy, **A**chieving, **N**urtured, **A**ctive, **R**espected, **R**esponsible, and **I**ncluded as shown in the table below.

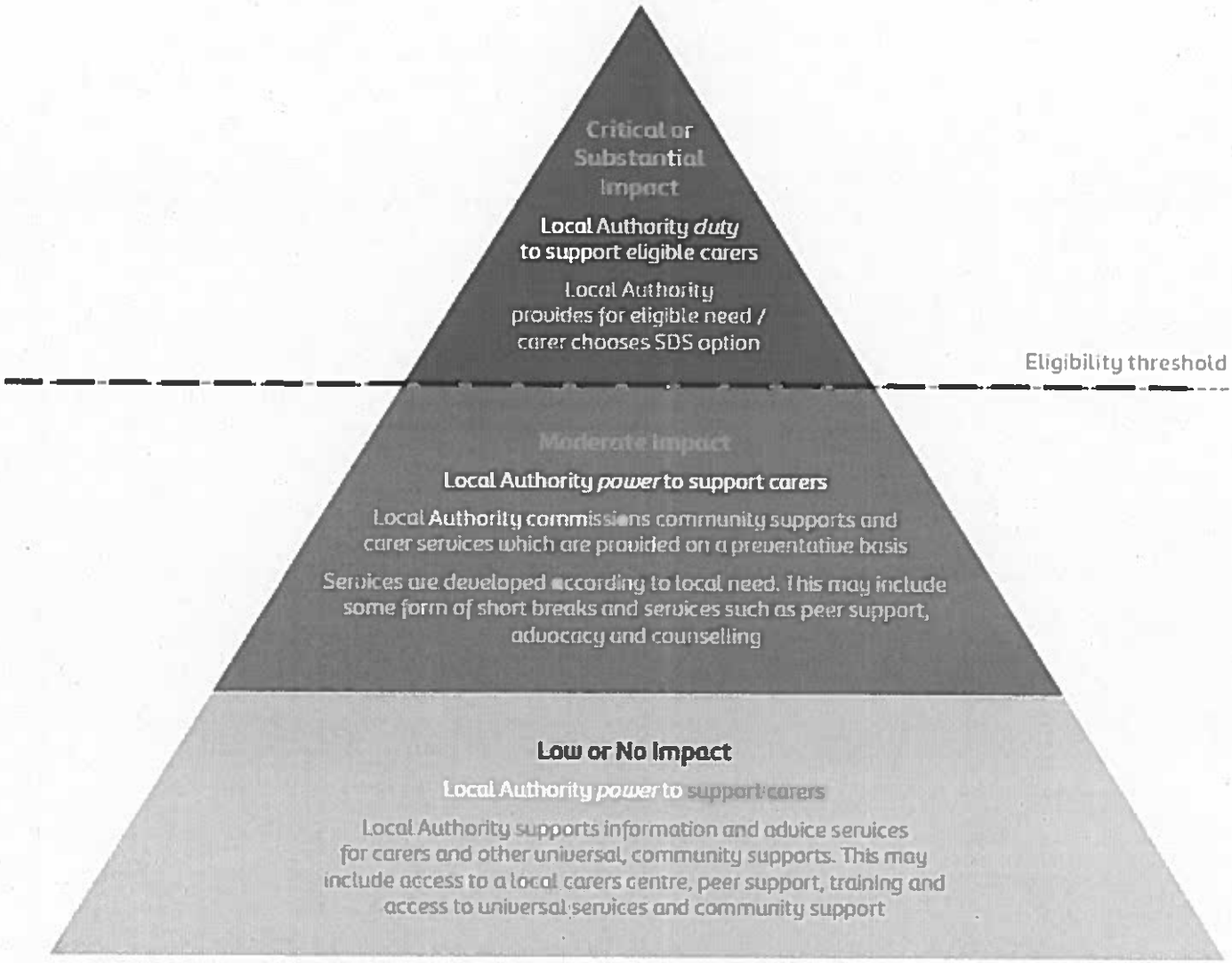
The use of the local eligibility criteria for young carers is in relation to the impact of the caring role on the young carer. The young carer might have other needs unrelated to the impact of the caring role. In these circumstances, they could be eligible for other services.

Local Eligibility Criteria Indicators and Comparison with Wellbeing Indicators:

Carer Indicator	Wellbeing Indicator	Comment
Health and Wellbeing	Healthy	Applies to young carers as caring can impact on their physical and mental health.
Relationships	Healthy, Safe and Nurtured	The relationships young carers have with their family and friends can be affected by caring and impact on the young carer's health as a result. A young carer might not be safe in the home due to their age. A young carer might not be nurtured in the family setting

		due to caring for a very ill parent.
Living Environment	Safe	Relevant to young carers where the living environment poses a risk to the young carer's safety e.g. because young carer is using a hoist for moving and assistance, or the living environment might include lots of medication and drugs lying around. However, in most circumstances the living environment is more an issue for the adult in the house or the whole family.
Education, training and employment	Achieving and Responsible	Mostly relevant to young carers aged 16 to 18 but adapt this to include education, which is relevant to all young carers. The young carer's achievement might be supported through a skills development course, paid-for tutor support, purchase of laptop. However, mostly, the support should be provided by the school.
Finance	Included	Mostly relevant to young carers aged 16-18 if they are spending money on, for example, utilities. However, also relevant to the younger age group if they are 'out of pocket' due to caring. Therefore, take age and circumstances of the young carer into account. Support to help deal with economic inequalities in particular.
Access to Breaks/ Life Balance	Active, Achieving and Included	Young carers require a good life balance in order to have time for activities, school and friendships.
Future Planning	Achieving	Relevant to planning for college, university, training and work and for the future care of the cared for person if the young carer moves away from home.

Threshold for Carer Support



Agenda Item Number: 17

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	Overview of the new GP Contract
Report By	Lisa Williams, Clinical Director
Contact Officer	Gillian Notman Occupational Therapy Professional Advisor/Change & Redesign Manager Gillian.notman@ggc.scot.nhs.uk

Purpose of Report	To inform the board on the new GP contract

Recommendations	To note the content of this report

Relevance to HSCP Board Strategic Plan	The new GP contract will have significant impact on the delivery of HSCP services.

Implications for Health & Social Care Partnership

Human Resources	HSCP to have active involvement in supporting the development of multidisciplinary teams within practices

Equalities:	None

Financial:	£250m has been committed nationally to support the new GP contract.

Legal:	None

Economic Impact:	None

Sustainability:	Refocusing of the new GP contract will require the HSCP to support and deliver through service redesign. The new arrangements are intended to reduce workload for GP partners, reduce financial risk and thereby promote GP Recruitment and practice sustainability.

Risk Implications:	Emerging risks will be managed through the HSCPs primary care improvement plan.

Implications for East Dunbartonshire Council:	To enable the GP to function as expert medical generalist, workload will require development of extended roles and functions to the wider multidisciplinary teams.

Implications for NHS Greater Glasgow & Clyde:	New GMS contract will impact on how community services are delivered.

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	**X**
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☐
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

1.0 MAIN REPORT

Background

1.1 In 2016 the Scottish Government and the British Medical Association (BMA) published a joint agreement on the future direction of General Practice in Scotland. This shared vision was for General Practice to be at the heart of the healthcare system, for GPs to have access to the right person at the right time, to be involved in the strategic planning and delivery of services and for multi-disciplinary teams to be in every locality, both in and out or hours. To develop this vision it required transformational change through a new GP contract.

1.2 In April 2016 the Quality Outcome Framework ended and in its' place transitional quality arrangements were developed including the creation of GP clusters and new reporting mechanisms for quality improvements, until the new changes to the GMS contract were finalised.

The new Scottish GP contract, agreed between Scottish Government and the BMA, was published on 13 November 2017. This contract proposes a refocusing of the GP role as the expert medical generalist, building on the core strengths and values of general practice

whilst enabling the GP to do the job they trained to do and thereby improve patient care.

2.1 **Key elements of the new contract offer include:**

Reduction in workload to enable GPs to develop their role as expert medical generalists: with a focus on undifferentiated presentation, complex care and whole system quality improvement and leadership.

- Extended multi-disciplinary team, employed by Boards, responsible for some of the activities currently being performed by practices.
- A new funding formula for practices based on workload (linked to age and deprivation).
- Practice income guarantee so that no practice loses out from the new formula.
- GP partner minimum income guarantee from 2019 (part of Phase 2)
- Out of hours will become an 'opt in' arrangement with a national specification rather than the current 'opt out'.
- Requirement for practices to provide data on activity, workforce and quality during Phase 1 to aid development of Phase 2.
- Continued commitment to GP clusters.
- The contract remains a practice based agreement with responsibility for a registered patient list, thus the GP retains Independent Contractor status.

2.2 The contract will be supported by the development of Primary Care Improvement Plans in each HSCP, setting out how the multi disciplinary team will be developed at practice and cluster level. This includes the delivery of specific commitments to provide immunisation and vaccinations, pharmacy services, 'treatment room' services, urgent care, link workers, physiotherapy and mental health support.

2.3 There are proposals to reduce the risk associated with GPs financing their own premises. This includes an option for Health Boards to take on leases or provide alternative accommodation, and interest free loans for GP owned premises, supported by a national fund.

2.4 NHS Boards and GP practices will be joint data controllers for the GP patient record and a national template for data sharing agreements is being developed.

2.5 £250m has been committed nationally in direct support of general practice by 2021. This will include the direct costs of the new contract and the investment in new multi-disciplinary teams. Funding for multi-disciplinary teams will be earmarked for this purpose.

2.6 The contract offer is currently being shared with GPs across Scotland. A poll took place in December, with the result in early January 2018. If the new contract is agreed, regulations will be laid down in Parliament in February 2018 and the new contract will take effect on 1 April 2018. HSCP Primary Care Improvement Plans are to be agreed by 1 July 2018.

The impact of the new GP contract to East Dunbartonshire HSCP:

3.1 Create protected time for all GPs to have clinical leadership development to assess and develop services to meet needs of local communities

HSCPs will provide employee support to help GPs manage the multidisciplinary teams and help share these workers across practices and build relationships. GP clusters will have an important role in facilitating cross practice working including common working practices and pathways

Multi disciplinary teams to take control of vaccination services

The aim is to reduce the workload for GPs and their staff. This will mean that primary care multidisciplinary teams will begin to deliver vaccination services instead of GPs. HSCPs require to have all vaccination work streams up and running by April 2021. These areas include pre-School (priority), travel vaccinations and Influenza.

Pharmacotherapy support to be provided in GP practices

The proposed contract includes an agreement that every GP practice will receive pharmacy and prescribing support. They will take on the responsibility for core elements for the service including acute and repeat prescribing, medicines reconciliation and monitoring high risk medicines. Additional elements of the service could include medication and polypharmacy reviews and specialist clinics (e.g. chronic pain)

Develop multidiscipline teams to redesign urgent and unscheduled care

There will be support for HSCPs to put in place health practitioners such as Advanced Nurse Practitioners and Advanced Paramedics, whose role will be to assess and treat urgent or unscheduled care presentations. This will allow GPs to focus on scheduled appointments with patients most in need of their skills as expert medical generalists. In time these advanced practitioners will carry out routine assessments and monitoring of chronic conditions for vulnerable patients.

Additional professional services.

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

Multidisciplinary teams to take control of community treatment and care services

HSCPs will need to provide community treatment and care services by April 2021 including Phlebotomy services, Chronic disease monitoring and data collection and minor injuries and dressings management.

Conclusion

The HSCP will require to develop a primary care Improvement Plan which will outline how these services will be introduced before the end of the transition period in 2021. There will be considerable challenges around delivery of these services, not least of which will be in securing the appropriate personnel to fulfil the described roles within the Multi-disciplinary teams.

It will be essential to ensure that all of our practices within East Dunbartonshire receive some level of support, to allow them to feel the benefit of the proposed changes, although delivering on all the promises within Phase 1 of the contract may take some time to achieve. However, if Phase 2 of the contract is to receive the backing of the GP community, there will require to be an acceptance that there has been some level of success in the delivery of Phase 1 in the first instance.

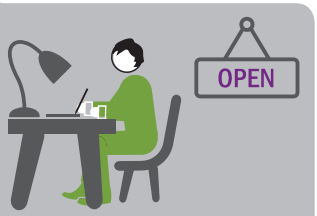
It is worth noting that the new contract has received the wholehearted backing of the Scottish LMC GP Sub-group.

THE 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND

A CLEAR ROLE FOR SCOTLAND'S GPs

BETTER CARE FOR PATIENTS

MANAGEABLE WORKLOAD



REDUCED RISK

INVESTING TO MAKE IT HAPPEN

BETTER HEALTH IN COMMUNITIES

BMA

Healthier Scotland
Scottish Government

THE 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND

The Scottish Government, Edinburgh 2017

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78851-347-0

Published by The Scottish Government, November 2017

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS305366 (11/17)

FOREWORD

Shona Robison
Cabinet Secretary for Health
Scottish Government

Alan McDevitt
Chair
Scottish GP Committee, British Medical Association

We are delighted to attach a joint statement of policy that will underpin a new distinctively Scottish General Medical Services contract due to take effect in 2018.

This document is intended primarily to provide an accessible explanation to Scotland's GPs of the changes we propose to effect in the new contract. The proposed changes will complement the complex wider contractual framework that underpins the provision of General Medical Services in Scotland. It will also be of significant interest to those planning and managing General Medical Services.

This document is the result of significant constructive engagement, over an extended period, between the Scottish General Practitioners' Committee of the British Medical Association and the Scottish Government, as the parties authorised to negotiate the provision of General Medical Services. All the commitments made in this document and the ambitions for future change set out are shared and agreed.

We believe this is a landmark step on a journey already begun.

On 3 November 2016 we wrote to all general practitioners in Scotland[1] setting out our shared vision for general practice in Scotland. We restated our commitment to general practice, and the essential generalist care it provides, with Scotland's GPs supported to be the expert medical generalists in our communities.

We equally recognised the fundamental challenges faced by general practice, not least growing workload and increasing risk. Given these challenges, we emphasised the need to ensure stability as we transform through taking a measured, step-wise approach.

We have already taken substantial practical steps on that journey, not least the removal of the Quality and Outcomes Framework and introduction of GP cluster working, and this joint statement of policy sets out the next practical steps we will take to deliver on our shared vision and to meet the challenges facing general practice.

1 http://www.gov.scot/Publications/2016/11/7258/0

We believe that the policies set out in this document will provide the secure foundation that general practice needs. It recognises that general practice is an essentially collaborative endeavour, collaborative in terms of the enhanced multi-disciplinary teams that are required to deliver effective care; the joint working between GP practices in clusters; and, essentially, as part of the wider integrated health and social care landscape.

More effective sharing of information and sharing of responsibilities is essential to better manage the challenges of increasing workload and risk. And if we can better manage these challenges it will achieve our most fundamental aim, which is to provide the very best care for the people of Scotland.

Shona Robison
Cabinet Secretary for Health

Alan McDevitt
Chair, SGPC

EXECUTIVE SUMMARY

The contract offer proposes a refocusing of the GP role as expert medical generalists. This role builds on the core strengths and values of general practice – expertise in holistic, person-centred care – and involves a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership. All aspects are equally important. The aim is to enable GPs to do the job they train to do and enable patients to have better care.

This refocusing of the GP role will require some tasks currently carried out by GPs to be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care. Integration Authorities[2], the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period. These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services and additional professional services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services. GPs will retain a professional role in these services in their capacity as expert medical generalists.

The funding of general practice in Scotland will be reformed and a phased approach is proposed. In Phase one, starting from April 2018, a new funding formula that better reflects practice workload will be introduced. A new practice income guarantee will operate to ensure practice income stability. The new funding formula will be accompanied by an additional £23 million investment in GMS to improve services for patients where workload is highest.

In addition, the contract offer proposes to introduce a new minimum earnings expectation to ensure no GP partner earns less than £80,430 (including pension contributions) NHS income for a whole-time equivalent post from April 2019. Evidence indicates this will benefit approximately one fifth of GP partners in Scotland.

GP and GP practice workload will reduce and refocus under the proposals, as the wider primary care multi-disciplinary team is established and service redesign embedded. By the end of the planned transition period, for example, GP pharmacists will deal with acute and repeat prescribing and autonomously provide pharmaceutical care through medication and polypharmacy reviews - all tasks currently requiring GP time.

We will ensure that engagement with patients, and other professionals delivering primary care, is a key part of the development and delivery of any service redesign.

A Memorandum of Understanding (MOU), in development between Integration Authorities, SGPC, NHS Boards and the Scottish Government, will set out agreed principles of service redesign (including patient safety and person-centred care), ringfenced resources to enable the change to happen, new national and local oversight arrangements and agreed priorities.

---

2 Integration Authorities were established by the Public Bodies (Joint Working) (Scotland) Act 2014 and are the statutory bodies responsible for the planning, design and commissioning of primary care services in Scotland. These responsibilities are typically delivered through Health and Social Care Partnership (HSCP) delivery organisations.

The contract offer proposes significant new arrangements for GP premises, GP information technology and information sharing. The effect of these arrangements will be a substantial reduction in risk for GP partners in Scotland, and a substantial increase in practice sustainability. Sustainable general practice is critical for better care for patients.

Under the proposed contract offer, a new GP Premises Sustainability Fund will be established, with an additional £30 million investment over the next three years. The investment will support a long term shift that gradually moves towards a model which does not presume GPs own their own premises. A new National Code of Practice for GP premises sets out how the Scottish Government will achieve a significant transfer away from GPs of the risk of providing premises. By 2023, interest free secured loans – "GP Sustainability Loans" – will be made available to every GP contractor who owns their own premises. NHS Boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases for GP practice premises.

New contractual provisions will reduce risk in information sharing by clearly setting out the roles and responsibilities of GP contractors and NHS Boards in relation to patient information held in GP patient records. The contract will recognise that GPs are not sole data controllers of the GP patient record, but are joint data controllers along with their contracting NHS Board. GP contractors will not be exposed to liabilities beyond their effective control. The proposals on information sharing have been developed with the support of the Information Commissioner's Office – Scotland.

Practice core hours will be maintained at 8am-6.30pm (or as previously agreed through local negotiation). Online services for patients will be improved and online appointment booking and repeat prescription ordering will be made available where the practice has the functionality to implement online services safely.

Service redesign, as set out in the MOU, will allow for longer consultations for patients where they are needed – in particular for complex care of patients with multi-morbidity, including co-morbidity of physical and mental health issues.

GP cluster quality improvement – introduced in the 2016/17 GMS contract in Scotland – will be further embedded. GP cluster core functions include an intrinsic function to improve care for their practice populations through peer led review and an extrinsic function to meaningfully influence the local system on how services work and on service quality. There will be a refreshed role for the GP Sub Committee in enabling this extrinsic function by facilitating the provision of combined professional advice to the commissioning and planning processes of Integration Authorities and NHS Boards.

GP clusters will have a clear role in quality planning, quality improvement and quality assurance. Existing analytical support from Information Services Division of NHS National Services Scotland will be further embedded. Practices will supply information on practice workforce and on demand for services to support quality improvement and practice sustainability.

The proposed contract offers new opportunities for clinical and non-clinical employed practice staff, including general practice nurses and practice managers and receptionists. The contract will support general practice nurses to focus on a refreshed role as expert nursing generalists providing acute and chronic disease management, supporting people to manage their own conditions where possible. Practice managers and receptionists will play an important role in supporting and enabling the primary care multi-disciplinary team to function smoothly, to the benefit of patient care.

1 INTRODUCTION

A strong and thriving general practice is critical to sustaining high quality universal healthcare and realising Scotland's ambition to improve our population's health and reduce health inequalities.

The 2018 Scottish General Medical Services (GMS) Contract has been developed by the (SGPC) and the Scottish Government to re-invigorate general practice and to re-energise its core values. It aims to create a dynamic and positive career for doctors and ensure that patients continue to have accessible, high quality general medical services.

The contract will be supported by a MOU between the Integration Authorities, SGPC, NHS Boards and Scottish Government. The MOU represents a statement of intent from all the parties to deliver the wider support and change to primary care services required to underpin the contract.

For the purposes of this document, we refer to Health and Social Care Partnerships (HSCP) as delivery agents of Integration Authorities, responsible for the planning and commissioning of primary care services.

NATURE OF THE CONTRACT

Since the inception of the NHS, general practice has developed as an independent contractor model. Some of the great strengths of general practice exist because of the independent nature of GPs under this model and their ability to prioritise and advocate for their patients.

After consideration and wide discussion, both the SGPC and the Scottish Government have agreed that the GMS contract will continue as an independent contractor model. In the BMA "The future of general practice" survey 2015, 82% of GPs supported maintaining the option of an independent contractor status for GPs.[3]

While the majority of general practice is intended to be delivered through the independent contractor model, we recognise there is an important, continuing role for non-GMS contractor GPs, often in a salaried positions, in a wide range of circumstances. The new contract will continue to specify that salaried GP contracts should be on terms no less favourable than the BMA Model Contract.

Our vision is that GPs will continue to run their practices to deliver GP care to their list of patients. However, practices will now be expected to carry less risk compared to previous contracts and be more embedded in the wider health and social care services in their communities. GPs will play a critical role as expert medical generalists and senior clinical leaders within those services.

3 https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-surveys/future-of-general-practice

In *Distilling the Essence of General Practice*,[4] following in-depth consideration by RCGP Scotland on the future of general practice, the authors reflect consensus that "contracts should be used to enable rather than limit developments in general practice". The Scottish Government and SGPC agree with this consensus, and the aim of the proposed new contract is to be just such an enabling contract.

General practice – the context

"General practice provides continuing, comprehensive, coordinated and person-centred health care to patients in their communities.

GPs and GP-led multi-disciplinary teams manage the widest range of health problems; providing both systematic and opportunistic health promotion, diagnoses and risk assessments; dealing with multi-morbidity; coordinating long-term care; and addressing the physical, social and psychological aspects of patients' wellbeing throughout their lives. GPs are also integrally involved in deciding how health and social services should be organised to deliver safe, effective and accessible care to patients in their communities.

With general practice carrying out 90% of patient contacts in the health service, it is the bedrock of the NHS."[5]

GPs – Expert medical generalist

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

General practice is a unique discipline. Rigorous scientific and clinical medical training and the ability to apply the evidence appropriately in community settings, places general practice at the centre of the NHS. This knowledge and skill set – when combined with the discipline's holistic, relationship based philosophy and broad generalist practice, distinguish the discipline in large measure from other medical disciplines."[5]

This document is organised into a further seven chapters that set out the proposed changes to the GMS contract and our vision for the future of primary care services in Scotland.

4 Gillies, J. (et al) (2009) Distilling the Essence of General Practice: a learning journey in progress. *BJGP*

5 http://www.rcgp.org.uk/training-exams/becoming-a-gp/what-is-general-practice.aspx

THE ROLE OF GPS IN SCOTLAND - EXPERT MEDICAL GENERALISTS

Barbara Starfield's "four Cs"[6] of primary care acted as a guiding principle throughout the negotiations:

- contact – accessible care for individuals and communities
- comprehensiveness – holistic care of people - physical and mental health
- continuity – long term continuity of care enabling an effective therapeutic relationship
- co-ordination – overseeing care from a range of service providers

The 2018 Scottish GMS contract is intended to allow GPs to deliver these four Cs in a sustainable and consistent manner in the future.

These four pillars of primary care are also evident in the landmark Royal College of General Practitioners report on *Medical Generalism*.[7] The ethos of generalism described in this report includes comprehensiveness, co-ordination and continuity. Generalism, by definition, is a form of care that is person - not disease - centred. It is precisely the type of medicine needed to meet the challenge of shifting the balance of care, realising *Realistic Medicine*,[8] and enabling people to remain at or near home wherever possible.

The future will see general practitioners in Scotland fulfilling roles supporting a wide range of clinical professionals, working as an expert medical generalist and senior clinical decision maker within multi-disciplinary community teams. The key contribution of GPs in this role will be in:

- undifferentiated presentations
- complex care in the community
- whole system quality improvement and clinical leadership

Chapter two sets out this vision in more detail

PAY AND EXPENSES

The GMS contract introduced in 2004 served a purpose for that time. No longer did GPs have individual contracts with the NHS. Contracts were with practices who were encouraged to provide a wide range of services outwith those provided directly by GPs. Alongside this came a structured attempt to promote quality improvement, the Quality and Outcomes Framework (QOF). Over time, QOF has been subject to much examination about whether its intended purpose was wholly achieved or brought about unintended consequence.[9]

---

6 Starfield, B. (1992) *Primary Care: Concept Evaluation and Policy.* OUP, New York.

7 http://www.rcgp.org.uk/policy/rcgp-policy-areas/medical-generalism.aspx

8 http://www.gov.scot/Resource/0049/00492520.pdf

9 http://www.SSPC.ac.uk/media/media-486342_en.pdf

The 2004 GMS contract also loosened the link between the income received by practices and the number of GPs. This has broadened the range of incomes of GPs in Scotland. While some have benefited from this (often as a result of entrepreneurial skills, hard work and long hours) others, despite all efforts, have found themselves financially compromised with difficulty recruiting new GPs, and keeping their practice viable. This is why, underlying all the proposed changes is a key intention to improve the sustainability of practices.

Proposed changes to the way that practices are contracted and funded in Scotland are ultimately intended to re-establish the link between practice income and the provision of GPs to the community. Most of the payments to practices will be intended as income for the right number of GPs, for paying for a core team of employed staff, and for meeting the necessary expenses of running the practice. As change progresses, the intention is that GPs are paid to be GPs rather than to provide a wide range of other services. The proposed changes are also intended to reduce the transactional business elements of the relationship between GPs and the rest of the system. These elements have, at times worked against the development of the collaborative relationships in health and social care necessary for good outcomes.

Chapter three sets out our proposals around pay and expenses, including a new workload formula and increased investment in general practice.

MANAGEABLE WORKLOAD

The consultation remains the foundation of general practice. It is where the values of compassion, empathy and kindness combine with expert scientific medical knowledge to the benefit of patient care and mental and physical health. The role of the modern GP, however, is wider than patient consultations. Repeat prescriptions, test results, home visits, telephone calls and other communication with patients and other services can all form a significant part of the GP day.

Chapter four sets out our proposals to provide additional primary care staff to work alongside and support GPs and practice staff to reduce GP practice workload and improve patient care. These additional staff will underpin a transformational service redesign over the next three years with the development of the multi-disciplinary team to support general practice.

IMPROVING INFRASTRUCTURE AND REDUCING RISK

As independent contractors running a practice, GPs are exposed to risk in a number of ways. This can be through the ownership and maintenance of practice premises, through acting as a data controller sharing information with the wider NHS, and through the risks of being an employer.

Chapter five introduces a number of significant new measures designed to manage and reduce these risks to GPs.

BETTER CARE FOR PATIENTS

With a focus on Barbara Starfield's four Cs, chapter six sets out the benefits the new contract will bring to patients. The proposals will help people access the right person at the right place at the right time, as described in the Scottish Government Primary Care Vision and Outcomes (see annex). In particular the chapter focuses on:

- maintaining and improving access (contact);
- introducing a wider range of health professionals to support the expert medical generalist (comprehensiveness);
- enabling more time with the GP for patients when it is really needed (continuity); and
- providing more information and support for patients (co-ordination).

In addition, the chapter sets out the critical role of meaningful patient engagement in ensuring services are designed in ways that meet the needs of individuals and communities.

BETTER HEALTH IN COMMUNITIES

Scotland's health and social care workforce continues to be at the forefront of a wide range of improvements in the safety, effectiveness and quality of care and treatment. General practice in Scotland took a distinctive path on quality improvement through the establishment of GP clusters in 2016/17 - enabling a peer-led, values-driven approach to quality improvement. The proposed new contract further embeds the cluster quality approach.

THE ROLE OF THE PRACTICE

The final chapter sets out the wider role of the practice and practice team, including general practice nurses, practice managers and practice receptionists.

Overall, the proposals represent both significant investment in primary care and significant change. At the heart of any change must be the core principle of patient safety. That is why our planned approach is of a three year transition with changes to services only taking place when it is safe, when it is appropriate, and when it improves patient care. By working together in this way we can build a GP service for the future, one that meets the changing needs and demands of the people of Scotland and enables GPs to do the job they train to do.

A range of supporting materials and evidence including the review of the Scottish Allocation Formula, the Premises Code of Practice and the Review of GP Earnings and Expenses will be published on the Scottish Government website. (http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract).

The next chapter sets out our vision of the role of the GP as an expert medical generalist.

2 THE ROLE OF GPs IN SCOTLAND – EXPERT MEDICAL GENERALISTS

Key Points

- The GP as expert medical generalist will focus on undifferentiated presentations, complex care and quality and leadership. All are equally important.
- GPs will lead and be part of an extended team of primary care professionals.
- GPs will have more time to spend with the people who need them most.

INTRODUCTION

The Scottish Government and the SGPC share a vision of the role of the GP as the expert medical generalist in the community. This is not a new role – generalism has always been at the heart of general practice: holistic care that sees the person as a whole in the context of their community is the very strength of general practice that we wish to enhance.

However, the context that GPs now work in is changing - multi-morbidity is more common; people are living longer and the demands on GPs have been growing. The challenge is ensuring GPs have the space and the time to carry out the expert medical generalist role that their communities need.

We intend to meet this challenge by focusing the role of the GP on activity that requires the skills of a doctor. The GP will be supported by an extended multi-disciplinary team that will be responsible for some of the activities currently being performed by the GP, where that is safe, appropriate and improves patient care. Practice workload will be more manageable, with patients consulting with the most appropriate professional in the team. Chapter four, describes how we will tackle rising GP workload in more detail.

We anticipate that an enhanced role for the GP as senior clinical leader in the community will lead to greater professional esteem. It will remain a challenging role, and a rewarding one.

THE GP AS EXPERT MEDICAL GENERALIST

In the previous chapter we introduced Barbara Starfield's four Cs of primary care - contact, comprehensiveness, continuity and co-ordination. Her pioneering research clearly demonstrated the benefits of strong general practice for the population and for the wider health and care system. The international evidence is clear – health and care systems with strong primary care demonstrate better population health outcomes more equitable outcomes and better cost efficiency than systems with relatively weak primary care. The aim of this contract – and wider primary care transformation – is to strengthen general practice for the benefit of all in Scotland.

Successfully addressing the health needs of individuals and communities requires an approach that makes the best use of the unique skills and experience of GPs and of other professionals in primary care. We expect that a modernised role for GPs will encourage recruitment and retention and strengthen the crucial role of general practice and primary care within the wider health and social care system.

We are proposing a refocused role for the GP from 2018. This will incorporate the core existing aspects of general practice and introduce a renewed focus on quality and the sharing of system wide clinical knowledge. It will acknowledge the GP's expertise as the senior clinical leader in the community, who will focus on:

- undifferentiated presentations
- complex care in the community
- whole system quality improvement and clinical leadership

A key change in the contract offer is the proposal that GPs become more involved in complex care and system wide activities, necessitating a refocusing of GP activity. As we refocus the GP role, we expect GPs to be less involved in more routine tasks, with these tasks being delivered by other health professions in the wider primary care multi-disciplinary team. To achieve this, the training needs of GPs and members of the wider primary care multi-disciplinary team, will need to be considered, developed and delivered. The third part of *National Health and Social Care Workforce Plan: Part 3 Primary Care* will set out plans for the development and training of GPs and this wider primary care multi-disciplinary team and is due to be published early 2018.

UNDIFFERENTIATED PRESENTATIONS

Seeing patients who are unwell, or believe themselves to be unwell, will remain a core part of general practice as it is the basis for the continuous development of the clinical skills required of a generalist and is essential for good patient care.

GPs are, however, a limited resource and their capacity to see patients is finite. There needs to be a balance between access to GP appointments, access to other health professionals where that is more appropriate, and encouraging patients to seek self-care advice, where appropriate. This will enable GP time to be available when really needed by patients.

The key direct clinical care role for the GP as expert medical generalist is in undifferentiated presentations which require the skills of a doctor trained in risk management and holistic care with broad medical knowledge. Often this care is delivered through the continuity of consultations over time.

People are often able to self-differentiate in their own presentations. For example, a person presenting with shoulder pain may choose to see a physiotherapist as a first point of contact if such a service is as responsive as their GP practice. This is also the case for minor illness and injury, where, if there is an advanced practitioner or other service available locally, patients may choose that practitioner rather than seek a GP appointment.

New models of care will require other health professionals to be more involved in meeting immediate patient needs as part of a wider team (see chapter four for further details). Working alongside GPs, other health professionals need to be able to efficiently assess and treat patients, within their clinical competence. It will be essential that they are able to complete episodes of care without recourse to the GP on a significant number of occasions.

GPs will retain oversight to ensure the service, as a whole, is working and patient needs are met. Other clinicians will work independently within their competencies as part of the extended team with mutual decision support.

GPs will be of particular importance in supporting and managing people with undifferentiated presentations especially in the context of multi-morbidity and complexity and will maintain longitudinal patient contact to support that role.

GP practices act as a patient gateway to ensure that people can access the right care. Patients should experience contacting the practice, either in person or remotely, as a way to obtain advice on how best to have their needs met safely, effectively and efficiently by services. GPs should oversee and manage this process to ensure it is effective and that patients can see the right person at the right place at the right time.

COMPLEX CARE IN THE COMMUNITY

As workload capacity is freed up, a key part of the GPs expert medical generalist role will be leading a primary care multi-disciplinary team to deliver care to patients with, for example, multiple co-morbidity, general frailty associated with age, and those with requirements for complex care (e.g. children or adults with multiple conditions, including mental health problems, or significant disabilities).

What do we mean by complex care?

Complex Care is most commonly the clinical care of patients who have multiple disease presentations. Such patients may have two or more diagnoses which, as they occur in the same individual, are therefore connected and interacting. Evidence based guidance and decisions which may be appropriate for one diagnosis may not be appropriate or may conflict with those for the other conditions. This uncertainty requires shared decision-making with patients and carers. Complexity can occur in the context of mental and/or physical ill health, at any age including end of life. The GP acts, as the expert medical generalist, giving advice on managing and treating these uncertainties to increase the likelihood of achieving the agreed outcomes.

The system, with the contribution of GPs and GP practices through cluster quality improvement, will be focused on knowing its population and assessing where there is potential to achieve better outcomes. GP clusters were introduced in Scotland with the 2016/17 GMS agreement between the SGPC Committee and the Scottish Government. In professional groupings of five to eight practices, clusters enable peer-led, values-driven quality planning, improvement and assurance.

Each GP practice will be supported with appropriate information to proactively identify the cohort of patients requiring complex care and to then work with others to devise an appropriate care plan to ensure patients receive the optimum care and support.

One of the main aims of this change in focus is to provide care to patients with complex needs at home wherever this is appropriate. Where care at home is desirable and adequately supported it is better for patients. GPs spending more time on patients with complex needs would help to ensure that admission to acute care should only be to achieve a specific outcome, or for an assessment or treatment that can only be provided in a hospital setting.

GPs will also be involved in establishing care plans for patients with complex needs, including anticipatory care plans, which can be used by community teams to enable patients to be cared for in their own homes for as long as possible. As the expert medical generalist in the community, GPs will also support these community teams, when any expert GP input is required.

WHOLE SYSTEM ACTIVITY – QUALITY IMPROVEMENT AND LEADING TEAMS

Ultimately all GPs must have regular protected time to be able to develop as clinical leaders. The intended outcome is that they become fully involved in assessing and developing services intended to meet the needs of their patients and local communities. Currently, only Practice Quality Leads (PQL) have access to protected time, although different GPs in the practice can perform that role over time.

The next step in this journey is to create additional protected time for each practice, to enable GPs to develop their clinical leadership role. Therefore, from April 2018, each practice will receive resources to support one session per month for Professional Time Activities. There is a clear intention to achieve, over time, regular protected time for every GP.

GPs are senior clinical decision makers and leaders. As such, and with a clear focus on outcomes of relevance for patients, they will assess the overall performance of their own practice, practices within their cluster, and the wider community team, leading to suggestions for improvement that will in turn be evaluated by them and others. This will require GPs to have influence to direct change within the wider health and social care system. Indeed, for wider health and social care to be successful, meaningful involvement of GPs is required.

Whilst some GPs may not see themselves attracted to broader leadership roles and responsibilities, all will need to be involved in improvement activity in both their practice and the wider system through cluster working. Any significant improvements in patient outcomes are only likely to be achieved if every senior clinician is engaged in these activities at some level.

GP training

The evolution of primary care will require training for doctors wishing to become GPs to have a renewed focus on the skills required to be an expert medical generalist: in leadership, multi-disciplinary team working and peer-led quality improvement. Increased time and wider expertise may be required for training practices, with review of funding for training to ensure appropriate support for the necessary expansion of medical training in the community.

ESSENTIAL SERVICES, ADDITIONAL SERVICES AND ENHANCED SERVICES

The refocusing of the GP role to expert medical generalist has implications for the current contracted service elements of Essential, Additional and Enhanced Services.

We are proposing the following service refinements in the new contract:

Essential Services

Essential Services will remain unchanged in the proposed new contract. The fundamental core principles of general practice – care based on the registered practice list, generalist care of the whole person and sufficient consultation time for patients according to their clinical needs – align with Essential Services.

Additional Services

The agreed direction of travel is to reduce the over-specification of services in the contract wherever it is safe to do so. That will begin with the proposed new contract.

For instance, latest evidence[10] suggests there is no longer a requirement for a separate Additional Service for minor surgery. GPs may still provide treatments which would have previously fallen under the Additional Service at their clinical discretion under core services. The Enhanced Service for minor surgery will continue.

Out of Hours

There will be changes to arrangements for out of hours services. Instead of the current opt-out arrangement a new opt-in Enhanced Service will be developed for those practices that choose to provide out of hours services.

The new out of hours Enhanced Service will have a nationally agreed specification, building on the quality recommendations within Sir Lewis Ritchie's out of hours review *Pulling Together*[11] and covering areas such as record keeping, anticipatory care planning, key information summary, use of Adastra and NHS24.

This will contribute to a consistency of approach to the provision of unscheduled care services across Scotland where practice-based service level agreements are in place. There is also an opportunity to develop a nationally agreed quality and person-centred specification which could be used by all NHS Boards to test and benchmark their current local service level agreements.

10 https://cks.nice.org.uk/warts-and-verrucae#!scenaico
11 http://www.gov.scot/Resource/0048/00489938.pdf

Enhanced Services

We have agreed a general principle (with the exception of the new out of hours approach) against the expansion of the number of Enhanced Services under the proposed new contract.

Chapter four describes the Vaccination Transformation Programme which will transfer responsibility for the delivery of vaccinations from GPs to NHS Boards. On completion, to the satisfaction of the SGPC, Scottish Government and local delivery and commissioning partners, the relevant Additional and Enhanced Services for vaccinations will no longer be included in the Scottish GMS contract. In rare circumstances it may be appropriate for GP practices, such as small remote and rural practices, to agree to continue delivering these services through locally agreed contract options.

The current direction of travel on maternity medical services – where responsibility already largely lies with other parts of the community team – is expected to continue. Similarly, for contraceptive services, current provision by other professionals and teams is expected to continue.

There is, at this stage, no real alternative to delivering many of the current Enhanced Services provided by practices and no intention of reducing the funding to practices. Any further changes will need to be carefully planned with a rate of change that ensures patient safety, quality of service and practice stability.

The continuation of locally determined Enhanced Services is for NHS Boards and local practices to agree. The expectation nationally is that Enhanced Services funding is not removed from practices as services are transitioned to NHS Boards over 2018-2021, as doing so could be destabilising to the system. As mentioned previously, there is an intention to reduce the transactional business elements of the relationship between GPs and the rest of the system. These at times, have worked against the development of the collaborative relationships in health and social care necessary for good outcomes.

At the start of this chapter we set out our belief that the enhanced role of the GP as senior clinical leader in the community will lead to greater professional esteem and that while the role will remain challenging, it will be a rewarding one. The cornerstone of this enhanced role is the GP's skill and expertise in dealing with undifferentiated presentations, complex care in the community and whole system quality improvement and clinical leadership.

We also recognise that GPs should be appropriately remunerated for their work. Chapter three sets out our proposals for pay and expenses.

3 PAY AND EXPENSES

Key Points

- A new practice income guarantee will operate to ensure practice income stability.
- A new funding formula that better reflects GP workload will be introduced from 2018 with additional investment of £23 million.
- A new minimum earnings expectation will be introduced from 2019.

INTRODUCTION

The SGPC and the Scottish Government recognise that an appropriate and secure level of income is a key prerequisite to attracting GPs to the profession and ensuring the future viability of general practice. Existing GPs need to be adequately rewarded for the work they do. GP trainees and anyone considering a career as a GP needs to have a clear understanding about the rewards of the career.

THE NEW FUNDING MODEL AND A PHASED APPROACH

We recognise that the current funding arrangement is complex, leads to uneven funding allocations and needs to be reformed. We also recognise that practices require funding stability. To deal with these historical shortcomings of the current system, we are proposing:

From 1 April 2018:

- To introduce a new funding formula to better address practice workload (details are provided below).
- That new arrangements will include the correction factor (Minimum Practice Income Guarantee) and core standard payments (previously QOF payments) in a consolidated global sum. The funding associated with these elements of the 2004 GMS Contract will be subject to the new formula and would cease to exist as separate funding streams thereafter.
- To make these changes in a protected manner so that no practice will lose funding. To maintain funding stability the Scottish Government has committed investment of an additional £23 million to fund the practices that receive a greater formula share and protect all other practices.
- That seniority arrangements remain unchanged
- That there will be no out of hours opt-out deduction under the new arrangements. Nationally, 6% will be deducted from the 2017/18 Global Sum prior to applying the new funding formula. This will conclude the opt-out arrangements made under the 2004 GMS contract.

From 1 April 2019:

- The government will introduce a GP partner whole-time equivalent minimum earnings expectation. On current evidence around one-fifth of GP partners earn less than a whole-time equivalent income of £80,430 (inclusive of pension contribution), based on partner shares of total practice GP income. We agree that no GP should receive less than £80,430 (inclusive of pension contribution) for a whole-time post. This is a first step towards greater income security that will be further bolstered in the following years.

From 1 April 2020 we propose to:

- Introduce an income range that is comparable to that of consultants
- Directly reimburse practice expenses
- As these measures would again change GP practice funding and GP income they will will be subject to negotiation and a second poll of the profession after specific details (including financial details) are available. Negotiations on this phase will include arrangements for the protection of GP income and practice expenses.

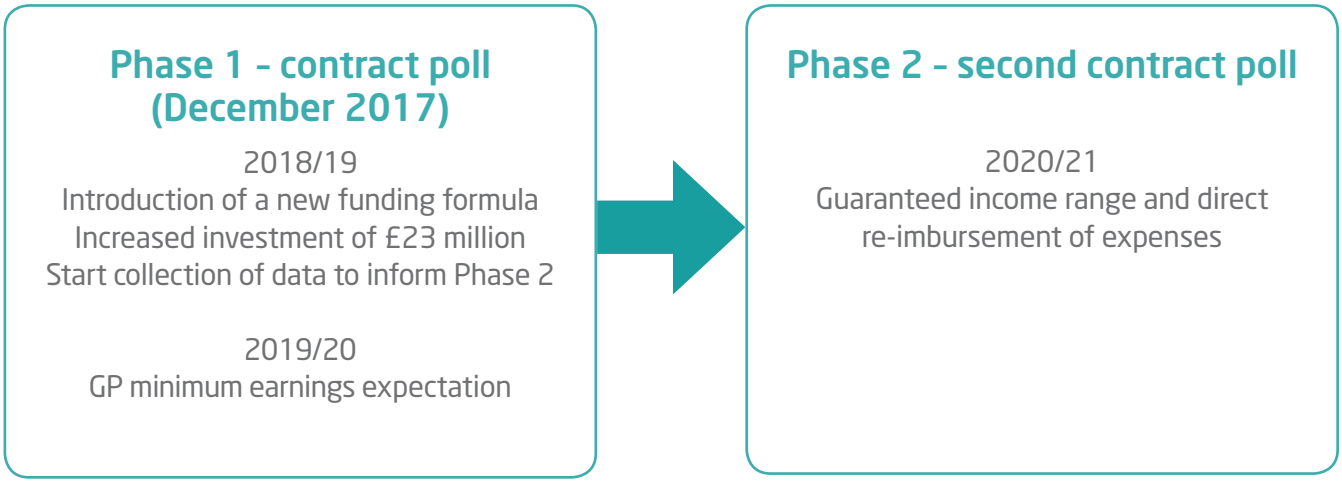
Underlying this investment are a number of key agreements:

- To invest £250 million in direct support of general practice by 2021/22
- To ensure that proposals stabilise practice income
- To ensure that an allocation mechanism better recognises the demand for GP and other staff time for any given practice population
- To develop a process that, at its endpoint, provides all GPs a guaranteed income on a range comparable to that of consultants and reduces risk through the direct reimbursement of premises and staff costs
- To ensure that there will be no loss of funding to general practice. Any disputes regarding funding will be ultimately reviewed by the Scottish Government and SGPC
- To ensure that practices can expect that support services they are provided with locally will continue

We have agreed that GP income should not be subject to arbitrary variation and should instead reflect the value a GP's work as an expert medical generalist. Ultimately, this can only be achieved by providing practices with the necessary funding for expert medical generalist work and the necessary expenses to support this work.

To achieve this, we propose two separate phases of transition:

Figure 1: Two-phased approach to funding



PHASE 1 - INTRODUCTION OF A NEW FUNDING FORMULA

The current funding model under the 2004 GMS contract has led to a disparity of income and expenses between practices in Scotland because it is based on a methodology that performs two distinct functions simultaneously:

1. It allocates resources to GP practices according to population requirements and differences in costs; and
2. It determines GP partner pay as the difference between this funding and GP practice expenses.

While this arrangement incentivises GP partners to use their funds in the most efficient way to maximise their income, differences in local circumstances that are not captured adequately by the formula lead to differences in costs, income and provision of services.

Phase 1 sees the introduction of a new GP workload based resource allocation formula (the GP Workload Formula) to replace the existing Scottish Allocation Formula (SAF).

The new formula was developed as part of a 2016 review of the SAF.[12] It re-estimates the number of consultations per patient, dependent, in the main, on their age, sex and the deprivation status of the neighbourhood in which they live.

The new formula is a methodological improvement to the previous SAF. It is based on the best available evidence and as such it more accurately reflects the workload of GPs. Compared to the workload-related weightings of the original SAF, the new formula gives greater weight to older patients and deprivation.

The impact of deprivation on the workload of a practice is better reflected in the new workload formula than the previous SAF. Methodological improvements mean both deprivation in urban areas and isolated pockets of rural deprivation are better addressed by the new formula.

With the introduction of the new formula, GP practices will be protected from any potential funding losses. To this end, the Scottish Government has committed to invest an additional £23 million to fund the practices that receive a greater share under the new formula while protecting all other practices. This additional investment is to improve services for patients in areas where workload is highest.

We will monitor the impact of the funding formula during implementation.

Increased investment of £23 million

We have calculated the impact of the new formula on GP practice funding for each GP practice in Scotland. This information will be provided to your GP practice in a separate letter in November 2017.

12 http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-contract

The guarantee to protect GP practice income and expenses in Phase 1 will continue until there is a proposal acceptable to the profession for the introduction of Phase 2. Future funding uplifts will apply to all GP practices' share of the total, derived by the new formula during Phase 1, including the new income guarantee. Population increases will apply to the formulasum only.

PHASE 1 - MINIMUM EARNINGS EXPECTATION

In early 2017 the Scottish Government and SGPC commissioned a review of GP earnings and expenses in Scotland.[12] The review found significant differentials in income and expenditure in the sample of 109 practices, with around one-fifth of GP partners earning less than £75,000 (including any private work, excluding employer superannuation) in a whole-time equivalent post.

We propose that no GP partner should receive less than £80,430 (including employer pension contributions) NHS income pro-rata up to a whole-time equivalent (40 hours) from April 2019.[13] This extra income will be provided through NHS: National Services Scotland Practitioner Services Division (PSD) on the basis of the income, hours and session information.

Start collection of data to inform Phase 2

We considered a single transition to an agreed income range with pay progression and direct re-imbursement of expenses (staff and premises), but there are a number of reasons why it is necessary to split the transition into two phases:

- We need time to develop the administrative capacity to enable the direct re-imbursement of expenses and payment of income.
- We need time to collect data to allow us to calculate the impact on individual partners if the funding model is replaced.
- We therefore cannot calculate the total cost and provide ministers. Parliament and the profession with the necessary assurance of the affordability of the preferred model.

In order to prepare for Phase 2 we need to fully understand the current expenses of running a GP practice, the income of salaried GPs and the income of GP partners as well as the hours worked by individual GPs.

This data is necessary to calculate partners' earnings entitlement and the total costs of introducing a consultant comparable income scale. We have agreed that all GP practices will be required to provide this data (earnings, expenses, hours/sessions) in a similar way to the data already provided for pension purposes.

13 Minimum earnings expectation is £80,430k per WTE GP in the practice, including employees and employers superannuation, and including all NHS practice income earned within practice opening hours, pro-rated to a WTE of at least 40 hours per week, and excluding all non-NHS income earned within practice opening hours.

To ensure confidentiality data will be held and processed by NHS National Services Scotland Practitioner Services (which currently handles GP income data for pension purposes) and only anonymised, non-identifiable data for the purposes of analysis will be provided to government, NHS Boards or the SGPC during Phase 1, In Phase 2 this data will be required to authorise payments and provide supporting information to ensure appropriate individual GP practice resourcing.

PHASE 2 - INCOME RANGE AND EXPENSES RE-IMBURSEMENT

In Phase 2, which is subject to further negotiations and another poll of the profession, an income range with pay progression for GPs (comparable to that of consultants) and direct re-imbursement of expenses (staff and premises) will be introduced. Negotiations will include the arrangements for protection of GP income and GP practice expenses.

Direct re-imbursement of expenses and an income range for GPs will remove the direct link between the new formula and practice funding. Instead, the new formula will act to define the GP input and an expenses 'norm' for a practice. This will guide the allocation of primary care resources across the country but will not be used to allocate money directly. The formula will indicate the necessary resources of individual practices to meet patient demand. The flexibilities that will be required under this proposal will be negotiated between the Scottish Government and the SGPC and presented to the profession before the poll for Phase 2.

Meeting the primary care needs of the people of Scotland

The intention of Phase 2 is that the new formula will inform the establishment of a baseline of the number of GPs required to meet the primary care needs of the people of Scotland. The determination of the baseline will be subject to negotiations and is also dependent on how much variability at a practice level is agreed to be allowed.

Once a baseline is determined, the new formula will help define the optimum GP supply required every year to deal with the workload generated by a growing and ageing population. This puts the onus on the Scottish Government to ensure sufficient training numbers and provide the necessary funding to enable the number of general practitioners to grow in line with overall workload. Further detail on initiatives to increase GP supply in Scotland will be contained in the forthcoming *Health and Social Care National Workforce Plan: Part 3* on primary care.

Phase 2 and GP pay

Under these proposals for Phase 2, GPs will have assured income and pay progression, providing stability. The allocation of GPs across GP practices will be informed (but not wholly determined) by the workload formula to allow for some flexibility while broadly ensuring the provision of GPs reflects population need.

In necessarily small remote GP practices, extra resources will continue to be made available to ensure long-term sustainability. Remote GP practices will, as they do now, continue to provide a broader range of services more appropriate to remote settings.

Phase 2 and GP Expenses

The composition and necessary amount of GP practice expenses will change over time in the context of the extra resources to be provided to the practice as part of the development of the wider multi-disciplinary approach.

We know that rural GP practices have, on average, higher expenses per patient than urban ones. Partly, these can be explained by the diseconomies of scale of small GP practices and the costs of dispensing, or having one or more site/branch surgeries and we recognise that these differences will need to be addressed by proposals for Phase 2.

We agree that GP practices need sufficient time to adjust their resources and that there needs to be sufficient flexibility to allow appropriate funding to account for exceptional circumstances.

This chapter started with a recognition that an appropriate and secure level of income is a key prerequisite to attracting GPs to the profession and ensuring the future viability of general practice. We believe that the proposals outlined deliver on these needs. We also recognise that as well as being rewarded financially for doing their work, GPs need to have a manageable workload. Chapter four explains how we plan to deliver this.

4 MANAGEABLE WORKLOAD

Key Points

- GP and GP Practice workload will reduce.
- New staff will be employed by NHS Boards and attached to practices and clusters.
- Priorities include pharmacy support and vaccinations transfer.
- Changes will happen in a planned transition over three years when it is safe, appropriate and improves patient care.
- There will be national and local oversight of service redesign and contract implementation involving SGPC and Local Medical Committees.

INTRODUCTION

We know that workload is currently one of the most challenging aspects of being a GP. We are introducing measures to address this by:

- continuing to reduce contractual complexity
- improving primary/secondary care interface working
- building a wider primary care multi-disciplinary team

Reducing contractual complexity

The process of reducing the contractual complexity of the Scottish GMS contract has already begun. In 2015 the Scottish Government and the SGPC announced that Scotland would become the first country in the UK to remove the Quality and Outcomes Framework (QOF). QOF no longer incentivised the direction of travel needed with respect to demographic change (an ageing population and increasing multi-morbidity), because the disease specific, procedural basis of QOF encouraged diseases to be viewed separately. This was counter to the holistic, person-centred care required for the increasing numbers of people with multiple long term conditions.

In April 2016, the remaining 659 QOF points were retired and transferred to the general practice core standard payments, signalling one of the first steps towards the development of the new contract, and a significant shift towards placing greater trust in the clinical judgment and professionalism of GPs. Transitional arrangements for quality assurance were introduced in the Statement of Financial Entitlements 2016/17 alongside the removal of QOF. These included early instructions for the creation of GP clusters in Scotland, setting the direction for the new contract.

Other arrangements have also been improved while the new contract was being developed. These include removing the discretionary element for parental leave and sickness leave locum cover payments so all eligible GP practices will receive these payments. We have also created an occupational health service that all GPs and GP practice staff can access, and improved the re-imbursement rate for appraisals.

The new contract will build on these improvements to further reduce contractual complexity. Some of the proposed simplification of the contractual landscape was set out in chapter two. Our proposed changes to the GMS regulations will include updates on dispute resolution, closing practice lists and defining the practice boundary. These changes are described more fully in chapter eight.

Improving interface working

- To ensure effective working between primary and secondary care, we will continue to implement the recommendations of the *Improving General Practice Sustainability Advisory Group* as set out in its report on November 2016.

Within the recommendations there are a number of broad themes including effective primary and secondary care interface working. Interface working will be better achieved through well-functioning primary and secondary care interface groups. These groups will support NHS Boards and HSCPs to reduce GP workload and provide a better patient experience by removing the need for GP involvement when it is not clinically necessary. The recommendations include:

- Improved processes for routine follow-up of hospital procedures and results of tests
- Allow the issuing of fit note certificates by secondary care providers at the time of discharge, where the condition being treated is the cause of a temporary disability
- More efficient use of the primary care multi-disciplinary team by ensuring secondary care staff request patient visits by the most appropriate professional for their condition e.g. social care or district nurse
- Changes to the referral pathway for patients who do not attend (DNA) hosptial appointments to remove the need for GP referrals

Building the primary care multi-disciplinary team

In line with commitments to be made in the MOU referred to in chapter one, HSCPs and NHS Boards will place additional primary care staff in GP practices and the community who will work alongside GPs and practice staff to reduce GP practice workload.

Practices will be encouraged to use the additional capacity created by reducing GP provided services to focus on activities that directly support GPs as expert medical generalists. We will increase protected time to allow GPs to maintain and develop their training and skills, and those of their practice teams.

SERVICE REDESIGN - 2018-2021

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

Local areas are already beginning to reconfigure primary care by redistributing workload to the multi-disciplinary team as capacity becomes available.

An MOU between these local commissioning and delivery partners, the SGPC and Scottish Government is in development. It sets out agreed principles of service redesign, identified ring-fenced resources to enable the change to happen, national and local oversight arrangements, and the priorities for the transfer of responsibility for service delivery.

These agreed principles include patient safety and person-centred care. Patient engagement in the planning and delivery of new services will be critical to their success.

It is intended that GPs will become better embedded in HSCPs as senior clinical leaders working in collaboratively with managers to achieve better outcomes for patients.[14]

To help ensure sufficient, visible change in the context of a new contract, we have agreed to focus on a number of specific services to be reconfigured at scale across the country. These include:

- vaccinations services;
- pharmacotherapy services;
- community treatment and care services;
- urgent care services; and
- additional professional clinical and non clinical services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services.

To ensure the continued delivery of high quality, safe, person-centred care, the transition will happen over an agreed period of time.

Primary Care Improvement Plan

Each of the 31 HSCPs in Scotland will develop a Primary Care Improvement Plan which will outline how these services will be introduced before the end of the transition period in 2021. These Plans will be overseen by a GMS Oversight Group with representation from the Scottish Government, the SGPC, HSCPs and NHS Boards. This group will be formed to oversee implementation by NHS Boards of the Scottish GMS contract and implementation by the HSCPs of the Primary Care Improvement Plans. Plans will include clear milestones for the redistribution of GP workload and the development of effective primary care multi-disciplinary team working.

---

14 Don Berwick's concept of the need to move to an Era 3 of medicine was a guiding touchstone during the negotiations. https://www.advisory.com/daily-briefing/2016/04/12/berwick

As well as the requirements on the HSCPs to develop Primary Care Improvement Plans, NHS Boards with HSCPs will develop clear arrangements to deliver the commitments in respect of the new Scottish GMS contract. These arrangements include the priority areas of service redesign set out below and must be agreed with the local GP Subcommittee of the Area Medical Committee and the Local Medical Committee (LMC).

Leadership and management

Under the new contract GPs will be concentrating on their role as expert medical generalists with a focus on improving outcomes for patients. There is an explicit understanding that part of this role will be senior clinical leadership of these multi-disciplinary teams.

Line management of much of the primary care multi-disciplinary team staff will be provided through the employing authority (usually NHS Boards). This will include the provision of employee support, training, cross cover and cover for holidays and other absences. The purpose of the line management is to support staff in their role as a member of the primary care multi-disciplinary team attached to one or more practices and their patient lists.

While all professionals involved in patient care have a leadership role to play, the senior clinical leadership role of doctors will be outlined in the GP role in Primary Care Improvement Plans. Not all GPs will feel that they have all the skills to undertake this role, but training will be available and be part of core curricula in the future. Leadership which is intended to improve outcomes for patients will clearly require collaborative working with a wide variety of professionals who will be involved in primary care multi-disciplinary teams. Various members of these teams will also undertake leadership roles to achieve changes and improvements.

There are many examples of effective teams whose membership have different employers. Many GPs will have had experience of this with district nurses and other professionals not directly employed by their practice. The MOU is a clear statement of intent to deliver this form of team working. We have agreed shared principles to ensure these teams operate in optimum ways to the benefit of patient care.

Some of these primary care multi-disciplinary team members will be attached to individual practices but inevitably, in some cases, resources may have to be shared between different practices. GP clusters will have an important role in facilitating cross practice working including developing common working practices and pathways.

We believe that the best way to deliver relationship-based care to patients is through the effective relationships between the members of these primary care multi-disciplinary teams.

VACCINATION SERVICES

In 2017, as part of the commitment to reduce GP workload the Scottish Government and SGPC agreed vaccinations would progressively move away from a model based on GP delivery to one based on NHS Board delivery through dedicated teams. The Vaccinations Transformation Programme is reviewing and transforming how we deliver vaccinations in Scotland. Delivery will move away from the current position of GP practices being the preferred provider of vaccinations on the basis of national agreements.

The vaccination services delivered by the programme will form part of the Primary Care Improvement Plan in each area. It is expected that each area will make meaningful progress over the first two years of transformation to demonstrate commitment to the change.

The aim of the programme is to reduce workload for GPs and their staff. This will mean that other parts of the system, with primary care multi-disciplinary teams, will begin to deliver vaccination services instead of GPs. This will be a step towards enabling GPs to focus their time on expert medical generalism, whilst ensuring that patients' needs are met through the reconfiguration of services which will make the best use of the mix of skills in primary care. How this programme is delivered will vary regionally, depending on local circumstances and factors.

The funding that was historically associated with the delivery of vaccinations will remain within general practice. An additional £5 million is being invested in 2017 to start the Vaccination Transformation Programme ahead of the delivery of the proposed new contract.

The Vaccination Transformation Programme will draw in expertise from across the NHS and will take three years to complete. Transition to the new model will be planned to ensure that it can operate safely and sustainably, and changes will be made only in line with an agreed process (detailed in the Primary Care Improvement Plans).

The Vaccination Transformation Programme can be divided into different work streams:

1. pre-school programme
2. school based programme
3. travel vaccinations and travel health advice
4. influenza programme
5. at risk and age group programmes (shingles, pneumococcal, hepatitis B)

We expect HSCPs and NHS Boards to have all of these programmes up and running by the end of the 3-year transition period - in April 2021. The order and rate at which HSCPs and NHS Boards make the transition may vary but progress is expected to be delivered against milestones in each of the 3 years.

1) **Pre-school programmes** in NHS Board areas such as Lanarkshire and Tayside are already established. This is a complex, time-critical programme and HSCPs and NHS Boards that do not currently provide this service will, early on in the transition period, prioritise the adoption of lessons learned from service delivery and workforce development in those areas that have already introduced the service.
2) The **school based programme** is already established across all areas delivering influenza vaccine and HPV vaccine to girls.
3) **Travel vaccinations and travel health advice** are currently a significant time burden on GP practices and the Vaccination Transformation Programme will prioritise optimal alternative options for re-provision in the first year.
4) The **influenza programme** will tackle the seasonal challenge of delivering to those in certain age categories and those at particular high risk. HSCPs will plan how they deliver vaccinations to the high volume over 65 category. Pre-school and school age children could have this vaccination delivered by their respective programmes. Consideration needs to be given to particular risk groups such as pregnant women and adult at-risk groups, and how vaccines can be provided in a way that is safe efficient and acceptable to patients.
5) For **at risk and groups programmes,** consideration needs to be given to providing relevant vaccines to eligible patients in a way that is safe, acceptable, and which maintains, or increases uptake.

PHARMACOTHERAPY SERVICES

Multi-disciplinary team working is crucial to reducing GP workload. The proposed contract includes an agreement that every GP practice will receive pharmacy and prescribing support.

The GP Pharmacy Fund has already enabled 160 pharmacists and 34 pharmacy technicians to be appointed to posts in over one third of GP practices across Scotland.

We are investing £12m in the GP Pharmacy Fund in 2017/18. We intend that investment in this service will continue under the new contract to allow more pharmacists and pharmacy technicians to work in general practice, reducing GP workload and improving patient care.

As part of the proposed contract, we would also introduce a new pharmacotherapy service to allow GPs to focus on their role as expert medical generalists, improve clinical outcomes, more appropriately distribute workload, address practice sustainability and support prescribing improvement work.

Case Study – Pharmacy support in Caithness

Pharmacists and pharmacy technicians are already developing an increased, specialised role within primary care multi-disciplinary teams. They are well placed to support GPs to focus on their role as expert medical generalists by ensuring workload is distributed more appropriately, undertaking prescribing improvement work, and providing medication reviews and specialised clinics.

In Caithness in NHS Highland, pharmacist prescribers are embedded in the primary care MDT. One pharmacist, who works in a GP practice with 5,447 patients, has taken over all the medication reviews that were previously provided by the practice GPs, and completed a total of 2,811 reviews in an 18-month period. This includes re-authorising repeat prescriptions and transferring suitable patients to serial prescribing. They also triage all daily acute requests, carry out all medicines reconciliation for hospital discharges and clinic letters and manage individual patients requiring more intensive medicines input, such as dose titration of a pain medicine. Caithness pharmacists also provide domiciliary medication reviews for patients in care homes and patients receiving care at home, reducing the number of visits required by GPs.

The pharmacist input has resulted in a marked reduction in GP time spent on medicines-related activities, enabling them to focus on other activities. Patient response has also been overwhelmingly positive.

"Having an in-house pharmacist has shown many benefits for patients including reducing polypharmacy, being able to monitor more closely patients on high risk medications, and supporting patients though medication changes after hospital discharge."

GP, Caithness

From April 2018, there will be a three year trajectory to establish a sustainable pharmacotherapy service which includes pharmacist and pharmacy technician support to the patients of every practice. This timeline will provide an opportunity to test and refine the best way to do this, and to allow for new pharmacists and pharmacy technicians to be recruited and trained.

In order to increase the pool of qualified pharmacists to provide the pharmacotherapy service, additional funding has been secured to increase the number of pharmacist training posts from 170 to 200 per year from 2018/19. This will ensure that there is sufficient capacity to deliver the pharmacotherapy service within the proposed timescales.

By April 2021, every practice will benefit from the pharmacotherapy service delivering the core elements as described below. Some areas will also benefit from a service which delivers some or all of the additional elements described below. The level of additional services available in different areas will be dependent on workforce availability which will build throughout the three years leading up to 2021 and beyond.

Figure 2: Core and additional pharmacotherapy services

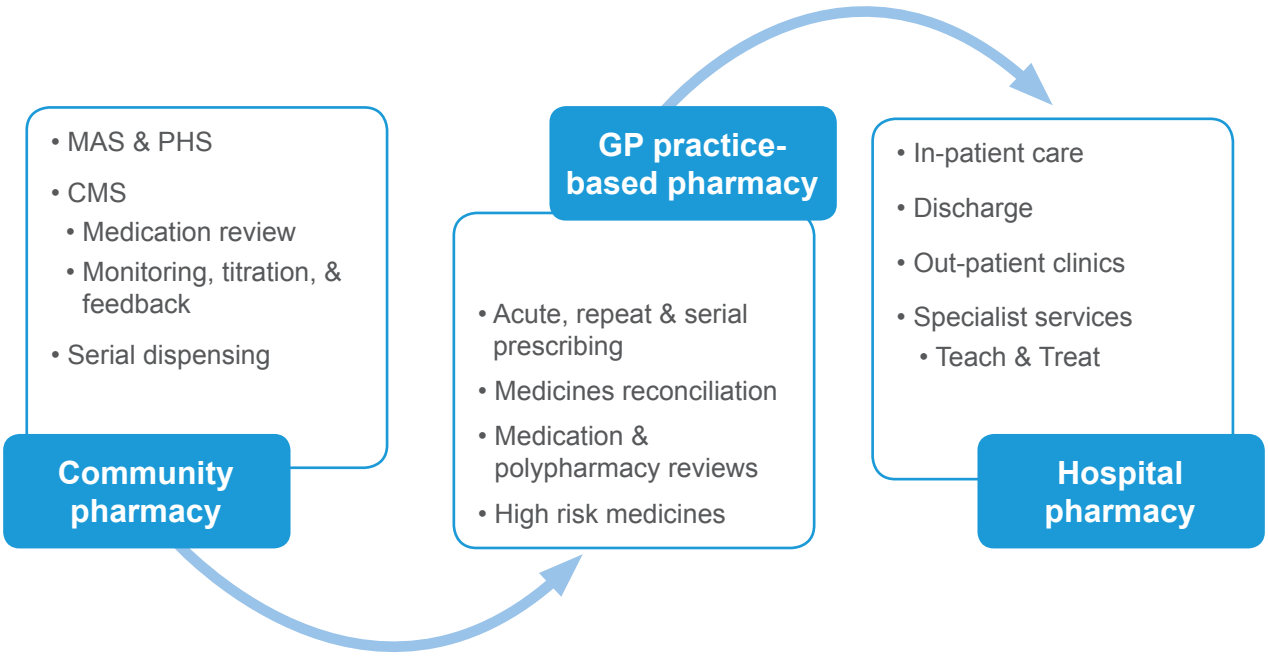
CORE AND ADDITIONAL PHARMACOTHERAPY SERVICES		
	Pharmacists	**Pharmacy Technicians**
Level one (core)	• Authorising/actioning[15] all acute prescribing requests • Authorising/actioning all repeat prescribing requests • Authorising/actioning hospital Immediate Discharge Letters • Medicines reconciliation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

15 Pharmacist Independent Prescribers can action (instigate and sign) prescriptions, non-prescriber pharmacists can action prescriptions but they still require to be signed by a prescriber.

As outlined in the MOU, the pharmacotherapy service will evolve over the three year transition, with pharmacists and pharmacy technicians becoming embedded members of the core practice clinical teams. While not employed directly by practices, the day-to-day work of pharmacists and pharmacy technicians will be co-ordinated by practices. Pharmacists and pharmacy technicians will take on responsibility for:

a) Core elements of the service, including: acute and repeat prescribing, medicines reconciliation, monitoring high risk medicines
b) Additional elements of the service, including: medication and polypharmacy reviews and specialist clinics (e.g. chronic pain)

Figure 3: Integrated pharmacotherapy service



COMMUNITY TREATMENT AND CARE SERVICES

Community treatment and care services include many non-GP services that patients may need, including (but not limited to):

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

There will be a three year transition period to allow the responsibility for providing these services to pass from GP practices to HSCPs. By April 2021, these services will be commissioned by HSCPs, and delivered in collaboration with NHS Boards that will employ and manage apprporiate nursing and healthcare assistant staff. Phlebotomy will be delivered as a priority in the first stage of the Primary Care Improvement Plans.

Local circumstances and demand will determine where it is most appropriate to safely situate these services. It is expected that many of these functions will be provided in the GP practice premises for patient convenience and the benefits of having these services carried out with the close support of the wider practice team. This would also enable easier sharing of necessary data and the patient records.

In some areas, (for reasons of premises, practicality or geography) the NHS Board may operate these services from separate facilities. The principles agreed by the parties to the MOU will ensure that patient safety, person-centred care and sustainability remain at the heart of these services as they develop, wherever they are delivered.

Patients should be able to conveniently and confidently access community treatment and care services. In some circumstances it may be appropriate for certain GP practices, such as small remote and rural GP practices, to locally agree to deliver these services. If GP practices locally agree to deliver community treatment and care services, then support will be provided in the form of either expenses for the required practice employed staff capacity, or the deployment of NHS Board employed staff.

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

It will be clear in the agreement represented by the MOU that local arrangements will determine how services will be provided. This will help to remove the responsibility for service provision away from GPs to the HSCPs, allowing GPs to focus upon their expert medical generalist role. NHS Boards and HSCPs will work with practices to plan and manage service transfers in a way that ensures patient safety and maximises benefits to patient care.

Delivery of the Vaccination Transformation Programme, pharmacotherapy service and community treatment and care service are priorities, and responsibility for these services will be transferred to HSCP by the end of the transition period in April 2021. Within that timeframe, delivery at a local level will vary based on local factors such as the extent to which comparable services are already in place, upon local geography, and prioritisation based on local demographics and demand.

URGENT CARE SERVICES

In addition to these priorities, the MOU will support the redesign of other services to reduce GP workload and free up GPs capacity to focus on their expert medical generalist role. These redesigned services will focus on urgent and unscheduled care, and developing the roles of other clinical and non-clinical professions, working in the practice, to support physical and mental health.

The Scottish Government and SGPC have agreed that another area of GP workload that needs to be addressed is urgent unscheduled care including the provision of advanced practitioner resource as first response for home visits.

A number of tests of change in Scotland over the last two years have focused on the role of Scottish Ambulance Service (SAS) paramedics in primary care. Evidence from pilots in Inverclyde, Hawick and Kelso shows that support (such as responding to urgent call out to patients) allows GPs to provide appropriate patient care. Relevant support includes advanced practitioner resource, such as a nurse or a paramedic, for GP clusters and GP practices, serving as first response for home visits.

The MOU will support the implementation of sustainable advance practitioner provision in all HSCP areas, based on local service design. These practitioners will assess and treat urgent or unscheduled care presentations. This will allow GPs to focus on scheduled appointments with patients most in need of their skills as expert medical generalists. Where service models are sufficiently developed, advanced practitioners will also directly support GPs expert medical generalist work by carrying out routine assessments and monitoring of chronic conditions for vulnerable patients at home, or living in care homes.

It is expected that the workload for paramedics would mean that most GP practices would not have sole access to a paramedic. It is likely that paramedics would work across a number of GP practices to meet patient needs. GP clusters will play an important role in enabling this service to ensure effective working and good patient outcomes.

Paramedics and specialist paramedics can practice in all aspects of urgent, unscheduled, and emergency presentations as needed, underpinned by GP review and consultation with the GP and wider multi-disciplinary team where required. A specialist paramedic in urgent and emergency care is a paramedic who has undertaken, or is working towards a post-graduate certificate in Specialist Paramedic Practice. They will have acquired, and continue to demonstrate an enhanced knowledge base, complex decision making skills, and competent judgement in urgent and emergency care. Paramedics (as non-specialists) can also provide care and support to patients in primary care, both in and out of hours as part of a wider primary health and care team.

Case Study - Paramedic Support in Inverclyde

Part of the Inverclyde tests of change included SAS supported transformational change in GP clusters. Regent GP practice in Greenock piloted paramedic support in general practice using a Trainee Specialist and a Paramedic; and Gourock Health Centre retained a Specialist and a Paramedic.

Baseline data was collected for the month of June 2016. In that month, practice paramedics carried out by Regent 102 home visits from Regent practice and 106 from Gourock. The average time taken for visits was 34 minutes. This includes travel time and updating patient records. In the first three months following paramedic support to practices being put in place, the percentages of home visits carried out by GPs reduced by over 60%. In addition to home visits, paramedics are also able to assess urgent presentations within the surgery. Referral rates to secondary care are very similar between GPs and paramedics. The most common conditions seen are acute respiratory illness, abdominal and back pain, UTIs and falls. Feedback from staff and patients so far has been positive. The GPs report they are happy with how the model is working and relationships between the professional groups continue to develop.

ADDITIONAL PROFESSIONAL SERVICES

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

Physiotherapy services focused on musculoskeletal conditions

Musculoskeletal problems frequently cause repeat appointments and are a significant cause of sickness absence in Scotland. The majority of a GP's musculoskeletal caseload can be seen safely and effectively by a physiotherapist without a GP referral. However the existing patient pathway often includes an unnecessary delay while initial non-physiotherapeutic solutions are attempted prior to access to a musculoskeletal physiotherapy service. There are variable waiting times across the country for access to face-to-face physiotherapy.

Physiotherapists are already well situated to work collaboratively with primary care multi-disciplinary teams and support the GP role as a senior clinical leader. Physiotherapists are an expert professional group. They have a high safety record and are trained to spot serious pathologies and act on them. Physiotherapists utilise their wider knowledge and skills as part of their assessment. A first point of contact service could also be seen in the context of the wider muscoloskeletal pathway.

Under the new contract, HSCPs will develop models to embed a musculoskeletal service within practice teams to support practice workload. In order to provide a realistic alternative for patients, access times must be comparable to those of general practice. Priority for the service, such as focusing on elderly care, will be determined by local needs as part of the Primary Care Improvement Plan.

Case Study - Physiotherapy services in Inverclyde

Inverclyde piloted the use of an Advanced Practice Physiotherapist (APP) as an alternative first point of patient contact within the GP practice. Since August 2016, an APP has worked in three GP practices with a total patient list of 14,000. Reception staff at each practice were trained to offer patients APP appointments where appropriate. To date the APP has provided over 1000 consultations, most of which would otherwise have been GP appointments. 94% of patients were seen once and did not need a further appointment with the physiotherapist.

GPs at one participating practice, Lochview practice in Greenock, noted a number of benefits. By seeing the majority of patients with musculoskeletal conditions the APP has freed up GP appointments. GPs are able to use their time more effectively by focusing on patients more in need of their expertise, and are spending more of their patient facing time on complex care needs. In qualitative evaluation, the pilot was rated highly by GPs, practice staff and patients, with patient feedback in particular being extremely positive.

'Of all the work that's ever been done in GP practices, this has been the one that feels like it has truly taken work away. Patients are safer - there is quicker access to the most appropriate intervention because triage assessment conducted by the physiotherapist gets people to the right place sooner'.
(GP, Greenock)

Community mental health services

Community clinical mental health professionals (eg nurses, occupational therapists), based in general practice, will work with individuals and families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression. The outcome sought is improved patient care through rapidly accessible, appropriate and timely mental health input.

Community Links Worker Services

A Community Links Worker (CLW) is a non-clinical practitioner based in or aligned to a GP practice or cluster who works directly with patients to help them navigate and engage with wider services. They often serve a socio-economically deprived community or assist patients who need support because of for example, the complexity of their conditions. As part of the Primary Care Improvement Plan, HSCPs will develop CLW roles in line with the Scottish Goverment's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models of care and support.

Rural support

The rural and remote GP shares much of the same generalist workload as their colleagues in urban areas. In many areas, being a rural GP means being the expert medical generalist providing the broadest range of skills because of their remoteness, because they usually have smaller primary care teams and because the locality services that may be available in areas with larger populations may not be available.

Many remote and rural GPs have chosen to work where they do in part because it fits with their desire to provide a more complete primary care service to their patients and see delivery of some services as welcome opportunities to engage with their patients. In some rural areas where there are larger list sizes, there will be the opportunity to move the responsibility for some services like immunisations to reduce workload pressures.

The service redesign described above requires practices to be involved via their GP clusters, so they have a say in how services will work locally.

Workforce

The introduction of the services described above relies on the establishment of a new workforce which will be part of practice teams but not employed by practices. These practice-attached staff will be largely employed by NHS Boards, embedded in practice teams with their day-to-day work co-ordinated by the practice.

Patient safety will be fundamental in delivering this workforce at scale. Taking the paramedic support service as an example, at all stages of the roll-out, we will ensure the capacity and capability of the workforce is sufficient. This means that the safety of patients requiring urgent unscheduled care is assured and core Scottish Ambulance Service performance is protected. This will require consistent and reliable provision of paramedic staff working in primary care teams, with appropriate training and education, supervision and support arrangements. Positive relationships between colleagues in the primary care multi-disciplinary teams will be crucial. This approach to attached staffing will be taken in the development and roll-out of all services – the principles for which are outlined in the MOU.

Further detail on delivering this new workforce will be in the Scottish Government *National Health and Social Care Workforce Plan: Part 3 Primary Care.*

As this chapter sets out, an expanded primary care multi-disciplinary team will bring substantial workload benefits to GPs and deliver better services and outcomes to patients. As well as improvements to workforce we will introduce measures to reduce risk and improve infrastructure in general practice. These are explained in chapter five.

5 IMPROVING INFRASTRUCTURE AND REDUCING RISK

Key Points

- The risks associated with certain aspects of independent contracting will be significantly reduced.
- GP Owned Premises: new interest-free sustainability loans will be made available, supported by additional £30 million investment over the next three years.
- GP Leased Premises: there will be a planned transition to NHS Boards leasing premises from private landlords
- New information sharing agreement, reducing risk to GP contractors.

INTRODUCTION

As independent contractors, many GP practices carry the responsibility for providing staff and infrastructure to support GPs and services to patients. With this responsibility can come risk which can include the risk of changes in funding. As outlined in chapter three one of the overarching aims of reforming practice funding is to increase practice stability and reduce risk. As outlined in chapter four, proposals for the NHS Boards to largely employ the expanding primary care multi-disciplinary team are specifically intended to avoid increasing the clinical and administrative risks of being an employer.

This chapter describes new measures to improve infrastructure and reduce risk in areas such as ownership of premises, IT and information sharing.

PREMISES

Practice premises are increasingly perceived as an unwanted liability by potential GP partners; and this has become a barrier to recruitment, retention and retirement.

The Scottish Government and SGPC recognise and support a long-term shift that gradually moves towards a model which does not presume GPs own their practice premises.

To this end the Scottish Government and the SGPC have agreed a National Code of Practice for GP Premises ("the Code") which sets out how the Scottish Government will support a shift, over 25 years, to a new model in which GPs will no longer be expected to provide their own premises. The contract offer proposes that from 1 April 2018, the Code will be introduced and revised Premises Directions will take effect. The Code sets out how the Scottish Government will achieve a significant transfer away from GPs of the risks of providing premises.

To enable this transfer of risk, the Scottish Government will make available assistance of up to £30 million by 2021 (£10 million per year from 2018) to GPs with premises related liabilities. This will be through the establishment of a GP Premises Sustainability Fund. This represents a 24% increase in funding for supporting GPs with premises (compared to 2015/16, the latest available figures).

GP Owned Premises

The Code sets out the measures the Scottish Government will provide to assist GPs who own their premises. These measures include interest-free secured loans, known as GP Sustainability Loans, to be resourced through the new GP Premises Sustainability Fund.

These GP Sustainability Loans will be made available to every GP contractor who owns their premises by 31 March 2023. The loans will help stabilise general practice as a whole. They will allow partners to release capital without destabilising their practice, reduce the up-front cost of becoming a GP partner, and make general practice more financially rewarding. The loans will encourage GPs to become partners in practices which own their premises.

GP Sustainability Loans

All GP contractors who own their premises will be eligible for an interest-free loan, including those in negative equity.

The loans will be for an amount of up to 20% of the Existing-Use Value of the premises and they will be secured against the premises.

Loans will be funded from the GP Premises Sustainability Fund.

NHS Boards will have the power to top-up the amount of the loans where they decide that there are exceptional circumstances.

The loans will be repayable if the premises are sold or are no longer used by the GP contractor for the provision of general medical services under a contract with an NHS Board.

The loan will have no effect on Notional Rent or borrowing cost payments. There will be no abatements due to a loan.

A system for prioritising applications will be put in place. To ensure that assistance is given first to those who need it most. However, all GP contractors who own their premises will be eligible to receive a GP Sustainability Loan by 31 March 2023.

The Scottish Government envisages that once the first cycle of GP Sustainability Loans is complete (2023) a further five yearly cycles will begin to further reduce the risk to GP practices which own their premises. The Scottish Government intends that these five year cycles of investment will continue until the transition to the new model where GPs no longer own their premises is complete (by 2043).

More information on GP Sustainability Loans can be found in the National Code of Practice for GP Premises.

GP Leased Premises

The Scottish Government's long term strategy is that no GP contractor will need to enter a lease with a private landlord for GP practice premises. NHS Boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases with private landlords and the subsequent obligations for maintaining the premises. NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions.

GP contractors who wish to continue to provide their own accommodation will be free to do so. They will continue to be eligible to receive rent re-imbursements under premises directions.

NHS Boards will support GP contractors who currently lease premises from private landlords. The Code sets out what GP contractors who lease their premises need to do to ensure that their NHS Board takes over the responsibility of providing their premises.

There are three ways in which NHS Boards can take on the responsibility of providing a GP contractor with practice premises. These are:

- negotiating a new lease for the GP contractor's current premises, with the NHS Board as the tenant
- accepting assignation of the GP contractor's current lease
- providing alternative accommodation for the GP contractor when its current lease expires

If a lease expires before 1 April 2023, the most likely course of action is for the NHS Board to negotiate a new lease or provide alternative accommodation.

If the lease expires after 1 April 2023, NHS Boards will take on the existing lease from GPs where:

- The practice has ensured that its premises are suitable for the delivery of primary care services and are sufficient to meet the reasonable needs of its patients
- The practice has met its statutory obligations regarding the premises
- The practice has provided all relevant information to its NHS Board
- The practice has given sufficient notice to its NHS Board of its need for assistance
- The practice has registered the lease with the NHS Board
- The practice has the agreement of the landlord to the assignation of the lease (and the other necessary conditions)
- The practice has complied with its obligations under its existing lease
- The rent represents value for money

Premises Survey

All premises used to provide GMS will be surveyed in 2018/19. This will provide the data which NHS Boards will require for their premises plans. Contractors will be contacted by the surveyor appointed by the Scottish Government to arrange a survey of their premises at a convenient time. This is essential if NHS Boards are to effectively support practices with premises issues in the future.

Risk of being an employer

Under the new contract GPs will be not be exposed to increased risks from being an employer as the joint intention of the negotiating parties is for the increased primary care team to be employed by NHS Boards and deployed in practices – details are outlined in chapter four.

Under Phase 2 of the funding changes it is proposed that practice expenses will be directly re-imbursed. This will include staff costs and those associated with staff sickness, maternity, paternity and adoption leave, including staff cover for long-term sickness and maternity leave.

GP CLINICAL IT SYSTEMS

NHS Boards have commissioned a procurement competition to provide the next generation of GP clinical IT systems for GPs in Scotland. This is being undertaken by NHS National Services Scotland.

The new systems will be more intuitive and user friendly. They will be quicker and more efficient, with increased functionality. They will be underpinned by strong service levels and performance management, with clear lines of responsibility and accountability, providing, overall, a more professional GP IT Service.

All GP practices will transition to the new systems by 2020. GPs will continue to have the right to choose a clinical IT system from those which have been approved by the Scottish Government.

The following groups will provide governance for Primary and Community Care eHealth:

Primary and community care e-health governance

GP IT Committee

Under the new contract, NHS Boards will remain responsible for providing integrated Information Management and Technology (IM&T) systems and telecommunications links within the NHS. However the Scottish Government will set national standards which will be developed with the assistance of a new GP IT Committee. The SGPC and RCGP will form this committee along with GPs and managers expert in information technology. These standards will be agreed between the Scottish Government and the SGPC.

The eHealth Strategic Assurance Board

The eHealth Strategic Assurance Board will provide strategic direction to the development of digital technology in NHSScotland and act as the senior governance group for the escalation of issues.

The Community Care Portfolio Management Group

The Community Care Portfolio Management Group will provide direction to the development of digital technology within the community and primary care sectors in line with the overall strategy set by the eHealth Strategic Assurance Board. It will also deal first with issues escalated to it by the governance boards of individual projects. It will escalate issues to the eHealth Strategic Assurance Board where appropriate.

Primary Care Contracts and Service Management Board

The Primary Care Contracts and Service Management Board will review the performance, financial status, and key issues and risks of the GP clinical IT system. This group will play the same role for the Community IT clinical system which is in an early stage of procurement.

INFORMATION SHARING

The proposed contract will set out the roles and responsibilities of GP contractors and NHS Boards in relation to information held in GP patient records. The contract will support adherence to the Data Protection Act 1998 and help prepare GP contractors and NHS Boards for the new General Data Protection Regulations (due to come into force in May 2018).

The new contractual provisions will reduce the risk to GP contractors of being data controllers. The contract will recognise that contractors are not the sole data controllers of the GP patient record but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GP contractors' responsibilities. GP contractors will not be exposed to liabilities beyond their effective control.

The work of identifying the roles and responsibilities of GP contractors and NHS Boards has been carried out with the assistance of the Information Commissioner's Office in Scotland, and in collaboration with stakeholders who have provided expert guidance as well as practical experience of managing patient data. This includes the Caldicott Guardians Forum, SGPC, RCGP, Central Legal Office, NHS National Service Scotland, and relevant teams within the Scottish Government including the E-health Division and the Chief Medical Officer. The proposed new provisions are also consistent with the General Medical Council (GMC) Confidentiality guidance.[16]

16 http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

6 BETTER CARE FOR PATIENTS

Key Points

- **The principles of contact, comprehensiveness, continuity and co-ordination of care for patients underpin the proposals.**
- **GP time will be freed up for longer consultations where needed – improving access for patients.**
- **There will be a wider range of professionals available in practices and the community for patient care.**

INTRODUCTION

The joint Scottish Government/SGPC Memorandum published in November 2016, described the aim of the negotiations to develop a contract that helps to reinvigorate the core principles of general practice in primary care, and frees up more time for the role of the GP as expert medical generalist. The four C's of primary care, discussed in chapter one, are: contact, comprehensiveness, continuity, co-ordination.

GPs recognise these attributes as the qualities patients value most in general practice; they are the key strengths of general practice and the guiding values underpinning the negotiations.

This is why the focus of the transition over the next three years is to move away from the over-specification of services as described in chapter two – to progressively, though not entirely, move away from Additional and Enhanced Services – and to focus on the core role of the GP as expert medical generalist.

In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care, based on an understanding of patient's needs, life circumstances and experiences it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. It is equally important that other health care professionals are part of the redesign process. We will therefore ensure that engagement with patients, and professionals delivering primary care, is a key part of the development and delivery of any service redesign.

This chapter is structured around the four Cs. The first section addresses how we will maintain and improve accessible contact.

The second section addresses comprehensiveness of care in the context of the multi-disciplinary team. The third and fourth section address how patients will have continuity of care and how that care will be co-ordinated.

CONTACT - MAINTAINING AND IMPROVING ACCESS

Improving patient access to primary care and general practice is multi-faceted. Access in general practice is influenced by a range of issues: the location of the practice; when it is open; how easy it is to make appointments; and the speed of access to appropriate care.

Speed is not the only aspect of access that matters to people. Convenience – how easily people can make appointments; who those appointments are with; and when those appointments are – also matters. Being able to see a practitioner of choice also matters to some groups. The importance of these different aspects of access – ease of making appointment; time to appointment; time of appointment and choice – varies among different groups.

We have agreed that practice core hours will be maintained at 8am to 6.30pm (or as previously agreed through local negotiation), and that practices will continue to be required to provide routine services to patients during this period as appropriate to meet the reasonable needs of their patients.

More accessible information on surgery times within these practice core hours will be available to help patients easily identify when they can see a GP and/or other healthcare professionals.

The Extended Hours Directed Enhanced Service will be maintained. It will be clearer to patients when their local GP practice offers care in Extended Hours and when appointments with GPs and other practice staff are available within the Extended Hours period. Services provided by healthcare assistants may also be available during Extended Hours periods.

There will be improved convenience for patients in how they can access their local practice. Under the proposed new contract, GP practices will be required to provide online services to patients such as appointment booking and repeat prescription ordering, where the practice already has the existing computer systems and software required to implement online services safely.

COMPREHENSIVENESS - A WIDER RANGE OF HEALTH PROFESSIONALS WITHIN THE EXPERT MEDICAL GENERALIST CONTEXT

Ensuring patients have sufficient time with their GP when it is needed means recognising that not all patient needs at all times require the expertise of a doctor. The agreement on service redesign reflected in the Memorandum of Understanding will underpin the contract and allow GPs to have more time to deliver the type of care that only their skills and training can provide. At the same time, comprehensive patient care will be maintained within an expanded primary and community care team, with GPs having a more prominent clinical leadership role.

The discontinuation in Scotland of the single disease-focused approach to quality represented by the Quality and Outcomes Framework, has been a major step in creating a renewed focus on whole person and whole community health. This renewed commitment to a more holistic approach to quality and outcomes is being supported by the development of peer-led GP quality clusters. Clusters, in addition to improving quality and patient outcomes across GP practices, will have a leading role in advising on quality, patient experiences, and patient outcomes across the wider primary, community and social care landscape.

Significant new investment in expanded teams of clinical and non-clinical professionals working in practices and localities will widen patient choice and ensure that GPs are able to focus on their expert medical generalist role. As set out in chapter four, additional professionals will include pharmacy; nursing; allied health professionals (physiotherapy, and paramedics and other urgent care practitioners); and non clinical support workers (e.g. links workers).

Seeing the right person at the right place at the right time will sometimes mean not seeing a GP first, if this is appropriate. This might represent a significant change over time, both to how work is carried out and patients' experience. Emerging evidence from the testing of new models of care in Inverclyde indicates patients can adapt quickly and respond positively to improvements brought by this model. For example, high levels of patient satisfaction have been recorded among those people who have accessed new first point of contact acute musculo-skeletal physiotherapy care in a group of practices in Inverclyde.

Realistic Medicine, Person Centred Care and Expert Medial Generalists

Scotland's Chief Medical Officer (CMO), Catherine Calderwood, published her first annual report *Realistic Medicine*[17] in 2016. The report explores whether improved healthcare can be achieved by combining the expertise of patients and professionals in a more equal relationship; through building a personalised approach to care; increasing shared decision making; reducing unnecessary variation in practice and outcomes; reducing harm and waste; managing risk better; and improving innovation. The CMO's second annual report, *Realising Realistic Medicine*[18], continued the debate - with widespread support and contributions from national and international clinicians, leaders in medicine and public health and stakeholders representing the public and patient voice.

The values of Realistic Medicine are wholly aligned with the values of general practice supported decision making; holistic care that focuses on the person - mind and body - not the disease; care that skilfully manages clinical risk with every encounter - these attributes of realistic medicine are already the hallmarks of general practice. Moreover general practice has a strong history of innovation, learning and collaboration and GP clauses offer an opportunity to revitalise and strengthen these traits over time.

Re-focusing the GP role as expert medical generalist enables GPs to further pioneer the practice of realistic medicine among their medical colleagues. General practice provides just the right amount of medicine for the best possible outcome to individuals and populations. The principle of shared decision making extends to genuine discussion and engagement with the public about how care is best delivered. All four parties to the MOU are committed to public engagement in the development of Primary Care Improvement Plans.

17 http://www.gov.scot/Resource/0049/00492520.pdf
18 http://www.gov.scot/Publications/2017/02/3336

CONTINUITY - TIME WITH A GP WHEN IT IS REALLY NEEDED

Continuity of care – the development of lifelong therapeutic relationships between doctor and patient – is a distinctive hallmark of general practice. The aim of the workload reduction measures described in chapter four is to free up GP capacity for those times when only the expertise of a doctor is sufficient. Scottish Government and SGPC agree it is not appropriate to contractually define consultation lengths, as that will continue to be a matter for clinical judgement. Freeing up capacity, through the redesign of services over the next three years, will allow for longer GP consultations when required by patients, particularly for complex care.

We agree that the independent contractor model of general practice is a benefit to continuity of care as it encourages a strong and enduring commitment from GPs to their community of patients.

The new proposed contract reduces current risks to practice stability and sustainability, for example, by addressing some of the key risk factors relating to rising workload, premises ownership and employment of staff. This in turn will make the partnership model more attractive to newer generations of GPs.

CO-ORDINATION - INCLUDING MORE INFORMATION AND BETTER HELP TO NAVIGATE THE SYSTEM

The 2004 GMS contract requires each practice to make a practice leaflet available to patients. This requirement will remain and the practice leaflet will continue to include important information for patients about the practice and how they can access available healthcare services in their local surgery. This includes: the name of the contractor; partners and all healthcare professionals who deliver services; how to register with the practice; the practice area; and the opening time of the practice premises; as well as how to access services in core hours of 8am to 6.30pm.

The Scottish Government and SGPC have agreed to modernise access to, and provide a consistent platform for, the supply of this key information for patients. This will involve better use of NHS 24 - the national agency for health advice and information in Scotland.

NHS24 will develop a national standardised website for each practice in Scotland that will contain all the key information required in the practice information leaflet. It will also consistently signpost practice patients to reliable self-care information and to wider health and care services in the community. This website will be made available at no cost to individual GP practices. Once available, practices will be able to choose whether to use this service or another service, but all practices will be required to make practice information available to patients digitally.

In summary, ensuring continuity, comprehensiveness, accessible contact and co-ordination for patients lies at the heart of the proposed new contract. As well as treating the individual, the proposed new contract offers a better contribution by general practice to local population health and ensuring the needs of the community are met.

The next chapter will cover the wider role of GPs and GP Clusters in population health, planning of local services, quality planning, quality improvement and quality assurance, and supporting information for quality and sustainability at local, regional and national levels.

7 BETTER HEALTH IN COMMUNITIES

Key Points

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

INTRODUCTION

GPs, working with colleagues across health and social care, continue to be at the forefront of a wide range of improvements in the safety, effectiveness and quality of care and treatment.

For over 10 years, the Quality and Outcomes Framework (QOF) largely defined the approach to quality in general practice. It was introduced in the 2004 GMS contract with the intention of providing improved, or consistently high, quality of care, whilst offering GP practices an opportunity to increase funding via an incentivised payment scheme.

Whilst the quality of care delivered in general practice has undoubtedly improved since the beginning of the century, the extent to which QOF contributed to this improvement is contended. There is some evidence to suggest that in the early years it accelerated the pre-existing trajectory of improvement in managing those chronic diseases that were included, and achieved greater equality in the standard of care across practices. However over time, and for a variety of reasons, this effect became diluted and perhaps had the unintended consequence of crowding out other chronic conditions not included.

A systematic review published in The British Journal of General Practice[19] concluded that any replacement for QOF needs to consider the evidence of effectiveness of pay-for-performance in primary care, and the evidence of what motivates primary care professionals to provide high-quality care.

19 http://bjgp.org/content/early/2017/09/25/bjgp17X693077

IMPROVING TOGETHER

Improving Together[20] a new quality framework for GP clusters in Scotland offers an alternative route to continuously improve the quality of care that patients receive by facilitating strong, collaborative relationships across GP clusters and localities. At the heart is learning, developing and improving together for the benefit of local communities.

As described in chapter two, GP clusters are professional groupings of general practices that meet regularly, with each practice represented by their Practice Quality Leads (PQL). Each GP cluster has a Cluster Quality Lead (CQL) who performs a co-ordinating role and liaises with locality and professional structures. This requires supporting measures such as the existing contractual provision for protected time. It also requires: infrastructure to support leadership; data provision and analysis; and facilitation and improvement activity within local governance structures. Clusters may be of different sizes, influenced by local circumstances and geography, but as a principle, they should be viable for small group work.

Improving Together describes the agreed 'intrinsic' and 'extrinsic' functions of GP clusters in Scotland. The intrinsic function refers to the role of GP clusters in improving the quality of care in their cluster through peer-led review. The extrinsic function refers to the critical role GP clusters have in improving the quality of care in general practice and influencing HSCPs regarding both how services work and the quality of services. The dimensions of these intrinsic and extrinsic functions are set out in the table below.

Figure 4 - Intrinsic and extrinsic functions of clusters

INTRINSIC	EXTRINSIC
Learning network, local solutions, peer support	Collaboration and practice systems working with Community MDT and third sector partners
Consider clinical priorities for collective population	Participate in and influence priorities and strategic plans of Integrated Authorities
Transparent use of data, techniques and tools to drive quality improvement - will, ideas, execution	Provide critical opinion to aid transparency and oversight of managed services
Improve wellbeing, health and reduce health inequalities	Ensure relentless focus on improving clinical outcomes and addressing health inequalities

20 http://www.gov.scot/Publications/2017/01/7911/10

As clinical leaders in the primary healthcare team, GPs will actively contribute to the clinical governance and oversight of service design and delivery across health and social care as part of the extrinsic GP cluster role.

CQL will work in close collaboration with the already established medical advisory structure including: Medical Directors (Primary Care) (usually AMDs); Clinical Directors; Locality Strategic Planning Groups; and GP Sub Committees in NHS Boards.

The GP Subcommittee of the Area Medical Committee should be responsible and funded for local arrangements to ensure effective collaboration between the GP Subcommittee, NHS Board medical directors, and CQL. The GP Subcommittee will be responsible for co-ordinating the agenda for this tri-partite collaboration and facilitating combined professional advice to the commissioning and planning processes of the HSCPs and NHS Boards.

GP Subcommittees need to be adequately funded to carry out these roles (as well as day-to-day advice to the Board and its representative committees). NHS Boards and HSCPs should be able to demonstrate to the Scottish Government that they are appropriately supporting these activities. It is recognised that, in many areas, the GP profession chooses to have the same members in the GP Subcommittee as from the LMC. Local discussion should enable the funding of the GP Subcommittee to be clearly seen as funding those activities separate to the LMC activities.

GP CLUSTER WORKING AND LOCAL POPULATION HEALTH

GP practices participate in cluster working through their PQL. The PQL engages with the CQL, the rest of the GP cluster and attends GP cluster meetings. The practice will provide agreed local and national data extractions to enable intelligence led quality planning, quality improvement and quality assurance.

Cluster working will contribute to the development of local population health needs assessments undertaken by public health and local information analysts. They will also provide professional clinical leadership on how those needs are best addressed.

The NHS National Services Scotland Local Intelligence Support Team (LIST) service has been supporting GP cluster working in Scotland since April 2017. This analytical support to clusters will continue and expand under the new contract.

Case Study - List analytical support for clusters

LIST analysts have already been working with clusters and practices across Scotland to help analyse data and introduce improved ways of working. These have included:

- safely reducing the number of home visits through the use of telephone triage
- analysis of appointment demand to inform staff scheduling
- analysis of data to create a health needs assessment for homeless patients
- gathering evidence to assist plans for GP services in relation to new housing development
- using data to help identify High Health Gain patients, to facilitate anticipatory care planning and additional preventative support measures

These initiatives help to both reduce GP workload and improve patient care.

"The main thing we want to take forward is a more in depth analysis of our frequent attenders, looking at who they are seeing, when, why and how often, and looking at interventions which may help them to better self-manage and use the service as appropriately as possible. We are hopeful that this could free up some capacity in the system and improve the right person right time goal". GP Inverclyde

"LIST have analysed our appointments data - we have now made some changes which has improved capacity and helped us to prioritise the patients. The DNA rate has also significantly reduced". Practice Manager - Lothian

There is enormous potential for improving local population health, including mental health, through GP clusters, better data on population health needs and better intelligence and facilitation through LIST analysts. The aim is for GPs to have a bigger impact on public health as an expert medical generalist than they do as service providers for services that can be safely delivered by other health professionals.

NHS Boards, as the lead agency for protecting health, will continue to be responsible for planning and responding to public health incidents. Operational management locally will remain the responsibility of NHS Boards, drawing on the expertise and support of a range of local partners, including GPs and NHS Board staff. NHS Board staff will support with screening, prescribing, prophylaxis and nursing as appropriate.

QUALITY PLANNING

Quality Planning is a structured process for designing and organising services to meet new goals and patient needs. This includes setting aims, identifying practice populations, identifying patient and carers' needs, developing plans to meet that need, and developing measures to ensure that the aim is met.

Agreement will be needed on the balance between local and national priorities for GP clusters to focus their quality improvement activity each year. GP clusters themselves will be critical in identifying priorities locally with the inclusion of regional/national priorities as required. The former will primarily lead the improvement agenda with the latter playing in on an as required basis only.

Thus GP clusters must decide the majority of their own clinical priorities in their own locale using both information gathered by analytical support and their own deep knowledge and understanding of the communities they serve.

GP clusters working and quality planning

GP practices will participate in cluster working and through cluster working will contribute to the development of cluster quality improvement plans.

Cluster quality improvement planning will be supported by training in quality improvement if required.

2018/19 – quality improvement planning and activity for many clusters will be based on existing Transitional Quality Arrangements (TQA)[21] information. This activity will be better enabled, as more analytic and public health support goes on line. Clusters will initially review comparative data between cluster practices on areas such as disease registers, referral, prescribing, access and use of unscheduled care to identify variation, peer-based learning, and areas for improvement supported by external resources. Maintaining comprehensive disease registers will remain critical to underpin activity in quality planning, quality improvement and quality assurance.

QUALITY IMPROVEMENT

Quality Improvement is a continuous process. On an individual level doctors have a professional responsibility to maintain their skills and knowledge and contribute and comply with systems to protect patients.[22] GPs will continue to be registered with the GMC, undergo annual appraisal, learn from Significant Adverse Events, contribute to confidential enquires and comply with NHS Complaints procedures and Duty of Candour legislation.

21 http://www.isdscotland.org/Health-Topics/General-Practice/Primary-Care-Information-and-TQA/

22 http://www.gmc-uk.org/guidance/good_medical_practice.asp

GP practices will engage in quality improvement activities as agreed through GP cluster quality improvement planning. Practices will supply information to HSCPs and NHS Boards on their workforce and demand for their services to improve sustainability and facilitate service redesign. GP clusters work with the wider system, in particular HSCPs, to achieve whole system quality improvement.

GP clusters and quality improvement

GP practices will engage, as agreed in GP clusters, in quality improvement activities, including providing comparative data[23] and sharing best practice.

GP clusters will work with the wider system, in particular HSCPs, to achieve whole system quality improvement for patients.

QUALITY ASSURANCE

GP practices will participate in a cluster quality peer review process, whereby their quality improvement activity and quality data will be reviewed by their local GP cluster. Support will be offered as appropriate.

The Healthcare Improvement Scotland Quality of Care Approach will involve an increased emphasis on local systems of assurance. Service providers will use the quality framework domains to evaluate the quality of care they provide and identify areas for local improvement work. As GP clusters mature, practices and clusters will be expected to take part in the peer-led values driven assurance process. The methodology for this will be negotiated by the Scottish Government and SGPC.

GP clusters and quality assurance

GP practices will participate in a cluster quality peer review process, whereby their quality improvement activity and quality data will be assessed by their local GP cluster and support will be offered as appropriate. That support could take the form of written advice and/or a supportive practice visit from peers and a local manager.

23 In normal circumstances, providing information means allowing appropriate electronic extraction of information where that is the preferred option by the GP practice.

SUPPORTING INFORMATION FOR QUALITY AND SUSTAINABILITY

GP clusters will need information to support their intrinsic role of peer-led quality work and their extrinsic role with wider systems. Some of the data for the new quality arrangements has already been identified in the TQA. To fulfil both intrinsic and extrinsic functions GP clusters will need a combination of nationally agreed information and locally agreed data.

The new quality arrangements will be supported by new technologies, such as the Scottish Primary Care Information Resource (SPIRE). Currently SPIRE software is being rolled out across practices in Scotland - this is expected to be complete by April 2018.

Nationally and locally agreed (by SGPC and the clusters respectively) datasets will be supplied by practices and the use of automated extraction tools, such as SPIRE, is recommended as good practice. Practices will not be contractually required to use SPIRE and may choose not to use it at all. In those circumstances, practices must still provide the information required by the national and local datasets.

The existing dataset for the TQA will be the starting point for an agreed national dataset under the new GMS contract. This will enable clusters to build on their experience under the TQA to date, and on the existing work by NHS National Services Scotland Information Services Division to develop easily accessible data dashboards to support quality improvement in general practice.

GP practices and clusters will continue to be supplied with information on prescribing, outpatient referrals and admissions to hospital to support quality activity in these areas.

To contribute to the sustainabillity of general practice and primary care, GP practices will engage in the collection or extraction of information on activity and capacity. This information will be used transparently to inform and influence the development of the extended primary care teams.

To support GPs to identify individuals with more complex needs and to deliver anticipatory care planning more consistently, practices will continue to be supplied with risk predictive information based on the current High Health Gain Potential predictive tool. Work is ongoing to assess the value and to improve the predictive power of this and other case finding tools.

GP practices have reported a considerable increase in workload over the last five years, with more patient contacts, more clinical letters, more results and a higher proportion of consultations with people who have very complex problems who require more time.

Since the cessation of the Practice Team Information survey in Scotland there has been a lack of comprehensive national information on changing rates and complexity of GP consultations.

This information needs to be made available to the practice, the cluster, the HSCP and collated nationally to support sustainability, planning and the evolution of the extended multi-disciplinary team.

In addition, practices will be required to supply regular information on the workforce employed in their practices. This dataset will be used to triangulate locally with other sustainability factors, such as GP vacancies, increasing deprivation, and local house building. The purpose is to support GP practices, GP clusters, NHS Boards and HSCPs to identify and address sustainability challenges using a whole system approach.

GP cluster working, data extracts, and supporting sustainability

GP practices will provide agreed information on consultation rates, consultation types, health care professional being consulted and complexity within consultations. This will be done using SPIRE electronic extraction unless the practice wishes to collect the information itself.

GP practices will participate in assessment of capacity using the third available appointment method. Support will be provided to allow this to be undertaken electronically[24].

GP practices, through cluster working, will be involved in discussions about, and provide advice on, sustainability issues using activity, demand and workforce data.

This chapter describes the proposed arrangements for continuous quality improvement in general practice in Scotland. The next chapter summarises proposed changes in the role of the practice and changes in other underpinning regulations.

24 It is acknowledged that those practices with open access arrangements will be supported with alternative arrangements.

8 THE ROLE OF THE PRACTICE

Key Points

- General practice nursing will continue to have a vital role under the proposed new contract.
- There will be new enhanced roles for practice managers and practice receptionists.
- In addition, a number of clarifications and improvements to the underpinning GMS and Primary Medical Services (PMS) regulations will be made.

INTRODUCTION

The table below sets out how the activities of the practice team might be expected to change in the next three years. The examples given below under the heading of each professional are indicative only, not exhaustive. More information on the services mentioned in the table is set out in chapter four.

Figure 5: Services in 2017 and 2021

2017

General practitioners
Independent contractor – based in the practice

- Default primary medical service provider
- Undifferentiated presentations- patients who are ill/believe themselves to be ill, who require diagnosis
- Complex care - including patients who have more than one diagnosis or medical issue
- Clinical leadership of the practice team to improve patient outcomes
- Home visits
- Delivery of chronic disease monitoring
- Chronic disease management
- Delivery of some nursing services (treatment room)
- Repeat prescribing, serial prescribing, 'specials', and polypharmacy reviews.
- Reviewing results (large Docman activity)
- Leading practice team/practice management

2021

General practitioners
Independent contractor – based in the practice

- Default responsibly for a reduced number of primary medical services
- Undifferentiated presentations- patients who are ill/believe themselves to be ill, who require diagnosis and cannot choose to see other health professionals
- Complex care - including more time with patients who have more than one diagnosis or medical issue
- Clinical leadership of extended primary care team to improve patient outcomes
- Fewer home visits but more complex and often as part of team assessment and support
- Oversight of chronic disease management
- Reduced volumes of Docman – outpatient and self-ordered test results
- Leading practice team / practice management
- Leading clusters
- Influencing local system

2017

General Practice nurses
Employed by the practice

- Treatment room services
- Chronic disease monitoring/management
- Vaccinations
- Minor injury, dressings

Practice manager
Employed by the practice

- Contract management
- Contract monitoring
- Business planning
- Contract and other regulatory compliance
- Staff management

Receptionists
Employed by the practice

- Organising patient appointments
- Managing communications to/from the practice
- Managing prescription requests/enquires
- Operating call/recall systems
- Administration

2021

General Practice nurses
Employed by the practice

- Minor illness management
- Chronic disease management
- Supporting GP to deliver care planning
- Monitoring lab results

Practice manager
Employed by the practice

- Contract management
- MDT coordination
- Contract monitoring
- Business planning
- Contract and other regulatory compliance
- Staff management

Receptionists
Employed by the practice

- Organising patient appointments
- Supporting patients with information on available services
- Managing communications to/from the practice
- Managing prescription requests/enquires
- Operating call/recall systems
- Administration

New for 2021

Pharmacotherapy services
HSCP/NHS Board Service

- Repeat prescribing, serial prescribing, 'specials', shortages
- Medication and polypharmacy reviews.
- Medicines reconciliation
- Medication enquiries
- Monitoring lab results for high risk medicines

Urgent Care Services
HSCP/NHS Board Service

- Assess and treat urgent and emergency care presentations
- Home visits
- Falls

Additional Professional Services
HSCP/NHS Board Service

- Acute musculoskeletal physiotherapy services
- Community mental health services
- Community link worker services

New for 2021

Community Treatment and Care Services
HSCP/NHS Board Service

- Management of minor injuries and dressings, phlebotomy, ear syringing, suture removal
- Chronic disease monitoring – routine checks, and related data collection
- Screening test results will go directly to requesting physician
- Monitoring lab results to pharmacist/general practice nurse
- Carrying out requests from secondary care

Vaccination Services
HSCP/NHS Board Service

- Provide all vaccinations previously provided by GP practices.
- Travel vaccines and travel health advice

Case Study - community treatment and care services in Lanarkshire

In Lanarkshire, most GP practices have access to a 'Treatment Room' (TR) service which enables a range of procedures, many of which were previously provided by a GP or GP employed-staff. The service provides core services which includes, amongst others, wound management, venepuncture, injections and ear irrigation.

For routine needs, patients are provided with appointments at health centres. However, both GPs and Board run treatment rooms have retained flexibility in how they provide services in order to deliver the best experience for the patient. For example, some GPs will take blood samples when the patient is in their practice if they have a view that there is an urgent need or to do so or it is clinically appropriate for the patient.

The service is also helpful in allowing a range of patients, where appropriate, who would previously have required a domicillary visit from a District Nurse to now receive such treatment in a more appropriate clinical setting. This is also more efficient than a domiciliary service with attendant treavel time between visits.

TR services are staffed, where possible, with an appropriate skill-mix to reflect the range and quantity of interventions.

GENERAL PRACTICE NURSING

General practice nursing is an integral part of the core general practice team. The profession provides primary care services, mainly through GP independent contractor employment, including general nursing skills as well as extended roles in health protection, urgent care and support for people with long term conditions.

General practice nurses had a key role in the achievement of QOF points as part of the 2004 GMS contract. However, many in the profession felt that QOF greatly increased bureaucratic workload and had a negative impact on consultations, supporting "box ticking" rather than facilitating holistic and person-centred consultations. The new general practice landscape in Scotland will enable general practice nurses to have more meaningful person-centred consultations.

With a dedicated community treatment and care services delivered through HSCPs the 2018 GMS contract will support GPN to focus on a refreshed role in general practice as expert nursing generalists. They will provide acute and chronic disease management, enabling people to live safely and confidently at home and in their communities, supporting them and their carers to manage their own conditions whenever possible.

To fulfil the challenges associated with the increasing complexity and demand of primary care in Scotland the role and career pathway of general practice nursing will need to adapt and evolve. A 'one size fits all' approach may not be appropriate for all posts, but there will be a common pathway to a lead general practice nurse or advanced nurse practitioner careers. At the present time variation in terms of both job titles and training is evident within general practice nursing.

To support an enhanced role safely integrated into general practice it is critical that there are agreed role definitions supported by a robust career and educational framework. The Transforming Roles General Practice Nurses Group was established by the Scottish Government in 2017 to refresh the role and educational requirements of general practice nurses. This work will be taken forward jointly by the Scottish Government's primary care and Chief Nursing Officer Directorates in 2017/18.

GPNs require a significant breadth of knowledge and need to access appropriate structured education and training. Investing in general practice nurses provides a valuable opportunity to deliver a highly skilled 'fit for purpose' profession. The Scottish Government has invested £2 million in 2017/18 for additional training for general practice nurses in recognition of the importance of this role in the future delivery of care to patients in the primary care setting. This training will enhance the skills of general practice nurses so that they are better equipped to meet the increasingly complex needs of patients. This training enhancement will also make it easier for patients to access the right person at the right time.

The Transforming Roles General Practice Nurses Group will oversee the continued funding of training for general practice nursing to enable the on-going development of this critical workforce during the three year transition period as outlined in the MoU.

Given the changes in service redesign in primary care, demand for nursing staff in the community will increase. We anticipate continued employment of the nursing workforce in primary care by both NHS Boards and Independent Contractors. There will also be opportunities, if individuals wish, to change roles to take on new opportunities in the community treatment and care services; in general practice nursing, and in advanced nursing practice.

PRACTICE MANAGERS AND PRACTICE RECEPTIONISTS

Practice Managers play a key role ensuring the smooth and efficient day-to-day running of practices and the long term strategic management and co-ordination of primary care, including supporting the development of the multi-disciplinary team.

The role of the primary care manager was introduced in the 1980s as a senior receptionist/office Manager role. With the introduction of the Red Book contract in 1990, which coincided with the introduction of the first IT systems into general practice including automated call and recall systems and electronic appointment systems, the role began to evolve and become more commonplace.

The 2004 GMS Contract formally recognised the contribution effective practice management has on reducing the administrative burden on clinical staff and included a core competency framework for practice management.

Since 2004 the role of practice managers has adapted to meet a number of new challenges such as the development of practice IT systems; larger practice employed clinical and administrative teams; the increasing complexity of the GMS contract; and payment processes including the management of regularly changing QOF criteria and Enhanced Services. Practice managers have had a key role as facilitators of many of these changes. Indeed, many practice managers are now in senior management roles, however there nevertheless remains large variation in practice managers' roles, responsibilities and skills from practice to practice.

GP practice in Scotland has a highly skilled and experienced practice manager workforce. These managers have skills and experience which will be vital to ensure the success of the proposed new contract.

Practice managers already have a wide range of skills which will be essential for the future including financial management, IT management, HR management, contract management, leadership and facilitation, Quality Improvement skills, change management, communication and patient engagement skills. Work is ongoing with NHS Education for Scotland to identify and meet practice managers' training needs. Career development and succession planning will also be important considerations going forward.

The introduction of the proposed 2018 contract will increase the need for highly skilled practice managers with wide ranging, adaptable and versatile skills. In addition to continuing to manage the practice employed team, they will work more with the wider primary care system including GP clusters, NHS Boards, HSCPs, and emerging new services.

Alongside the changing role of practice managers, the roles of receptionists and other non-clinical staff in the practice have also evolved.

Practice receptionists have an important role supporting patients and enabling practices to run smoothly.

Opportunities to develop the skills of practice receptionists to support patients with information on the range of primary care multi-disciplinary team services available, or to increase their role in the management of practice documentation and work optimisation, are currently being explored with Healthcare Improvement Scotland (HIS). HIS will be working with GP clusters to develop training and resources to support these staff.

There is also a wide range of practice administrative staff carrying out a diverse number of tasks from prescription management, medical secretarial skills and IT management including call and recall, to documentation management, health and safety monitoring, and finance management. These staff are a highly skilled and adaptable workforce who will continue to have an important role in general practice in the future.

Strong leadership by practice managers supported by their teams, and by the practice GPs will be hugely important to the success of the proposed new contract and new ways of working.

IMPROVEMENTS TO REGULATIONS AND OTHER ISSUES

In addition to the proposals set out in previous chapters, a range of clarifications and improvements will be made to the underpinning regulations for General Medical Services contracts and Primary Medical Services contracts. These, and other issues not contained in underpinning regulations but pertinent to general practice, are set out below.

Indemnity

In the spirit of reducing risk for GPs, the Scottish Government and the SGPC are working collaboratively with Medical Defence Organisations to seek the best solution for indemnity in Scotland, following the announcement of changes to the discount rate in February 2017 and subsequent announcement by the UK Department of Health of its intention to introduce a state-backed scheme. The solution will take into account the indemnity needs of partners, locums and sessional GPs.

Temporary Residents

Practices are currently paid to treat Temporary Residents under the Temporary Patient Adjustment provisions of the Statement of Financial Entitlements. Before the 2004 contract this treatment was paid for by the temporary residents' fees, emergency treatment fees and immediately necessary treatment fees under the Red Book. All contractors currently receive a payment for unregistered patients as an element in their global sum allocation. The amount each contractor receives is generally based on the average amount that, historically, the contractor's practice claimed for treating such patients each year under the Red Book prior to 1 April 2003.

The Temporary Patient Adjustment leaves practices exposed to the risk of their number of Temporary Residents fluctuating while the resources to treat them remains constant. Under the new contract, practices will be required to report on numbers of Temporary Residents in 2018/19 to allow the Temporary Patient Adjustment to be reformed and uplifted on the basis that funding will follow activity as soon as practicable and by 2020/21.

Data also will be collected on activity around care homes to ensure that funding follows activity on a similar basis to Temporary Residents.

Dispensing

The current arrangements for dispensing in Scotland will not change under the proposed new contract. As part of the preparation for a Phase 2, we will establish a short-life working group to consider the current dispensing arrangements and look for any mutually beneficial improvements. Relevant interest groups will be consulted to ensure their views are incorporated.

Challenging Behaviour Scheme

All NHS Boards are required to establish a Violent Patients Scheme, the underlying purpose of which is to ensure that there are sufficient arrangements in place to provide general medical services to patients who have been subject to immediate removal from a GP's patient list of a general medical services contractor because of an act or threat of violence.

Under the new contract, this Directed Enhanced Service will be revised to introduce a greater degree of consistency across NHS Boards ensuring that practices and staff are protected from patients who have been violent or threatening.

Practice Areas

The current regulations provide limited information and guidance on practice areas beyond the need for practices to refer to their area by reference to a sketch diagram, plan or postcode in their practice leaflet. The new contract will clarify how practice areas should be agreed as part of the contract between NHS Boards and practices. The regulations will introduce processes for the formal variation of practice areas to ensure that NHS Boards do not make unilateral decisions and patient wishes are respected. This will enable practices to make changes in a timely fashion whilst ensuring that the interests of other practices in the vicinity are taken into account by NHS Boards.

Patients will retain the right to remain on the list of a practice if they live outwith a boundary which has been reduced. Not all patients will wish to remain on the list of a practice which no longer covers their area, and NHS Boards will be empowered to help practices rationalise their lists where patients are willing, even to the extent of assigning patients to practice lists which are otherwise closed where practices agree.

Practice List Closures

Under the current regulations practices must apply to their NHS Board to submit a notice to close their patient list. Closing a practice list is a last resort for a practice and the process for closing lists is intended to function as a failsafe to ensure that NHS Boards work with their contractors to keep lists open for patients wherever possible.

Under the new regulations, if NHS Boards have not completed discussions concerning support with practices within three months, a closure notice will be considered as accepted. Where assessment panels do not accept applications to close practice lists they should nonetheless agree the increase in terms of either a percentage of the current number of patients or an actual number of patients which would trigger a closure of the list.

Contract Disputes

The NHS Dispute Resolution procedure provides an inexpensive way for parties to the GMS contract to hold each other to account. Under the new contract the Local Dispute Resolution procedure will be formalised giving practices confidence that their disputes are recognised and are being taken forward

within specified timescales. Local dispute processes will address practice boundary and list closures. The constitution of local resolution panels will include: a representative from the NHS Board; a representative from the LMC; and an independent chair.

Certificates fees and charges

GPs are not always the best or only person to provide the various certificates prescribed in current regulations and this will be reflected in new regulations which will make alternative and routine providers clear.

The new regulations will provide a list of certificates which, through primary legislation, GPs are entitled to charge for providing. The regulations will be clear that other work falls outwith the GMS contract.

Emergency Responders

GPs have a professional duty to provide immediate and necessary treatment due to accident or emergency in their practice areas. However GPs should be understood as a last resort for these situations and the new regulations will reflect that.

Patient checks

The new regulations will clarify that while new patient checks will still be required, they can be conducted by members of the wider multi-disciplinary team.

All practices are currently required to offer patients who have not been seen within 3 years and patients aged 75 years and over (on an annual basis) appointments. Patients are not obliged to take up the offer.

As all patients are entitled to request an appointment with their GP regardless of when they last attended, these specific provisions will be removed from the existing regulations.

New practices

The arrangements for Phase 2 will include developing proposals for creating new practices. This will usually be in areas where the population is growing rapidly and established practices are unable to expand their patient list further. The proposals will include specific financial support for new practices while their list size is growing, and a mechanism to target size and a mechanism for establishing new premises. Additional funding for supporting new practices will not affect the funding of other practices as funding in Phase 2 will be practice specific.

Community hospitals

The current local arrangements for community hospitals in Scotland rest with HSCP and are unaffected by the proposed new contract. As part of the preparation for Phase 2, consideration will be given to reviewing the current arrangements and how they align with the proposed new contract and the role of the GP as expert medical generalist. Relevant interest groups will be invited to contribute to such a review process.

Primary Medical Services ("17C")

Alongside updating the NHS (General Medical Services Contracts) (Scotland) Regulations 2004 (17J), the Scottish Government and the SGPC have also agreed to update the NHS (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004. This will ensure that both contracts will support the transformation of primary care services and deliver significant benefits to patients, GPs and practice staff. The proposed changes outlined in this document will apply equally to both GMS contracts and 17C agreements. The intention is that practices in 17C and 17J will, in future, have equity of access to funding.

The revised sets of Regulations will not remove the right for any practice which currently operates under a 17C agreement to choose to revert to a 17J contractual status.

AFTERWORD

Much of the content of this document has focussed on improving the terms and conditions for GPs in Scotland – in particular, maintaining income stability, reducing workload and reducing risk. The ultimate reason behind all these proposals is to improve patient care. There is clear evidence to link workforce morale with better patient experience – with the new contract we have the opportunity to create a virtuous circle that delivers a thriving future for GPs and for patients.

In itself, a contract can never be the sole answer to the challenges facing primary care. However, the manner in which a contract is developed, agreed and implemented can demonstrate underlying common aims and purposes for mutual benefit. In complex and challenging times, a collaborative approach to a common vision certainly appears, based on our experience, far more productive and more likely to succeed.

We hope that the collaborative relationship which we have created to agree this contract will set the tone for the future of primary healthcare in Scotland. We have developed what could be called a Scottish Negotiating Approach which we agree has been essential to delivering this significant change. We set out initially to both develop and agree a vision for general practice and its place in the Scottish NHS of the future. We had no difficulty in agreeing that the very strengths of general practice are those core values which we wish to enhance and support to meet the needs of the people of Scotland. This is a bold statement of confidence that Scottish general practice is the right kind of medicine for the future.

Both the contract, and the surrounding support structures of the primary care multi-disciplinary team, are intended to enable GPs to be GPs. This approach will underpin delivery of the new contract as well as setting the direction for future development beyond the first three years.

This document describes a very significant degree of necessary system change. It is essential that patient safety and confidence is maintained during this change. Successful delivery will therefore require the support and commitment of all those in the health and care system. We all have a vested interest in the success of general practice and the primary care system for our patients, our families and our communities.

We all have to be active in managing our own care and health. To support this the contract is intended to ensure that GPs are available when needed to help the people of Scotland achieve the best agreed outcomes for their health. GPs will also have a clear role in assessing how well the health and care system delivers these outcomes and advising on how we might better improve on them. There will be better primary care services for patients, more time with a GP when it is really needed, quicker access to other healthcare professionals in the community and a more convenient, wider range of services.

We believe that these changes will enable the GPs of Scotland to make the best contribution possible to achieving better health outcomes. For those who are, or may aspire to become, GPs in Scotland, we invite you to join us in delivering, for the people of Scotland, better health and better care.

Shona Robison
Cabinet Secretary for Health

Alan McDevitt
Chair, SGPC

ANNEX

NATIONAL OUTCOMES Our children have the best start in life and are ready to succeed	We live longer, healthier lives	Our people are able to maintain their independence as they get older	Our public services are high quality, continually improving, efficient and responsive
We start well	**We live well**	**We age well**	**We die well**
PRIMARY CARE VISION Our vision is of general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multidisciplinary teams will deliver care in communities and be involved in the strategic planning of our services.			
HSCP OUTCOMES	***People can look after own health***	***Live at home or homely setting***	***Positive Experience of Services***	***Services improve quality of life***
Services mitigate inequalities	***Carers supported to improve health***	***People using services safe from harm***	***Engaged Workforce Improving Care***	***Efficient Resource Use***
PRIMARY CARE OUTCOMES				
We are more informed and empowered when using primary care	***Our primary care services better contribute to improving population health***	***Our experience as patients in primary care is enhanced***		
Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care	***Our primary care infrastructure – physical and digital – is improved***	***Primary care better addresses health inequalities***		

GLOSSARY

BMA – the British Medical Association, the registered trade union for doctors in the United Kingdom.

CQL – Cluster Quality Lead, a GP appointed by a NHS Board to coordinate a cluster.

EMG – Expert Medical Generalist, a GP when they are performing those GP roles and duties only a GP can do.

GMC – General Medical Council.

GMS – General Medical Services, the range of healthcare services that is provided by general practitioners under a General Medical Services contract with an NHS Board.

GMS contract – the national Scottish General Medical Services contract entered into under section 17J of the National Health Service (Scotland) Act 1978.

GP – General Practitioner, a doctor specialising in primary care and registered in the General Practitioner Register of the General Medical Council.

GP partner (as opposed to a GP) – a Partner in a GMS or 17C medical services practice.

GPN – General Practice Nursing.

HIS – Healthcare Improvement Scotland.

HSCP – Health and Social Care Partnership, the organisations formed as part of the integration of services provided by NHS Boards and Councils in Scotland.

IA – Integration Authority. Statutory body resposible for the planning design and commissioning of primary care services in Scotland.

LMC – Local Medical Committee, the local committees of the BMA representing general practitioners.

MDT – multi-disciplinary team, where primary care professionals work as an integrated team.

NHS – National Health Service.

PMS – Primary Medical Services.

PQL - Practice Quality Lead, the GP quality leadership role in practice.

PSD – Practitioner Services, the division of NHS National Services Scotland which, among other roles, processes payments for practices.

QOF – Quality and Outcomes Framework.

RCGP – Royal College of General Practitioners, the professional body for GPs.

2004 Contract– the national GMS contract prepared in accordance with the rules set out in The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004.

SAF – the Scottish Allocation Formula.

SGPC – the Scottish General Practitioners' Committee of the BMA.

TQA – Transitional Quality Arrangements.

Scottish Government
Riaghaltas na h-Alba
gov.scot

ISBN: 978-1-78851-347-0

This document is also available on The Scottish Government website:
www.gov.scot

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS305366 (11/17)

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Susan Manion

Agenda Item Number: 18

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	Adult Mental Health Services Transformation
Report By	Paolo Mazzoncini, Chief Social Work Officer/Head of Children and Criminal Justice Services
Contact Officer	David Aitken, Joint Services Manager Adult David.aitken@eastdunbarton.gov.uk 0141 355 2200

Purpose of Report	Summary briefing to HSCP Board on Draft Five Year Strategy for Adult Mental Health Services in Greater Glasgow & Clyde.

Recommendations	It is recommended that the Board notes the report and considers the strategic direction and implications.

Relevance to HSCP Board Strategic Plan	Glasgow City HSCP, on behalf of all six Partnerships, leads on the strategic planning for Mental Health and manages the inpatient services. This paper outlines the intent behind a new five year strategy which will lead to significant change across the system. We are working with Glasgow City HSCP and our Partnership colleagues to help shape the new strategy and are now considering the detailed implications locally of the proposed changes. It is anticipated that the final strategy will be put to Glasgow City HSCP by the end of March and our contribution will have been made by then. East Dunbartonshire's HSCP Board will receive a further update at its March meeting with a local plan in response, alongside the financial framework.

Implications for Health & Social Care Partnership

Human Resources	A requirement for staff engagement is acknowledged within the draft strategy to support staff through the change process. The proposals will have implications across acute and community services.

Equalities:	Policy, practise or activity may in this regard require to be assessed as to the impact on any individual or group of people with a protected characteristic as determined by the Equality Act 2010.

Financial:	There will be a supporting financial framework when our local plan is brought back to the HSCP Board in March.
Legal:	N/A.

Risk Implications:	These will be assessed in the coming period and reflected in our local plan. It is evident that the proposals are likely to see a reduction in the available in-patient beds available as plans move towards more community based services.

Implications for East Dunbartonshire Council:	To be determined when the Strategy and local plan are agreed

Implications for NHS Greater Glasgow & Clyde:	To be determined when the Strategy and local plan are agreed.

Direction Required to Council, Health Board or Both	**Direction To:**	**Tick**
	1. No Direction Required	**x**
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

1.0 MAIN REPORT

1.0 Background

1.1 Over the past two decades Adult Mental Health Services in Greater Glasgow and Clyde have been subject to transformational change with a pronounced shift in the balance of care significantly reducing the level of inpatient beds and reinvesting progressively in a community and specialist services with a subsequent improvement in quality.

1.2 The current service delivery model for mental health within NHSGGC was set out in an original framework and re-iterated in the subsequent NHSGGC Clinical Service Review of 2012-13.

1.3 Provision of mental health services have largely been planned and in some cases managed at a GGC level. As a hosted service this is widespread and detailed collaboration across the Partnerships to agree a single vision, taking into account local circumstances.

2.0 Strategy Drivers

2.1 HSCPs in NHS GG&C are working together to develop a whole system five-year strategy for mental health because:

- The adult mental health system is operating under unsustainable pressure with 3% annual growth demand and bed occupancy frequently operating at over 100%. There is no prospect of an easing of these pressures in the short to medium term.
- Implementing conventional efficiencies and seeking modest incremental change will not be sufficient to meet financial targets while maintaining safe and effective services.
- There is still some scope for system-wide pooling and consolidation of resources, including performance improvement, pathway redesign and innovative forms of support.
- Cross-system interdependencies are strong and complex, and need to be coordinated in a GGC-wide context

3.0 Principles and Levels of Care Underpinning the new Revised Strategic Approach

3.1 The strategy requires system wide engagement by all HSCPs, and of the NHS GG&C Board. The following principles underpin the 5 year strategy:

Key Principles

1. A whole-system approach to Mental Health across the NHS GG&C Board area, recognising the importance of interfaces with primary care, Acute, public health, health improvement, social care and third sector provision.

2. A model of stepped/matched care responding to routine clinical outcome measurement and with an emphasis on using low-intensity interventions whenever appropriate
3. A focus on minimising duration of service contact consistent with effective care, while ensuring prompt access for all who need it – the principle of "easy in, easy out".
4. Identification and delivery of condition pathways, based on the provision of evidence-based and cost-effective forms of treatment.
5. Attention to trauma and adversity where that influences the presentation and response to treatment.
6. Prevention and early intervention.
7. Recognition of the importance of recovery-based approaches, including peer support
8. Meaningful service user and carer engagement and involvement to help guide the implementation process
9. A workforce development approach that supports staff through the change process and equips staff with the necessary training and skills for the future
10. A robust risk management process to inform and guide the implementation process

3.2 The "care needed" means timely access to the full range of interventions recommended by NICE, SIGN, the Matrix and other accepted care standards in Scotland. Using a "stepped" or "matched" care model, services tailor the intensity of care provided to meet patient needs. To this end, five levels of care were identified:

- public health interventions,
- open access services that did not require referral and supported self-care
- Early responses and brief interventions
- longer-term multi-disciplinary ongoing care
- intensive treatment and support.

An "unscheduled care" element is also needed to respond to crises and emergency needs, for all conditions and setting.

4.0 Complex Adaptive System

4.1 Mental Health services can be considered to be a "complex adaptive system" in which each service element is dependent on many others to function properly. Changes in one part of the system are likely to have consequences elsewhere, and those inter-dependencies need to be identified and managed carefully.

4.2 To address the challenge ahead, the 5 year strategy is concentrating on the following 7 strands of work:

1. **Unscheduled care**, including crisis responses, home treatment, and acute MH in-patient care.
2. **Recovery-oriented care** including inpatient provision and a range of community-based services, including local authority and third sector provision.
3. **Well-being-orientated care including working with children's services** to promote strong relational development in childhood, protecting children from harm and enabling children to have the best start.
4. **Productivity** initiatives in community services to enhance capacity while maintaining quality of care
5. Medium-long term planning for **prevention** of mental health problems.
6. **Bed modelling** - **Short Stay mental health beds:** underpinning the first three strands is the need to estimate the number and type of hospital beds that the system needs to provide in order to deliver effective care.
7. **Shifting the Balance of Care - Rehabilitation and Long Stay Beds:** moving away from hospital wards to community alternatives for people requiring longer term, 24/7 care, with residual mental health rehabilitation hospital beds working to a consistent, recovery-focussed model.

Agenda Item Number: 19

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	11th January 2018
Subject Title	East Dunbartonshire HSCP Strategic Planning Group Minutes of 14th November 2017
Report By	Susan Manion Chief Officer
Contact Officer	Fiona McCulloch Planning performance & Quality Manager

Purpose of Report	This report provides the Strategic Planning Group Draft minutes for 14th November 2017 to inform the Board of the actions of the Strategic Planning Group

Recommendations	It is recommended that the HSCP Board note the content of the minutes.

Relevance to HSCP Board Strategic Plan	The Strategic Planning Group is established in accordance with section 32 of the Public Bodies (Joint Working) (Scotland) Act 2014, to provide views on the development, implementation and review of the East Dunbartonshire HSCP Strategic Plan. The role of the Group is to help determine the HSCP priorities, consider the effects of proposals for change, and make recommendations for the reallocation of resources through the Strategic Plan. At this meeting, the Group discussed the draft Strategic Plan 2018-21 and the draft eligibility criteria for carers and the questions for the consultation on the eligibility.

Implications for Health & Social Care Partnership

Human Resources	N/A

Equalities:	N/A

Financial:	N/A

Legal:	N/A

Economic Impact:	N/A

Sustainability:	N/A

Risk Implications:	N/A

Implications for East Dunbartonshire Council:	N/A

Implications for NHS Greater Glasgow & Clyde:	N/A

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	☐
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☐
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

EAST DUNBARTONSHIRE HSCP

Minute of the **Strategic Planning Group**

Tuesday the 14th of November at 2:00pm at EDVA, Kirkintilloch, G66 1NL

Present

Fiona McCulloch	Planning & Performance Manger (Chair)
Jean Campbell	Chief Finance and Resource Officer
Avril Jamieson	Carers Representative
Scott Lafferty	TSI Manager (Core Services)
David Aitken	Joint Integrated Services Manager
Lynette Harkins	General Practitioner
Gillian Notman	Occupational Therapy Professional Advisor/Change & Redesign Manager
Diane Meek	General Practitioner
Marion Menzies	Service User Representative
David Radford	Health Improvement Lead
Claire Carthy	Fieldwork Manager Children & Families

In Attendance

		Action
1	**Introductions & Apologies** Apologies: Susan Manion, Kathleen Halpin, Gillian Healey, Paolo Mazzoncini, Ian Brodie, Sandra Cairney, Janice Cameron.	
2.	**Notes of Previous Meeting & Action Plan Updates** The minutes of the meeting held on 15th August 2017 were accepted as an accurate record without amendment, and actions updated.	
3.	**Matters Arising** There were no matters arising	
4.	**Public Engagement Event Report** DR provided a verbal report outlining the process and main themes from the engagement events The themes were similar at each of the events, and have informed the priorities within the Strategic Plan. MM suggested that there was not enough notice given of the events, and that more agencies attended the Bishopbriggs event than service users. Attendees agreed that overall that they though the events went well and provided a good opportunity for people to contribute. DR was asked when the final report would be available. He explained that the report was being finalised and that it would be sent to all attendees as soon as it was completed. **Action: DR to send the final report to all attendees at the engagement events**	**DR**

5. Strategic Plan 2018-2021 Development Process

FMcC tabled draft copies of the Strategic Plan 2018-2021. There was general consensus that the format of the document was easy to read and that the priorities could be easily identified.

FMcC advised of the timescales for finalising the plan, informing the group that a draft would be circulated for comment, and asked that all SPG members share it and encourage comment from those they represent

6. Carers Eligibility Criteria Consultation

FMcC tabled a copy of the draft Carers Eligibility Criteria which will be consulted on in accordance with the Carer (Scotland) Act 2016. The group were informed that the consultation will take the form of a web based survey hosted on both the HSCP and Carers Link websites. There will also be engagement discussions with carers in Bearsden and Bishopbriggs.

The draft eligibility criteria and consultation questions were agreed.

Action: FMcC to inform the group when the consultation begins **FMcC**

7. Locality Planning Groups Update

GN informed the group that she had arranged to visit locality planning groups in other HSCPs to share structures, arrangements and progress. Visits have been arranged with N Ayrshire, Fife, and W Dunbartonshire. GN will update the group on the key learning points at the next meeting, and discuss in detail at the LPGs.

Action: GN to share key learning from visits to HSCP LPGs **GN**

8. PSU&C

AJ and MM informed the group that the PSU&C meetings had received informative presentations on GP clusters and finance, and further topics were arranged for forthcoming meetings. They also advised that service user and carer representatives have been identified for the LPGs.

9. Date of Next Meeting

FMcC informed the group that the meeting dates for 2018 would be circulated. Attendees were asked about the suitability of day, time and length of meeting. Wednesdays and Thursdays were not suitable for some members, and Tuesday afternoon was the preferred time by all present. It was agreed that the meetings should start later in the afternoon with a suggested finish of 4.30pm.

FMcC thanked the group for their suggestions, and will arrange for dates to be circulated

Action: FMcC to circulate meeting dates for 2018 **FMcC**

East Dunbartonshire Health & Social Care Partnership

`

Item 20

East Dunbartonshire HSCP Schedule of Topics / Business plan for HSCP Board meetings 2017 / 2018

HSCP Board Development Sessions
Half day Seminars – All held in Training Room 2 Enterprise House, from 9.15am to 12.30pm
4th April 2018 – Children & Families & Criminal Justice
Service Visits – All 10am to 11.30am
5th of February 2018 - Visit to Lennoxtown Community Hub
16th April 2018- Service visit to Woodlands Resource Centre
HSCP Board Meeting - 15th March 2018
Workforce Plan
Strategic Needs Assessment – Children and Young People
Annual Governance Documents / Control Lists
Annual Business Plan 2018/19
Performance Improvement Report – Quarter 3
Strategic Plan Final Draft
Draft Joint Health Improvement Plan
Mutual GGC Health Strategic Plan
Learning Disability Strategy
HSCP Board Meeting - 10th May 2018
HSCP Board Development – Topic specific seminar on this meeting date on Oral Health Directorate - 9am -930am only.
Register of Interests
Business Plan update
iMatter update

East Dunbartonshire Health & Social Care Partnership

HSCP Board Meeting - 28th June 2018
Annual Performance Report
Performance Improvement Report (SC) – Quarter 4
Carer Strategy Draft
OHD Performance Report for OHD and GGC - per Frances

ED HSCP BOARD - DISTRIBUTION LIST		
ED HSCP BOARD MEMBERS - VOTING		
Name	**Designation**	
Ian Fraser	Chair - NHS Non Executive Board Member	1
Susan Murray	Vice Chair -EDC Elected member	1
Sheila Mechan	EDC Elected member	1
Alan Moir	EDC Elected member	1
Jacqueline Forbes	NHS non-executive Board Member	1
Ian Ritchie	NHS non-executive Board Member	1
ED HSCP BOARD MEMBERS - NON VOTING		
Susan Manion	Chief Officer	1
Jean Campbell	Chief Finance & Resources Officer	1
Gordon Thomson	Voluntary Sector Representative	1
Martin Brickley	Service User Representative	1
Jenny Proctor	Carers Representative	1
Wilma Hepburn	Professional Nurse Advisor -NHS	1
Andrew McCready	Trades Union Representative	1
Gillian Cameron	Trades Union Representative	1
Lisa Williams	Clinical Director for HSCP	1
Adam Bowman	Acute Services Representative	1
Paolo Mazzoncini	Chief Social Work Officer	1
ED HSCP SUPPORT OFFICERS - FOR INFORMATION		
Linda Tindall	Organisational Development Lead	**e-copy only**
Sandra Cairney	Head of Strategy Planning and Health Improvement	1
Vacancy	Head of Adult and Primary Care Services	1
Fiona McCulloch	Planning & Performance Manager	**e-copy only**
Gillian McConnachie	Chief Internal Auditor HSCP	**e-copy only**
Karen Donnelly	EDC Chief Solicitor and Monitoring Officer	**Paper copy / e-copy**
Martin Cunnigham	EDC Corporate Governance Manager	7
John Hamilton	Head of NHS Board Administration	**e-copy only**
Louise Martin	Head of Administration, ED HSCP	**e-copy only**
Frances McLinden	General Manager, Oral Health Directorate	**Paper copy / e-copy**
Tom Quinn	Head of Human Resources	**e-copy only**
Sharon Bradshaw	Human Resources	**e-copy only**
For information only (Substitutes)		
Councillor Mohrag Fischer	EDC Elected member	**e-copy only**
Councillor Graeme McGinnigle	EDC Elected member	**e-copy only**
Councillor Rosie O'Neil	EDC Elected member	**e-copy only**
A. Jamieson	Carers Representative	**1 copy**
I Twaddle	Service User Representative	**1 copy**