For meeting on
9 November 2017

Agenda 2017

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, 9th November 2017** 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 **31st August 2017**

Seminar**: Not scheduled for this meeting**.

Item	Contact officer	Description	Page
STANDING ITEMS			
1.	Ian Fraser	Expressions of Interest	
2.	Martin Cunningham	Minute of HSCP Board held on 31st August 2017	1 - 6
3.	Susan Manion	Chief Officers Report	Verbal
GOVERNANCE ITEMS			
4.	Jean Campbell	ED HSCP Corporate Risk Register	7 – 14
5.	Jean Campbell	Financial Performance Period 6 and Budget 2017/18 Update	15 – 26
6.	Gillian Notman	Intermediate Care Unit Evaluation Report	27 - 46
7.	Sandra Cairney	East Dunbartonshire HSCP Board Complaints Handling Procedure	47 – 72

8.	Paolo Mazzoncini	Self-Directed Support: Audit Commission Follow Up Evaluation	73 - 78
9.	Paolo Mazzoncini	Adult Support and Protection Thematic Review	Verbal
10.	Fiona McCulloch	Performance Improvement Report – Q1	79 – 110
11.	Martin Brickley / Jenny Proctor	Public, Service User & Carer Representative Support Group report	111 - 120
12.	Lisa Williams	East Dunbartonshire HSCP Clinical & Care Governance minutes of meeting on 26th July 2017	121 – 130
13.	Jean Campbell	East Dunbartonshire HSCP Audit Committee Minutes of 26th September 2017	131 – 136
14.	Tom Quinn	East Dunbartonshire HSCP Staff Partnership Forum minutes of 18th September 2017	137 - 144
15.	Sandra Cairney	East Dunbartonshire HSCP Climate Change Duties	145 – 152
STRATEGIC ITEMS			
16.	Sandra Cairney	Strategic Plan development update	Verbal
17.	Sandra Cairney	Moving Forward Together: NHS GGC's Health and Social Care Transformational Strategy Programme	153 – 204
18.	Chris Bancroft	Springfield House Podiatry Service relocation, Bishopbriggs	205 – 210
19.	Susan Manion	East Dunbartonshire HSCP Strategic Planning Group Minutes of 23rd May and 15th August 2017	211 – 222
ITEMS FOR INFORMATION or NOTING			
20.	Susan Manion	Position paper and discussion document on a Regional Delivery Plan for the West of Scotland	223 – 308
21.	Susan Manion	Updated Strategic Management Team arrangements	309 – 316

FUTURE HSCP BOARD AGENDA ITEMS			
22.	Susan Manion	HSCP Schedule of Topics/Business Plan	317 - 318
23.		Date (s) of next meeting **Thursday 11th of January 2018** - Council Committee Room, Southbank Marina Future dates; 15th March 2018 10th May 2018 28th June 2018 Seminars will be held on **11/01/18** and **10/05/18** commencing at 9am.	

East Dunbartonshire Health & Social Care Partnership

Item 2

Minute of meeting of the Health & Social Care Partnership Board held within the Committee Room, 12 Strathkelvin Place, Kirkintilloch on **Thursday, 31 August 2017.**

Voting Members Present: EDC Councillors **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
G. **Cameron**	Trades Union Representative
W. **Hepburn**	Professional Nurse Advisor
A. **McCready**	Trades Union Representative
A **McDaid**	Trades Union Representative
P. **Mazzoncini**	Chief Social Work Officer
J. **Proctor**	Carers Representative
G. **Thomson**	Voluntary Sector Representative
I. **Twaddle**	Service User – Substitute Representative
L. **Williams**	Clinical Director for HSCP

Ian Fraser (Chair) presiding

Also Present:	F. **Borland**	HSCP Communications
	S. **Cairney**	Head of Strategy, Planning & Health Improvement
	J. **Campbell**	Chief Finance and Resources Officer
	M. **Cunningham**	Corporate Governance Manager
	L. **Johnston**	Clinical Service Manager Oral Health
	A. **Martin**	Head of Adult & Primary Care Services
	G. **McConnachie**	EDC Audit & Risk Manager
	F. **McCulloch**	Planning & Performance Manager
	L. **Tindall**	Organisational Development Lead

APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Councillor Mechan

CHAIR'S REMARKS

The Chair welcomed all present, particularly those attending their first meeting. The Chair also thanked Fiona Borland for her service to the Board and intimated congratulations on her new appointment. The Chair then paid tribute to Andy Martin on his impending retiral and thanked him for his long and distinguished service and commitment to Education, Social Work services and more recently as the Head of Adult & Primary Care Services.

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.

APPPOINTMENT OF VICE CHAIRPERSON

Nominations were sought from the EDC Councillors appointed to the Board for the position of Vice Chairperson of the East Dunbartonshire HSCP. The Board approved the nomination of Councillor Murray as Vice Chair of the HSCP Board.

PRESENTATION – UNSCHEDULED CARE

The Board heard from the Head of Adult & Primary Care Services on the topic of Unscheduled Care. The presentation included examination of the Unscheduled Care Action Plan; a Single Point of Access; Care Homes & their roles; complimentary alternatives including the current pilot flexible step/step down model; Improved Acute Services / Community Interface; and the importance of Information development and management to feedback into the model.

The Head of Adult & Primary Care was heard in response to members' questions and thereafter the Board thanked him for an informative presentation on a significant subject matter for all HSCPs.

1. MINUTE OF MEETING – 22 JUNE 2017

There was submitted and noted minute of the meeting of the HSCP Board held on 22 June 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:-

- Regional Plans for the delivery of Health & Social Care – meeting of All HSCP Chief Officers in the West of Scotland.
- NHS Staff Governance Committee – Annual Report – Tom Quinn's progress re joint staff governance arrangements.
- Development Programme – Session with Service Heads and visits to Services.
- Operational matters – thanks to Fiona Borland for her contribution over the past year and in particular to the Communications Framework**.**

Following consideration the Board noted the Report.

3. HSCP RISK MANAGEMENT POLICY

The Head of Strategy, Planning & Health Improvement submitted a Report, copies of which had previously been circulated, which provided the Board with a draft Risk Management Policy

Following discussion, the Board approved and adopted the Risk Management Policy.

4. FINANCIAL PERFORMANCE PERIOD 4 & 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 out turn for 2016/17 and presented the draft Annual Accounts.

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.

Following further consideration, the Board:-

a. Noted the performance of the budget i.e. a projected breakeven position for the year as at period 4 of 2017/18.
b. Noted the position in relation to the achievement of savings identified to deliver financial balance for 2017/18.
c. Noted the position in relation to Partnership reserves as detailed in 1.18.
d. Noted the risks associated with the delivery of a balanced budget as detailed in 1.19
e. Approved the proposed action in respect of the outstanding issue in agreeing the financial allocation to the HSCP from NHSGG&C relating to historic savings dating back to 2015/16.
f. Noted the updated position in relation to the allocation of Prescribing Budgets for 2017/18.

5. INTERMEDIATE CARE & DELAYED DISCHARGES - UPDATE

A Report by the Head of Adult & Primary Care Services, copies of which had previously been circulated, updated the Board on the recent developments and performance with respect to hospital discharge and intermediate care.

Following further consideration, the Board noted the Report.

6. HSCP SOCIAL WORK COMPLAINTS HANDLING POLICY & PROCEDURES

A Report by the Head of Strategy, Planning & Health Improvement, copies of which had previously been circulated, advised the Board of the requirement to develop a specific Social Work Complaints Handling Policy & Procedure based on the Scottish Public Service Ombudsman Model.

Following further consideration, the Board noted the Report.

7. CLINICAL & CARE GOVERNANCE ANNUAL REPORT

A Report, by the Head of Strategy, Planning & Health Improvement, copies of which had previously been circulated, summarised the Clinical & Care Governance activities across East Dunbartonshire and highlighted specific instances.

Following consideration, and having heard members in relation to the content, the Board noted and approved the Report as a demonstration of service users being provided with safe, effective and person-centred care.

8. CLINICAL & CARE GOVERNANCE MINUTES

The Board noted the Minutes of the Clinical & Care Governance Meeting of 31 May 2017.

9. JOINT STAFF PARTNERSHIP MINUTES

The Board noted the Minutes of the Staff Partnership Forum Meeting of 22 May 2017.

10. PROFESSIONAL ADVISORY GROUP MINUTES

The Board noted the Minutes of the Professional Advisory Group Meeting of 7 June 2017.

11. PUBLIC SERVICE USER & CARER REPRESENTATIVE SUPPORT GROUP

The Board noted the Minutes of the Public Service User and Carer Group of Meeting of 7 August 2017.

12. PROCESS FOR PREPARING THE HSCP STRATEGIC PLAN 2018 - 2021

A Report by the Head of Strategy, Planning & Health Improvement, copies of which had previously been circulated, informed the Board of the process and timescales for the development, engagement and compiling the HSCP Strategic Plan 2018-21.

Following further consideration, the Board noted that the Report and approved the process and timescales for preparing the Strategic Plan.

13. COMMUNICATION FRAMEWORK

A Report by the Head of Strategy, Planning & Health Improvement, copies of which had previously been circulated, provided the Board with a draft of the HSCP Communication Framework.

The Board approved the Communication Framework.

14. DRAFT HSCP WINTER PLAN 2017 - 18

A Report by Head of Strategy, Planning & Health Improvement, copies of which had previously been circulated, presented members with the HSCP Draft Winter Plan 2017/18.

Members noted that this first draft would be submitted to the Scottish Government by 31 August and the final Winter Plan was required to be submitted to the Scottish Government and made available online by 31 October 2017

Following further consideration the Board noted the report.

15. CHILD PROTECTION COMMITTEE - UPDATE

A Report by the Chief social Work Officer, copies of which had previously been circulated, updated the Board on the progress being made by East Dunbartonshire Council's Child Protection Committee (CPC) in driving forward key policy, legislative and service developments, and professional practice. It further highlighted important national developments around child protection, which would influence the direction of future work.

The Chief Social Work Officer responded to questions and following further consideration, the Board noted the Report and agreed to support the inter-agency work of the Child Protection Committee.

16. UNSCHEDULED CARE COMMISSIONING

A Report by the Head of Adult & Primary Care Services, copies of which had previously been circulated, updated the Board on the introduction of changes and additions to services to improve unscheduled care performance as per commitments made in report of 22 June 2017.

Following further consideration the Board approved the progression of the priorities outlined in the report and the use of financial reserves in the areas identified in the report.

17. WEST GLASGOW - MINOR INJURIES SERVICES

A Report by the Head of Adult & Primary Care Services, copies of which had previously been circulated, outlined the proposals for a joint NHS Board and HSCP process to review options for minor injuries in West Glasgow.

Following further consideration the Board noted the joint review of minor injuries services in West Glasgow to be undertaken with the NHS Board to cover the areas identified in the report, including:- Access; Demand; Financial Appraisal and Patient Engagement.

18. PLANNING AND DELIVERING CARE AND TREATMENT ACROSS THE WEST OF SCOTLAND

A Report by the Chief Officer, copies of which had previously been circulated, updated the Board on the work across Scotland to develop Regional Plans for the

delivery of Health and Social Care. A report had been drafted by John Burns the lead Health Board Chief Executive for this process in the West of Scotland. It outlined the requirement to produce the first Regional Delivery Plan by March 2018 and sought the support of Health Boards and Integrated Joint Boards to work collaboratively to achieve the best outcomes delivered sustainably for the citizens across the West of Scotland.

Following discussion, the Board noted the report and the active involvement of the Chief Officer in this project.

19. THEMATIC INSPECTION OF ADULT SUPORT 7 PROTECTION IN EAST DUNBARTONSHIRE

A Report by the Chief Officer, copies of which had previously been circulated, informed the Board of the planned thematic inspection by Care Inspectorate, of Adult Support and Protection (ASP) services in East Dunbartonshire.

Following discussion the Board noted the report, intimated support for the work underway in preparation for the thematic inspection and agreed that a further report would be considered upon completion of the full inspection.

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

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

Following consideration, the Board noted the information.

21. DATE OF NEXT MEETING – 9 NOVEMBER 2017

The HSCP Board noted that the next meeting would be held on Thursday 9 November 2017 in the Council Chambers / Committee Room.

Future dates were also provided as under:-

11th January 2018	15th March 2018
10th May 2017	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.

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 4

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	Thursday 9th November 2017
Subject Title	ED HSCP Corporate Risk Register
Report By	Jean Campbell Chief Finance and Resources Officer
Contact Officer	Jean Campbell 0141 232 8237 Jean.campbell@ggc.scot.nhs.uk

Purpose of Report	To provide the HSCP Board with an update of the Corporate Risks and how they are managed.

Recommendations	The HSCP Board is requested to review the Corporate Risk Register and approve the content.

Relevance to HSCP Board Strategic Plan	High level risks may impact on certain areas within the Board Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	The Senior Management Team are required to review the Corporate Risk Register twice per year.

Equalities:	Nil

Financial:	Nil

Legal:	The H&SCP Board is required to develop and review strategic risks linked to the business of the Board twice yearly.

Economic Impact:	Nil

Sustainability:	Nil

Risk Implications:	This risk register is an aggregate of all service specific Risk Registers and control measures must be reviewed and updated regularly to reduce risk.

Implications for East Dunbartonshire Council:	The H&SCP Board Risk Register contributes to East Dunbartonshire Council Corporate Risk Register and ensures the management of the risks with robust control measures which are in place.

Implications for NHS Greater Glasgow & Clyde:	The H&SCP Board Risk Register contributes to NHS GG&C Corporate Risk Register and ensures the management of the risks with robust control measures which are in place.

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 The attached HSCP Corporate Risk register reflects the HSCP Board's Commitment to a culture of improved performance in the management of Corporate Risks.

1.2 Individual Service Risk Registers are reviewed and updated on a quarterly basis by the Operational Leads within the HSCP.

1.3 The Corporate Risk Register is reviewed twice per year by the Senior Management Team and updated.

1.4 The Risk Register provides full details of all current risks, in particular high level risks and the control measures that are in place to manage these. The Corporate Risk register at October 2017 has been approved by the Senior Management Team.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Completed by	Jean Campbell	Date created/ updated	November 2017

Risk is the chance of something happening which will cause harm or detriment to the organisation, staff or patients. It is assessed in terms of likelihood of an event occurring and the severity of its impact upon the organisation, staff or patients.

The Shadow Integration Joint Board has adopted the following scoring system which enables risks to be prioritised.

Likelihood (L)		Consequence (C)		Risk (LxC)	=	Priority
Almost certain	5	Extreme	5	20 - 25	=	Priority 1: VERY HIGH
Likely	4	Major	4	12 - 16	=	Priority 2: HIGH
Possible	3	Moderate	3	6 - 10	=	Priority 3: MEDIUM
Unlikely	2	Minor	2	1 - 5	=	Priority 4: LOW
Rare	1	Negligible	1			

The Boards Shared Risk Register comprises those risks that have been assessed as being high or very high.

Risk Appetite/Tolerance matrix

Likelihood	Consequence /Impact				
	1 - Negligible	2 - Minor	3 - Moderate	4 - Major	5 - Extreme
Almost Certain - 5	5	10	15	20	25
Likely - 4	4	8	12	16	20
Possible - 3	3	6	9	12	15
Unlikely-2	2	4	6	8	10
Rare - 1	1	2	3	4	5

Risk Reference	Risk Event	Cause	Effect	Category of risk	Control Measures	Residual Likelihood	Residual Impact	Rank (Equals L*I)	Priority	Strategy for Risk	Risk Management Actions	Acceptable Likelihood	Acceptable Impact	Rank (Equals L*I)	Priority	Risk Owner
HSCP1	Failure to rebalance care from hospital to community settings in line with the Strategic plan	Lack of resource(Housing, Care Home,Personnel,Community Packages) Increased demand in Acute Sector Carer and Service user expectations Underdeveloped low level and preventative services	Delays in discharging patients to appropriate settings. Cost implications Quality of Life Poorer outcomes	Service User	Strategic plan with accompanying Financial plan and Performance Management Framework. Unscheduled Care Plan Older People Plan Workforce Plan.	4	4	**16**	**2**	Tolerate	Range of Strategic Planning Groups to provide reporting frameworks to SMT, outlining progress against priorities.	4	4	**16**	**2**	Chief Officer
HSCP2	Inability to effectively manage demand on financial capacity.	Demographics;OP, LD, Children's service and Criminal Justice Increasing number of vulnerable children identified and referred to social work Changes in legislation / Statutory requirements / Policy context, SDS, Carers legislation, Children and Young Person (Scotland) Act Criminal Justice redesign Lack of provision/alternative services Enhanced early identification/diagnosis i.e. autism Expectations in society built up over 20-30years Increased cost of services Savings realisation year on year. Inadequate Infrastructure Insufficient Resource to meet need Ineffective communication with Service Users and Carers Relaxed requirements around SDS training and registration of carers	Budgetary restriction elsewhere in Social Work or Council Reduced ability to maintain Service Levels Reduction in jobs Budgets overcommitted Political implications Reputational damage Policy changes Inadequate care arrangements for vulnerable adults and children Financial impact due to double funding requirements through service default Potential exploitation of Service users Deconstruction of In-house provision Litigation Demoralised workforce (poor staff morale) Absence levels Increased scrutiny Injury to service users	Financial	Financial Regulations Eligibility criteria Internal Budget controls/Management systems Internal Audit Policy and Procedure guides Budget Management processes Training and Awareness for managers Resource Screening groups	4	4	**16**	**2**	Treat	Liaison with other Chief Finance Officers Homecare Review Introduction of CM 2000 Learning Development Programme Infrastructure being developed Staff training - including forthcoming policy and legislation Children Services Strategic Review	4	3	**12**	**2**	Chief Officer
HSCP3	Failure of protection procedures for vulnerable adults and children at risk.	Disjointed communication, insufficient scrutiny and monitoring of commissioned services, insufficient staffing. Lack of clarity around roles and responsibilities Inadequate training. Inconsistent assessment and application of protection procedures.	Death or Injury to Service user Reputational damage Litigation Poor Staff morale. Legislative requirements not being complied with.	Health and Safety	Work plan in place for audit, training & development. Robust policies and procedures are in place and have been communicated through all partner organisations. An ongoing comprehensive training programme is in place. Monitoring systems are established and all adverse events investigated and reported for learning outcomes at Child Health Steering TGroup and periodic reporting to the NHS Board. Audit availability of Child protection information in all clinical areas. All appropriate partner organisations staff complete child protection training and participate in audits, adverse event reviews and improvement plans. East Dunbartonshire Adult Protection and Child Protection Committees . Use of Anticipatory Care Plans (ACP's) to ensure identification of protection issues. Multiagency training available to staff. Primary Care Adult Protection Group	2	5	**10**	**3**	Tolerate	GGC Primary Care Child and Adults Protection Groups, HSCP Child and Adult Protection Groups, Public Protection structures in the process of being developed. Actions taken in PLACE communities. Targeted investment. Reporting mechanisms. Performance management	2	5	**10**	**3**	Chief Officer
HSCP4	Inability to effectively manage Data Protection Standards	Structural changes require new and more sophisticated forms of data management. Lack of understanding and awareness of Data Protection rules Increasing demand and competing priorities cause workers to have decreased awareness and lessened regard for Information Security. Inadequate training for staff and use of technologies. New duties incorporated within the Children and Young Person (Scotland) Act - in particular the named person	Breach of Information management legislation. Financial impact Increased external scrutiny Reputational damage Litigation	Data Protection	Information sharing protocols, Commissioning Strategy Codes of Practice Guidance - Information Commissioners Office External Scrutiny systems - (Care Inspectorate) Procedures are in place on all sites for use/release of data, including Multi-Agency Public Protection Arrangements (MAPPA) related information, monitoring of Information Governance Standards and Security Policy, Caldecott Guardian responsibilities, Information Sharing Protocols, NHSGGC-wide Information Governance Steering Group. All laptops (now including University equipment) encrypted. Information Sharing Protocol (endorsed by the Information Commissioner) in place. New information governance policies approved. New e-mail policy in place. Extended use of electronic records. A programme of work re the systematic audit of access to electronic records is being extended beyond the Emergency Care Summary. Access is controlled via a role based access protocol signed off by senior clinicians and the Caldecott Guardian. An on-going programme of awareness and training will continue.	3	4	**12**	**2**	Treat	SMT implements and reviews governance arrangements to comply with legislative requirements.	2	3	**6**	**3**	Chief Officer
HSCP5	Medication errors	Errors in patient information Errors in drug information Poor or inadequate communication Inadequate medication storage, stock, standardization, and distribution Drug device acquisition, use, and monitoring Environmental factors Staff education and competency Patient education Poor quality processes and risk management. Failure of Compliance with mediation protocols amongst partner organisations	Death or Injury to Service user Reputational damage Litigation Poor Staff morale .Wasteful expense on medication	Health and Safety	Regular training for employed staff, educational events for contractors, complaints handling procedures within Partner Organisations Monitoring by Clinical Governance Group. PC Support Pharmacy Programme. Enhanced Pharmacy support to Care Homes. Improved transition protocol.	4	3	**12**	**2**	Treat	Public and Patient awareness. Appropriately trained pharmacy team and nursing staff.	3	3	**9**	**3**	Chief Officer
HSCP6	Failure to comply with requirements of Patients Rights Act (Scotland) act 2012 in relation to New Ways of Working. Failure to raise awareness of complaints process to patients	Failure to prepare staff to interpret New Ways of Working, failure to raise patient awareness of this. Patients lack of understanding of complaints process, how to complain and who can assist with complaints	Reputational damage Litigation Regulatory censure	Regulatory	Awareness raising for New Ways of Working is in place. Description of criteria displayed on the NHS GGC Website.A range of staff protocols ahve been developed to enable staff to responde to feedback, on concerns, comments and complaints.	3	3	**9**	**3**	Treat	Staff have received training on the New Ways of Work and are now knowldgemable on 18 week RTT and management of waiting times. A range of staff protocols have been developed to enable staff to responde to feedback, on concerns, comments and complaints.	2	3	**6**	**3**	Chief Officer
HSCP7	Inability to maintain continuity of service due to catastrophic events e.g. Pandemic Flu). Failure to respond effectively to major emergencies/incidents.	Poor/ineffective Civil contingencies planning, Lack of suitably trained resource, Disjointed partnership working.	Death or Injury to Service user Reputational damage Litigation Poor Staff morale Legislative requirements not being complied with. Disruption to services. Loss of life or injury to public and or staff across the HSCP. We do not fully meet the requirements of the Civil Contingency (Scotland) act 2005.	Business Continuity	Major incident plans and associate guidelines; Control of Major Accident Hazard Plans; Regular testing and updating of emergency plans (multi-agency response); Business Continuity Plans; Comprehensive plans for a Pandemic outbreak; Formal meetings and co-ordination between Partner Organisations; Strategic planning meetings; Acute Division Civil Contingencies meetings; Comprehensive exercise programme. In the event of a pandemic: - CEO chairs weekly meeting of Pandemic Executive Group; - Daily conference call on Pandemic Flu; - Daily sickness monitoring; - Regular reports to the NHS Board.	3	4	**12**	**2**	Treat	Business Continuity plans. Mutli agency working. Compliance with national alerts. Civil contingency. Prevent training. Winter planning.	3	4	**12**	**2**	Chief Officer
HSCP8	Failure to secure the annual revenue budget allocation to support delivery of the Strategic Plan.	Deterioration in Financial Settlements from Scottish Government and Constituent Bodies that are worse than currently reflected in the Financial Planning Assumptions; Delays to budgeted savings and planned cost efficiencies are delayed or not fully deliverable. Escalation in anticipated cost pressures due to matters out with the partnerships ability to influence and control. Increase in demographic pressures from older people and demand pressures in respect of transitions and Children's Services.	Overspends within financial years; Depletion of Contingency & General Reserves; Requirement to make unplanned reactive savings and service reductions with a short lead-in period during financial years Reduced ability to deliver planned application of resources to priority areas due to the need to address emerging cost pressures.	Financial	Robust financial planning to predict areas of future cost pressure and factoring all variables in assumptions with sensitivity testing of varying scenarios. Detailed scoping of business cases to determine and give assurance on the level of financial savings with governance provided by the HSCP Board and transformational arrangements within constituent bodies. Regular review of future year demand pressures a to be represented to the IJB and constituent bodies. Financial Risk Register - reviewed by the SMT to assess the short-term risks to resources facing the Partnership	3	4	**12**	**2**	Treat	Informed negotiation and discussion with constituent bodies on the implications of poor settlements. Robust action plans and direction of reserves to maximise impact on future service redesign.	3	3	**9**	**3**	Chief Officer

Risk Reference	Risk Event	Cause	Effect	Category of risk	Control Measures	Residual Likelihood	Residual Impact	Rank (Equals L*I)	Priority	Strategy for Risk	Risk Management Actions	Acceptable Likelihood	Acceptable Impact	Rank (Equals L*I)	Priority	Risk Owner
HSCP9	Failure to secure effective service delivery from Support and Hosted services	Increasing demands on staff Shared electronic systems Limited resources to implement CareFirst Reliance on multiple/obsolete systems Competing Priorities Poor Communication Lack of clarity around roles and responsibilities	Failure to accurately assess and respond to risk Failure to effectively and securely store and retrieve records Inability to effectively and timeously share SDS information Inability to be effective in electronic management and communication (e.g. arranging meetings) Inability to progress service redesign in delivery of the strategic priorities for the partnership.	Service Delivery	Staff Training Technology Infrastructure. Engaged in Board wide process to ensure proportionate allocation. Chief Officer attend constituent body CMT / SMT meetings.	3	3	**9**	**3**	Treat	Re-structuring senior management to ensure proper representation on board wide groups. Chief Officer Group. Chief Finance Officer group. Strategic Planning Group. Audit Committee. Primary Care representative on strategic group. Hosted Services monitored through the HSCP Board and SMT	3	3	**9**	**3**	Chief Officer
HSCP10	Inability to recruit, retain the appropriate numbers of trained staff to meet requirements resulting in reduction in service.	The reduction in numbers of registered staff in post. Aging workforce able to retire, limited numbers of staff in training to take up post requiring a secondary qualification, changes in registration requirements, changes to service workforce requirements to meet patient pathways, small workforce lack of opportunities for promotion, local labour market shortages for general posts. Possible delay in recruitment	Unable to provide/arrange care services Inability to meet statutory requirements/duties Service is reduced Fragmented services Increased complaints Service user detriment Reputational damage	Service Delivery	Local workforce plan in place, Robust Recruitment Processes, SMT report on vacancies, Work with Medical Staffing to monitor any medical short falls. Local intelligence on labour market trends,	3	3	**9**	**3**	Tolerate	Develop workforce plan for 2018-21 inline with HSCP Strategic Plan. Revised recruitment protocol in place to support SMT overview of workforce issues.	2	3	**6**	**3**	Chief Officer
HSCP11	Failure of contract compliance framework.	Ineffective monitoring of contract management services. Failure to follow established procedures for commissioning. Limited resources re-directed to other commissioning priorities. Lack of proper, effective contracts in place with clear service specifications.	Limited monitoring of auditing of contracts/services across adult services Failure to meet legal & inspection requirements. Failure to satisfactorily measure quality of service provision. Failure to secure best value	Governance	Performance and management scrutiny by the planning and commissioning via the contract management framework Workload prioritisation by P & D team Partnership working with care providers in Care Inspectorate. Liaison with legal and procurement to ensure adherence to legislation and support to deliver.	3	3	**9**	**3**	Treat	Internal Audit scrutiny and Action plan. Review of staffing structures to ensure priority reflected and establish contract monitoring team.	2	3	**6**	**3**	Chief Officer
HSCP12	Failure of external care provider to maintain delivery of services.	Collapse of Care Provider; care homes and practice failures. Capacity of market, staff recruitment issues, impact of living wage changes, failure of business continuity procedures, contractual negotiations through procurement.	Unable to provide/arrange care services Inability to meet statutory requirements/duties Service is reduced Fragmented services Increased complaints Service user detriment Reputational damage	Service Delivery	Financial Monitoring system Contingency planning arrangements Contract Management Framework Regulation/Inspection Performance improvement Internal Audit Service user feedback mechanisms - including complaints procedures	3	3	**9**	**3**	Treat	Support to providers. Provider Forums. Care home liaison. Contract Management Framework liaison post.	3	3	**9**	**3**	Chief Officer
HSCP13	Failure of infection Control	Failure to comply with national patient safety programmes; audits and inspections Lack of suitably trained resource, Disjointed partnership working.	Death or Injury to Service user Reputational damage Litigation Poor Staff morale Legislative requirements not being complied with.	Health and Safety	Development of local action plan, current overall NHS Board action plan in place Implement the Patient Safety Programme and prescribing audits. HSE Implementation Plan / Complaints	3	3	**9**	**3**	Treat	Scottish Patient Safety Programmes. Action Plans to ensure that HSE Implementation plan is in place and updated. Core audit results reviewed and acting plans implemented if failure to reach targets on hand hygiene. Action Plans. Robust monitoring of standards through SMT and Operational groups.	2	3	**6**	**3**	Chief Officer
HSCP14	Significant IT failure impacting on Service delivery	Lack of or ineffective contingency planning Outdated or unreliable IT systems Lack of trained resource	Loss of or disruption to service Reputational damage Litigation Unforeseen costs Death or injury to Service User	Service Delivery	Business Continuity Planning. ICT Steering Group	3	3	**9**	**3**	Treat	Action Plan - SCIs. Implement Emmis. Updating Care first. Joint IT Forum. Reviewing, testing and updating the Business Continuity Plan on a regular basis. Contingency plans in place through Business Continuity Planning	2	3	**6**	**3**	Chief Officer
HSCP15	Failure to implement performance management systems to measure,analyse,interpret and report on national and local outcome indicators and targets.	Lack of clarity around roles and responsibilities Inadequate training Incompatible IT systems Lack of clarity around the totality of Performance Requirements	Inability to accurately measure Service Delivery Inability to effectively benchmark Ineffective resource allocation	Strategic	Develop and implement a robust performance management framework to inform progress against Strategic Plan priorities	3	3	**9**	**3**	Treat	Develop a matrix management approach to performance management and increase capacity within the team. SOP in place to meet all statutory	3	3	**9**	**3**	Chief Officer
HSCP16	Inability to secure capital funds to meet the priorities in the Strategic Plan.	Deterioration in Financial Settlements from Scottish Government and constituent bodies that are worse than currently reflected in the Financial Planning Assumptions. Conflicting Priorities. Lack of appropriate future planning to meet capital needs.	Inability to deliver aims of the Strategic plan.	Financial	Local Authority and Health Board capital Planning Groups	3	3	**9**	**3**	Treat	Capital / Accommodation Strategy. Establishment of a joint forum for progressing discussions on joint initiatives. CO representation on respective partner CMT's / CO Group to ensure priorities are reflected in wider planning assumptions.	2	3	**6**	**3**	Chief Officer
HSCP17	Inability to meet new and existing duties/ Statutory requirements	Substantial and multiple legislative changes across a range of disciplines within the same time period. Increased complexities of risk which require to be managed Cross cutting issues that are complex(e.g. mental health addictions) at a time when there is significant structural changes (Integration) Staffing issues (Inadequate , Staff turnover) Lack of experienced staff.	Service users sustain increased levels of harm Reputational damage Increased litigation Demoralised workforce Poor staff morale Public protection compromised	Service Delivery	Multi-agency planning forums (e.g. DCYPP) Multi-agency training Policies and Procedures Capacity Planning Eligibility Criteria Equality Impact Assessments	2	4	**8**	**3**	Treat	SMT implement process to review and scrutinise compliance against statutory requirements.	2	4	**8**	**3**	Chief Officer
HSCP18	Failure to meet regulatory and inspection requirements	Pattern of increasing demand against reducing resource base. Increased national expectations. Inability to meet training requirements Physical environment Underinvestment Inability or delay in recruitment of key staff	De-registration Inability to deliver core services Increased scrutiny Adverse publicity Low staff morale	Regulatory	Training Care Inspectorate Preparation. Care Inspectorate Improvement action plans in place. LAN Corporate Reporting Internal Quality Assessment Quality assurance Management Minimum qualification requirements Chief Social Work officer oversight Quality care Standards Internal CMT scrutiny	2	4	**8**	**3**	Treat	Staff training, proper arrangements in place for registration with SSSC. Secure post within homecare structure to focus on service improvement and preparation for inspection. SOP in place to meet all statutory requirements.	1	4	**4**	**4**	Chief Officer
HSCP19	Failure to effectively manage levels of violence to staff	Increasing levels of resistance to interventions by service users New Risk connected to Social networking - web usage Public expectation/Changes to Service Delivery Technology moving more quickly in wider population	Staff stress levels increasing Increased absence levels Lack of interaction Defensive Reputational damage Physical and Emotional Harm to staff	Health and Safety	Violence against Staff Policy (Under Review) Lone Working policy in place. Enhanced use of technology within EDC (CCTV,Buzzers,Panic alarms, Mobile phones) Staff supervision Staff briefings Warning Management system - Care first VTS Working group Health and Safety Committee Reporting of all incidents and near misses in accordance with procedures and undertaking of appropriate follow up action.	2	4	**8**	**3**	Treat	PIN POINT alarm is active. Training and induction on De escalation training. Monitoring through Datix. SM2000. Policies in place . Environmental assessment.	2	4	**8**	**3**	Chief Officer

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 5

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	Financial Performance Period 6 and Budget 2017/18 Update
Report By	Jean Campbell Chief Finance and Resources Officer
Contact Officer	Jean Campbell 0141 232 8237 Jean.campbell2@ggc.scot.nhs.uk

Purpose of Report	To update the Board on the financial performance of the partnership as at period 6 of 2017/18 and to provide an update on the finalised budget for 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 6 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 1.19 e. Approve the proposed action in respect of the additional savings required in respect of the allocation from East Dunbartonshire Council

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 6 reporting cycle for the period to the 30th September 2017. It is mid-way through the financial year and 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 6 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	21,569	11,217	11,153	63	200
ED Social Care Fund £250m +£100m)	6,000	3,000	3,000	0	0
Oral Health	10,094	4,945	4,713	232	0
FHS & Prescribing	43,509	22,170	22,170	0	0
Adult Social Care	39,379	17,255	17,133	122	(993)
Children & CJ Services	11,296	5,672	6,013	(341)	(885)
Care of Gardens	78	39	39	0	0
Adaptations (PSHG)	450	225	225	0	0
Care and Repair	214	107	107	0	0
Fleet	452	226	226	0	0
SUB-TOTAL	**133,041**	**63,856**	**63,780**	**76**	**(1,678)**
Acute Set Aside	17,381	8,691	8,691	0	0
TOTAL	**150,422**	**72,547**	**72,471**	**76**	**(1,678)**

HSCP Budget Outturn

1.3 The current position indicates a projected overspend of £1.7m for the Health & Social Care Partnership (HSCP) for the year to 31st March 2018. The year to date position is showing to be on budget, albeit there are a number of variations within this in relation to emerging pressures in Children's Social Work Services and some capacity in 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 is expected 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 6 month period to the 30th September 2017.

1.10 The projected out turn for the health element of the partnership budget is that of £200k underspend at this point in the financial year.

1.11 The current year to date position shows an underspend of £295k 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 – July 2017. This was showing that prescribing expenditure, for East Dunbartonshire, was running slightly ahead of budget at that point to the tune of £9k. 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 a favourable variance of £78k, however this will change as efficiency programmes are progressed and the pressures resulting from short supply of certain drugs is quantified. The Board is reporting a projected breakeven for the year. 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 6 month period to the 30th September 2017.

1.17 The projected outturn for the Social Work element of the partnership budget is that of an overspend of £1.9m at this point in the financial year. This is caveated with concerns regarding the delay in processing payments to care providers which may not accurately be reflected in the financial information system 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 £221k which relates to emerging pressures in relation to residential and fostering placements for children.

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 emerging 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 will commence in mid-November when the Project Manager will take 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.**

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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.

2.0 Financial Planning 2017/18

2.1 Following the last IJB report on the 31st August 2017, there has been further discussion with East Dunbartonshire Council Chief Executive and Chief Finance Officer regarding savings identified in relation to total resourcing and transformational savings primarily in the areas of overtime, mileage and the use of agency staff for Social Work. The partnership had previously reported its intention to assume these savings to address the £500k shortfall in the partnership's savings programme; however this does not align to assumptions made in the financial planning for the Council.

2.2 It is acknowledged that further budget reductions would not comply with the Scottish Government circular as part of the financial settlement to both the NHS and local authorities which provided that to reflect additional support to partnerships in relation to further delivery of the living wage, Local Authorities will be able to adjust their allocations to IJBs in 2017/18 by **up to** their share of £80m below the level of budget agreed with the IJBs for 2016/17. The share of this for East Dunbartonshire is £1.38m The full extent of this reduction in the settlement to the partnership was made from East Dunbartonshire Council.

2.3 Therefore similarly to the agreement reached in respect of the health settlement and the issue pertaining to previously unallocated savings of £3.6m, the partnership will adopt a similar position for the Council in that the additional savings will be taken as a one off in year recharge as opposed to a budget reduction on the proviso that a recurring solution be found to accommodate these savings going forward. This equates to £306k for the partnership and has been reflected in the current forecast position for Social Work Services. This ensures that the 2017/18 budget for the IJBs remains compliant with the Scottish Government settlement.

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NHS Greater Glasgow & Clyde

East Dunbartonshire Hscp: Summary by Care Group Report as at Month 6, 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	345.1	336.8	8.3	57.5	52.6	5.0
Adult Community Services	4,371.9	2,181.0	2,191.6	(10.7)	364.9	351.3	13.6
Integrated Care Fund	684.2	2.9	4.1	(1.3)	3.9	0.8	3.1
Child Services - Community	1,386.4	694.2	655.0	39.2	115.7	101.0	14.7
Fhs - Prescribing	18,920.3	9,507.3	9,507.4	(0.1)	1,454.0	1,454.1	(0.1)
Fhs - Gms	12,940.3	6,807.1	6,807.1	0.0	1,340.9	1,340.9	0.0
Fhs - Other	12,932.1	6,525.3	6,525.3	0.0	1,040.2	1,040.2	0.0
Learn Dis - Community	611.8	305.1	243.9	61.2	50.6	48.0	2.7
Men Health - Adult Community	1,356.0	677.4	691.1	(13.8)	112.7	116.5	(3.8)
Men Health - Elderly Services	731.7	364.7	416.2	(51.5)	73.7	87.8	(14.1)
Oral Health	10,879.2	5,342.9	5,111.2	231.7	866.7	822.0	44.6
Other Services	2,660.9	1,130.8	1,102.2	28.6	165.2	262.2	(97.1)
Planning & Health Improvement	659.4	380.7	377.5	3.2	57.2	50.9	6.2
Resource Transfer - Local Auth	15,345.8	7,638.3	7,638.3	0.0	1,273.0	1,273.0	0.0
Expenditure	84,170.1	41,902.8	41,607.7	294.8	6,976.2	7,001.3	(25.2)
Adult Community Services	(0.2)	(0.2)	(0.2)	0.0	0.0	0.0	0.0
Fhs - Other	(1,283.2)	(668.6)	(668.6)	0.0	(122.5)	(122.5)	0.0
Men Health - Adult Community	(218.7)	(113.9)	(113.9)	0.0	(19.0)	(19.0)	0.0
Men Health - Elderly Services	(161.8)	(68.9)	(68.9)	0.0	(11.5)	(11.5)	0.0
Oral Health	(784.9)	(398.4)	(398.4)	0.0	(114.4)	(113.9)	(0.5)
Other Services	(213.1)	(145.7)	(145.7)	0.0	(6.9)	(7.0)	0.0
Planning & Health Improvement	(28.2)	(21.3)	(21.3)	0.0	(3.8)	(3.8)	0.0
Resource Transfer - Local Auth	(307.0)	(153.5)	(153.5)	0.0	(25.6)	(25.6)	0.0
Income	(2,997.1)	(1,570.5)	(1,570.5)	0.0	(303.7)	(303.3)	(0.5)
East Dunbartonshire Hscp	**81,173.0**	**40,332.3**	**40,037.2**	**294.8**	**6,672.5**	**6,698.0**	**(25.7)**

SOCIAL WORK REVENUE MONITORING 2017/18	Annual	Budget	Expenditure	Projected	Variation	Projected Year
SUMMARY FINANCIAL POSITION as at Period 6	Budget	Period 6	Period 6	Annual	at period 6	End Variation
	£000	£000	£000	£000	£000	£000
INTEGRATED HEALTH AND SOCIAL CARE						
ADULT SOCIAL CARE						
1 **Employee Costs**	13,680	6,858	7,058	13,640	200	-40
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 vear.						
2 **Property Costs**	108	64	42	108	-22	0
Underspends in utilities and rates are due to profiling and will come in on line as the year progresses.						
3 **Supplies and Services**	944	476	286	944	-190	0
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 06.						
4 **Agencies and Other Bodies**	41,847	19,124	19,034	42,353	-90	506
At this stage there is increased commitment against Daycare, Homecare and Supported Living. There is pressure in learning disability services as a consequence of challenging savings targets and the impact of children trasitioning into Adult Services from Childcare. This, however, is being offset by a lower than anticipated cost of Residential Care homes and Supported Accommodation for Older People. These commitments do not include all uplifts in respect of the introduction of the Scottish Government's Living Wage and there is also a backlog in data entry into the Carefirst system. This may also include 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	-253	0	0	253	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	173	176	416	3	0
No variation on budget is expected at this time.						
7 **Admin and Other Costs**	146	73	-77	146	-150	0
Underspends are due to profiling and will come in on line as the year progresses.						
8 **Health Board Resource Transfer Income**	-16,058	-8,085	-8,802	-16,033	-717	25
A small varaition on budget expected a year end.						
9 **Other Income**	-1,202	-1,175	-584	-1,202	591	0
No variation on budget is expected at this time.						
Total - Adult Social Care	39,379	17,255	17,133	40,372	-122	993

SOCIAL WORK REVENUE MONITORING 2017/18 SUMMARY FINANCIAL POSITION as at Period 6	Annual Budget £000	Budget Period 6 £000	Expenditure Period 6 £000	Projected Annual £000	Variation at period 6 £000	Projected Year End Variation £000
CHILDREN'S SOCIAL WORK & CRIMINAL JUSTICE						
1 Employee Costs	**5,587**	**2,801**	**2,619**	**5,204**	**-182**	**-383**
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**	**63**	**13**	**92**	**-50**	**0**
No variation on budget is expected at this time.						
4 Supplies and Services	**91**	**46**	**34**	**91**	**-12**	**0**
No variation on budget is expected at this time.						
5 Agencies and Other Bodies	**6,247**	**3,103**	**3,702**	**7,510**	**599**	**1,263**
There is currently pressure on Residential school payments, Homecare and Foster Carers' Allowances. The anticipated projection for these has been reported at this time, however, the additional pressures in relation to fostering payments may be funded by the Scottish Government. We have still to seek clarification on this and will advise in the next report.						
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.						
It is assumed that some of the overspend within agencies and other bodies will be offset by savings in employee costs - however this is not materialising as expected.						
6 Transport and Plant	**84**	**35**	**42**	**84**	**7**	**0**
No variation on budget is expected at this time.						
7 Admin and Other Costs	**134**	**67**	**65**	**139**	**-2**	**5**
Hgher than anticipated spend is projected in relation to pathways payments (leaving care).						
8 Income	**-939**	**-443**	**-462**	**-939**	**-19**	**0**
No variation on budget is expected at this time.						
Total - Children's Social Work & Criminal Justice	**11,296**	**5,672**	**6,013**	**12,181**	**341**	**885**
Total Integrated Health and Social Care	**-50,675**	**-22,927**	**-23,146**	**-52,553**	**-219**	-1,878

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
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	

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 6

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	Intermediate Care Unit Evaluation Report
Report By	Jean Campbell Chief Finance and Resources Officer 0141 232 8237 Jean.campbell2@ggc.scot.nhs.uk
Contact Officer	Gillian Notman Occupational Therapy Professional Advisor/Change & Redesign Manager Gillian.notman@ggc.scot.nhs.uk

Purpose of Report	To inform the board of the evaluation of the intermediate care pilot

Recommendations	To note the content of this report

Relevance to HSCP Board Strategic Plan	Reduction of delayed discharges and shift the balance of care.

Implications for Health & Social Care Partnership

Human Resources	Review of staffing levels for this service

Equalities:	none

Financial:	Ongoing costs of project following pilot

Legal:	None

Economic Impact:	None

Sustainability:	Mainstream pilot to a service providing intermediate care

Risk Implications:	Emerging risks will be managed via the Older Peoples Planning groups and the delayed discharge working group.

Implications for East Dunbartonshire Council:	As noted

Implications for NHS Greater Glasgow & Clyde:	As noted

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

Intermediate Care Unit Evaluation Report
East Dunbartonshire Health and Social Care Partnership

1.0 Background

East Dunbartonshire Health and Social Care Partnership (HSCP) commissioned a step down intermediate care pilot within Westerton Care Home in November 2016. The service aimed to include a model of GP provision, care management, rehabilitation and home care support. The beds were planned to allow service users to transition from the hospital setting when medically fit for discharge to a homely environment, allowing them time for additional recovery, rehabilitation and to enable a comprehensive assessment of their longer term health and social care support needs.

Within this eight bedded unit, the initial purpose was to provide:-

- Further assessment of service users who were likely to require admission to a residential or nursing care home.
- A “step down” function where the service user would receive intensive goal focussed rehabilitation and reablement provided via the care home, care at home service and community rehabilitation with a view to returning to their own home or other appropriate community setting.

National Health and Well being outcomes

Outcome 2 – People are able to live as far as reasonably practicable, independently and at home or in a homely setting in their community

This pilot aimed to test a model of intermediate care to support service users in their transition from hospital to home and in doing so empower them towards recovery and independence.

The service went live on the 14th November 2016. The plan was to run it for a year.
The outcomes for the project were:-

- To bridge the gap by supporting people with a timeous, smooth discharge from hospital to home or into a homely setting within the care home.
- To maximise the service user's ability for rehabilitation and reablement.
- To reduce the number of people delayed in hospital when they had been declared medically fit for discharge.
- To respond flexibly to the needs of service users through implementation of an agreed outcome focused, person centered support plan.
- To support carers in their role and promote their assistance in the rehabilitation and socialisation process.
- To support the individual and their carers to move back into the community or into long term residential/nursing care.

2.0 Eligibility Criteria for the Intermediate Care Unit

- The service user was to be an adult (aged 65 and over) and live within East Dunbartonshire and a patient in a hospital setting.
- The service user would be medically stable, fit for discharge and deemed appropriate for intermediate care.
- The service user would have the capacity to consent and engage in the process
- The service user and any other relevant persons would be made aware of the intermediate care process.

2.1 Exclusions from the Intermediate Care facility

- Any service users not deemed medically fit for discharge.
- Any service users referred directly from the Accident and Emergency Units within the hospital environment.
- Any service users requiring end of life/palliative care.
- Any service user who had dementia

3.0 Skill mix for the Intermediate Care Unit

The skill mix for the unit comprised of:-

- Social workers from the Hospital Assessment Team (HAT) and AHPs from the Rehabilitation Assessment Link Service (RAL) who are part of the Community Rehabilitation Team employed from the HSCP
- A nursing/support worker component from the care home.
- GP contracted to do 2-3 clinical sessions weekly.

Contracts with Westerton Care Home and the GP services from Garscadden Burn Practice were offered following intensive scoping and discussions with wider primary care colleagues and engagement with other care homes. Their contracts reflected the ethos and outcomes which the HSCP wanted to deliver for an intermediate care step down service.

4.0 Intended outcomes for the intermediate care pilot

- RAL would screen 20% of service users admitted to the intermediate care unit with the aim for them to return back to their own home.
- All service users would be receiving intermediate care within a placement lasting up to four weeks.

5.0 Evaluation methodology

The pilot's evaluation utilised a variety of quantitative and qualitative approaches to measure effectiveness against planned outcomes. These included

- Data related to bed days, delays and throughput within the Unit
- Outcomes in relation to the customer's final destination following discharge from the unit
- Financial Evaluation
- Service user, carer and staff perceptions of the Intermediate Care Unit
- A RAL time in motion study.
- Case scenarios

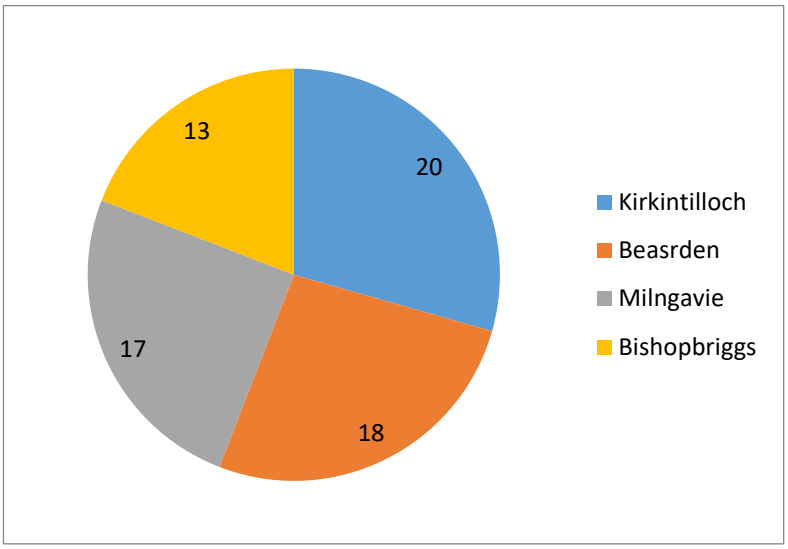
6.0 Performance information

68 patients had been admitted or are currently in the unit from November 2016. The original plan was for the Rapid Assessment Link Service (RAL) to assess 20% of the referrals into the unit. The RAL team quickly identified the need to screen all new referrals to establish their potential for rehabilitation. This resulted in them getting more people home than planned, as well as also providing guidance to the management of service users who were moving to other care homes. The data below is presented as a percentage and as actual numbers in brackets

- 74% (48) of clients were screened by the RAL. 31% (21) of that cohort returned home. From a rehabilitative perspective, an additional 7% (5) were deemed suitable to return home but chose to go in to long term care.
- 21% (14) of clients remained at Westerton following their stay in the unit
- 41% (28) moved to other care homes
- 7% (5) of people subsequently died.

6.1 Postcodes

All of East Dunbartonshire had access to the intermediate care unit. The breakdown of postcodes shows that there was generally an even split across all geographical areas.



6.2 Hospital referrals to intermediate care

The intermediate care unit accepted referrals from all hospitals. Most referrals come from Gartnavel General Hospital (24) and Glasgow Royal Infirmary (20). The busiest months being from April – June 2017

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Total
Stobhill	1	0	1	0	0	0	1	1	1	3	**8**
GRI	0	2	1	4	4	3	2	2	1	1	**20**
GGH	3	1	0	2	2	2	3	4	4	3	**24**
QEUH	2	2	4	0	1	3	0	2	0	0	**14**
Lightburn	0	1	0	0	0	0	1	0	0	0	**2**

6.3 Pattern of referrals in to the unit

Monday, Wednesdays and Fridays were the most frequent days for referrals into the unit. Since the LES GP attended on a Tuesday and Thursday, the paper work could be completed in advance of their visits. Initial discussions with the practice around allocated days highlighted a potential gap nearer and over the weekend. Whilst the GPs did state that they would attend if a clinical need was identified, the frequency with the attendance of the on call GP was a minimum.

6.4 Length of stay within the unit

Service users were informed that the assessment period would usually last no longer than four weeks. Below is a breakdown of the numbers of service users and their movement through the unit in relation to the amount of weeks used. Further discussion with the teams is required as to why 22 service users required/needed an extension to the planned four week placement.

- Moved within 1 week - 2
- Moved within 2 weeks - 6
- Moved within 3 weeks - 9
- Moved within 4 weeks - 22
- Over 4 weeks – 22

Further discussion with the teams is required as to why 22 service users required/needed an extension to the planned four week placement.

6.5 Voids related to bed day capacity

The actual weekly cost of a bed in the intermediate care unit was £830 which was paid by the HSCP. The assessment period would usually last no longer than four weeks and there was no charge to the client for this time. If the service user stayed on in the intermediate care unit after the assessment period was completed, they would be charged a weekly fee. Normally the cost of a bed in Westerton was £1150. Generally in these circumstances the council would pay a cost of £670 with additional contributions by customer from their benefits.

The average bed capacity figure was 84%, however the first few months were challenging in getting the service up and running. Exploring how the HSCP could utilise these empty beds in a more creative way for example as respite, or having discussions with partners on bed management is required to reduce these voids further. Further analysis on service users waiting for placements within the unit should also inform these discussions.

	Beds	Beds Used	Voids	Capacity	Cost of Voids
Nov	102	43	59	42%	£6,995.63
Dec	186	149	37	80%	£4,837.09
Jan	198	149	49	75%	£8,809.93
Feb	224	218	6	98%	£711.42
Mar	248	236	12	95%	£1,422.84
Apr	240	213	27	89%	£3,201.39
May	248	230	18	93%	£334.26
Jun	240	202	38	84%	£4,505.66
Jul	248	238	10	96%	£1,185.70
Aug	248	219	29	89%	3,438.53
Total	**2182**				**£35,442.45**

7.0 Outcomes of delayed discharges

The following statistics compare the previous ten months prior to the unit opening to the ten months during the project.

During the ten months prior to the intermediate care pilot opening, 64.7% of people recorded on Edison as being delayed in hospital were awaiting a long term placement, which extended the number of days for which they were delayed. Following the introduction of the project :-

- 24.5% of those recorded on Edison were able to be timeously transferred to the intermediate care facility, thereby preventing further delay in their discharge.
- This resulted in a reduction in the number of bed days lost to delayed discharge being realised, from a mean 294 bed days per month prior to the project to 238 bed days during the project; an average reduction of 56 bed days per month.
- There was also a reduction in those whose discharge was delayed being discharged from hospital into a long term placement with only 35.3% being discharged into long term care during the first ten months of the project.

	Recorded on EDISON	Delayed Discharge Bed Days	Long Term Placement	Westerton Intermediate Care
2016				
Jan	27	476	19	
Feb	25	349	19	
Mar	17	287	6	
Apr	18	302	11	
May	13	187	9	
Jun	19	333	14	
Jul	19	229	10	
Aug	17	248	12	
Sep	21	246	13	
Oct	14	287	10	
Total	**190**	**2944**	**123 (64.7%)**	
Intermediate care unit - Nov 2016 - Aug 2017				
Nov	24	304	10	4
Dec	20	232	9	4
Jan	20	267	8	5
Feb	18	315	9	6
Mar	15	167	3	6
Apr	17	187	7	6
May	21	278	4	5
Jun	24	225	10	5
Jul	23	166	5	3
Aug	22	Not Available	7	6
Total	**204**	**2141**	**72 (35.3%)**	**50 (24.5%)**

These statistics begin to show that East Dunbartonshire's balance of care is shifting from predominantly care home placements to now offering a wider range of services to meet the needs of the service user and their carers.

8.0 Financial evaluation

- Whilst the HSCP paid £259,658 for the beds in Westerton, the actual cost of £225,743 reflected the 84% capacity.
- If these services user had remained in hospital, the cost for a bed within the acute would have been £910,560. A bed costing £480 per day.

Indicative Costs from November 2016		**Current Financial statement to August 2017**	
Item	**Full year costs**	**Part year cost**	**Comments**
8 bedded unit for 52 weeks based on £830 per bed per week	345,280	259,658	Number of bed days used was 2182
Extended GP LES contract £210 per session	31,200	26.000	Basing figures on £600 per week. This is nearly x 3 sessions weekly
Transport	5,000	1410	
Resource Worker	28,000	23,333	
Fees for registering of Smart flat	4,000	0	This did not materialise
Total	**413,480**	**310,401**	

The feedback from the GPs was that the contracted sessions were adequate for the direct and indirect work they did for intermediate care. Where possible families were used to transport service users and ambulances were only used when medically deemed appropriate. The development around telecare and the use of the Smart flat did not materialise within the time line of this pilot.

9.0 Rapid Assessment Link Service Time in Motion study

As part of the evaluation, stakeholders requested the RAL to undertake a time in motion study to ascertain the skill mix and the type of tasks carried out by the team. The Physio, OT and two Rehab Support Workers (RSW) were asked to record activity over a month's period under the following headings:-

- Face to face
- Admin
- Travel

This was very much a snapshot; however interviews with the RAL service state that there was fluidness in how their team worked due to their commitment to keeping people safe within the community. The data would suggest that the skill mix within the team reflected a different balance of activity undertaken by the Physio, OTs and the RSWs. Whilst there was more face to face activity undertaken by the RSWs; the Physio and OT spend more time on phone calls, emails and clinical discussions.

Average time spent on intermediate care activity	
Profession	**Per week**
OT	1 day per week
Physio	1 .7 days per week
RSW	2 days per week
RSW	1.5 days per week

There was a general perception that travelling to and from Westerton was labour intensive. The proportion of time worked out at about 16% overall. As much as possible the team tried to co-ordinate visits related to the wider RAL service around their commitment to the unit. If staff were travelling directly to and from the unit, the time spent travelling was about an hour. There was additional pressure on travel time due to the RAL visiting intermediate care residents in other care homes or within their own home post discharge from the unit.

10.0 Stakeholder Interview

A range of stakeholders were interviewed as part of the evaluation. See appendix 1 and 2 for questions and further detailed of interviews. The cohort interviewed included:-

- Managers from the HSCP and the Care Home
- GPs
- Practitioners from RAL/HAT and Westerton

The themes for the interviews focused on the following areas:-

- What worked well
- What did not worked well
- What do they want to keep
- What do they want to start doing
- What do they want to stop doing

In total 15 people provided feedback.

11.0 Feedback from service users and carers

Information on the service user question and comments are in appendices 3-4. Unfortunately formal responses from service users and carers were very small. This could have been for a variety of reasons including teams not handing out the evaluation sheets, other feedback forms being requested by the care home or difficulty in completing these forms.

12.0 Case studies

A number of case studies were done which looked at the service user's assessment, planned goals and outcomes following discharge. Refer to appendix 5 for more details of these.

13.0 Conclusions

This evaluation has demonstrated that the intermediate care pilot has been successful. The pilot has met the service outcomes:-

- It has outperformed expectations by supporting and returning over 30% service users back to their own home.
- There has been a reduction in the number of bed days lost from a mean 294 bed days per month prior to the project to 238 bed days during the project;
- There has been a reduction of the number of people placed within care homes.
- RAL screened and offered rehabilitation to over 70% services users.
- The service demonstrated flexibly to the needs of service users through implementation of outcome focused, person centered support plans.

The project has highlighted a strong committed workforce who was focused towards achieving the best outcomes for service users. The pilot had started to improve team working but there is recognition that further work is required to enhance these relationships.

There are sufficient beds to meet the needs for this step down provision and all geographical areas across the authority have accessed this facility.

14.0 Next Steps

- Continue to deliver this current model of intermediate care.
- Establish a clinical outcome measure to show service user improvement within the unit.
- Increase usage of service user occupancy to target of between 90-95% for 2017-2018
- Consider a model for those who have dementia.
- Follow up on outcomes for people who have gone through the unit.
- Improve flow for the acute into intermediate care.
- Explore and widen the intermediate care continuum across East Dunbartonshire to ensure best value.
- Review staffing component to the unit.
- Provide better engagement opportunities and outcomes for carers.

Appendix 1

Intermediate Care Pilot Project - Questions for stakeholders

General questions

What worked well?

What did not worked well?

What do you want to keep?

What do you want to start doing?

What do you want to stop doing?

Specifically for the GPs

In relation to the intermediate care project, how was your interface with:-

- Acute
- Patients GPs
- Pharmacy
- Care Home staff
- HSCP staff - social workers and AHPs

A few questions about the service users in the intermediate care unit.

- How did their clinical needs different from other residents?
- What was your input to case reviews?

Contract – roughly how much time a week did you spend directly at Westerton and indirectly doing admin off line?

- How did this work with wider LES activity in the care home
- What happened when service users are admitted to the unit but not on your standard visit days
- How did you cover for annual leave

Stakeholder Feedback

What worked well?

Service user outcomes
The unit was very beneficial to clients and their families as it provided opportunities for further assessment and rehabilitation. The service helped to get people out of hospital whilst also giving them breathing space to make decisions for the longer term.
At times families were frustrated with the discharge process from the acute and the lack of rehabilitation within the wards. In the unit client goals were aimed to maximise functionally and performance and as a result of that, there are some very good examples of service user journeys through the unit.
Practitioners commented that the unit helped to build and consolidate relationships with clients and carers in a less pressurised environment. Taking part in planned therapeutic programmes and reviews often had a positive effect on people's general mental health as well. The fact that there was no financial cost to the service user for up to a four week placement was also beneficial.
It was useful for service users and relatives to have this extended experience in Westerton. It helped to change people's perception of what it was like to be in a care home and also to support transitions and alleviate fears for onward placements. Feedback to the care home staff included comments about how homely the environment was, how fresh and clean the unit was and the helpfulness of the staff.

Skilled staff
As a whole the HAT/RAL 'rolled their sleeves up and got on with it'. There were a lot of potential stumbling blocks which the practitioners were very proactive in addressing. Informally they did PDSA cycles where they made small changes to things which were deemed as not working. This helped to evolve the model of delivery and at times changed how they operated. The staff were skilled, organised, experienced, focused, committed, and driven to working with people and their carers to get the best outcomes. The size of the HAT/RAL teams was also advantageous. In their own respective teams, they were cohesive, organised themselves well, worked well under pressure and were able to continually prioritise their workload.

Interface with the acute
There was improvement in delayed discharge figures against heavy demographic demands for admissions to hospital. The unit offered a new service for East Dunbartonshire's portfolio of services for people who had complex needs who required an opportunity for further interventions and time to reflect on future plans. The pilot consolidated the essential role of rehabilitation in the interface between the acute and the community.

Throughput of service users receiving rehabilitation
The evidence suggests that the percentage of service users who received rehabilitation increased the initial expectation. The original plan was for the RAL to assess about 20-25% of the referrals into the unit. The RAL team quickly identified the need to screen all new referrals to establish their potential for rehabilitation. This resulted in them getting more people home than planned, as well as also providing guidance to the management of service users who were moving to other care homes.

Relationships
The RAL contact with the Resource Worker from HAT was viewed as being extremely valuable for the project. Two weekly catch up meetings assisted the RAL to be informed of service user's progress as well as giving them a 'heads up' about admissions to the unit. This helped them plan their weekly input into the unit.
There was a wide consensus from the HSCP staff that there was good engagement with the care home staff. They found the manager very approachable. There was openness and recognition by the manager that the model would evolve throughout the year's project. The staff were all proactive in ironing out issues as they arose. Whilst the RAL/HAT found the staff allocated to the unit helpful and committed to their job, there were comments about how busy these workers were and the challenges there were in trying to support them to provide holistic care.
The doctors were also very positive about the staff in the care home. Prior to clinical visits, the staff

were organised in their preparation of paper work, knowledge of the discharge information including medications and having patients primed for interviews and examinations if required. This greatly assisted the GPs to focus on their clinical commitments.
The medical staff had very little contact with service users named GPs. The care home staff arrange for a summary sheet to come from the relevant practice which normally arrived quickly. Equally information to the named GPs about their service user attending intermediate care was usually sent out within a matter of days. There were no complaints from the GPs about the clinical and/or care delivered to their patients.

Coordination of intermediate care
This tended to sit with the HAT Team Leader who had a good overview of all admissions and discharges. Having that SPOA helped with the coordination and the smooth transitions from the hospital through to a permanent placement, whilst also having the flexibility of dealing with the unpredictably elements of the project.

What did not worked well?

Clinical input
In the hospital wards, promotion of the benefits of intermediate care and the ethos of the unit at times raised service user/relative expectations of getting intensive rehabilitation. Due to the demands on the wider RAL service, their contact with clients was on average 1-2 sessions weekly. The complexity of some client's clinical needs meant that daily rehabilitation could have been helpful to maximise potential. The practitioners and managers expressed their frustrated that the RAL were not doing as much as they wanted to do. They provided a quality service but quantity was lacking due to the small resource, competing priorities and other demands. There were also observations that if daily rehabilitation input had been possible, it may have prevented some of the extensions to the four week stay at Westerton or respite into other units.

Service user reviews
There was little capacity for the RAL staff to attend service user review meetings which took place weekly for each person. These meetings lasted between 1-2 hours and were often arranged around the availability of relatives making these difficult for the RAL service to commit to. If it was possible to have these reviews planned in a more coordinated manner, it would have benefited the care home staff as well. Due to their capacity they tended to attend part of these reviews or to catch up with the named social worker on a more informal bases.

Competing priorities
When this pilot project was set up, the development of the resource worker's post was the only additional resource to HAT/RAL to deliver a model of intermediate care in East Dunbartonshire. Feedback from managers and practitioners described challenges:-

- Both teams required to be responsive to support quick and safe discharges from hospitals and to prevent inappropriate admissions. To do so meant that these teams needed to be flexible whilst also adapting their workload accordingly to prevent crises and to assist in getting the best outcomes for the service users and their carers. The nature of these services meant that the volume and throughput of service users could be busy and could feel quite pressurised.

- From this existing resource, the RAL required to also deliver a rapid response service to all GPs within East Dunbartonshire

- The HAT had recently taken on the full assessments for continuing care beds in Four Hills and Greenfield Park Care Homes

- The care home staff had a heavy commitment to undertake activities of daily living tasks with their residents which did not always allow much capacity for doing rehabilitation work as well.

Communication between the teams and access to IT

The lack of multi disciplinary discussions was a frequent theme from the interviews. Sessional input from busy teams (including GPs) who had other commitments meant that the opportunities for establishing and reviewing goals and promoting anticipatory care planning was not maximised. There were some examples where discharge planning was either rushed or not fully multi disciplinary in its considerations.
Each service had their own case file systems. There was no joined up system that allowed for sharing of information electronically. The care home had developed a communication sheet (per case record) which the teams were invited to update regularly. Working towards having some form of joint agreed care plan to allow practitioners to update progress towards agreed goals should be considered as a means of facilitating better communication, planning and person centred care.
At times some of the other GPs in the practice did on call cover to the unit. They did not have universal access to the clinical portal which meant that they had limited knowledge on clients they were assessing for the first time. The doctor who was responsible for the clinical delivery to the intermediate care beds did however have a wider range of access to clinical portal due to her wider involvement to intermediate and continuing care services across Glasgow

Dialogue with Consultants
At times there was confusion about getting information from a relevant consultant if there were any clinical queries. The name of the consultant on the discharge letter tended to be the doctor who was responsible for the service user at the point of discharge, however often this client had been in various wards where there was more involved interactions with different consultants who could clarity issues/queries better.

Disjointedness within the Teams
The impression was that the RAL and the HAT need to do further work around understanding each other's team's purpose and role in intermediate care. Whilst the resource worker did a commendable job in pulling together and co-ordinating data and information from both teams, there were examples where misunderstandings or lack of clarity should have been avoided if more proactive dialogue between the practitioners had happened.
Both teams were heavily committed to wider service demands. Their input to the unit was partly planned around the needs of their service/service users on any given day. This flexibility was advantageous but it also meant that they did not have a permanent base or a consistent presence in the unit. Laptops helped to support smart working,

Transfer of service users to other units and or back home.
The RAL had concerns around delivering rehabilitation programmes to service users who had, after their placement in Westerton, moved to other care homes. There were practical issues like moving equipment to other homes but also worries about how they could communicate and expect different care staff to undertake goal directed therapeutic programmes safety within tight time frames.

Lack of Management structure
Whilst there is a strong appreciation for the role of the senior carer within the unit, there were strong views that there was a lack of a collective leadership function within intermediate care. Prior to the implementation of this pilot, there had been extensive discussions around the skill mix required. Decisions made resulted in no direct Nurse being attached to the unit. There was a perception that a few service users were not admitted for assessment to the unit partly due to their challenging nursing issues, for example one person who needed oxygen therapy. The care home staff challenged these opinions, stating that the reasons that service users were not admitted to the unit were because it was not safe to do so or because of the existing level of dependency at that time. Recently they changed their model on clinical discussions within the wider care home. All state registered nurses now take part in daily progress reports of all residents which means that they have some knowledge of those clients in the unit which is beneficial if they require providing cover at any time.
The question of what this leadership role/function would look like varied across those interviewed. The following were some suggestions:-

- Taking on a clinical and care co-ordinating role where daily updates on all service users would be communicated to those visiting practitioners.
- Ensuring that service user programmes were ongoing and that the ethos of rehabilitation was complied with.

- A clear and timely overview of the actual bed management, admissions and discharges
- A facilitator for supporting enhanced training of support staff using a competency based framework.
- A conduit for being a single point of access for acute discharge staff, GPs and intermediate care staff.
- To lead on the identification and escalation of issues as they arise.

Without being too prescriptive, it would be useful having a presence of this role on a daily bases but not necessarily on a full time bases. What grade this role/post should be requires further debate.

Staffing within the care home

Feedback for practitioners commented that there was not enough staff on the unit. On a daily bases there were always two people roistered on. They often appeared to be swamped with tasks and when a service user required moving to another unit/care home or needed the attention of two staff, it meant the unit was stretched in its staffing capacity. At times service users did not want to approach staff around their specific needs as they were aware how busy the staff appeared to be.

The care home staff acknowledged the challenges in staffing the unit. They commented that everything could happen at once at times but equally that there were down times as well. The manager had discretion to increase staffing levels which had been done from time to time. There was one particular time when there had been a discussion with the joint service manager around having a member of staff working a 10.00 – 4.00 shift as this was perceived as being a critical time for activity in the unit. This potential development requires further discussion as there would be an impact on the care homes regulation with the care inspectorate.

There was an expectation from some of the stakeholders that the care home support staff were more advanced in their ethos and delivery of rehabilitation tasks than what actually happened. Having this level of experience would have been useful to keep the momentum going with individual programmes and to help support the development and maintenance of skills and function.

HSCP staff

This evaluation has highlighted that existing resources (plus an additional resource worker) were used to deliver this intermediate care home pilot. Extensive feedback from practitioners and managers comment that:-

- There was constant pressure to continually review service priorities to maintain a presence in the unit.
- Less active direct work was delivered during pressurised times like annual leave and sick leave.
- Limited frequency of visits and lack of training of care staff was a consequence of these other demands.
- The shift towards utilising complex and continuing care beds in Fourhills and Greenfield Park had changed the nature of work (and priorities) which social workers were doing, resulting in more demands placed on a small team.

Financial arrangements

The administration process for invoicing service users for extension payments remained a clunky system which proved to be problematic and time consuming.

The bed capacity was on average 84%, costing the HSCP 35K in bed days lost in the unit. Exploring how the HSCP could utilise these empty beds in a more creative way for example as respite, or having discussions with partners on bed management is required to reduce these voids further. Further analysis on service users waiting for placements within the unit should inform these discussions.

Bed management

There will always be an element of unpredictability around the planning of discharges from the acute and the availability of beds in the unit. The unit preferred to try and arrange for these admissions to happen to fit round the pattern of days when the GP attended. They were also sensitive to the cohort of service users in the unit and would at times challenge or debate the potential admission of a person if they felt it was not safe or conductive to the person or the unit

The pressure of trying to get people out of hospital within stated times lines and the strong dynamic of trying to reduce the number of bed voids resulted at times in tensions between the HAT and the care

home staff. Equally dialogue with acute colleagues to free up beds was at times challenging for the care home staff and not helped when there were delays in forwarding on summary sheets with vital service user information. The HAT Team Leader's committeemen to daily phone calls did not always materialise.

What do you want to keep?

- There was an overwhelming response to keep the unit and to keep its function open.
- The experienced, professional staff from the care home, GPs, RAL and HAT
- Some staff commented that they would have liked to have kept some of the service users. They received a lot of validation for what they were doing when they observed the positive impact to their service users and feedback from carers.
- The homely environment of the unit.
- Flexibility in allowing the servicer user to extend their length of stay in the unit if it added value to the person's planned outcomes.
- The function of the resource worker strongly assisted in supporting a coordinated approach to new admissions and dischargers. It was invaluable in leading on the gathering and analysis of data for performance and ongoing evaluation.
- Generally the transport from the acute to the unit worked well, however there were additional challenges around the ordering of ambulances when required.
- RAL wanted to keen screening all new admissions. This helped to provide service users/carers with opportunities to objectively view and plan for longer term placements.
- Practitioners within the HAT wanted to continue to do the transitional work from the acute into the unit as this service flow helped to support continuity and maintain professional skills.
- Opportunities of developing more robust anticipatory care planning of all service users prior to discharge
- The Doctors commented that the community Pharmacist was very responsive when needing advice, medication changes and discussions on supply shortages.

What do you want to start doing?

Training
Support and empower the unit staff and relatives to undertake basic rehabilitation tasks including delivering exercise programmes, ADL practice, be involved in joint home visits and to get a wider knowledge of rehabilitation approaches

.

Time in unit
Spend more time in the unit so that more consistent, intensive and holistic care could be done. This cohort of service users are complex and challenging in that their identified needs and goals needed regular reviews and graded activities. Their function and performances could change daily which would have benefited from a more regular HSCP service who could respond to these challenges and changing goals. The RAL would have liked to have capacity to attend more review meetings and to offer therapeutic group work as part of clinical interventions.

Internal HSCP pathways
Develop quicker and easier pathways between the HAT and the Social Work Older Peoples Team for those service users who have been placed into long term care

RAL/HAT staff
Have the recognition of a highly skilled and experienced group of staff working on behalf of the HSCP in the unit.

Equipment
Develop a protocol to support better transitions between the acute, the care home and the rehab staff on the assessment and ordering of equipment. This was hap hazard resulting at times in equipment

needing to be ordered quickly to allow for functional assessments to be undertaken or to support safe discharges.

Complex and continuing care
Continue to develop a range of services which supports the HSCP to shift the balance of care. Use a SPOA model to support a number of functions for service users who require residential and care services.

What do you want to stop doing?

- Arranging review meetings as short notice
- Having to do ad hoc reactive work around Edison. There is a need to get hospitals to inform the HSCP earlier about those service users who are complex and require some form of continuing care.
- In relation to placement reviews, the HAT does not want duplication of assessment work on Carefirst which is currently happening.

Appendix 3

SERVICE USERS SATISFACTION QUESTIONAIRE

This questionnaire is about the Intermediate Care Team's work with you and the information they provided for you. Your answers are confidential and will only be used to help us improve our service.

Can you tell me what members of the team have been involved with your care?
(Please circle)

GP	Nurse
Social Worker	Case Assistant
Social Work Assistant	Health Care Support Worker
Physiotherapist	Other
Occupational Therapist	

If possible, please answer the questions below and write any additional comments you may have in the space under each question (or on a separate sheet if necessary). Leave any questions blank of you feel it does not relate to you

1. I was satisfied with the length of time that I waited to be seen by the Therapist from the Intermediate Care Home Team (if relevant).

YES NO

Comment

2. The Intermediate Care Home Team involved me in planning my current and future outcomes.

YES NO

Comments

3. In what ways do you think the Team has helped you or your carer

Please describe

5. I am satisfied with how often I am seen by the Intermediate Care Home Team
Yes No

Comments

6. If I need help out with arranged appointments; I know how to make contact with the team?
Yes No

7. The Team member's that worked with me.
Identified themselves in a professional manner. Yes No

Presented themselves as open and approachable.	Yes	No
Had a good awareness of my health and social care needs.	Yes	No
Worked well with other services on my behalf.	Yes	No

Comments

7. Within the Intermediate Care Home Unit did you feel that:-

The environment enabled you to make decisions about your future care?	Yes	No
The staff gave you enough time to allow you to make these decisions?	Yes	No

11. Do you and your carer know how to make a complaint if you are not satisfied with the service offered to you by the Team?

Yes **No**

Comments

12 Please make any additional comments or suggestions on the service you have received in the space below

Comments

Service user feedback

- To everyone's surprise, my grandmother has made a substantial recovery and got back to her own home last week - after initial discussions of hospice 'end of life' care! Our experience of the Intermediate Care Unit was very positive. It afforded us the opportunity to establish the care needs of my grandmother following her stay in hospital. We could investigate, in a safe environment, whether my grandmother could cope with moving from the nursing care provided in the hospital to the residential care offered in the Intermediate Care Unit and ultimately establish whether she could cope at home with support.

- Staffing levels in the unit were too low and waiting times for toileting was unacceptable.

- The staff were incredibly helpful, friendly and supportive with the care home providing a good environment for my grandmother to recover.

- Mr X was an exceptionally supportive and efficient social work practitioner who listened to my needs and assisted me to come to the decision that I needed full time nursing care.

- The unit helped to rehabilitate me and to give me a feel for living in a full time care home. My carer was also able to experience the first class service that Westerton care home provided for their residents. They liaised with other services on my behalf.

- The service was of an exceptionally high standard

- Good support from carers on return to home, greatly appreciated it

- I had the expectation that Physio would have been on a daily basis in a rehab unit

- The staff was very beneficial in seeing my father out of the hospital environment. It was reassuring how quickly he settled at night compared to hospital, as well as during the day, in a more homely environment.

- Overall the unit and the staff were very good and my father enjoyed his stay which was reassuring to us in thinking of future needs.

Appendix 5

Case studies

Case Study A
Client A was referred to Intermediate Care following two failed discharged after sustaining a head injury. Client A had four falls within a short period of time which lead to admission in December 2016. Client A was referred by hospital staff as there were increased concerns for the person to return home in regards to health and social care.

Reason for admission: 4 falls in 2 days
.
Previous social support: carers four times daily.

Carer: It was identified there was a large carers stress for Client A's spouse as they had completed full caring role prior to admission and had no support from social work despite this having been agreed following discharge from client A's head injury.

Rehab Goals: Ward staff felt there were further rehab goals for client A. A full assessment was completed which identified client A would benefit from an environmental visit and physiotherapy review at home as they were independent with all transfers within the intermediate care unit and mobile with x1 stick.

At discharge - Health and social care staff worked closely together to ensure there was minimal risk for the discharge failing. A comprehensive package was organised by social work including, rolling respite, respite hours throughout the week and homecare to ensure client A and spouse were well supported. Client A was reviewed at home by rehab staff. Physiotherapist reviewed outdoor mobility and provided appropriate aid. OT ensured environment safe to return to home to and reviewed stair mobility. No additional equipment was required for discharge as all was in place following previous discharge.
Client A continues to remain at home after 7 months post discharge. Client A and spouse have felt well supported by the intermediate care staff and were very grateful for the interventions from the whole team.

(ii)Case study B
Client B as referred to the intermediate care unit following admission to hospital with diarrhoea and vomiting. Their mobility had declined because of this and family were wishing for a further period of assessment as unsure whether client B would benefit from long term care placement.

Reason for admission: diarrhoea and vomiting

Previous social support: Package x 3 times daily and day care once weekly however client B had stopped going to day care.

Rehab Goals: Client B had previously been known to RAL staff and it was felt by staff that her cognition levels had not deteriorated since previous intervention 5 months before.
Client B's mobility had deteriorated as previously mobile with a stick indoors and outdoors. She was mobile with wheeled zimmer frame on assessment however progressed back to a stick with wheeled zimmer frame available if fatigued.
Client B and her daughters were unsure whether she was to return home or not as she enjoyed the social aspect and company whilst in Westerton. Client B and her family decided to return home as they felt she were not ready for 24 hour care.

At discharge - Client B returned home with her existing package of care but with an addition of support from Alzheimer's Scotland.
Rehab staff continue to support her with outdoor mobility 4 months post discharge however this goal is almost complete and client B has been out with their daughter utilising outdoor walking aid. Client B has had no readmissions to hospital since discharge from the intermediate care unit.

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 7

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	East Dunbartonshire HSCP Board Complaints Handling Procedure
Report By	Sandra Cairney, Head of Strategy, Planning & Health Improvement
Contact Officer	Sandra Cairney, Head of Strategy, Planning & Health improvement 0141 232 8224 Sandra.cairney@ggc.scot.nhs.uk

Purpose of Report	To advise the HSCP Board of the requirement to develop a Complaints Handling Procedure that covers the specific business of the Board.

Recommendations	The HSCP Board is asked to approve the attached Complaints Handling Procedure

Relevance to HSCP Board Strategic Plan	Relates to priorities and investment decisions

Implications for Health & Social Care Partnership

Human Resources	Health and social care staff working within the HSCP are expected to comply with this Complaints Handling Procedure with immediate effect.

Equalities:	Fair policies for customers/service users and carers

Financial:	Nil

Legal:	Legal duty to comply with the Complaints Handling Procedure

Economic Impact:	Nil

Sustainability:	Nil

Risk Implications:	Non compliance

Implications for East Dunbartonshire Council:	Social Work employees will be expected to comply with this Complaints Handling Procedure immediate effect.

Implications for NHS Greater Glasgow & Clyde:	Community Health employees will be expected to comply with this Complaints Handling Procedure immediate effect.

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 attached Complaints Handling Procedure **[Appendix A]** reflects the HSCP Board's commitment to valuing complaints. It seeks to resolve customer/service user dissatisfaction as close as possible to the point of service delivery and to conduct thorough, impartial and fair investigations of complaints so that, evidence-based decisions are made regarding the response to complaints.

1.2 This HSCP Board Complaints Handling Procedure aligns to the NHSGGC's and East Dunbartonshire Council's complaints handling procedures and is based on the Scottish Public Services Ombudsman Model Complaints Handling Procedure.

Appendix A

East Dunbartonshire Health & Social Care Partnership

Health & Social Care Partnership Board

COMPLAINTS HANDLING PROCEDURE

DRAFT September 2017

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

NHS
Greater Glasgow and Clyde

CONTENTS

FOREWORD

The East Dunbartonshire Complaints Handling Procedure reflects our commitment to valuing complaints. It seeks to resolve dissatisfaction as soon as possible and will conduct thorough, impartial and fair investigations of complaints so that, where appropriate, we can make evidence-based decisions on the facts of the case.

The procedure introduces a standardised approach to handling complaints, which complies with the SPSO's Guidance on a Model Complaints Handling Procedure (CHP). This procedure aims to help us 'get it right first time'. We want quicker, simpler and more streamlined complaints handling with local, early resolution.

Complaints give us valuable information we can use in terms of how we fulfil our responsibilities. Our complaints handling procedure will enable us to address dissatisfaction and may also prevent the same problems that led to the complaint from happening again. Handled well, complaints can give customers/complainants a form of redress when things go wrong, and can also help us continuously improve.

Resolving complaints early saves money and creates better customer relations. Addressing complaints as close to the point of service as possible means we can deal with them locally and quickly, so they are less likely to escalate to the next stage of the procedure. Complaints that we do not resolve swiftly can greatly add to our workload.

It will help the HSCP Board keep the public at the heart of the process, while enabling us to better understand how to improve how we deliver our responsibilities by learning from complaints.

Susan Manion
Chief Officer
East Dunbartonshire
Health & Social Care Partnership

INTRODUCTION

The Public Bodies (Joint Working) (Scotland) Act (2014) sets out a framework within which Local Authorities, NHS Boards and Health & Social Care Partnership Boards (HSCP Boards) integrate health and social care service planning and provision. East Dunbartonshire HSCP Board has responsibility for the strategic planning, direction and operational oversight of a range of health and social care services whilst East Dunbartonshire Council and NHSGGC Health Board retain responsibility for direct service delivery of social work and health services respectively, as well as remaining the employer of health and social care staff. Under these integrated arrangements, there will remain separate complaints handling procedures for the planning and delivery of health and social care services.

As a public body, the HSCP Board is required to develop complaint handling procedures in line with its area of responsibility but also link where appropriate to each of the constituent bodies' policies and procedures. The alignment of these complaints handling procedures aims to provide consistency and clarity around the handling of integrated complaints. The purpose is to make it simpler for people to complain and identify and make best use of lessons from complaints

Application of these procedures must ensure the organisation complies with the duties placed on it by equalities legislation to treat all individuals on an equitable basis, with an understanding of issues relating to age, disability, gender, race, religion, sexual orientation, or socio-economic status in accordance with the equality legislation.

In practice, this includes:

- providing accessible information in appropriate formats
- supporting complainants or their representative needing assistance
- resolving complaints immediately to prevent where possible progressing to a formal complaints investigation process
- being open and transparent whilst safeguarding confidentiality and data protection compliance.

ABOUT THE HSCP BOARD COMPLAINTS HANDLING PROCEDURE

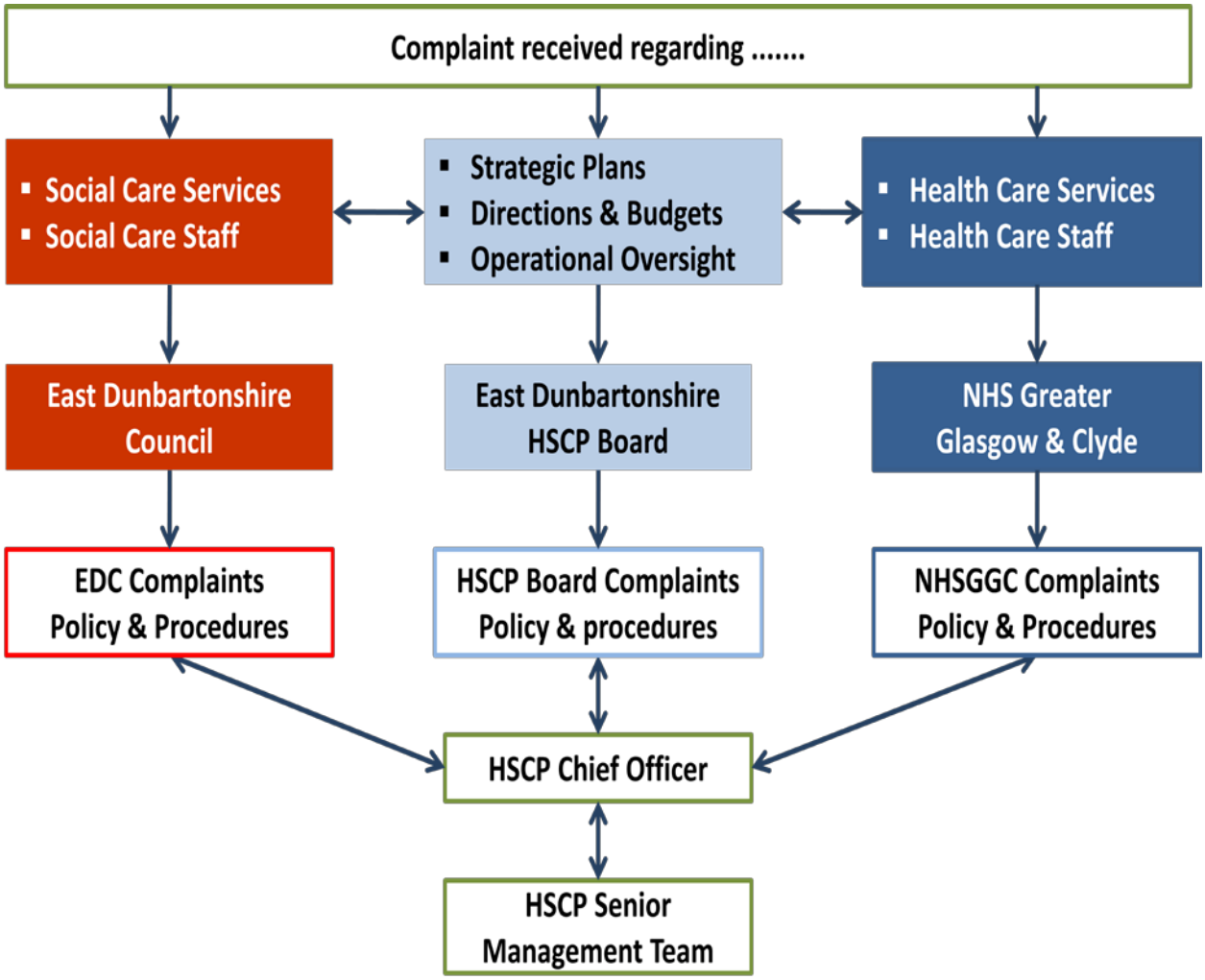
This Complaints Handling Procedure has been approved by the SPSO and has been developed from the SPSO's Model Complaints Handling Procedure for the Scottish Government, Scottish Parliament and Associated Public Authorities in Scotland. It explains how the HSCP Board will handle complaints. The HSCP Board provides information for customers on the complaints procedure and together, these form the organisation's Complaints Handling Procedure.

The HSCP Board is responsible for complaints relating to its own Directions, Accounts and Strategic Plans whilst service or employee complaints will refer to EDC and NHSGGC complaints handling policies and procedures where appropriate. This Complaints Handling Procedure explains the processes the HSCP Board will follow in responding to complaints regarding the business of the Board. It contains references and links to more details on parts of the procedure, such as how to record complaints); the steps taken to ensure that the people are aware of how they can give feedback or make a complaint; and

how complaints inform learning and improvement. These explain how to process, manage and reach decisions on different types of complaints. The HSCP Board, through the Chief Officer, will ensure that staff working within the Health & Social Care Partnership are aware of and comply with this and their employing organisations' complaints handling policies and procedures.

Diagram 1 describes the accountability arrangements for complaints relating to the strategic planning and delivery of health and social care services by East Dunbartonshire Council, NHSGGC and the HSCP Board.

Diagram 1 Complaints Accountability Arrangements



WHAT IS A COMPLAINT?

East Dunbartonshire Health & Social Care Partnership Board complaints relate to:

'An expression of dissatisfaction, by one or more members of the public about the HSCP Board's action or lack of action, or about the decisions taken relating to the strategic planning and directions for health and social care services delegated to the HSCP Board.'

A complaint may relate to **dissatisfaction with**:

- East Dunbartonshire HSCP Board policies;
- East Dunbartonshire HSCP Board decisions; and
- the administrative or decision-making processes undertaken by East Dunbartonshire HSCP Board in coming to a decision

Complaints regarding health and social care employees, direct health and/or social care service delivery or members of the HSCP Board are not covered by this Complaints Handling Procedure. These complaints are covered by East Dunbartonshire Council and NHS Greater Glasgow & Clyde Complaints Handling procedures.

A complaint is **not**: (this list is not exhaustive)

- a first time request made to EDHSCP;
- a request for compensation only;
- issues that are in court or have already been heard by a court or a tribunal;
- disagreement with a decision where a statutory right of appeal exists; and
- an attempt to reopen a previously concluded complaint or to have a complaint reconsidered where we have already given our final decision.

The HSCP Board will not treat these issues as complaints, but will instead direct the customer/complainant to the appropriate procedures.

WHO CAN MAKE A COMPLAINT

Anyone who is affected by the decisions made by the HSCP Board can make a complaint. Sometimes a customer may be unable or reluctant to make a complaint on their own. Complaints brought by third parties will be accepted as long as the customer has given their personal consent.

HANDLING ANONYMOUS COMPLAINTS

The HSCP Board value all complaints. This means treating all complaints including anonymous complaints seriously and will take action to consider them further, where this is appropriate. Generally, the HSCP Board will consider anonymous complaints if there is sufficient information in the complaint to enable the organisation to make further enquiries. If, however, an anonymous complaint does not provide enough information to enable further action to be taken, the HSCP Board may decide not to pursue it further. Any decision not to pursue an anonymous complaint must be authorised by a senior manager.

If an anonymous complaint makes serious allegations, it will be considered by a senior manager immediately. If an anonymous complaint is pursued, the issues will be recorded as an anonymous complaint on the complaints system. This will help to ensure the completeness of the complaints data recorded and allow corrective action to be taken where appropriate.

IF THE CUSTOMER DOES NOT WANT TO COMPLAIN

If a customer has expressed dissatisfaction in line with the definition of a complaint but does not want to complain, they will be advised that the HSCP Board considers all expressions of dissatisfaction, and that complaints offer the opportunity to improve services where things have gone wrong. Customers are encouraged to submit their complaint and allow it to be dealt with through the Complaints Handling Procedure. This will ensure that they are updated on the action taken and receive a response to their complaint.

If however, the customer insists they do not wish to complain, it will be recorded as an anonymous complaint. This will ensure that their details are not recorded on the complaints database and that they receive no further contact about the matter. It will also help to ensure the completeness of the complaints data recorded and will still allow full consideration of the matter and take corrective action where appropriate.

COMPLAINTS INVOLVING THE HEALTH & SOCIAL CARE PARTNERSHIP BOARD OR MORE THAN ONE ORGANISATION

A complaint may relate to a decision that has been made by the HSCP Board, as well as a service or activity directed by the HSCP Board to the constituent bodies (EDC and NHSGGC). Initially, these complaints should all be handled in the same way. They must be logged as a complaint, and the content of the complaint must be considered, to identify which services are involved, which parts of the complaint the HSCP Board can respond to and which parts are appropriate for others to respond to. A decision must be taken as to who contributes and investigates each element of the complaint, and that all parties are clear about this decision. The final response must be a joint response, taking into account the input of all those involved.

Where a complaint relates to a decision made jointly by the HSCP Board and the Health Board or Local Authority, the elements relating to the HSCP Board should be handled through this Complaints Handling Procedure. Where possible, working together with relevant partners, a single response addressing all of the points raised should be issued.

Should a member of staff who represents the HSCP Board receive a complaint in relation to HSCP Board business, and they have the relevant and appropriate information to resolve it, they should attempt to do so. If the staff member feels unable to offer a response, the complaint should be passed to the HSCP Senior Management Team as early as possible to allow a response/resolution.

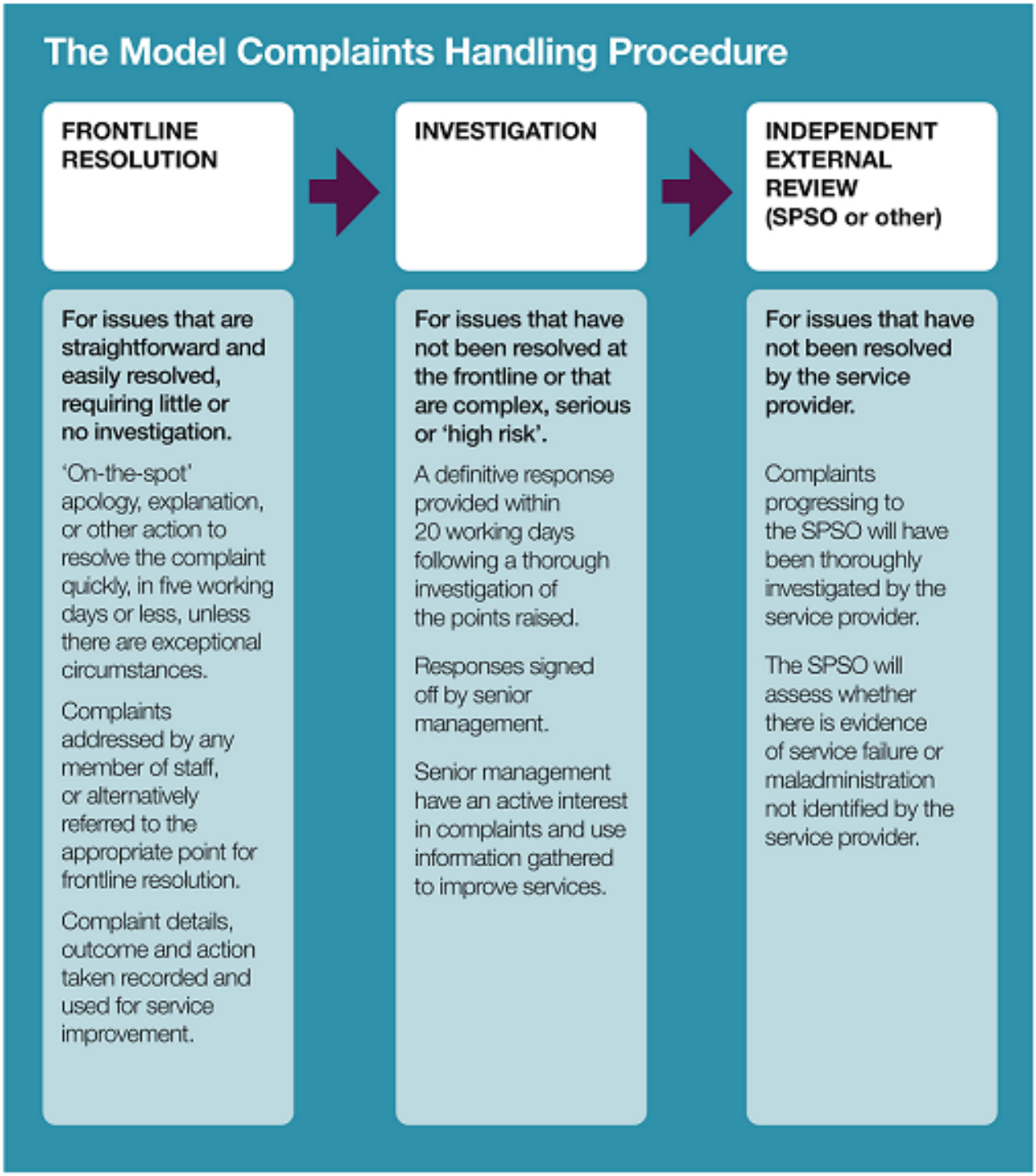
If a customer makes a complaint to the HSCP Board about services of another agency or public service provider, but HSCP Board has no involvement in the issue, the complainant will be advised to contact the appropriate organisation directly.

If the HSCP Board needs to make enquiries to an outside agency in relation to a complaint, data protection legislation and SPSO guidance on handling customer's personal information will always be taken into account. The Information Commissioner has detailed guidance on data sharing and has issued a data sharing code of practice. The address for all HSCP Board complaints should be sent to; East Dunbartonshire HSCP Board Complaints.

COMPLAINTS HANDLING PROCESS

The Complaints Handling Process aims to provide a quick, simple and streamlined process for resolving complaints early and locally by capable, well-trained staff. This process provides two opportunities to resolve complaints internally:

- **frontline resolution**, and
- **investigation**.



Stage one: Frontline Resolution

Frontline resolution aims to quickly resolve straightforward customer complaints that require little or no investigation. Any member of staff may deal with complaints at this stage; if the member of staff receiving the complaint is not able to provide a response, then it should be referred on to a more appropriate member of staff.

The main principle is to seek early resolution, resolving complaints at the earliest opportunity. This may mean a face-to-face discussion.

Whoever responds to the complaint, it may be settled by providing an on-the-spot apology where appropriate, or explaining why the issue occurred and, where possible, what will be done to stop this happening again. They may also explain that, as an organisation that values complaints, the information given will be used when reviewing policies and processes in the future.

A customer can make a complaint in writing, in person, by telephone, by email or online, or by having someone complain on their behalf. Frontline resolution will always be considered, regardless of how the complaint has been received.

What will the HSCP Board do on receiving a complaint

1 On receiving a complaint, the HSCP Board will first decide whether the issue can indeed be defined as a complaint. The customer/complainant may express dissatisfaction about more than one issue. This may mean we treat one element as a complaint, while directing them to pursue another element through an alternative route.

2 After receiving and identifying a complaint, the details are recorded on the HSCP Board complaints system.

3 Next, a decision will be made as to the suitability of the complaint for frontline resolution. Some complaints will need to be fully investigated before a suitable response is provided and in this case a senior manager will escalate these complaints immediately to the investigation stage.

4 Where frontline resolution is deamed to be appropriate, four key questions are considered:

- What exactly is the complaint (or complaints)?
- What does the complainant want to achieve by complaining?
- Can this be achieved, or explain why not?
- If it cannot be resolved, who can help with frontline resolution?

What exactly is the complaint(s)?
It is important to clarify exactly what the customer is complaining about. Supplementary questions may need to be asked to gain a full picture.

What does the complainant want to achieve by complaining?
At the outset, it is important to clarify the outcome the complainant wants. The complainant, however, may not be clear about this, so there may be a need to probe further to find out what they expect and whether they can be satisfied.

Can this be achieved, or explain why not?
If the expected outcome can be achieved by providing an on-the-spot apology this should be provided or explain why this is not possible. If an apology is deemed suitable, the SPSO's guidance on the subject should be followed which can be found on the SPSO

website.
The customer/complainant may expect more than the HSCP Board can provide. If their expectations appear to exceed what the organisation can reasonably provide, a senior manager will advise them as soon as possible in order to manage expectations about potential outcomes.
Decisions at this stage may be conveyed face-to-face, by telephone or via e-mail. In these instances, there is not a requirement to write to the customer, although this may be an option. A full and accurate record of the decision reached must be kept, including the information provided to the customer.

If this cannot be resolved, who can help with frontline resolution?
If the complaint raises issues which cannot be responded to in full, for example, it relates to an issue or area of service a health or social care employee is unfamiliar with, they must hand over to a member of the HSCP Senior Management Team who will try to resolve it.

Timelines

Frontline resolution must be completed within **five working days** of the HSCP Board receiving the complaint, in practice it is to be expected that the complaint will be resolved sooner.

Staff may need to obtain more information or seek advice to resolve the complaint at this stage. However, they will respond to the complainant within **five working days**, either resolving the matter or explaining that further investigation is required.

Extension to the timeline

In exceptional circumstances, where there are clear and justifiable reasons for doing so, the Senior Management Team may agree an extension of no more **than five working days** with the complainant. This will only happen when an extension is likely to resolve the complaint at the frontline resolution stage.

If, however, the issues are so complex that the complaint cannot be resolved in five days, it will be appropriate to escalate the complaint straight to the investigation stage.

If the complainant does not agree to an extension and it is unavoidable and reasonable, a Senior Manager can still decide upon an extension. In those circumstances, the complainant will be informed about the delay, with reasons for this being provided for the decision to grant an extension.

Such extensions are not considered normal practice. The timeline at the frontline resolution stage will be extended on rare occasions. All attempts to resolve the complaint at this stage will take no longer than **ten working days** from the date the HSCP Board received the complaint.

The proportion of complaints that exceed the five-day limit will be evident from reported statistics. These statistics will be presented to East Dunbartonshire Health & Social Care Partnership Board on a quarterly basis.

Appendix 1 provides further information on timelines.

Closing the complaint at the frontline resolution stage

When staff have informed the complainant of the outcome, they are not obliged to write to the complainant, although they may choose to do so. The response to the complaint must address all areas the HSCP Board is responsible for and must explain the reasons for the decision. Staff will keep a full and accurate record of the decision reached. The complaint will then be closed and the complaints system updated accordingly. The complaints resolved at the frontline stage will be reported to the HSCP Board on a quarterly basis.

When to escalate to the investigation stage

The HSCP Board will escalate a complaint to the investigation stage when:

- frontline resolution has been attempted but the complainant remains dissatisfied and requests an investigation. This may happen immediately when the decision at the frontline stage is communicated, or some time later
- the complainant refuses to take part in frontline resolution
- the issues raised are complex and require detailed investigation
- the complaint relates to serious, high-risk or high-profile issues.

When a previously closed complaint is escalated from the frontline resolution stage, the complaint should be reopened on the complaints system.

The HSCP Board will take particular care to identify complaints that might be considered serious, high risk or high profile. The SPSO defines potential high-risk or high-profile complaints as those that may:

- involve a death or terminal illness
- involve serious service failure, for example major delays in providing, or repeated failures to provide, a service
- generate significant and ongoing press interest
- pose a serious risk to an organisation's operations
- present issues of a highly sensitive nature, for example concerning a particularly vulnerable person or child protection.

Stage two: Investigation

Not all complaints are suitable for frontline resolution and not all complaints will be satisfactorily resolved at that stage. Complaints handled at the investigation stage of the Complaints Handling Procedure are typically complex or require a detailed examination before we can state the position. These complaints may already have been considered at the frontline resolution stage, or they may have been identified from the start as needing immediate investigation.

An investigation aims to establish all the facts relevant to the points made in the complaint and to give the complainant a full, objective and proportionate response that represents our final position.

What will the HSCP Board do on receiving a complaint for investigation

It is important to be clear from the start of the investigation stage exactly what is being investigated, and to ensure that all involved – including the complainant - understand the investigation's scope. It may be helpful for an investigating officer to discuss and confirm

these points with the complainant at the outset, to establish why they are dissatisfied and whether the outcome they are looking for sounds realistic.

In discussing the complaint with the complainant, the investigating officer will consider three key questions:

1. What specifically is the complaint or complaints?
2. What does the complainant want to achieve by complaining?
3. Are the complainant's expectations realistic and achievable?

It may be that the complainant expects more than the HSCP Board can provide. If so, staff will make this clear to them as soon as possible. Where possible the HSCP Board will also clarify what additional information will be needed to investigate the complaint. The complainant may need to provide more evidence to help the HSCP Board reach a decision.

Details of the complaint must be recorded on the system for recording complaints. Where appropriate, this should be a continuation of frontline resolution. The details must be updated when the investigation ends.

If the investigation stage follows attempted frontline resolution, staff will ensure that all relevant information will be passed to the officer responsible for the investigation, and record that they have done so.

Timelines

The following deadlines are appropriate to cases at the investigation stage:

- complaints must be acknowledged within **three working days**
- the HSCP Board will provide a full response to the complaint as soon as possible but not later than **20 working days** from the time they received the complaint for investigation.

Extension to the timeline

Not all investigations will be able to meet this deadline. For example, some complaints are so complex that they require careful consideration and detailed investigation beyond the 20-day limit. However, these would be the exception and we will always try to deliver a final response to a complaint within 20 working days.

If there are clear and justifiable reasons for extending the timescale, Senior Management will set time limits on any extended investigation, as long as the complainant agrees. They will keep the complainant updated on the reason for the delay and give them a revised timescale for completion. If the complainant does not agree to an extension but it is unavoidable and reasonable, then Senior Management can consider and confirm the extension. The reasons for an extension might include the following:

- Essential accounts or statements, crucial to establishing the circumstances of the case, are needed from staff, customers or others but they cannot help because of long-term sickness or leave.
- Further essential information cannot be obtained within normal timescales.
- Operations are disrupted by unforeseen or unavoidable operational circumstances, for example industrial action or severe weather conditions.

- The complainant has agreed to mediation as a potential route for resolution.

These are only a few examples, and the Senior Management Team will judge the matter in relation to each complaint. However, an extension would be the exception and we will always try to deliver a final response to the complaint within a further 20 working days but before the 40 day deadline.

As with complaints considered at the frontline stage, the proportion of complaints that exceed the 20-day limit will be evident from reported statistics. These statistics will be presented to the HSCP Board on a quarterly basis.

Appendix 1 provides further information on timelines.

Mediation

Some complex complaints, or complaints where complainants and other interested parties have become entrenched in their position, may require a different approach to resolving the complaint. Where appropriate, mediation or conciliation services may be considered using suitably trained and qualified mediators to try to resolve the matter and to reduce the risk of the complaint escalating further.

Mediation will help both parties to understand what has caused the complaint, and so is more likely to lead to mutually satisfactory solutions.

If the HSCP Board and the complainant agree to mediation, revised timescales will need to be agreed.

Closing the complaint at the investigation stage

The complainant will be informed of the outcome of the investigation, in writing or by their preferred method of contact. This response to the complaint will address all areas the HSCP Board is responsible for and explain the reasons for the decision. The decision will be recorded, and details of how it was communicated to the complainant, on the system for recording complaints. The complaint will then be closed and the complaints system updated accordingly. The complaints resolved at the investigation stage will be reported to the HSCP Board on a quarterly basis.

In responding to the complainant, it will be made clear:

- of their right to ask SPSO to consider the complaint
- the time limit for doing so, and
- how to contact the SPSO.

Independent external review

Once the investigation stage has been completed, the complainant has the right to approach the SPSO if they remain dissatisfied. The SPSO considers complaints from people who remain dissatisfied at the conclusion of our complaints procedure. The SPSO looks at issues such as service failures and maladministration (administrative fault), as well as the way we have handled the complaint.

The HSCP Board will use the wording below to inform complainant of their right to ask SPSO to consider the complaint. The SPSO provides further information for organisations on the ‘Valuing Complaints’ website. This includes details about how and when to signpost customers to the SPSO.

Information about the SPSO

The Scottish Public Services Ombudsman (SPSO) is the final stage for complaints about public services in Scotland. This includes complaints about the Scottish Government, NDPBs, agencies and other government sponsored organisations. If you remain dissatisfied with an organisation after its complaints process, you can ask the SPSO to look at your complaint.

The SPSO cannot normally look at complaints:

- where you have not gone all the way through the organisation's complaints handling procedure
- more than 12 months after you became aware of the matter you want to complain about, or
- that have been or are being considered in court.

The SPSO's contact details are:

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Freepost SPSO

Freephone: **0800 377 7330**
Online contact **www.spso.org.uk/contact-us**
Website: **www.spso.org.uk**

GOVERNANCE OF THE COMPLAINTS HANDLING PROCEDURE

Roles and responsibilities

East Dunbartonshire Health & Social Care Partnership Board as per the Public Bodies (Joint Working) Act and as specified within the integration authority's Integration Scheme, the Chief Officer's role is to provide a single senior point of overall strategic and operational advice to the integration authority. In line with this, overall responsibility and accountability for the management of complaints lies with the Chief Officer.

The final position on a complaint must be signed off by an appropriate senior officer who will confirm that this is the final response. This ensures the Senior Management Team owns and are accountable for the decision. It also reassures the complainant that their concerns have been taken seriously.

Chief Officer:

The Chief Officer provides leadership and direction in ways that guide and enable the HSCP Board to perform effectively. This includes ensuring that there is an effective complaints handling procedure, with a robust investigation process that demonstrates how the HSCP Board learns from the complaints received. The Chief Officer will take a professional interest in all complaints, but may delegate responsibility for the Complaints Handling Procedures to appropriate members of the Senior Management Team. Regular management reports assure the HSCP Board of the quality of complaints performance.

Senior Management Team:

The Senior Management Team of the Health & Social Care Partnership is responsible for:

- managing complaints and the learning from complaints
- overseeing the implementation of actions required as a result of a complaint
- investigating complaints
- deputising for the Chief Officer.

The Senior Management Team may delegate some elements of complaints handling (such as investigations and the drafting of response letters) to other senior staff. Where this is the case, the Senior Management Team should retain ownership and accountability for the management and reporting of complaints and retain responsibility for preparing and signing decision letters to customers and should therefore be satisfied that the investigation is complete and the response addresses all aspects of the complaint.

Complaints investigator:

The complaints investigator is responsible and accountable for the management of the investigation, co-ordinating all aspects of the response to the customer. This may include preparing a comprehensive written report, including details of any procedural changes that could result in wider opportunities for learning across the organisation.

All staff:

A complaint may be made to any member of staff working within the Health & Social Care Partnership. All staff must be aware of both their employing organisation's and the HSCP Board complaints handling procedures including how to handle and record complaints at the frontline stage. Staff should also be aware of whom to refer a complaint to if they are not able to personally handle the matter. The HSCP Board encourages all staff to try to resolve complaints early, as close to the point of service delivery as possible, and quickly to prevent escalation.

The HSCP Board SPSO Liaison Officer [Head of Administration]:

The HSCP Head of Administration will provide complaints information in an orderly, structured way within requested timescales, providing comments on factual accuracy on behalf of the HSCP Board in response to SPSO reports, and confirming and verifying that recommendations have been implemented.

Complaints about senior staff

Complaints concerning health and social care practitioners, Senior Management staff, Chief Officer or HSCP Board members can be difficult to handle, as there may be a

conflict of interest for the staff investigating the complaint. Such complaints must be handled through the employing/appointing organisation's complaints handling procedure.

Recording, reporting, learning and publicising

Complaints provide valuable customer feedback. One of the aims of the Complaints Handling Procedure is to identify opportunities to improve services across East Dunbartonshire Health & Social Care Partnership. All complaints are recorded in systematic way so that these can be used for data analysis and management reporting. Recording and using complaints information in this way means the root causes can be identified and addressed, and where appropriate, learning opportunities for improvement can be embedded.

Recording complaints

To collect suitable data it is essential to record all complaints in line with SPSO minimum requirements, as follows:

- the complainant's name and address
- the date the complaint was received
- the nature of the complaint
- how the complaint was received
- the date the complaint was closed at the frontline resolution stage (where appropriate)
- the date the complaint was escalated to the investigation stage (where appropriate)
- action taken at the investigation stage (where appropriate)
- the date the complaint was closed at the investigation stage (where appropriate)
- the outcome of the complaint at each stage
- the underlying cause of the complaint and any remedial action taken.

The HSCP Board has structured systems for recording complaints, their outcomes and any resulting action.

Reporting of complaints

Complaints details are analysed for trend information to ensure we identify procedural failures and take appropriate action. Regularly reporting the analysis of complaints information helps to inform improvement actions.

The HSCP Board publishes the outcome of complaints and the actions that has been taken in response on a quarterly basis. This demonstrates the improvements resulting from complaints and shows that complaints can influence processes. It also helps ensure transparency in the complaints handling service and will help the public to see that their complaints are valued.

The HSCP Board must:

- publicise on a quarterly basis complaints outcomes, trends and actions taken
- complaints where and when possible, use case studies and examples to demonstrate how complaints have led to improvements.

Learning from complaints

At the earliest opportunity after the closure of the complaint, officers involved in handling the complaint will make sure that the complainant and HSCP Board members understand the findings of the investigation and any recommendations made.

The Senior Management Team will review the information gathered from complaints regularly and consider whether processes could be improved or internal policies and procedures updated.

As a minimum, the HSCP Board will:

- use complaints data to identify the root cause of complaints
- take action to reduce the risk of recurrence
- record the details of corrective action in the complaints file, and
- systematically review complaints performance reports to improve processes.

Where there is an identified need for improvement:

- the action required must be agreed by the HSCP Board
- the Senior Management Team will designate the 'owner' of the issue, with responsibility for ensuring the action is taken
- a target date must be set for the action to be taken
- the designated individual must follow up to ensure that the action is taken within the agreed timescale
- where appropriate, performance should be monitored to ensure that the issue has been resolved
- the HSCP Board should demonstrate learning from complaints.

Publicising complaints performance information

The HSCP Board will report on complaints performance annually in line with SPSO requirements. This includes performance statistics showing the volumes and types of complaints and key performance details, for example on the time taken and the stage at which complaints were resolved.

Maintaining confidentiality

Confidentiality is important in complaints handling. It includes maintaining the complainant's confidentiality and explaining to them the importance of confidentiality generally. The HSCP Board must always bear in mind legal requirements, for example, data protection legislation, as well as internal policies on confidentiality and the use of customer's information.

Managing unacceptable behaviour

People may act out of character in times of trouble or distress. The circumstances leading to a complaint may result in the complainant acting in an unacceptable way. Complainants who have a history of challenging or inappropriate behaviour, or have difficulty expressing themselves, may still have a legitimate grievance.

A complainant's reasons for complaining may contribute to the way in which they present their complaint. Regardless of this, all complaints will be treated seriously and properly assessed. However, it is recognised that the actions of complainants who are angry, demanding or persistent may result in unreasonable demands on time and resources or unacceptable behaviour towards staff. The HSCP Board will, therefore, work with the Health Board and the Council to apply the relevant organisational policies and procedures to protect staff from unacceptable behaviour such as unreasonable persistence, threats or

offensive behaviour. Where a decision is made to restrict access to a complainant under the terms of an unacceptable actions policy, the relevant constituent body's procedure will be followed to communicate that decision, notify the customer of a right of appeal, and review any decision to restrict contact with us. This will allow the customer to demonstrate a more reasonable approach later.

Supporting the complainant

All members of the public have the right to equal access to the HSCP Board complaints handling procedure. Complainants who do not have English as a first language may need help with interpretation and translation services. Other customers may have specific needs that the HSCP Board will seek to address to ensure easy access to the complaints handling procedure taking into account a commitment and responsibilities to equality. This includes making reasonable adjustments to processes to help the complainants where appropriate.

East Dunbartonshire has a local support and advocacy grouporganisation available to support individuals in pursuing a complaint and customers/complainants should be signposted to:

Ceartas Advocacy

Unit 5-7, McGregor House

10 Donaldson Cres, Kirkintilloch

Glasgow G66 1XF.

Time limit for making complaints

This Complaints Handling Procedure sets a time limit of six months from when the complainants first knew of the problem, within which time they may ask the HSCP Board to consider the complaint, unless there are special circumstances for considering complaints beyond this time.

The HSCP Board will apply this time limit with discretion. In making this decision the HSCP Board will take account of the Scottish Public Services Ombudsman Act 2002 (Section 10(1)), which sets out the time limit within which a member of the public can normally ask the SPSO to consider complaints. The limit is one year from when the person first knew of the problem they are complaining about, unless there are special circumstances for considering complaints beyond this time.

If it is clear that a decision not to investigate a complaint will lead to a request for external review of the matter, the HSCP Board may decide that this satisfies the special circumstances criteria. This will enable the HSCP board to consider the complaint and try to resolve it.

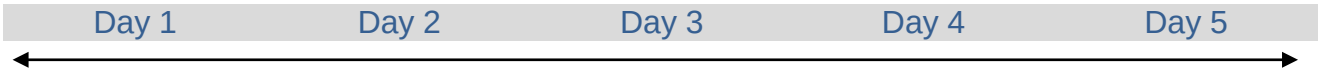
APPENDIX 1 - Timelines

General

References to timelines throughout the complaints handling procedure relate to working days. When measuring performance against the required timelines, the HSCP Board does not count non-working days, for example weekends, public holidays and days of industrial action where our service has been interrupted.

Timelines at frontline resolution

The HSCP Board aims to achieve frontline resolution within five working days. The day the Chief Officer receives the complaint is day 1. Where they receive it on a non-working day, for example at the weekend or on a public holiday, day 1 will be the next working day.



Day 1:
Day *the HSCP Board* receives the complaint, or next working date if date of receipt is a non-working day.

Day 5:
Frontline resolution achieved or complaint escalated to the investigation stage.

The date of receipt will be determined by the HSCP Board's usual arrangements for receiving and dating of mail and other correspondence.

Extension to the five-day timeline

If the HSCP Board has extended the timeline at the frontline resolution stage in line with the procedure, the revised timetable for the response will take no longer than 10 working days from the date of receiving the complaint.

Day 1:
Day *the HSCP Board* receives the complaint or next working date if date of receipt is a non-working day.

In a few cases where it is clearly essential to achieve early resolution, the HSCP Board may authorise an extension within five working days from when the complaint was received. They must conclude the frontline resolution stage within 10 working days from the date of receipt, either by resolving the complaint or by escalating it to the investigation stage.

Day 10:
Frontline resolution achieved or complaint escalated to the investigation stage.

Transferring cases from frontline resolution to investigation

If it is clear that frontline resolution has not resolved the matter, and the complainant wants to escalate the complaint to the investigation stage, the case must be passed for investigation without delay. In practice this will mean on the same day that the complainant is told this will happen.

Timelines at investigation

The HSCP Board may consider a complaint at the investigation stage either:

- after attempted frontline resolution, or
- Immediately on receipt if they believe the matter to be sufficiently complex, serious or appropriate to merit a full investigation from the outset.

Acknowledgement

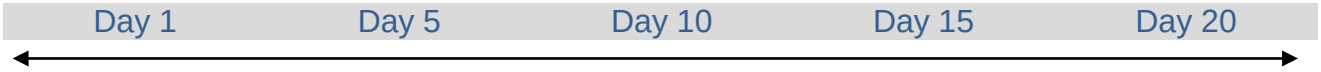
All complaints considered at the investigation stage must be acknowledged within **three working days** of receipt. The date of receipt is:

- the day the case is transferred from the frontline stage to the investigation stage, where it is clear that the case requires investigation, or
- the day the complainant asks for an investigation after a decision at the frontline resolution stage. It is important to note that a complainant may not ask for an investigation immediately after attempts at frontline resolution, or
- the date *the HSCP Board* receives the complaint, if it is sufficiently complex, serious or appropriate to merit a full investigation from the outset.

Investigation

The HSCP Board will respond in full to the complaint within **20 working days** of receiving it at the investigation stage.

The 20-working day limit allows time for a thorough, proportionate and consistent investigation to arrive at a decision that is objective, evidence-based and fair. There is 20 working days to investigate the complaint, regardless of any time taken to consider it at the frontline resolution stage.



Day 1:
Day complaint received at investigation stage, or next working day if date of receipt is a non-working day. Acknowledgement issued within three working days.

Day 20:
The decision issued to complainant or agreement reached with them to extend deadline

Exceptionally the HSCP Board may need longer than the 20-day limit for a full response. If so, the Chief Officer will explain the reasons to the complainant, and agree with them a revised timescale.

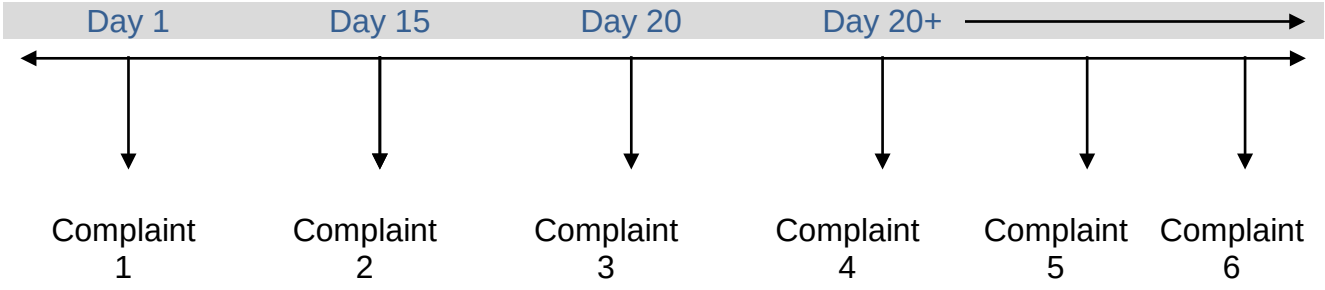
Day 1: Day complaint received at investigation stage, or next working day if date of receipt is a non-working day. Acknowledgement issued within three working days.

By Day 20: In agreement with the complainant where possible, decide a revised timescale for bringing the investigation to a conclusion.

By agreed date: Issue our final decision on the complaint

Timeline examples

The following illustration provides examples of the point at which the HSCP Board concludes consideration of a complaint. It is intended to show the different stages and times at which a complaint may be resolved.



The circumstances of each complaint are explained below:

Complaint 1

Complaint 1 is a straightforward issue that may be resolved by an on-the-spot explanation and, where appropriate, an apology. Such a complaint can be resolved on day 1.

Complaint 2

Complaint 2 is also a straightforward matter requiring little or no investigation. In this example, resolution is reached at day three of the frontline resolution stage.

Complaint 3

Complaint 3 refers to a complaint that it was considered appropriate for frontline resolution. The complaint was not resolved in the required timeline of five working days. However,

an extension was authorised with a clear and demonstrable expectation that the complaint would be satisfactorily resolved within a further five days. The HSCP Board resolved the complaint at the frontline resolution stage in a total of eight days.

Complaint 4

Complaint 4 was suitably complex or serious enough to pass to the investigation stage from the outset. A frontline resolution was not tried; rather the case was investigated immediately. The HSCP Board issued a final decision to the complainant within the 20-day limit.

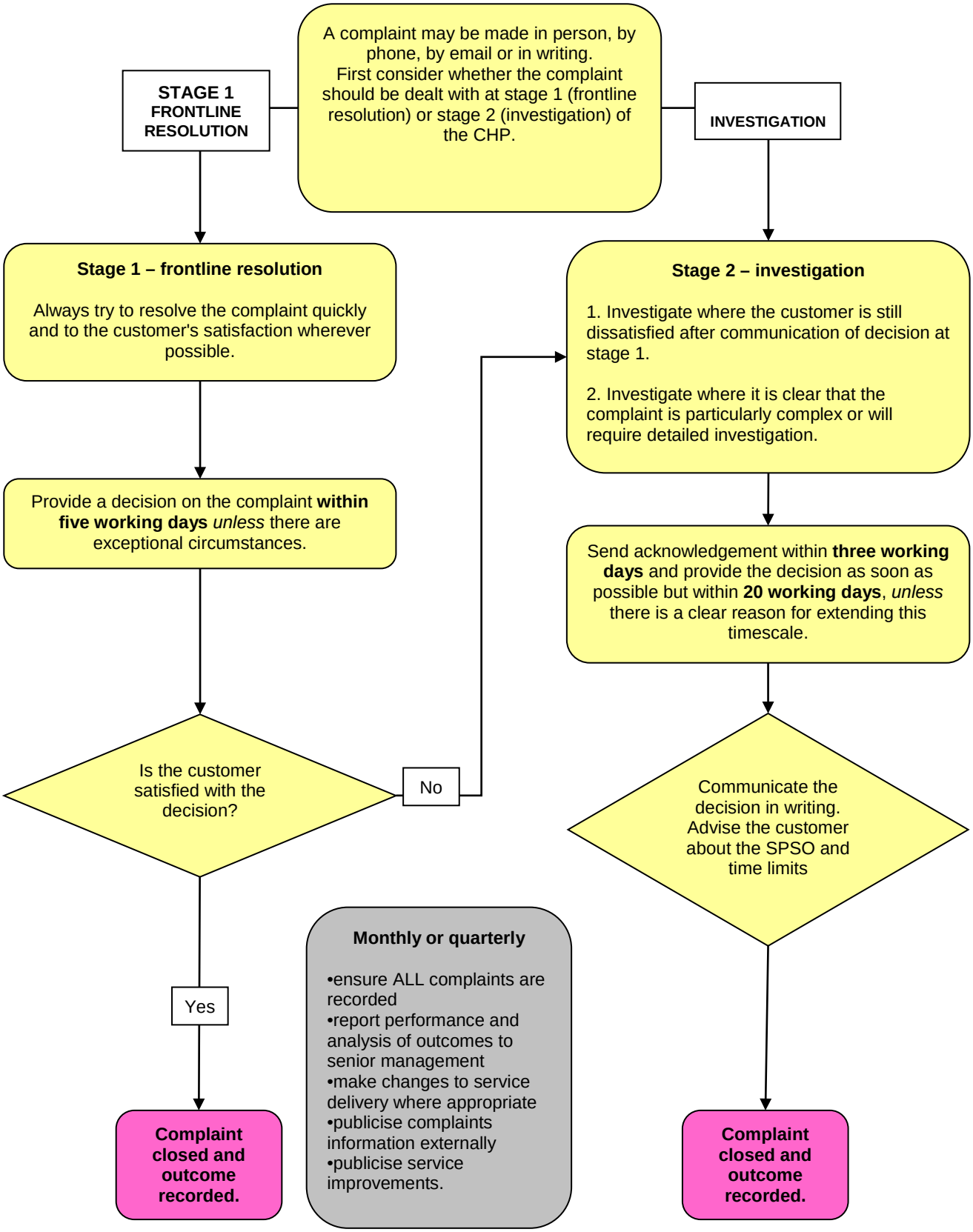
Complaint 5

The HSCP Board considered complaint 5 at the frontline resolution stage, where an extension of five days was authorised. At the end of the frontline stage the complainant was still dissatisfied. At their request, an investigation was conducted and a final response issued within 20 working days. Although the end-to-end timeline was 30 working days The HSCP Board still met the combined time targets for frontline resolution and investigation.

Complaint 6

Complaint 6 was considered at both the frontline resolution stage and the investigation stage. The HSCP Board did not complete the investigation within the 20-day limit, so it was agreed a revised timescale with the customer for concluding the investigation beyond the 20-day limit.

APPENDIX 2 - Complaints handling procedure flowchart



East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 8

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	Self-Directed Support: Audit Commission Follow Up Evaluation
Report By	Paolo Mazzoncini, Chief Social Work Officer and Head of Children & Criminal Justice Services
Contact Officer	Kelly Gainty, Adults and Community Care Support Worker 0141 777 3000 Kelly.gainty@eastdunbarton.gov.uk

Purpose of Report	The purpose of the report is to inform the Board about the key recommendations contained within the Audit Commission's *Progress Report on Self Directed Support (2017)* and to advise on East Dunbartonshire HSCP's achievements and further developments related to those recommendations. The Report and accompanying documentation can be found at http://www.audit-scotland.gov.uk/report/self-directed-support-2017-progress-report

Recommendations	It is recommended that the HSCP Board: • Consider the Audit Commission's key recommendations for the continued development of Self Directed Support; • Consider and approve the further developments proposed within East Dunbartonshire.

Relevance to HSCP Board Strategic Plan	Self-Directed Support (SDS) is the legal, mainstream process for the delivery of social care packages to all eligible customers. SDS is required to be considered and feature in all activities associated with social care activities contained within the Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	East Dunbartonshire Council employs a dedicated member of staff within the HSCP who has responsibility for leading on the continued implementation of SDS. Other Social Work practitioners and staff within Planning and Commissioning Services, Procurement, Legal and Shared Services along with health staff support SDS.

Equalities:	The current SDS Strategy and provision of the SDS options meets all equality duties and has been subject to an Equalities Impact Assessment.

Financial:	SDS support packages are funded from mainstream budgets. The customers' individual budgets are based on an equivalency model meaning that packages will not cost more than a support package provided under SDS Option 3. However, there are impacts on financial budgets where customers choose alternative supports where services provided or commissioned under Option 3 includes staffing and building costs.

Legal:	The legislation, '*The Social Care (Self Directed Support) (Scotland) 2013*' was enacted on 1st April 2014. It contains legal duties, which require that, any customer: child, adult or older person, irrespective of disability; is entitled to utilise SDS options to arrange and manage their support package.

Economic Impact:	SDS brings opportunities to expand the social care market. However, the management of this market is crucial to ensuring that social care services continue to develop and maintain the capacity to meet and respond to identified needs within East Dunbartonshire. It has already become evident both locally and nationally that social care providers, including the employment of private Personal Assistants, are struggling to meet the increasing demands within the social care market. This has been recognised by Social Work Scotland as an area that requires further development at a national level.

Sustainability:	The HSCP's forthcoming commissioning and marketing strategy will consider how the HSCP can ensure sustainability of different types of support provisions. This will involve the review of current social care support services to explore how they may be required to change and develop to remain within the social care market.

Risk Implications:	The HSCP will ensure that it has clear plans within its commissioning and marketing strategy for reviewing the use and effectiveness of the different SDS services provided. This will lessen the risk of over commitment and avoid the HSCP not being able to provide social care support for everyone who needs it.

Implications for East Dunbartonshire Council:	All East Dunbartonshire Council staff who are involved in assessing customers for social care support as per the Social Work and Children's Act legislation have to meet their legal duties under the SDS legislation. This means that those staff are required to be involved in the activities associated with meeting the key recommendations contained within the Audit Commission's Follow Up Evaluation of SDS.

Implications for NHS Greater Glasgow & Clyde:	All staff employed by Greater Glasgow and Clyde Health Board, who are involved in the assessment and arrangement of social care support for East Dunbartonshire customers are required to meet the duties contained within the SDS legislation. This means that those staff are required to be involved in these same activities outlined for Council staff.

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**

1.0 MAIN REPORT

1.1 The Self Directed Support legislation was enacted on 1st April 2014. The legislation offers those customers assessed as eligible for social care support different options that proffer varying levels of flexibility, choice, control and responsibility for the delivery of their support package.

1.2 There are four SDS options:

- SDS Option 1 (Direct Payments) – the budget is provided directly to the customer who takes responsibility for arranging and managing their own support package;
- SDS Option 2 (Individual Service Fund) – the budget is paid directly to the customer's chosen support provider and the customer liaises with the provider regarding the arrangement and management of their support package;
- SDS Option 3 (Local Authority Provided Service) – the customer asks their Social Work practitioner to arrange and manage their support package;
- SDS Option 4 (Mixture of Options) – the customer can utilise SDS Options 1, 2 and/or 3 to meet different needs and outcomes contained within their Support Plan.

1.3 The majority of customers continue to choose SDS Option 3 however, increases in the numbers of customers choosing SDS Options 1 and 2 while low is steadily continuous. The Scottish Government recognised within their 10 year National SDS Strategy that the introduction of the SDS options would not be an "overnight transformation".

1.4 The Audit Commission undertook a progress evaluation of SDS in Scotland, following their initial evaluation in 2015. This involved examining progress of SDS in five local authority areas: East Ayrshire, Glasgow, Highland, Perth and Kinross and the Western Isles. The Audit Commission interviewed 37 national and local (to those authority areas) organisations and received 110 responses to their customer and carer survey. They also held nine focus groups involving a total of 55 customers and carers.

1.5 The key recommendations made by the Audit Commission are that the authorities should:

- work in partnership with customers, carers and providers to design more flexibility and choice into support options;
- review their processes for supporting children to transition into adult services;

- provide staff with further training and help on identifying and planning for outcomes;
- work with customers and carers to review their assessment and support planning processes, making them simpler and more transparent;
- establish clear guidance for staff on discussing the balance between innovation, choice and risk;
- support staff in developing innovative solutions to meet individual needs flexibly;
- ensure the provision of sources of information is available to those accessing SDS;
- work with customers, carers and providers to review information and help offered during assessment, reviews and planning discussions;
- develop longer-term commissioning plans that clearly set out choice and flexibility;
- work with customers, carers and providers to develop flexible outcome focused contract arrangements;
- continue to work with communities to develop alternative services and activities;
- develop targeted information and training on SDS for healthcare professionals;
- monitor and report the extent to which people's personal outcomes are being met.

1.6 East Dunbartonshire HSCP has a number of achievements that relate to the key recommendations outlined by the Audit Commission. These include:

- the development of outcome focused support planning and review tools;
- numerous examples of flexible, creative and innovative support packages across all customer groups;
- SDS strategy, process and operational procedures that fit with all customer groups including young people in transition to adult services;
- the provision of training to practitioners in subjects that include: SDS, Outcomes; Just Enough Support, Good Conversations, and Personalisation and Risk;
- a well-established risk management and risk enablement process and procedures;
- an abundance of information materials available in different formats covering subjects that include SDS, Becoming an Employer, SDS and Adult Support and Protection, Individual Budgets, Good Conversation Cards, twice yearly SDS Newsletter and more recently a SDS leaflet written in consultation with the Young Carers Forum specifically for young people;
- a long term contract with an independent, user-led, SDS information, advice and support service;
- using the SDS Implementation Budget to funding pilot projects (Arts Project for customers with Learning Disability, Brokerage Service for customers with Mental Health illness) and kick start funding for early intervention/prevention assets (Recovery Café, Men's Shed Project, Get, Set and Go);
- an established SDS Stakeholder and Reference Group;
- SDS Workshops with Support Provider Organisations and delivery of training and awareness raising with provider staff;
- provision of funding and participation in the development training for local Personal Assistants;
- delivery of a bespoke training course, in partnership with Carers Links, incorporating SDS, Carers legislation, Good Conversations, Risk and Personalisation to unpaid carers.

1.7 The HSCP is committed to further developing SDS and has a number of activities planned and/or progressing:

- benchmarking and exploring alternative, more flexible contract arrangements for Option 2;

- developing further training opportunities for social work and health practitioners, providers, customers and carers including the consideration of e-learning modules;
- continued funding of pilot project and early intervention initiatives (dependent upon continued Scottish Government SDS implementation funds);
- review of the local SDS Strategy in line with the four outcomes identified in the national SDS Implementation Plan 2016 – 2018;
- the inclusion of SDS within the Commissioning and Marketing Strategy;
- benchmarking and exploration of commissioning for outcomes;
- establishment of a Transitions Sub Group to review the HSCP's Transition processes and ensuring the full inclusion of SDS options;
- the continued development of the CareAssess tool (module of the Social Work CareFirst database system) to record customer's individual outcomes;
- the employment of Local Area Co-ordinators for Older People to develop community based assets and supports as an alternative to day centre support which targets customers who have a requirement for a lower level preventative support;
- a local SDS conference in March 2018 giving local people and practitioners the opportunity to hear SDS experiences told directly by customers and carers.

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 10

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	Quarter 1 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

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 April – June 2017 (Quarter 1).

Recommendations	It is recommended that the Health & Social Care Partnership Board: Notes the content of the Quarter 1 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 1 2017/18 PERFORMANCE REPORT

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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, KSF, PDP & PDR reviews.

SECTION 2
Performance Summary

- Positive Performance (on target) improving (12 measures)
- Positive Performance (on target) declining (6 measures)
- Negative Performance (below target) improving (3 measures)
- Negative Performance (below target) declining (3 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
4.3	Percentage of service users (65+) meeting the target of 6 weeks from completion of community care assessment to service delivery
4.4	Number of peple 75+ with a telecare package (at quarter end)
4.7	Percentage of Adult Protection cases where the required timescales have been met
5.2	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral
5.4	Sustain & embed alcohol brief interventions in three priority setting (primary care, A&E, Antenatal) and broaden delivery in wider settings.
5.6	18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services
6.3	Percentage of first 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 month Assessment

Positive Performance (on target but declining) is reported in

Ref.	
4.1	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 (% at quarter end)
4.5	Number of new permanent admissions to care homes 65+
5.5	Sustain and embed smoking quits, at 12 weeks post quit, in the 40% SIMD areas
6.1	Percentage of Child Care Integrated Assessments (ICA) for SCRA completed within target timescales (20 days)
7.2	Percentage of CJSW submitted to Court by due date

Negative Performance (below target but maintaining/improving)

Ref.	
5.1	Percentage of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery
5.3	Percentage of people newly diagnosed with Dementia accessing a minimum of one year's post-diagnostic support
7.1	Percentage of Individuals beginning a work placement within 7 days of receiving a Community Payback Order

Negative Performance (below target and declining)

Ref.	
4.6	Number of people aged 65+ in permanent care home placements (at quarter end)
6.2	Percentage of Initial Child Protection Case Conferences taking place within 21 days from receipt of referral
6.4	Balance of care for Looked After Children: Percentage of children being looked after in the community

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

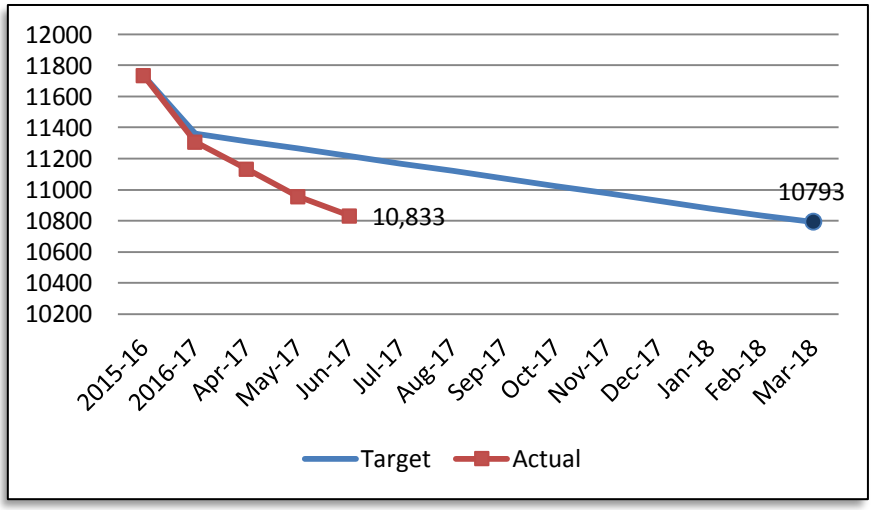


Table 3.1 Quarterly number of Unplanned Acute Emergency Admissions

Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	2017/18 (quarter)
3,004	2,739	2,550	2,540	2,698

Situational Analysis:
The HSCP agreed a target of a 5% reduction in the number of unplanned admissions by March 2018 from the 2015/16 baseline. The quarterly performance continues to improve and we will maintain this downward trend through the implementation of our actions set out in the HSCP Unscheduled Care Plan.

Improvement Actions:

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

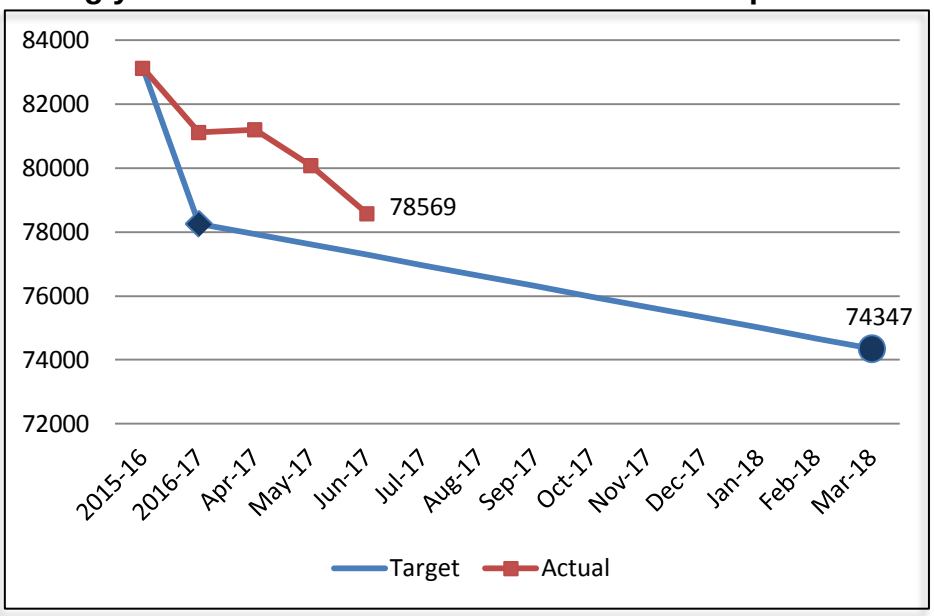


Table 3.2 Quarterly number of Unscheduled Hospital Bed Days

Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	2017/18 (quarter)
20,247	19,543	20,626	18,153	18,586

Situational Analysis:

The HSCP agreed a target of a 5% reduction in the number of unscheduled hospital bed days by March 2018, from the 2015/16 baseline. During this quarter, the actual number of bed days was below target for the first time. The improvement in performance is also illustrated in the rolling year trend graph.

Improvement Actions:

We will continue to implement the actions set out in our HSCP Unscheduled Care Plan, including initiatives currently in place such as; intermediate care, rapid response, falls prevention, and links with Care Homes.

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

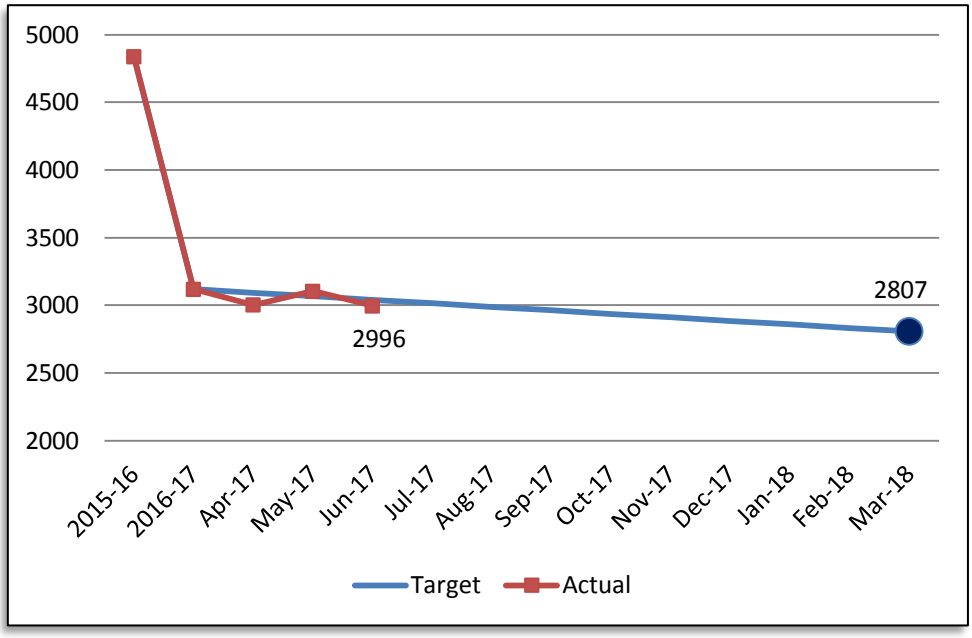


Table 3.3 Quarterly number of Delayed Discharge Bed Days

Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	2017/18 (quarter)
723	823	751	690	702

Situational Analysis:
The HSCP agreed a target of a 10% reduction in the number of delayed discharge bed days by March 2018, from the 2015/16 baseline. Delayed discharges continuing along projected downward trend.

Improvement Actions:
The multi-disciplinary Delayed Discharge Group meets weekly to identify patients at risk of being delayed, and agree actions to expedite discharge.

SECTION 4
Social Care Core Indicators

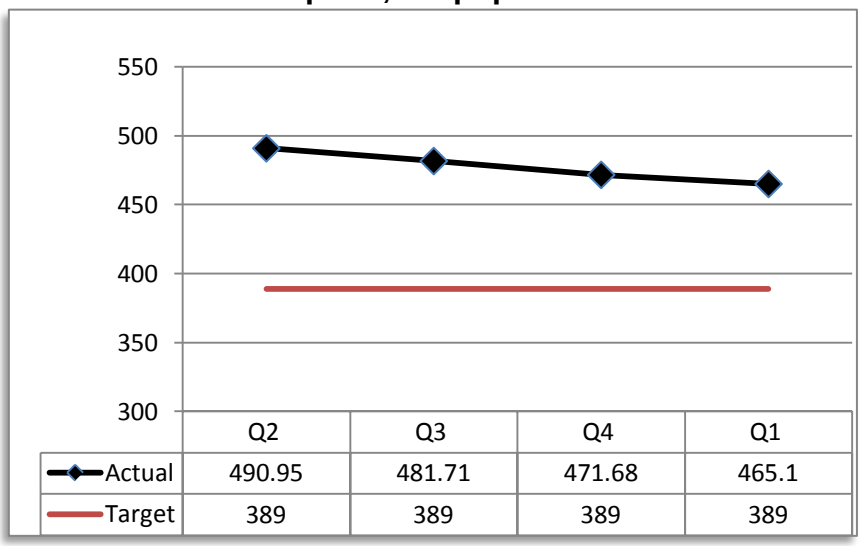
This section provides an updated report of Social Care core dataset and includes data collated by East Dunbartonshire Council Performance & Research Team. Although reported separately from the Health and Social Care data, the following indicators are integral to achieving the targets set out in Health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



	Q2	Q3	Q4	Q1
Actual	490.95	481.71	471.68	465.1
Target	389	389	389	389

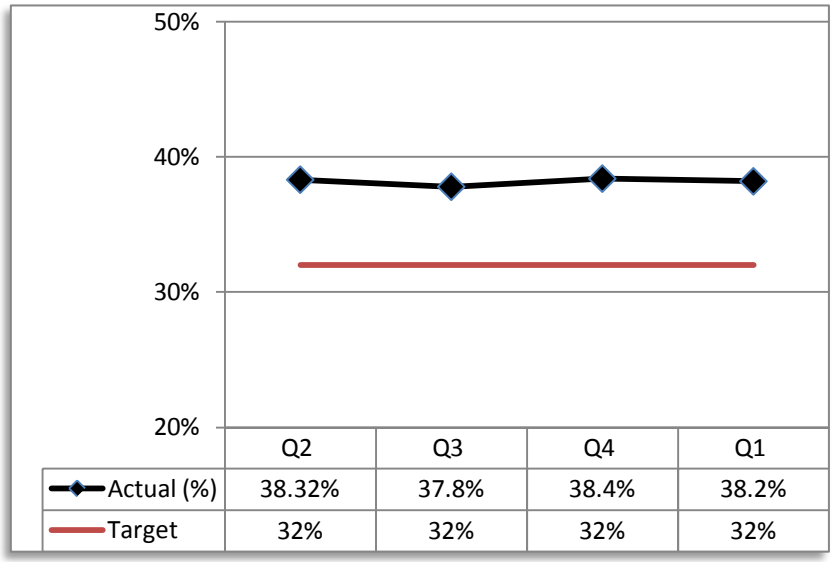
Situational Analysis:
This indicator is expected to see an upward trend as more people are supported to remain in their own home. Performance appears to be declining, but more detailed analysis of this indicator will be undertaken during 2017/18 to inform improved reporting.

Improvement Actions:
This historical target will be reviewed during 2017/18 so that it better reflects local priorities and ambitions.

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



	Q2	Q3	Q4	Q1
Actual (%)	38.32%	37.8%	38.4%	38.2%
Target	32%	32%	32%	32%

Situational Analysis

This indicator is expected to see an upward trend as more people with complex needs are supported to remain in their own home. The data are based on mainstream homecare only and do not include the supported living element.

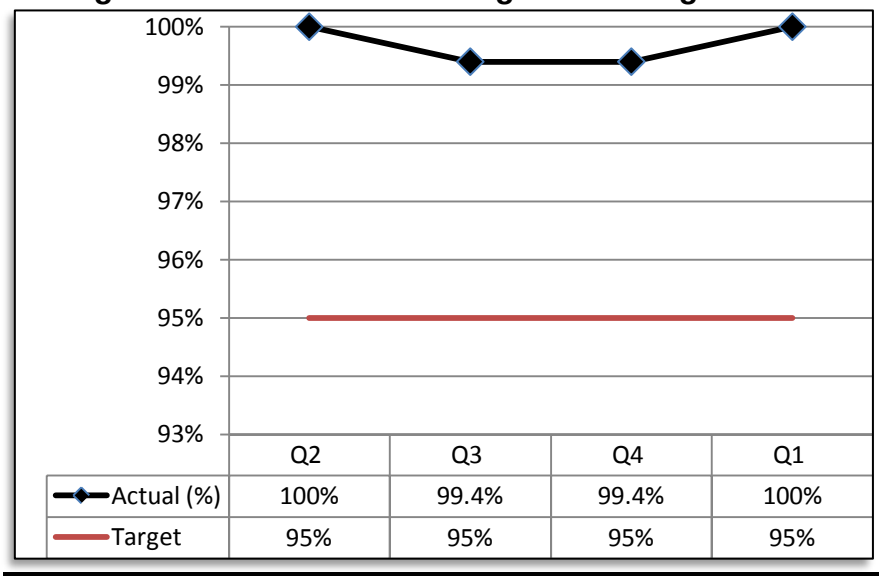
Improvement Actions:

This historical target will be reviewed during 2017/18 so that it better reflects local priorities and ambitions.

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

Rationale Key indicator required by Scottish Government. 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.

Figure 4.3 Percentage of service users meeting 6 week target



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

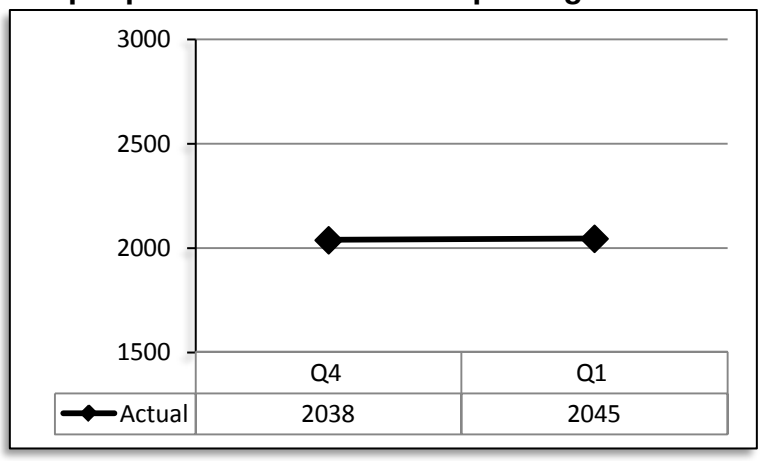
Situational Analysis:
Target met during Q1.

Improvement Action:

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



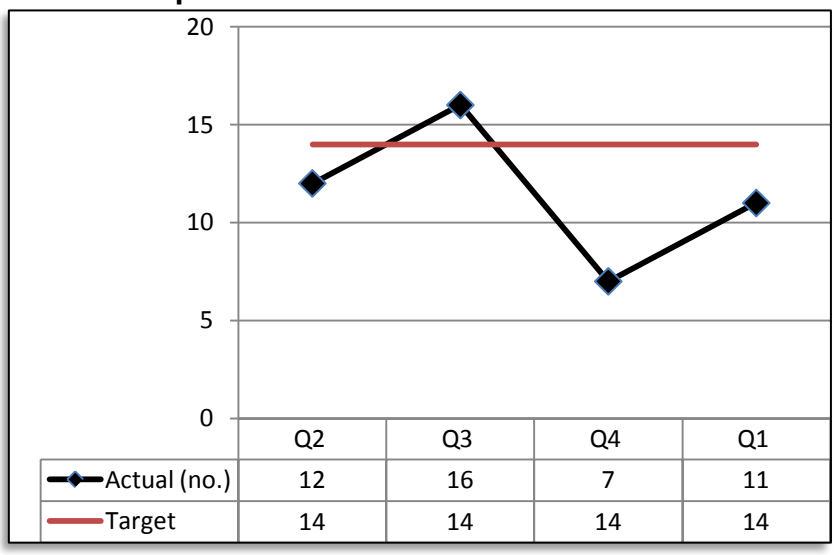
Situational Analysis:
Telecare / Telehealth working group is being established and the group will agree an action plan to take forward initiatives to improve the implementation of appropriate individual telecare packages across client groups.

Improvement Actions:
The HSCP is currently developing a robust recording system for Telecare. Data for Q4 and Q1 is an average of the overall total, mainly of those with community alarms. During 2017/18 robust measures and a recording system will be established to monitor performance.

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+



	Q2	Q3	Q4	Q1
Actual (no.)	12	16	7	11
Target	14	14	14	14

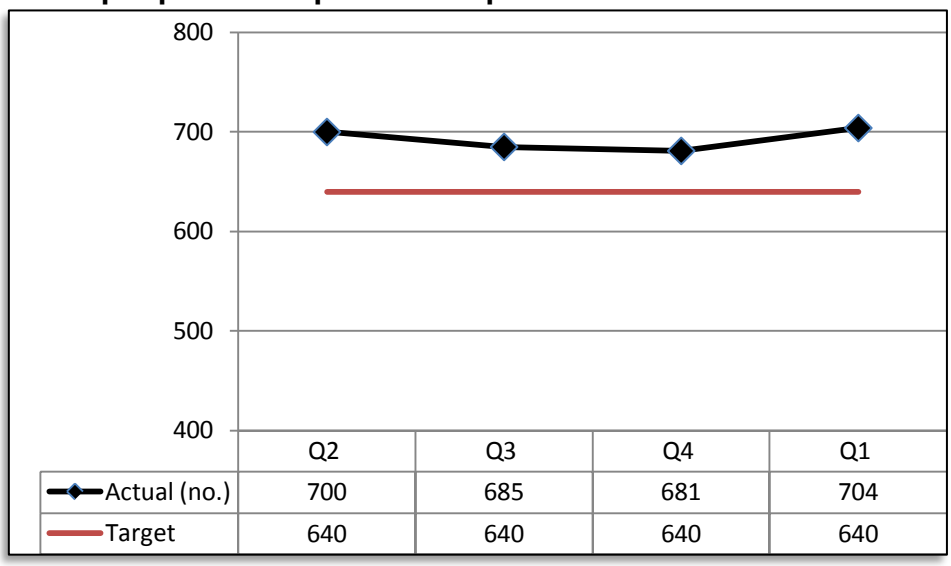
Situational Analysis:
Continue to maintain the current practice and processes to remain below target.

Improvement Actions:

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



	Q2	Q3	Q4	Q1
Actual (no.)	700	685	681	704
Target	640	640	640	640

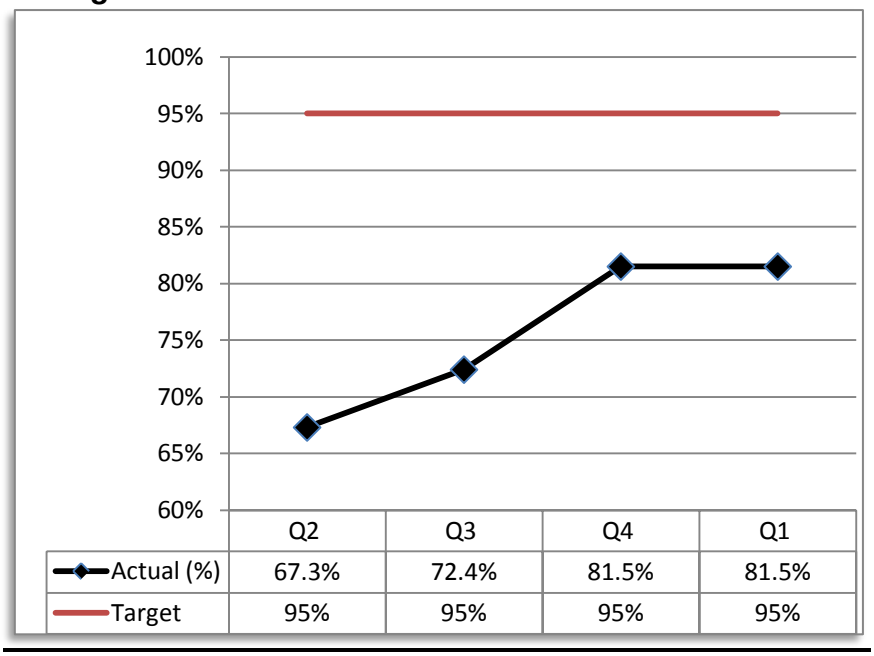
Situational Analysis:
This nationally reported data provides the number of people in a Care Home at a given point in time. It does not consider age on admission or average length of stay, which better reflect appropriate admissions.

Improvement Actions:
Explore further data to provide better understanding of the target reported.

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

Rationale: Council social work services 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



	Q2	Q3	Q4	Q1
Actual (%)	67.3%	72.4%	81.5%	81.5%
Target	95%	95%	95%	95%

Situational Analysis:
The performance target was met or exceeded every quarter between mid-2012 and the end of 2015. The indicator measures the time taken to initiate inquiries, visits and multi-agency meetings. Performance fell below target and has remained there since the beginning of 2016. Analysis shows that this fall is specifically linked to an increase in the time taken to initiate inquiries in response to ASP referrals. During this period there has been a 25% increase in ASP referrals being made to social work, equating to 2 additional referrals per week. The increase in referrals is thought to be linked to improved awareness and reporting by partner agencies including Police Scotland and independent sector care providers.

Improvement Actions:
A task group will be set up to review referral handling processes. The initial referral discussion (IRD) model for screening ASP referrals made by Police Scotland is established elsewhere in Scotland, and the potential to introduce this model in East Dunbartonshire will be considered by the Adult Protection Committee.

SECTION 5
NHS Local Delivery Plan Indicators

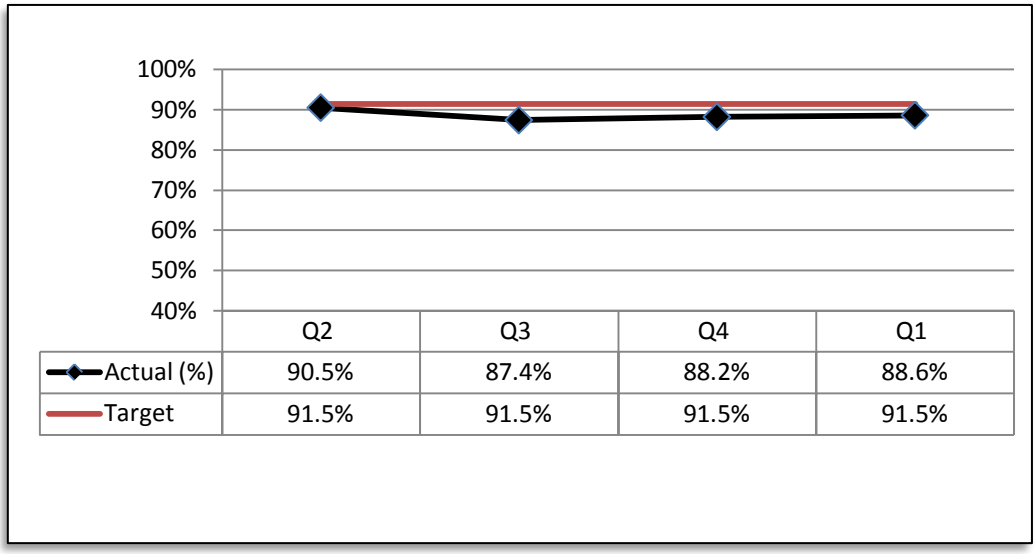
LDP Standards refer to a suit of targets which are set annually by the Scottish Government, and which define performance levels which all Health Boards are expected to either sustain or improve. The HSCP has devolved responsibility for a number of the LDP Standards, namely:

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



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

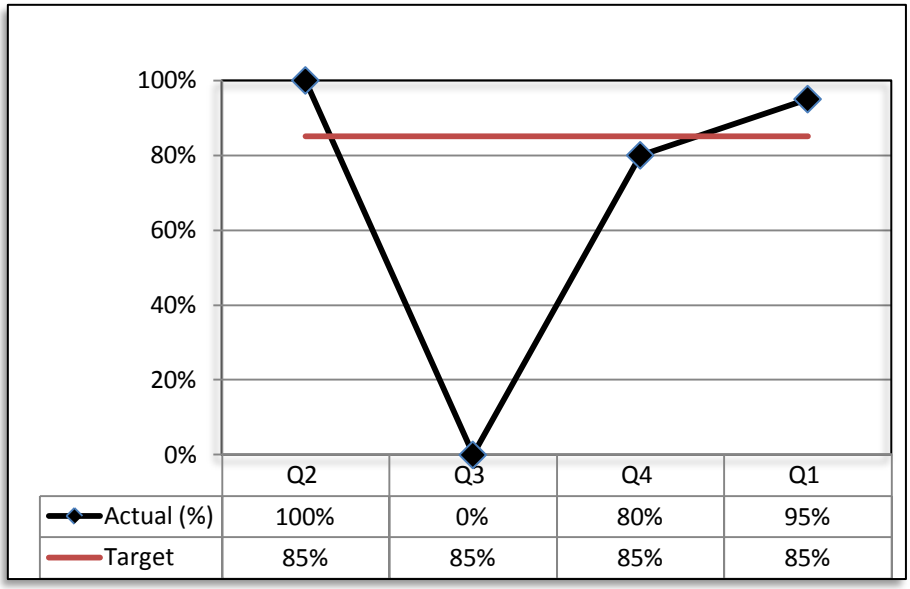
Situational Analysis:
Performance continues to be slightly below target due to vacancies leading to pressures in the service.

Improvement Actions:
Vacant posts have been advertised and it is anticipated that the performance will improve when the posts are filled.

5.2 Percentage of patients who started 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



	Q2	Q3	Q4	Q1
Actual (%)	100%	0%	80%	95%
Target	85%	85%	85%	85%

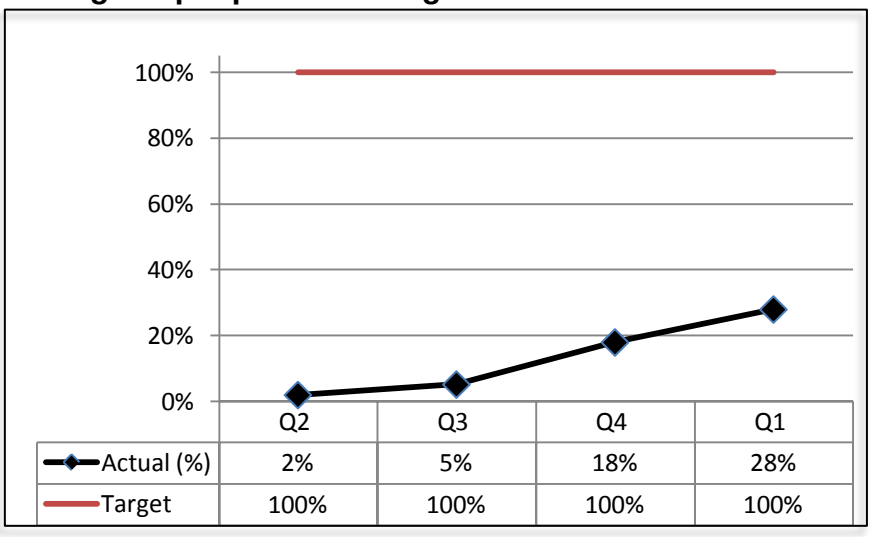
Situational Analysis:
Data for Q1 has not been collated by GG&C due to the roll out of the EMIS information system across all HSCPs. Information was gained from local intelligence for this quarter and is therefore provisional.

Improvement Action:

5.3 Percentage of people newly diagnosed with dementia accessing a minimum on 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



	Q2	Q3	Q4	Q1
Actual (%)	2%	5%	18%	28%
Target	100%	100%	100%	100%

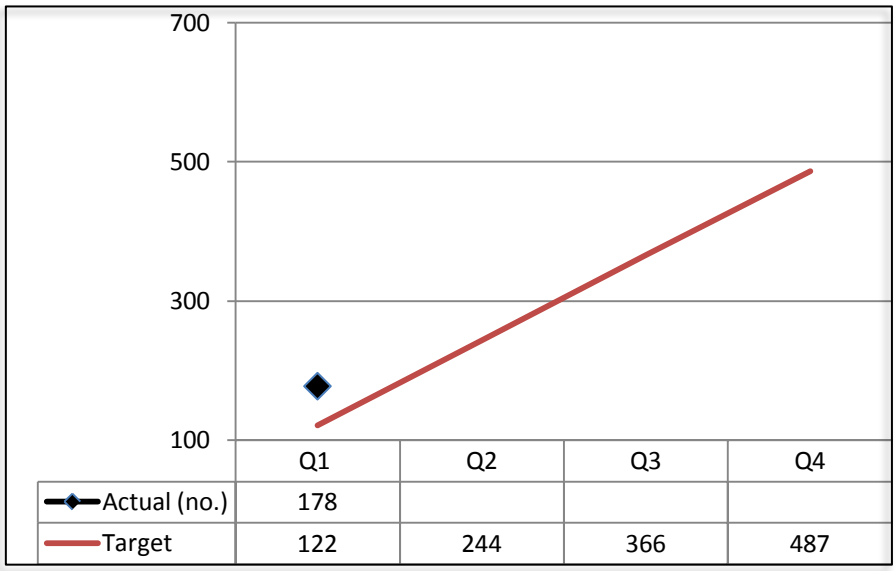
Situational Analysis:
Figure for Q1 is under target but has increased from previous quarter. Due to vacancies within the service, existing caseloads had to be disseminated to ensure continuity of care for existing clients.

Improvement Action:
Staff have been now been appointed to all vacancies and access to PDS will be addressed as a priority.

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			
Target	122	244	366	487

Situational Analysis:

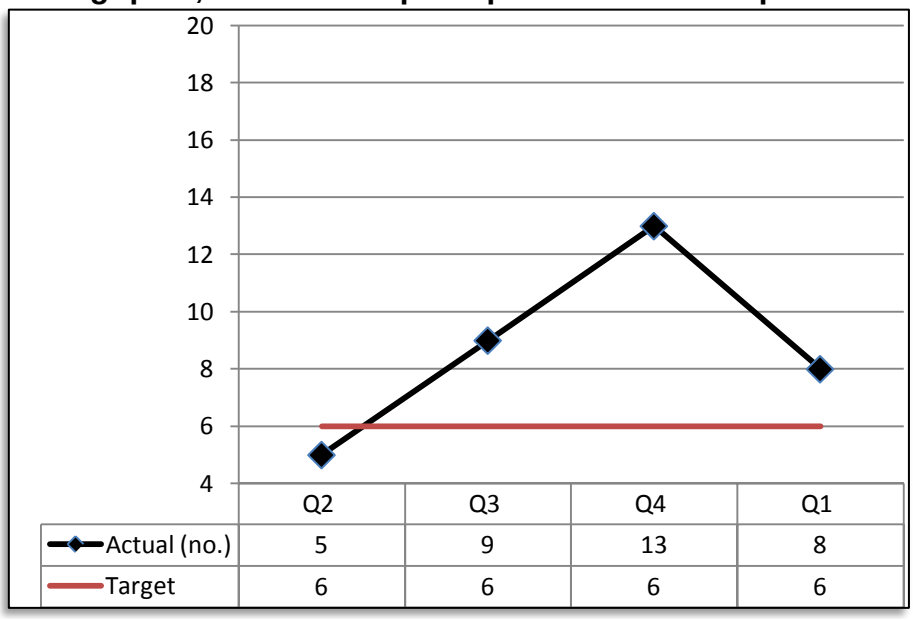
The data for ABIs is refreshed each year (1st Apr – 31st Mar). This is measured against an annual cumulative target.

Improvement Action:

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



	Q2	Q3	Q4	Q1
Actual (no.)	5	9	13	8
Target	6	6	6	6

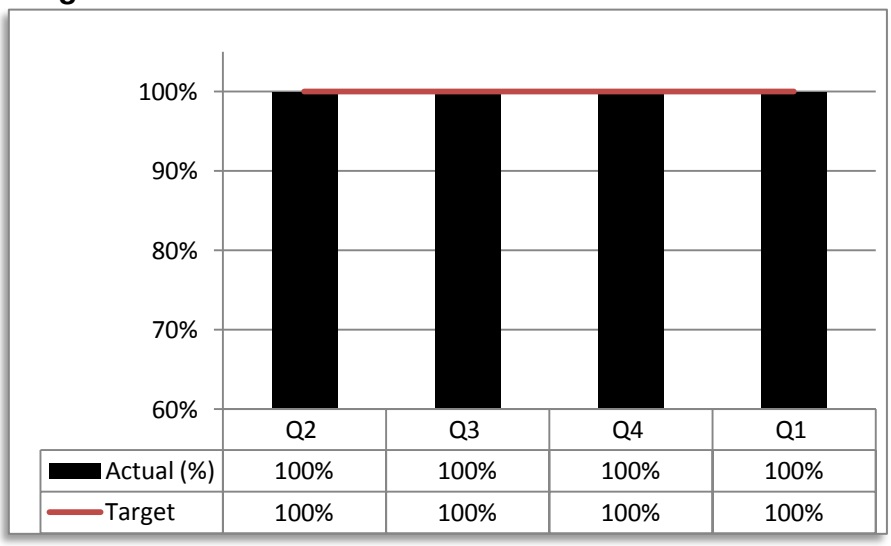
Situational Analysis:
Continue with our current initiatives to remain above target

Improvement Action:

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



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

Situational Analysis:
Continue to maintain the 100% national target.

Improvement Actions:

SECTION 6
Children's Service Performance

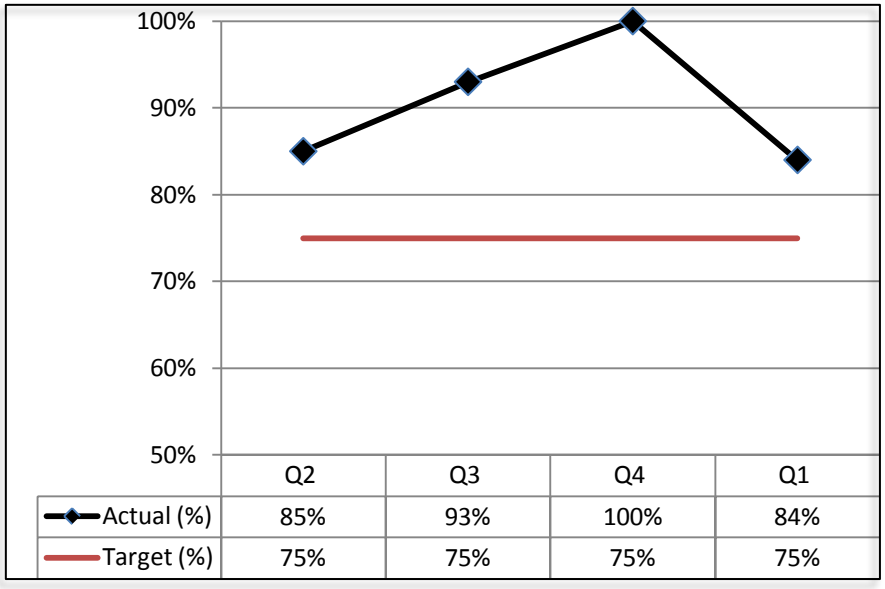
This section provides an updated report performance against key Children and Families indicators. The indicators reported are:

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 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



	Q2	Q3	Q4	Q1
Actual (%)	85%	93%	100%	84%
Target (%)	75%	75%	75%	75%

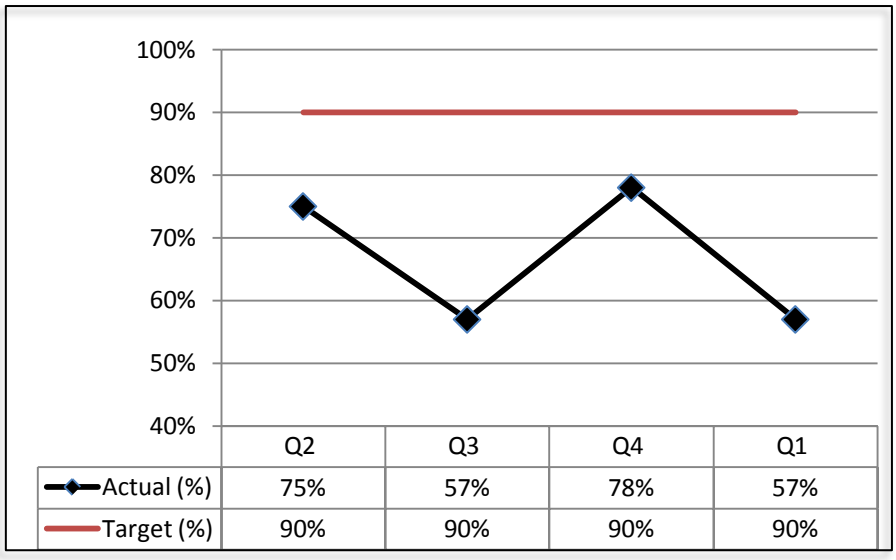
Situational Analysis:
Performance in this area has dropped from the previous quarter but continues to be above the national target. 19 ICA reports were submitted to SCRA during Q1, 16 of which were submitted within requested timescale.

Improvement Action:

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



	Q2	Q3	Q4	Q1
Actual (%)	75%	57%	78%	57%
Target (%)	90%	90%	90%	90%

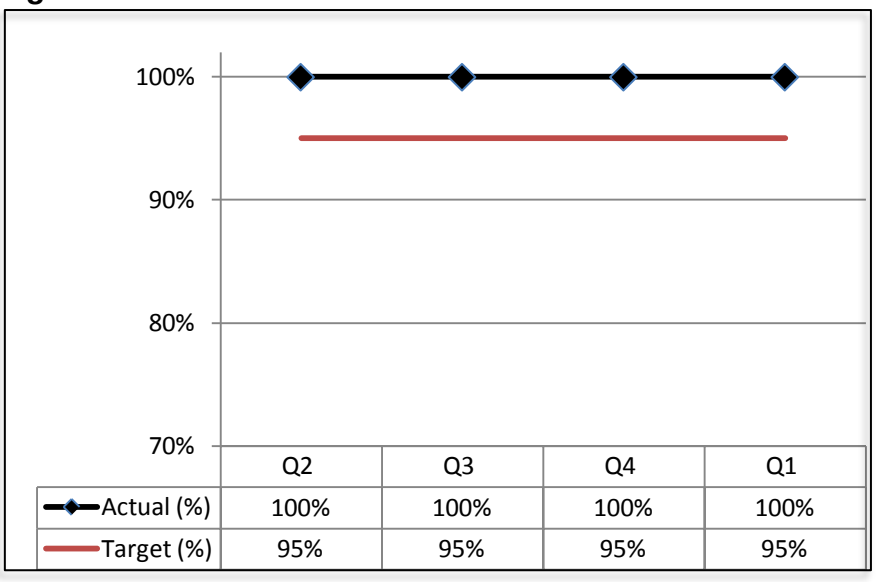
Situational Analysis:
Performance in Quarter 1 is below target for the fourth consecutive quarter. 14 Initial Child Protection Case Conferences were held during Quarter 1, 8 of which were within timescale. However for the other 6, ongoing work was undertaken with these families in terms of assessments. The children were safe throughout this period.

Improvement Action:
Continue to ensure Initial Child Protection Case Conferences are scheduled within the timescales and supported by Shared Services to ensure invites are sent out timeously. Additionally, ensure families are supported to attend to avoid rescheduling.

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



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

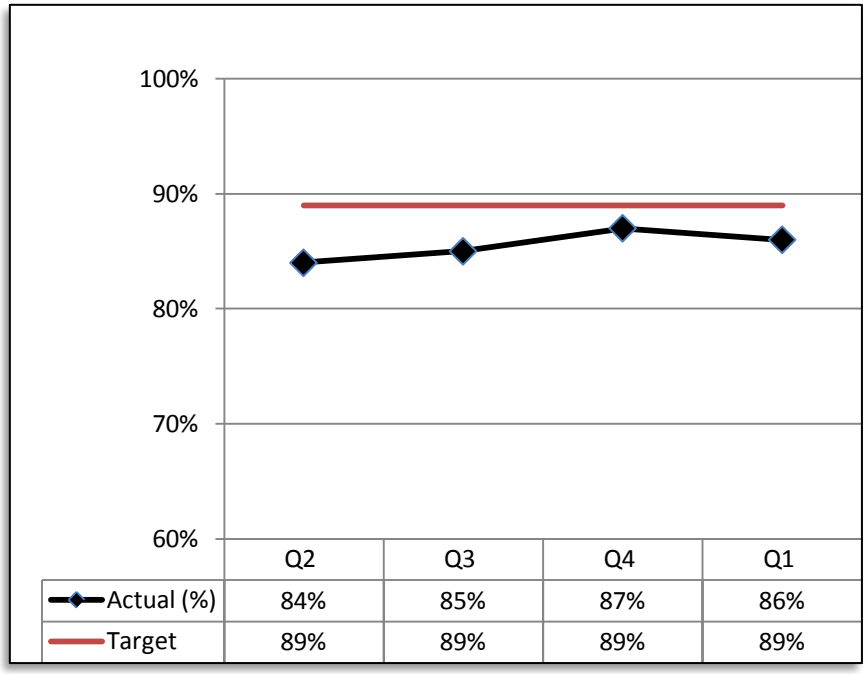
Situational Analysis:
Performance in Quarter 1 is above target. 16 First Child Protection Reviews took place during Quarter 1 and all of these were within timescale.

Improvement Action:

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



	Q2	Q3	Q4	Q1
Actual (%)	84%	85%	87%	86%
Target	89%	89%	89%	89%

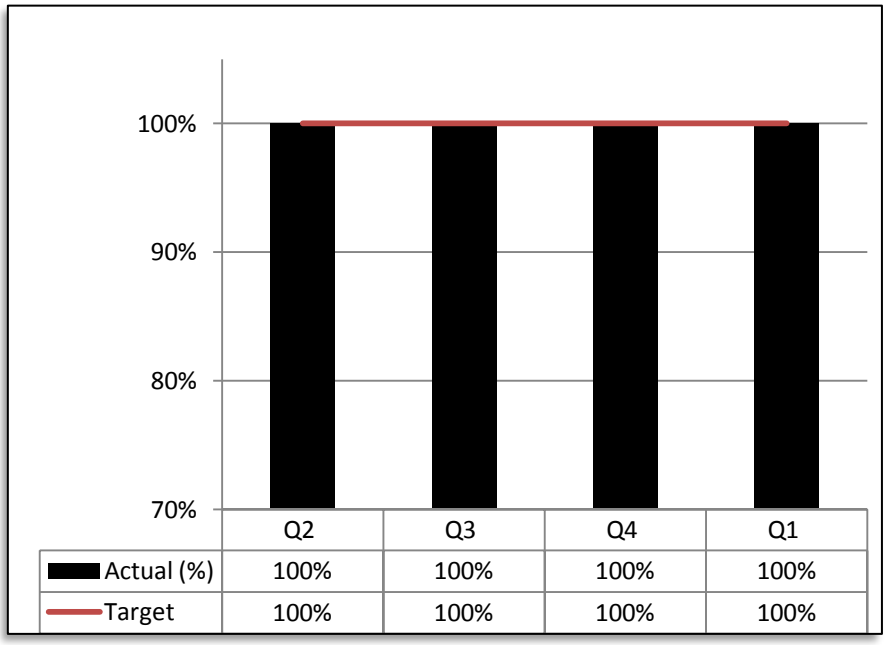
Situational Analysis:
Performance at the end of Quarter 1 has marginally declined from the previous quarter, and is still slightly below the target figure. There has been an increase of 1 child in community placements and an increase of 2 children in the number of residential placements.

Improvement Actions:
This is an area for improvement identified in the HSCP Strategic Plan and will be addressed accordingly.

6.5 Percentage of first Looked After & Accommodated 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



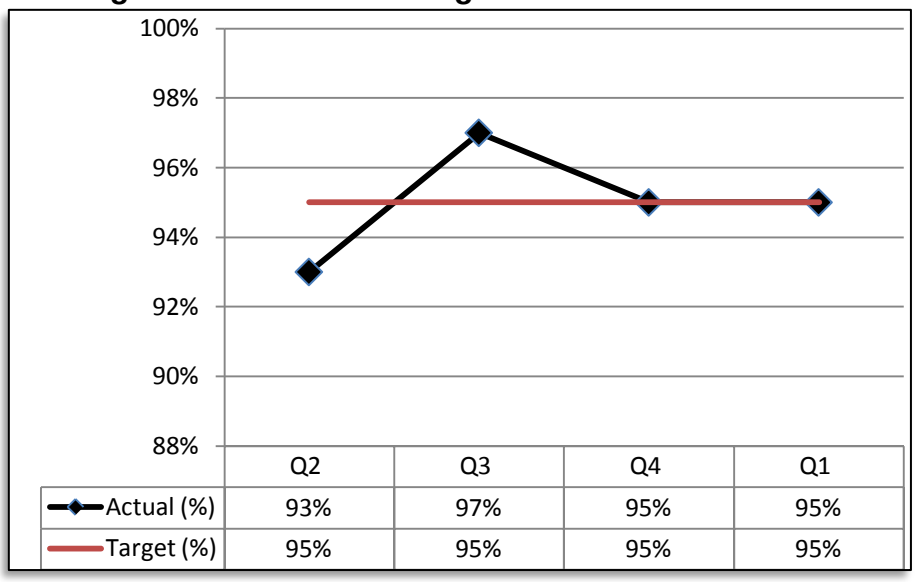
Situational Analysis:
Performance in Quarter 1 is on target. There were 11 first LAAC Reviews held during Q1, all of which took place within the target timescale.

Improvement Actions:

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



	Q2	Q3	Q4	Q1
Actual (%)	93%	97%	95%	95%
Target (%)	95%	95%	95%	95%

Situational Analysis: Currently meeting target at 95%. Within this period 7% of children assessed where identified as requiring a referral to another service for assessment.

Improvement Action: Continue to monitor uptake of the 27-30 month assessment to ensure we maintain 95% target.

SECTION 7
Community Justice Performance

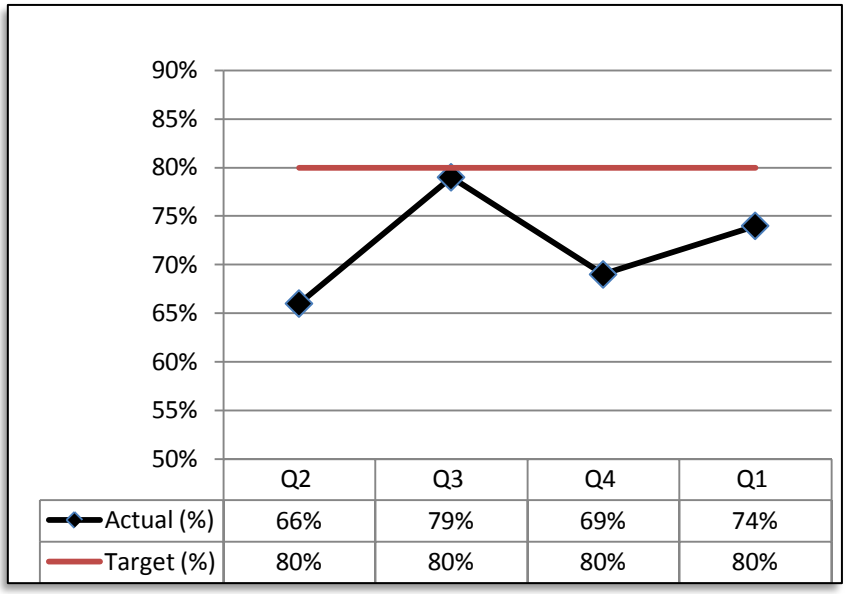
This section provides an updated report performance against key Criminal Justice indicators. The indicators reported are:

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



	Q2	Q3	Q4	Q1
Actual (%)	66%	79%	69%	74%
Target (%)	80%	80%	80%	80%

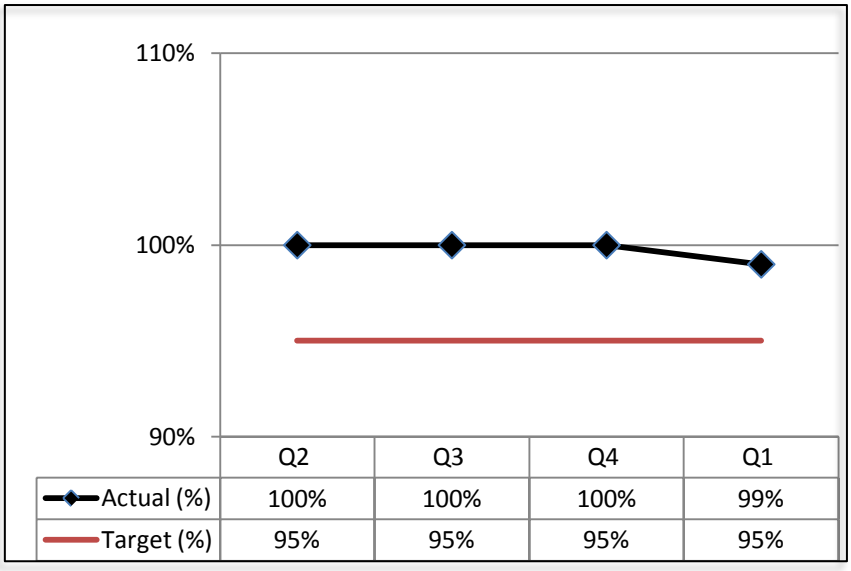
Situational Analysis:
Performance in quarter 1 is below target. Reasons as to why work placement did not begin within 7 working days for the other individuals were as follows; 2 undertaking paid employment; 1 currently on placement; 1 individual placement; 1 refused CPO; 6 failed to attend, and 1 client was ill

Improvement Action:
Scope opportunity to increase capacity for those in employment to undertake community payback order (CPO) at alternative times.

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



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

Situational Analysis:
Performance in Q1 remains above target, however, has declined from previous quarter. Court reports are due to be submitted to the court by 12pm, however, due to staffing issues 1 court report was submitted after deadline.

Improvement Action:
Continue to monitor and maintain target

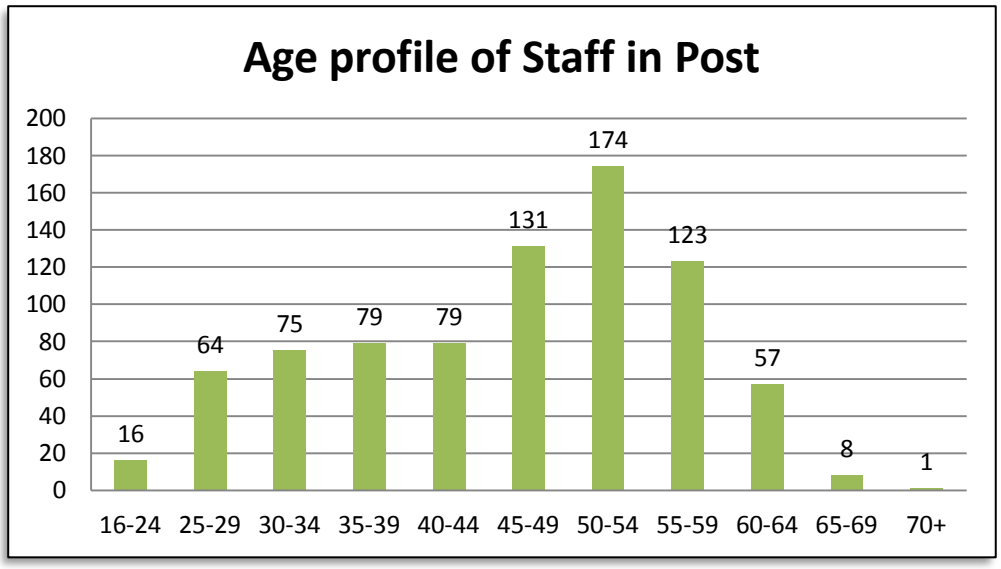
SECTION 8
Corporate Performance

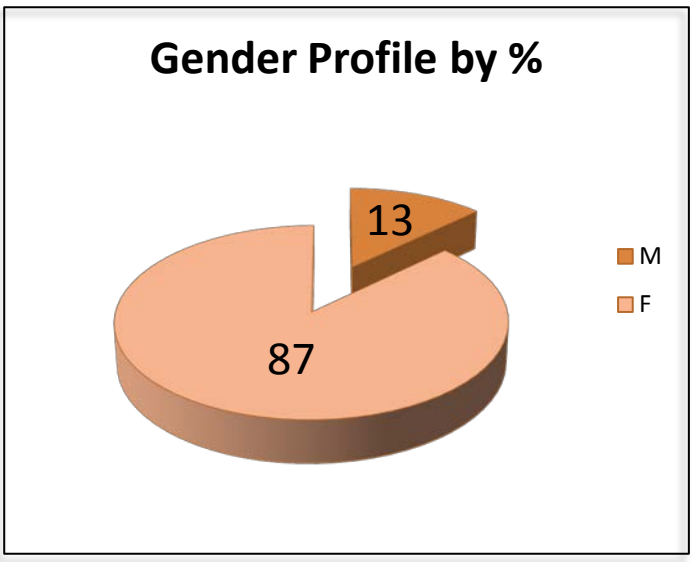
The following data focus on corporate performance indicators, namely:

- Workforce Demographics
- Sickness / Absence Health Staff / Absence Social Care Staff
- KSF / PDF / 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 Staff

Month	EDC	NHS HSCP
Apr-17	7.76	2.4
May-17	7.16	4.86
June - 17	5.95	6.10
Average	6.95	4.45

KSF / PDP / PDR

	Apr	May	Jun
KSF %	65	65	64
PDP %	68	67	69
Trajectory %	80	80	80

PDR	
Quarter	**% Complete on system**
Q1	36.15

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 11

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	Public, Service User & Carer Representative Support Group report
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 processes and actions undertaken in the development 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, highlighting their progress as detailed in **Appendix 1**.
2.0	**SUMMARY**
2.1	In total 8 meetings have taken place, the most recent was on the 2nd October 2017.
2.2	Members continue to become familiar with the role and function of the Health & Social Care Partnership (HSCP). To date, members have received presentations from the Planning Manager, Change and Redesign Manager, Chief Social Work Officer, Chief Finance Officer, with the Clinical Director presenting to the group on the 9th of October 2017.
2.3	The group have requested an invite be extended to the Lead for Clinical Pharmacy and Prescribing to attend a future meeting.
2.4	Members actively promoted and attended the HSCP Strategic Planning community consultation events in; Bishopbriggs and Bearsden and also participated in the event held for the Strategic Planning and Locality Planning Groups.
2.5	Following the Community events 4 new Service User and Carer representatives (1 x service user and 3 x carers), have been invited to a meet and greet opportunity with the existing members, with the aim to maximise the membership of the PSUCRG.
2.6	Members have received their full induction pack; this has been created in co-production with the PSUCRSG and has been made available in both paper and electronic format.

2.7	The PSUCRSG has agreed to work with the HSCP to support future succession planning of the group and looking to create a Wider Network' of 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.

East Dunbartonshire Health & Social Care Partnership

Appendix 1

Public Service User and Carer Support Group / 2nd October 2017 – Room G34, KHCC.

Attending: Gordon Cox, David Bain, Martin Brickley, Sandra Docherty, Avril Jamieson,

Apologies: Isobel Twaddle, Marion Menzies, Jenny Proctor and Susan Manion.

HSCP Staff present; David Radford, Jean Campbell, Anthony Craig

Action points agreed at meeting;

Action	By who	When	G	A	R
Feedback from SMT on options paper to PSUC group by 4th December	DR	Before next meeting.			
Clinical Director to be invited to a meeting - Update on Localities and clusters. (09thOctober)	DR	For 9th October / SHC Consultation same day			
Request for presentation by J Campbell to be made available and distributed to the group membership.	AC	05/09/17			
HIS consultation on SHC, resend diary request and invite new prospective PSUC member(s) to meeting.	AC	02/10/17			
PSUC group will collate hospital discharge case studies/stories.	PSUC members	By next meeting 04/12/17			
PSUC group will collate Dementia review meetings with service users attending Woodlands.	PSUC members	By next meeting 04/12/17			
Invite to future meeting, to be extended to Carolyn Fitzpatrick (Lead for Clinical Pharmacy and Prescribing costs), To update group.	DR/AC	By next meeting 04/12/17			
Invite to future meeting to be extended to Fiona	DR/AC	By next meeting			

McCulloch (Planning manager) ED residents acute statistics / hospital bed stays, To update group		04/12/17			
PSUC group agreed on an action plan to be drafted for 2018/19, aim is to increase membership for PSUC network and for future succession planning.	AC	By next meeting 04/12/17			
Venue options given to members for 2018 meeting dates, Quorum of members (1/3 rd) and Chairperson agreed on a venue. AC to confirm and send out dates and times.	AC	By next meeting 04/12/17			

East Dunbartonshire Health & Social Care Partnership

Appendix 2

Public Service User and Carer Support Group

5th June 2017 – Room G34, KHCC.

Attending: Martin Brickley, Gordon Cox, Avril Jamieson, Jenny Proctor, Isobel Twaddle, Marion Menzies,

Apologies: David Bain, Sandra Docherty,

HSCP Officers In attendance; Susan Manion, David Radford,

Action points agreed at meeting;

Action	By who	When	G	A	R
Induction pack to be reviewed by group, amendments requested by 16th June	AC	Electronic format (16/06/17)			
Review the Service User/Carer presentation and forward to Chair.	DR	(09/06/17)			
Consider options in supporting carers to attend future meetings	DR	30/06/17			
Full induction packs to be created and distributed to members.	AC & All members	(30/06/17).			
3rd Sector awareness Letter – review and forward to Chair	DR	(09/06/17)			
PSUC Group - IJB, LPG and SPG meetings feedback / updates - to be moved up agenda.	AC	Next meeting (05/06/17)			
September event / Information day - further discussion at next meeting. Summary of HSCP engagement plans to be forwarded to all members	PSUC Group	Next meeting (30/06/17).			
Scope alternative options for PSUC engagements and have them available for the next meeting.	AC & PSUC	Next Meeting (05/06/17)			
Invite Paolo Mazzoncini (Head of Children and Criminal Justice and Social Work Services) and Jean Campbell (Head of Finance) to next two meetings	AC	Next meeting			

Appendix 3

Public Service User and Carer Support Group

27th March 2016 – Room G34, KHCC.

Attending:

Martin Brickley, Gordon Cox, Avril Jamieson, Jenny Proctor, Claire Taylor, Isobel Twaddle.

Apologies: David Bain, Sandra Docherty, Marion Menzies, Chris Shepherd.

HSCP Officers In attendance; Susan Manion, Fiona McCulloch, David Radford, Anthony Craig,

Action points agreed at meeting;

Action	By who	When	G	A	R
Induction pack reviewed by group, amendments requested - AC completed	AC	Electronic format (03/04/17)			
Request by LPG (West), rep (GC) for feedback from last meet to be sent to rep.	AC will liaise with G Notman, request that update from LPG be sent out.	(03/04/17)			
Full induction packs to be created and distributed to members at next meet.	AC & All members	Present at next meet (05/06/17).			
Knowledge hub log-in details and passwords to be cascaded to members.	AC	03/04/17			
PSUC Group - IJB, LPG and SPG meetings feedback / updates - to be moved up agenda.	AC	Next meeting (05/06/17)			
September event / Information day - further discussion at next meeting.	PSUC Group	Next meeting (05/06/17)			
Scope alternative event options for PSUC and have them available for the next meeting.	AC & PSUC	Next Meeting (05/06/17)			
Invite Paolo Mazzoncini (Head of Children and Criminal Justice and Social Work Services) to next meeting	AC	10/04/17			

Appendix 4

Public Service User and Carer Support Group

13th February 2016 – Room G34, KHCC.

Attending:

David Bain, Martin Brickley, Gordon Cox, Sandra Docherty, Avril Jamieson, Marion Menzies, Chris Shepherd, Isobel Twaddle, Claire Taylor

HSCP Officers In attendance; David Radford, Anthony Craig, Gillian Notman

Action points agreed at meeting;

Action	By who	When	G	A	R
Draft induction pack to be sent to group (Electronic format)	AC	20/02/17			
Draft induction pack to be reviewed by group and feedback to be sent to AC on content.	All group members	06/03/17			
Draft communication strategy to be sent out and be reviewed by group. Feedback to be sent to AC on content.	AC & All members	Send out by 06/03/16, group responses by 13/03/17			
Draft Terms of Reference to be sent out and be reviewed by group. Feedback to be sent to AC on content.	AC & All members	Send out by 13/03/17, group responses by 20//03/17			
Knowledge hub info to be cascaded to group with log-in details and passwords	AC	20/02/17			
Confirm change of next meeting date from 03/04/17 to 27/03/17	AC	20/02/17			
Invite F McCulloch to next meeting - 27/03/17 - SPG update	AC	20/02/17			
Knowledge hub info to be put on agenda for next meeting - crib sheet / user manual.	AC for group	Next meet			
Board meeting presentation to be sent to group	AC & DR	20/02/17			

East Dunbartonshire Health & Social Care Partnership

Appendix 5

Public Service User and Carer Support Group

19th December 2016 – Room G34, KHCC.

Attending:
Martin Brickley, Marion Menzies, Isobel Twaddle, Claire Taylor, David Bain, Sandra Docherty, Avril Jamieson, Gordon Cox

HSCP Officers: David Radford, Anthony Craig

In attendance: Cllr Anne McNair

Action	By who	When	G	A	R
Send out Support group meeting dates for 2017. (6) (preferred option - Monday 10am-12pm)	AC	End Dec 2016			
Confirm meeting dates for HSCP board meetings and distribute to support group.	AC	End Dec 2016			
Group agreed to send Anthony a list of "Their networks" i.e. – who they can network with, (Older people, Comm councils, carers networks etc.).	Support Group – email to AC	January 2017			
Share support group contact details with all attendees	AC to distribute	End December 2016			
Members agreed to feedback from their respective HSCP meetings they attend to initiate information exchange – 3 main bullet points from each meeting.	Support Group	Next meeting			

East Dunbartonshire
Health and Social Care Partnership

Appendix 6

Public Service User and Carer Support Group

17th November 2016

Attending: David Bain, Sandra Docherty, Marion Menzies, Isobel Twaddle, Claire Taylor, Avril Jamieson, Chris Shepherd, Gordon Cox, Martin Brickley

HSCP Officers; Sandra Cairney, David Radford

In attendance; Cllr Anne McNair

Action points agreed at meeting;

Action	By who	When
Explore roles and remit of Representatives - Distribute revised list of groups and representatives	David R	Before next meeting
Highlight current vacancies / opportunities Within the locality groups to respective wider networks	Public Service Users and Carers	Next meeting
Distribute following Documents: • HSCP scheme of integration • HSCP annual performance report • HSCP strategic priorities 16/17 • HSCP Strategic Planning Structures	David R	By next meeting
Present a series of questions aide / memoir to support group members to participate at the: Board / Strategic Planning Groups Locality Groups	David R Service Users and Carers	Presented to next meeting
Develop process to distribute consultations and meeting invitations From: Scottish Government/ National organisations, Regional organisations, local statutory service providers	Engagement and capacity officer	Progress to report to next meeting
Identify a list of the wider networks with which PSU&C representatives are associated	Engagement and capacity officer / service user and carers	Update at next meeting
Develop a terms of reference based on the discussion from this meeting	David R	Presented to next meeting
Send out a series of meeting dates between Dec and Feb 2017	David R	By next meeting

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number:12

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	Minutes of Clinical and Care Governance meeting on 26th July 2017
Report By	Lisa Williams, Clinical Director
Contact Officer	Lisa Williams, Clinical Director Lisa.williams@ggc.scot.nhs.uk

Purpose of Report	To assure the board appropriate governance arrangements within the HSCP, Clinical Director

Recommendations	To note the contents of the minutes

Relevance to HSCP Board Strategic Plan	N/A

Implications for Health & Social Care Partnership

Human Resources	Nil

Equalities:	N/A

Financial:	N/A

Legal:	N/A

Economic Impact:	N/A

Sustainability:	N/A

Risk Implications:	Appropriate risks noted and acted upon

Implications for East Dunbartonshire Council:	Nil

Implications for NHS Greater Glasgow & Clyde:	The local Clinical and Care Governance group reports into the Primary care and Communities Clinical Governance Forum, which in turn reports to the Board Governance group.

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	Note that the Terms of Reference and Reporting Structure has been reviewed and updated, and agreed within the membership of the group.
1.2	The minutes highlight the Incident reporting mechanism and Significant Case Incident (SCI) review process, to provide assurance to the Board of appropriate arrangements to ensure delivery of safe and effective care.
1.3	Highlight any outcomes which are not completed and ensure these are reviewed and progressed.
1.4	Review of complaints within the HSCP and allied service areas, with appropriate actions taken to address any outcomes.
1.5	Provide assurance to the board of robust and effective governance arrangements.

Clinical & Care Governance Sub Group
26th July 2017, 2.30pm
F33A, Kirkintilloch Health & Care Centre

Members Present

Name	Designation
Lisa Williams	Clinical Director
Susan Manion	Chief Officer
Paolo Mazzoncini	Head of Children's Services / Chief Social Work Officer
Claire Carthy	Fieldwork Manager, Children's SW
Andrew Millar	Clinical Effectiveness Co-ordinator
David Aitken	Joint Adult Services Manager
Wilma Hepburn	Professional Nurse Advisor
Lorna Hood	Senior Nurse, Children & Families
Fiona Munro	Manager, Rehab & Older Peoples Services
Fraser Sloan	Clinical Risk Co-ordinator

In Attendance

Name	Designation
Dianne Rice	Clinical Governance Support Officer
Catherine McCrae	Nurse Team Leader, CMHT

Apologies

Name	Designation
Andy Martin	Head of Adult and Primary Care Services
Carolyn Fitzpatrick	Lead for Clinical Pharmacy and Prescribing
Michael McGrady	Consultant in Dental Public Health
Fraser Ross	Senior Nurse

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 – 31st May 2017**	
	The minutes of the meeting on 31st May 2017 were agreed as an accurate reflection.	
3.	**Matters Arising**	
	<u>Sign Off – Outstanding SCIs</u> The group reviewed the actions of the outstanding SCIs. Dianne Rice to circulate to the group for action. <u>Terms of Reference</u> The terms of reference were circulated prior to the meeting, where members were asked to review and comment on the document. The group expressed their thoughts and comments. Lisa Williams and Dianne Rice will update the documents to reflect the comments made. <u>Reporting Structure</u> The reporting structure was circulated prior to the meeting where members were asked to review and comment on the structure. The group expressed their comments and suggestions. Lisa Williams and Dianne Rice will update the document to reflect these changes.	**DR / All** **LW/DR** **LW/DR**
4.	**Governance Leads Update / Reports**	
(a)	<u>Core Audit Reports</u> All Core Audit Reports received for inclusion in the agenda showed 100% with the exception of Community Nursing. Wilma Hepburn informed the group that although the report did not show 100% that there were no concerns. Wilma assured the group that if there are concerns then an action plan will be compiled.	
(b)	<u>Safety Cross Report</u> Wilma Hepburn advised that that the Community Nursing Team had raised an SCI in relation to a pressure ulcer incident. It was noted that the incident had been found to be managed well and appropriately and that the SCI was used in a learning capacity. David Aitken asked if the investigation and learning would include care homes. Wilma informed the group that although care home staff can report pressure ulcers to the Care Home Liaison Nurse or Tissue Viability the responsibility for management of the pressure ulcer remains with the care home staff. This procedure is also the same for the 8 intermediate care beds within the Westerton Care Home.	

(c)	LD Governance Lisa Williams advised that there are issues with the transition of individuals from children's services into adult services. David Aitken advised that there is an IQ test available to test individual's abilities. David also informed the group that this would be part of the LD redesign. David advised that there will be case studies developed for Partnerships to review and respond.	
(d)	Mental Health Governance No update available for meeting	
(e)	Primary Care & Community Partnerships Governance Group update Lisa Williams advised that the response and referral process for Scottish Ambulance Service (SAS) was discussed and that the Governance Lead from SAS would be invited to the next meeting of the group. Lisa will keep this group informed of any updated.	
(f)	Board Clinical Governance Forum update The meeting of the Board Clinical Governance Forum will take place on Monday 31st July 2017; therefore, there was no update available for this group.	
5.	**Risk Management**	
(a)	Care Home Update No concerns were noted	
(b)	Clinical Risk Update Fraser Sloan, Clinical Risk Co-ordinator, Clinical Risk attended the group today and provided an overview of the Clinical Risk report. Fraser advised that the report covers the period from April – June 2017 and that there were 2 SCIs commissioned 1 has since been closed and the other is outstanding. There were 39 clinical incidents reported within this period with the highest being Pressure Ulcer and Record management incidents. Fraser informed the group that since May 2014 there had been 6 SCIs. There are a total of 22 actions in relation to these incidents of which 17 are outstanding, 15 of which are overdue. This report was not previously circulated with the agenda. Lisa Williams requested that Dianne Rice circulate the report to all members for action.	**DR**

(c)	Incident Report – 07/04/17 – 14/07/17 The group reviewed the report. The following incidents were discussed **468124** - It was noted in the incident that there was a delay with informing the relevant team with significant information. **465961** – Further delays were noted. David Aitken will review both incidents and investigate delays. Lisa Williams will feedback any GP related issues to the GP colleagues through the GP Forum.	**DA/LW**
6 (a)	SCI Policy Final Lisa Williams advised that the policy had now been rolled out and embedded throughout NHS Greater Glasgow & Clyde. Lisa asked that the members familiarise themselves with the document and share with their staff.	**All**
(b)	SCI Report – 13/07/16 – 13/07/17 Outcomes / Action Plan The group reviewed the report provided. David Aitken was asked to provide an overview and update from incident 380298 & 394205. **380298** – This incident was in relation to a suicide. David advised that the rapid alert template showed that this incident required carrying out an SCI. This investigation is now complete and a revised action plan has been added to the Datix Reporting System. Lisa acknowledged that there were recommendations from the SCI for the GP Practice in relation to the recording of all information received for a service user. The GP practice completed a Significant Event Analysis in relation to this incident and all information is now recorded. **394205** – David advised that this incident had been signed off and all actions, with the exception of 1 were now complete. Unfortunately no further information was available at the time of the meeting as all paperwork in relation to this incident is contained within the patient record which is stored off site. All current patient records are now contained within the electronic EMIS system.	
7.	MAPPA Lisa Williams receives MAPPA notifications and enquired what the correct process is for sharing this information with colleagues should be. Paolo Mazzoncini responded to ensure the group that there is a robust mechanism in place for the circulation and sharing of MAPPA notifications. Paolo informed the group that the majority of MAPPAs are managed by the Police, however, if sent to a GP Practice then the GP should shared with only relevant colleagues. Fiona Munro advised that there are MAPPA alerts within the electronic system EMIS.	
8.	**Reducing Harm from Medicines**	
	Public Health Report / Prescribing Updates Lisa Williams advised that Carolyn Fitzpatrick is currently looking at prescribing budgets with East Dunbartonshire HSCP. Lisa informed the group that a report had been received in relating to vaccination incidents. These have been reviewed and it was noted that all incidents were unavoidable, however, there were concerns noted around storage of vaccinations within Kirkintilloch Health & Care Centre.	

9.	**Clinical Effectiveness / Quality Improvement**	
(a)	Quality Improvement Work Plan Andrew Millar advised that there was 1 update to the work plan since the previous meeting. The Community Nursing quarterly "How are we doing" surveys had been received and is currently in the data collection phase. Once this is complete a report will be available.	
(b)	Clinical & Care Governance Work Plan for update The work plan was circulate prior to the meeting. All members are asked to update and send back to Dianne Rice no later than 16th August 2017.	**All**
10.	**Scottish Patient Safety Programme**	
(a)	Scottish Patient Safety Programme The above programme was circulated previously with the agenda for information and further circulation to staff.	
(b)	Clinical Governance Related Guidance Newsletter The above newsletter was circulated previously with the agenda for information and further circulation to staff.	
(c)	SPSO Update – June 2017 The above report was circulated previously with the agenda for information and learning.	
11.	**Enabled to Deliver Person Centred Care**	
(a)	Complaints Report **(i) Health Complaints Report – 07/04/17 – 13/07/17** Within this period, Health received a total of 1 complaint. This complaint was later withdrawn by the individual. **(i) Social Work Complaints Report – 07/04/17 – 14/07/17** Within this period, Social Work received a total of 5 complaints. All complaints were informal and resolved at a local resolution 1 stage.	
(b)	GP Complaints Report There was no update available for the meeting.	
(d)	Pharmacy Complaints Report There were no complaints received for Pharmacy within the previous quarter.	
(e)	Optometry Complaints Report There was no update available for the meeting.	
12	Upheld Complaints Received – 13/07/14 – 13/07/17 (Health only) The group were provided with a report detailing a list of upheld / partially upheld complaints received within a 3 year period. Wilma Hepburn, Professional Nurse Advisor and Catherine McCrae, Nurse Team Leader, Community Mental Health Team were asked to provide an overview and update of the following 2 complaints. **22729 –** This incident related to an appointment being cancelled at short notice with no subsequent appointment offered which meant the individual waited an extensive period without access to medical support from the service. In the	

	complaint it was also noted that a referral was also made for the individual for another service which again there was no communication in relation to an appointment. Catherine advised that this complaint was fully upheld and an action plan was devised. Actions included; • Desk Duty contact details given when appointments are cancelled • Process in place for re-allocation of cancelled appointments by the means of a cancellation list. • Process in place for instances where Doctor is off for a long period of time. These patients will be reviewed and contacted by other members of the team. • All contact with patients are now recorded • Regular meetings between Clinical Team and admin every 6 weeks **28185 –** This incident related to the lack of support, advice and care in relation to a palliative care patient. Wilma advised that the complaint was fully upheld and an action plan was devised. Actions included; • Developed good examples of person centred care plans for palliative and end of life care and provided learning sessions to all District Nursing staff. Palliative Resource Nurse and District Nurse from each area also attends Palliative Care Forum. • Standard practice that all care plans of anyone receiving, or recently received end of life care will be reviewed at supervision reviews. • Audits are carried out on palliative care register at regular intervals. • Experience survey in place with outcomes reported	
13.	**Vulnerable Children and Adults**	
(a)	Child Protection Claire Carthy updated the group with information relating to the Child Protection Register. Claire assured the group that the there is a robust quality assurance system in place and that a quarterly report is provided to the Child Protection Committee and an annual report is provided to the Scottish Government.	
(b)	Child Protection Case Conference Attendance – Q4 The report was circulated previously with the agenda for information. Claire advised that group that she had met with Dianne Rice to discuss the Single Point of Access for Child Protection Invites and that they are meeting again in 28th September. Dianne and Claire will keep the group informed of any updates.	**CC/DR**
(c)	Looked After & Accommodated Children Claire updated the group on current data in relation to Looked After & Accommodated Children. Claire advised that joint working and sharing of information has improved with the GIRFEC agenda and & Shannari indicators. It was also noted that this has improved relations and joint working with Education colleagues. Next steps will include joint training.	
(d)	Child protection Forum Minutes – 10/07/17 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.	
14.	**Infection Control Minutes – 11th May 2017**	
	The minutes were circulated previously with the agenda for information.	
15.	**AOCB**	
	Template & Content of Clinical & Care Governance Agenda Susan Manion raised a concern in relation to the templates used and the content included within the Clinical & Care Governance Agenda. Lisa Williams advised that the templates used where produced and issued by NHSGG&C Clinical Support Unit. Susan and Lisa will meet to discuss templates and content.	**SM/LW**
16.	**Date and time of next meeting** **Tuesday 5th September 2017, 2.30pm, Room F33A, KHCC**	

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 13

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	East Dunbartonshire Audit Committee Minutes of 26th September 2017
Report By	Jean Campbell Chief Finance and Resources Officer
Contact Officer	Jean Campbell Chief Finance and Resources Officer 0141 232 8237 Jean.campbell2@ggc.scot.nhs.uk

Purpose of Report	To provide the Board with an update on the business of the Audit Committee held on the 26th September 2017.

Recommendations	The Integration Joint Board is asked to: a. Note the contents of the minute of the Audit Committee held on the 26th September 2017. b. Ratify the decision to nominate the Chair of the Audit Committee and Vice Chair of the IJB to sign off the Final Audited Annual Accounts

Relevance to HSCP Board Strategic Plan	This committee provides support to the IJB in its responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge and provide a robust framework within which the objectives within the Strategic Plan are delivered..

Implications for Health & Social Care Partnership

Human Resources	none
Equalities:	N/A
Financial:	None.
Legal:	None.
Economic Impact:	None
Sustainability:	None

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	**x**
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

Minutes of
East Dunbartonshire Health & Social Care Partnership Audit Committee Meeting
held at 1:00pm on Tuesday 26th September 2017
in F33, Kirkintilloch Health & Care Centre

Present:	**Susan Murray (Chair)**	**(IF)**	**Jean Campbell**	**(JC)**
	Sheila Mechan	**(SMe)**	**Susan Manion**	**(SMa)**
	Peter Lindsay	**(PL)**	**Kenny McFall**	**(KM)**
	Fiona Mitchell-Knight	**(FM)**	**Alan Moir**	**(AM)**
	Ian Ritchie	**(IR)**	**Gillian McConnachie**	**(GM)**

In attendance: **Kirsty Gilliland (Minutes)** **(KG)**

No.	Topic	Action by
1.	**Welcome and Apologies**	
	Ms Jean Campbell welcomed those present. Ian Fraser's apologies were noted.	
2.	**Minutes of previous meeting – 20th March 2017**	
	The minute of the meeting held on 20th March 2017 was approved as an accurate record.	
3.	**Audit Scotland – Draft 2016/17 East Dunbartonshire IJB Annual Audit Report**	
	Mr Lindsay and Mrs Mitchell-Knight gave an overview of the plan for 2016/17, which was previously circulated with the agenda along with the Auditor's letter and letter of representation from the Chief Finance & Resources Officer. Mr Lindsay highlighted the key issues and advised that there are no matters other than those set out in the report that need to be brought to the attention of the Committee. Mr Ritchie asked whether the £5.1 million of savings required in order to breakeven was achievable? He enquired whether the surplus of £4.1 million achieved in 2016/17 would be offered up to address this. Ms Campbell explained that although £4.6 million in savings has been previously indentified, there have been a number of areas where there has been a delay in progressing these savings. Ms Campbell is confident that reserves can be used to address this gap. Mr Ritchie asked whether the £4.1 million is part of the reserve. Ms Campbell clarified that this was part of the reserves of £5.3 million - £2.6 million of this earmarked for service redesign and £2.7 million to mitigate against in year pressures and any shortfall in the savings programme. Mr Moir referred to the £5.1 million of savings forecast and asked what percentage this was. Ms Campbell clarified that this was approximately 3% of the partnership's overall budget. The Committee noted the report.	

4.	**ED HSCP 2017/18 Final Audited Accounts**	
	Ms Campbell presented the final audited annual accounts 2016/17 and advised that this had been updated to remedy any consistency and presentational issues identified throughout the audit process. The report shows a favourable year end position for the partnership with an overall surplus of £4.1 million. This will help to meet the priorities set out in the plan and provide some resilience for ongoing pressures and slippage in savings plans. Ms Campbell advised that there is a requirement for financial accounts to be signed by the Chair, Chief Officer and Chief Finance & Resources Officer. Ms Campbell asked that it be formally recorded that the recommendation be amended in the absence of the Chair to allow the Vice Chair to sign the final audited accounts. This adheres to part 3, section 10(4) of the Local Authority Accounts (Scotland) Regulations 2014 which provides that a nominated person can be identified for the purposes of signing the Accounts. The Committee approved the recommendations and the accounts and Ms Campbell extended her thanks to Audit Scotland.	
5.	**PwC Internal Audit Report 2016/17**	
	Mrs McConnachie gave an overview of the Internal audit annual report 2016/17. This is a high level summary as PwC do not currently share individual reports. The audit opinion given by PwC on NHS Greater Glasgow & Clyde is generally satisfactory with some improvements required. There are some areas of weakness and non compliance in the framework of governance, risk management and control. Some improvements are required in these areas. NHS Greater Glasgow & Clyde has accepted their findings. The Committee noted the report.	
6.	**East Dunbartonshire Council Internal Audit Update 2017/18**	
	Mrs McConnachie advised that progress is being made toward the completion of the audit plan with the team progressing work in a number of separate areas which include; Annual Audit and Risk; Annual Follow Up; Consultancy Reviews; Social Work Contract Monitoring follow up, Home Care follow up and Internet Monitoring. Risks are identified in the course of Internal Audit work and highlighted to management. Mr Ritchie asked whether there was potential for fraud and whether there are systems in place to prevent this. Mrs McConnachie advised that there is potential, however, this is not common although there are always areas for improvement. The Annual Internal Audit Report looks at this in more detail outlining controls and recommendations. The Committee noted the report.	

7.	**East Dunbartonshire Council Internal Audit Annual Review 2016/17**	
	Mrs McConnachie presented the annual internal audit report 2016/17. This report provides an overall opinion concluding on the adequacy and effectiveness of the Council's framework of governance, risk management and control. Mr Moir referred to Table 1 which discusses systems. Only 31% of planned audits were complete and he highlighted that this should be brought to our attention. Mrs McConnachie explained that there was a resourcing issue within the team as they were without a manager for a year. Audit work has now been completed in terms of outputs and the final is around 89% completion. The Committee noted the report.	
8.	**A.O.C.B.**	
	Mrs McConnachie advised that after the papers for the Audit Committee were issued, PwC had issued a further report on behalf of NHS Greater Glasgow & Clyde on Property Transactions. The report was classified as Low Risk and PwC did not issue any individual finding. The Committee noted the update.	
9.	**Date of Next Meeting**	
	To be arranged.	

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 14

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	Minutes of Staff Partnership Forum - 18 September 2017 (Draft)
Report By	Tom Quinn, Head of HR
Contact Officer	Tom Quinn, Head of HR 0141 232 8227 Tom.quinn@ggc.scot.nhs.uk

Purpose of Report	To provide the re-assurance that Staff Governance is monitored and reviewed within the HSCP. Key topics covered within the minute include: - The success of the staff awards presentation at Kilmardinney House and the time taken by staff to put on the information stands. - The success of our 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 encouraged staff to complete the survey - An update on the contribution that staff have made to the Strategic Plan for 2018-21.

Recommendations	Note for information

Relevance to HSCP Board Strategic Plan	

Implications for Health & Social Care Partnership

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

Equalities:	Only in relation to our Human Resources

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	☒
	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 18 September 2017 (Draft) attached.

East Dunbartonshire Health & Social Care Partnership

Chief Officer
Mrs Susan Manion

Minutes of East Dunbartonshire Staff Forum Meeting
Monday 18 September at 2pm in F33A&B, Kirkintilloch Health & Care Centre

PRESENT

Jamie Carrick (JC)	Unison (Co-Chair) Chairing
Susan Manion (SM)	Chief Officer (Chair)
Lyndsay Ovenstone (LO)	British Dental Association Area Representative
Diana McCrone (DMc)	British Association of Occupational Therapists
Billy McLeod (BMc)	Unison
Michael Crainey (MC)	Unison H&S Rep
Marie Lowe (ML)	RCN Rep
Sandra Cairney (SC)	Head of Planning & Health Improvement
Anne McDaid (AMc)	RCN SPF Joint Secretary
Wilma Hepburn (WH)	Professional Nurse Advisor
Katherine Turnbull (KT)	Management Trainee – OD
Lorna Hood (LH)	Senior Nurse – Children & Families
Caroline Smith (CS)	HR Business Partner
Tom Quinn (TQ)	Head of People & Change
Linda Tindall (LT)	Senior Organisational Development Advisor
Andrew McCready (AMC)	Unite Oral Health (Co Chair) Chairing
Esther O'Hara (EO)	UNITE
Frances Mclinden (FMc)	General Manager Oral Health
Jean Campbell (JCa)	Chief Finance & Resource Officer
Simon McFarlane (SMc)	Unison
Tommy Robertson (TR)	Unison (part of meeting)
Karen Gillespie (KG)	HSCP Administrator – Minute Taker

ITEM	SUBJECT	ACTION
1.	**Welcome & Apologies** Apologies were submitted on behalf of Andy Martin, Stephen McDonald, Margaret McCarthy, Paolo Mazzonicini, Margaret Hopkirk, David Aitken JC welcomed everyone to meting and advised he would be co-chair of the proceedings today. SM requested that as the last meeting could not be considered as quorat; that the staff side reps ensure that they have deputies in place if they cannot attend a meeting.	
2.	**Minutes of previous meeting** Minutes of meeting held on 24 July 2017 were agreed as an accurate reflection of discussions.	

3.	**Matters Arising** **Joint Health & Safety Committee** - SC confirmed that progress is being made with regards to a HSCP H&S committee and that the ToR are being amended to reflect the retirement of Andy Martin. Both ToR and membership list will be brought to the next meeting. **KHCC Refurbishment** - TQ advised that the completion of phase one should take place within the next few weeks and the delay had been due to a change in the furniture required half way through project. Preparation for phase two is underway and updates will be brought to next meeting. **Unison Care Charter** - SMc requested clarification if both NHS & EDC had signed up to this charter. It was agreed that JCa will submit a paper to both the IJB and SPF for approval prior to the sign off.	**Louise Martin** **Gillian Notman** **Jean Campbell**
4.	**Staff Awards** Event took place on 18 September 2017 with initial feedback as positive. LT gave overview of the winners in each category and advised that the overall HSCP winner would be announced at the Chairman's Awards Ceremony in November 2017. SC took opportunity to thank LT for arranging the event.	
5.	**iMatters** LT advised that both the HSCP & Oral Health were not at the action plan update stage and requested that everyone be encouraged to do this as soon as possible.	
6.	**Staff Governance Committee** TQ and SM recently reported to the GG&C Board on the staff governance arrangements for the NHS staff within the HSCP and Oral Health. The process highlighted areas of improvement and the staff governance group will take these forward.	
7.	**Management Structure** SM spoke to paper previously circulated with the agenda. SM advised that the IJB has approved the recruitment of two separate posts to cover the position of Head of Community Health & Care Services and Head of Mental Health, LD & Addiction Services; posts previously held by Andy Martin under his Head of Adult and Primary Care Services role. SM advised that it would be the decision of the successful candidates on who would be their lead employer; this would ensure that there would be no detriment to their terms and conditions.	

8.	**Finance Update** JCa spoke about the report that was submitted to the IJB at end of August covering to period four of this financial year. The report shows that there is an anticipated break even at the end of the financial year but highlights risks around Social Work expenditure on areas such as Homecare. JCa advised that there has been a reserve set aside to support the outcomes of the Strategic Planning Events and these will be brought to future meetings for discussion and approval.	
9.	**Unscheduled Care Plan** Andy Martin had submitted to paper to IJB meeting held on 31 August 2017, requesting approval of the priorities outlines within the report and the use of the reserves as identified. In absence of Andy Martin, JCa advised that the intermediate care facility is now imbedded however discussions now need to take place around the other posts such as Community Pharmacy and Care Home Liaison posts to ensure they are financially sustainable in the future.	
10.	**Values and Behaviours** HSCP staff have been asked to complete a survey monkey on the behaviours that are required to underpin the previously identified values. It is anticipated that this analysis of the information should be completed and agreed by the IJB by February 2018.	
11.	**HR Update** CS gave overview of the report for both the HSCP & Oral Health. The report shows a reduction in absence within the HSCP during the first quarter of the year and an underlying trend of reduction for 2017. The completion of KSF within the HSCP remains consistent and although PDR reporting is low for Social Work staff it is recognised that there has been an emphasis on providing a meaningful review liked to the strategic plan.	
12.	**Strategic Plan** SC advised that feedback from the engagement events would be collated and would influence a robust strategic plan. A draft plan will be circulated for comment during November 2017.	

13.	**Oral Health Workforce Plan** FMc spoke to paper that was circulated with the agenda and advised on the current activity underway to support the workforce plan. LO requested clarification on the timescales for the PDS review – FMc advised that this was a fact finding mission to inform discussions with staff and that she expects a draft plan to be circulated by the end of 2017.	
14.	**Pre-5 Immunisation** LH advised that NHS GG&C has agreed on changes to the delivery of the pre-5 immunisation programme; this will now be carried out by the local Children and Families teams as opposed to the GP Practice staff. A scoping exercise is taking place to identify facilities where the clinics can take place. LH requested support from Staff side representatives at the staff information meetings – LH to send dates to AMc/JC who will discuss and agree how best to support.	**Lorna Hood**
15.	**School Nursing** SM will led on this review on behalf of NHS GG&C, this is the same group as previously chaired by Keith Redpath and membership will remain the same, although the initial meeting will be used to bring SM up to speed on discussions. SM advised regular updates will be brought to the SPF.	
16.	**Winter Plan – staff flu immunisation** Agreement has been reached that all staff who come under the HSCP umbrella will be able to receive the seasonal flu vaccination at clinics run by GG&C here at KHCC. Staff are required to complete OHS form prior to attending and attendance should be encouraged by line manager. Peer immunisation can also be arranged for some teams. WH is working on a paper on the actual process.	
17.	**Staff Bursary Scheme** Congratulations were given to the five HSCP and four Oral health staff who have been awarded in the bursary scheme. Line Managers are asked to encourage staff to apply for this in the future.	
18.	**IJB Planner** It was agreed that the agenda for the IJB would be circulated to the SPF members prior to the meeting for information. It was also agreed to change the schedule of the SPF meetings to come into line with the IJB. TQ will circulate dates for 2018	**Tom Quinn**
19.	**A.O.C.B** Recognition – SM took opportunity to acknowledge the contribution made to East Dunbartonshire HSCP by Andy Martin and wished him well on his	

	retirement.	
20.	**<u>Date & Time of next meeting</u>** Monday 27 November 2017 @ 2pm Room F33A&B, Kirkintilloch Health & Care Centre Room available from 1pm for Staff Side meeting	

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 15

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	East Dunbartonshire HSCP Climate Change Duties
Report By	Sandra Cairney, Head of Strategy, Planning & Health Improvement
Contact Officer	Sandra Cairney, Head of Strategy, Planning & Health Improvement 0141 232 8224 Sandra.cairney@ggc.scot.nhs.uk

Purpose of Report	To advise the HSCP Board of their responsibility to prepare reports on compliance with climate change duties.

Recommendations	The HSCP Board is asked to approve the attached Climate Change Duty Report

Relevance to HSCP Board Strategic Plan	Forms part of the HSCP Board legislative governance requirements

Implications for Health & Social Care Partnership

Human Resources	Nil

Equalities:	Nil

Financial:	Nil

Legal:	Legal duty to comply with the *Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015*

Economic Impact:	Nil

Sustainability:	Nil

Risk Implications:	Non compliance

Implications for East Dunbartonshire Council:	EDC is also required separately to comply with the *Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015*

Implications for NHS Greater Glasgow & Clyde:	NHSGGC is already required to comply with the *Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015*

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 & Clyde	☐

1.0	**MAIN REPORT**
1.1	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.
1.2	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.
1.3	IJBs are expected to work alongside Health Boards and Local Authorities to complete their climate change reports as per the Climate Change Order, taking account of the unique nature of these bodies as strategic planners of services rather than being service delivery organisations with responsibility for staff and buildings.
1.4	**Appendix A** is an extract from the HSCP Board online Climate Change submission and has been developed following discussion with Keep Scotland Beautiful and liaison with East Dunbartonshire Council, NHS Greater Glasgow & Clyde Health Board and the other 5 HHSCPs across NGHGGC.

Appendix A.

EAST DUNBARTONSHIRE REPORT ON PUBLIC BODIES CLIMATE CHANGE DUTIES REPORT: 2016-17

The following information is an extract from the online Climate Change submission and has been developed following discussion with Keep Scotland Beautiful and liaison with East Dunbartonshire Council, NHS Greater Glasgow & Clyde Health Board and the other 5 HHSCPs across NGHGGC.

Part 1: Profile of reporting body

1a	**Name of reporting body**
	East Dunbartonshire HSCP
1b	**Type of body**
	Integrated Joint Board
1c	**Highest number of full-time equivalent staff in the body during the report year.**
	0
1d	**Metrics used by the body**
	0
1e	**Overall budget of the body**
	£150million. This is an approximate figure for the financial year (April 2016-March 2017). East Dunbartonshire HSCP Board budget consists of financial allocations and budgets delegated from East Dunbartonshire Council and NHS Greater Glasgow and Clyde, which the HSCP Board then delegates back to the Council and the Health Board with directions for them to deliver health and social care services.
1f	**Report Year**
	Financial (April to March) 2017/18
1g	**Context**
	The Public Bodies (Joint Working) (Scotland) Act (2014) sets out a framework within which Local Authorities, NHS Boards and Integration Joint Boards integrate health and social care service planning and provision within a Health & Social Care Partnership construct. Under these integrated arrangements, there are separate but inter-related responsibilities and accountabilities for the planning and delivery of health and social care services. Integrated Joint Boards have responsibility for the strategic planning, directions to the Council and Health Board and operational oversight of a range of health and social care services whilst Local Authorities and NHS Boards retain responsibility for direct service delivery of social work and delegated health services respectively, as well as remaining

	the employer of health and social care employees. East Dunbartonshire Council (EDC) and NHS Greater Glasgow and Clyde (NHSGGC) agreed to integrate adult health and social care services, as well as NHS Community Children services, Social Work Children's services and criminal justice services. The HSCP Board strategically plans for these services and provides directions to the Council and Health Board to deliver these services in line with its Strategic Plan and defined level of financial resources.

Part 2: Governance, Management and Strategy

2a	**How is climate change governed in the body?**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde. Both organisations have established infrastructures that govern sustainability planning, climate change adaptation and service improvement, including risk management, communications with staff and public, monitoring performance reporting and scrutiny. East Dunbartonshire Council and NHS Greater Glasgow & Clyde submit a Public Bodies Climate Change Duties Report that will detail these aspects.
2b	**How is climate change action managed and embedded in the body?**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde. **East Dunbartonshire Council Arrangements** It is the responsibility of the Sustainability Policy Team to ensure the Council meets its statutory duties in relation to sustainability and climate change while working with relevant teams within the council to identify existing good practice, highlighting gaps, and ensuring a consistent approach is adopted to dealing with climate change. In relation to corporate emissions the Carbon Management Plan provides a council-wide approach to measuring and reducing emissions, and the Carbon Managers Officers Group (CMOG) acts as a cross-council forum for ensuring the successful implementation of this plan. **NHS Greater Glasgow & Clyde Arrangements** NHSGGC Sustainability Manager is responsible for sustainability and environmental issues and provides professional support (including technical and managerial advice) to the Health Board to identify, plan develop and implement strategies and policies.
2c	**Does the body have specific climate change mitigation and adaptation objectives in its corporate plan or similar document?**
	N/A
2d	**Does the body have a climate change plan or strategy?**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent

	bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.
2e	**Does the body have any plans or strategies covering the following areas that include climate change?**
	N/A
2f	**What are the body's top 5 priorities for climate change governance, management and strategy for the year ahead?**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.
2g	**Has the body used the Climate Change Assessment Tool (a) or equivalent tool to self-assess its capability/performance?**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.
2h	**Supporting information and best practice.**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.

Part 3: Emissions, Targets and Projects

3a	**Emissions from start of the baseline year (for body's carbon footprint) to end of the reporting year.**
	N/A
3b	**Breakdown of emission sources.**
	N/A
3c	**Generation, consumption and export of renewable energy.**
	N/A
3d	**Targets.**
	N/A
3e	**Estimated total annual carbon savings from all projects implemented by the body in the report year.**
	N/A
3f	**Detail the top 10 carbon reduction projects implemented by the body in the report year.**
	N/A
3g	**Estimated decrease or increase in emissions from other sources in the report year.**
	N/A
3h	**Anticipated annual carbon savings from all projects implemented by**

	the body in the year ahead.
	N/A
3i	**Estimated decrease or increase in emissions from other sources in the year ahead.**
	N/A
3j	**Total carbon reduction project savings since the start of the year which the body uses as a baseline for its carbon footprint.**
	N/A
3k	**Further information**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.

Part 4: Adaptation

4a	**Has the body assessed current and future climate-related risks?**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.
4b	**What arrangements does the body have in place to manage climate-related risks?**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.
4c	**What action has the body taken to adapt to climate change?**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.
4d	**Where applicable, what progress has the body made in delivering the policies and proposals included in the Scottish Climate Change Adaptation Programme (a) ("the Programme")?**
	N/A
4e	**What arrangements does the body have in place to review current and future climate risks?**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.
4f	**What arrangements does the body have in place to monitor and evaluate the impact of the adaptation actions?**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent

	bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.
4g	**Future priorities for adaptation**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.
4h	**Further information - Supporting information and best practice.**
	N/A

Part 5: Procurement

5a	**How have procurement policies contributed to compliance with climate change duties?**
	East Dunbartonshire HSCP Board has no legal basis on which to procure community health and social care services.
5b	**How has procurement activity contributed to compliance with climate change duties?**
	East Dunbartonshire HSCP Board has no legal basis on which to procure community health and social care services.
5c	**Supporting information and best practice**
	East Dunbartonshire HSCP Board has no legal basis on which to procure community health and social care services.

Part 6: Validation & Declaration

6a	**Internal validation process**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.
6b	**Peer validation process**
	N/A
6c	**External validation process**
	N/A
6d	**No Validation undertaken**
	N/A
6e	**Declaration**
	Sandra Cairney, Head of Strategy, Planning & Health Improvement

Part 7: Recommended Reporting: Reporting on Wider Influence

1	**Wider Influence on GHG emissions**
	N/A
2a	**Targets**

	N/A
2b	**Does your body have an overall mission statement, strategies, plans or policies outlining ambition to influence emissions beyond your corporate boundaries? If so, please detail this in the box below.**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.
3	**Policies and Actions to reduce Emissions**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.
4	**Partnership Working, Communications and Capacity Building**
	N/A
5	**Other Notable Reportable Activity**
	N/A
6	**Please use the text box below to detail further climate change related activity that is not noted elsewhere within this reporting template.**
	The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with the constituent bodies – East Dunbartonshire Council and NHS Greater Glasgow & Clyde.

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 17

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	Moving Forward Together: NHS GGC's Health and Social Care Transformational Strategy Programme
Report By	Sandra Cairney, Head of Strategy, Planning & Health Improvement
Contact Officer	Sandra Cairney, Head of Strategy, Planning & Health Improvement 0141 232 8224 Sandra.cairney@ggc.scot.nhs.uk

Purpose of Report	To advise the Integration Joint Board of work being carried out by NHS Greater Glasgow & Clyde to develop a Transformation Strategy for NHS services within the Health Board area.

Recommendations	The HSCP Board is asked to: a) note this report b) agree to ongoing involvement of officers from the HSCP in work to develop the Moving Forward Together Strategy c) Delegate authority to the Chief Officer to identify an appropriate member(s) to represent the HSCP Board and HSCP on the Stakeholder Reference Group

Relevance to HSCP Board Strategic Plan	Relates to HSCP key strategic priorities relating to the need to deliver significant transformation across the health and social care system.

Implications for Health & Social Care Partnership

Human Resources	No immediate impacts, however the outcome of the completed programme could recommend changes to the workforce. Some HSCP officer time is currently being utilised to support development of the Moving Forward Together Strategy.

Equalities:	No immediate impacts arising from this paper. It is expected that the final draft Moving Forward Together Strategy will be subject to a full Equality Impact Assessment by the Health Board.

Financial:	An outline of the budget position previously presented to the HSCP Board indicated that within both the Council and the Health Board there will be significant financial challenges for 2018-19 and beyond. The transformation programme will be the main vehicle for the delivery of future savings and efficiencies. HSCP officers are developing proposals for 2018 onwards on the basis of a reduction in the overall budget in each of the next three years.

Legal:	A number of functions which may be considered 'in scope' for the Moving Forward Together Strategy are delegated to the HSCP Board, therefore statutory responsibilities for decision making in relation to the Strategy may rest with both the HSCP Board and Health Board.

Economic Impact:	The extent of that impact cannot be quantified at this point

Sustainability:	No immediate impacts arising from this paper

Risk Implications:	Failure to deliver the scale of transformation required across the health and social care system presents a significant risk to the HSCP Board discharging its statutory duty of delivering the Strategic Plan within available budget.

Implications for East Dunbartonshire Council:	The Council delivers health and social care services under direction from the HSCP Board.

Implications for NHS Greater Glasgow & Clyde:	The Health Board delivers health and social care services under direction from the HSCP Board.

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 Background and Context

There are a number of local, regional and national drivers around development of a Transformation Strategy for NHS Greater Glasgow & Clyde Health Board iincluding:

- conclusion of the acute services review for Glasgow in May 2015, with the opening of the new Queen Elizabeth University Hospital;
- the clinical services strategy for NHS Greater Glasgow and Clyde (2015);
- national strategies published by the Scottish Government, including the national clinical strategy, strategies for mental health, major trauma services, cancer services and the health and social care delivery plan;
- emerging work around regional planning across health boards in the west of Scotland; and
- the Public Bodies (Joint Working) (Scotland) Act 2014, and the establishment of six Integration Joint Boards within the NHS Greater Glasgow and Clyde area, with responsibility for the strategic planning of, as a minimum, social care, primary and community healthcare and unscheduled hospital care for adults.

In 2016, the Audit Scotland report 'NHS in Scotland' identified a set of key messages for the NHS in Scotland, as outlined below.

- There have been significant improvements both in population health and healthcare over the last decade.
- The demands on health and social care services are escalating and NHS funding is not keeping pace.
- NHS boards are struggling to meet the majority of national standards and it is increasingly difficult to balance the demands of hospital care alongside providing more care in the community.
- There are significant workforce pressures due to an ageing profile and difficulties in recruitment and retention.

The report goes on to recommend that NHS Boards should '*take ownership of changing and improving services in their local area and, working with partner agencies, develop long term workforce plans and work with the public about the need for change'*

The Scottish Government published a response to this report with 3 main aims: reducing inappropriate use of hospital services**;** shifting resources to primary and community care; and supporting capacity of community care**.**

1.2 NHS Transformation Strategy

In response to the drivers, NHS Greater Glasgow & Clyde Health Board has initiated work to develop a health-board wide Transformation Strategy **(Appendix A)**. The aim of this work is to develop a medium term (5-10 year) transformational plan for NHS Greater Glasgow & Clyde. The scope of this work will include the development of a system wide strategic framework, with associated implementation plans for acute, primary care and community health services. It is anticipated that this work will be carried out in 4 phases, with completion expected in mid 2018:

- Phase 1 - Establishing baseline position, and mapping against current strategy/work streams and gap analysis.
- Phase 2 – Establishing gaps and commissioning work streams to inform those gaps. Clinical discussion on principles leading to the development of plans to implement new models of care and the quantification of the impact of those changes
- Phase 3 - Drawing together and quantifying the impact of predicted demand changes and new models of care to describe options for a new service configuration across primary, community, secondary and tertiary care

- Phase 4- Engagement, consultation and revision.

Governance arrangements are currently under discussion, however it is expected that Executive-level governance will be carried out by a Programme Board, chaired by the Chief Executive and with membership comprising Executive Directors, Chief Officers, Acute Services, clinical leads and Regional Planning representation.

The Programme Board will review outputs and provide guidance to the Project Team and will report to the NHS Greater Glasgow and Clyde Senior Management Team, Health Board and the six Integration Joint Boards.

Project activity will be undertaken by a system wide core Transformation Team comprising cross system clinical, managerial, HSCP, planning, public health, communications and public engagement, data analysis, finance and estates. This Transformation Team will be responsible for developing the project plan and taking forward the 4 phases of the programme.

The Transformational Team had their first meeting in early September and has begun initial activity to take forward Phase 1 of this project. Further updates will be provided to the HSCP Board.

1.3 HSCP Involvement

A range of individuals have been co-opted to the Transformational Team on a temporary basis, including a number of officers from HSCPs representing primary and community care. Further, it is expected that two Chief Officers will be appointed to the Programme Board, representing the six IJBs in the NHSGGC area.

The role of HSCP officers on the Transformational Team, and of Chief Officers on the Programme Board, will be to provide support, advice and scrutiny of development of the Moving Forward Together Strategy from an HSCP perspective. This will include for example, articulating the aims of the strategic plans of the six IJBs and how the Moving Forward Together Strategy can align with these, and describing the scale of the financial challenge facing IJBs and the extent of the transformation work already underway within Partnerships.

To support wider engagement in development of the Moving Forward Together Strategy, a Stakeholder Reference Group will be established. The purpose of this group will be to:

- act as a sounding board for testing plans and materials;
- advise on the development of information for wider public use;
- communicate back to stakeholder groups; and
- strengthen and play a significant role in wider public communication.

Membership of the Stakeholder Reference Group is currently under consideration by the Transformation Team, however it is expected that representation from each of the six IJBs in the NHSGGC area will be sought. The HSCP Board is therefore asked to delegate authority to the Chief Officer to identify an appropriate member(s) to represent the HSCP Board and HSCP on the Stakeholder Reference Group.

MOVING FORWARD TOGETHER: NHS GGC'S HEALTH AND SOCIAL CARE TRANSFORMATIONAL STRATEGY PROGRAMME

PART ONE: NHSGGC Strategic Background and National Strategies/Plans and Requirements

NHSGGC strategic background

NHS services in general and NHSGGC acute services in particular have gone through a period of ongoing change since the millennium. The delivery of the Glasgow Acute Services Review first approved in 2002 and the South Clyde Strategy (2006) and the North Clyde Strategy (2009) have seen changes across services in what is now Greater Glasgow and Clyde. The achievement of the various infrastructure and service improvements embedded within these strategies culminated in the opening of the new Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children in May 2015.

In addition, in 2012 the NHSGGC Board commissioned a strategic review of clinical services to ensure their fitness for future demands. This work was completed and approved by the NHSGGC Board as the Clinical Services Strategy in January 2015. This Clinical Services Strategy was also adopted by the emergent Health and Social Care Partnerships as a framework for planning clinical services. That position remains extant.

National and regional strategic background

Since 2015 there have been a number of National Strategies published by the Scottish Government, including the National Clinical Strategy and Health and Social Care Delivery Plan as well as strategies for mental health, major trauma, cancer services, maternity and neonatal care, primary care, intermediate care and realistic medicine.

The Scottish Government have confirmed that by 2021 there will be Diagnostic and Treatment Centres (DTC) across the country, in addition to the enhancements to the current Golden Jubilee National Hospital. This investment is to build capacity for diagnostics and planned surgery away on dedicated sites away from the emergency and trauma centres and units. The precise configuration of these centres is yet to be fully defined but in planning for the future, it is essential that NHSGGC and West of Scotland plans influence and take account of this development.

The Health & Social Care Delivery Plan (HSCDP) reaffirms the need for planning regionally a range of clinical services on a population (cross geographical boundaries) basis. The West of Scotland Regional Planning Group is therefore developing its strategic planning programme in line with these requirements, with all component NHS Boards, including therefore, NHSGGC. This too must include forward planning towards establishment of the DTCs as well as within estates, capital and revenue planning.

Under the Public Bodies (Joint Working) (Scotland) Act 2014, Integration Authorities are responsible for the planning, commissioning and delivery of a range of services across the boundaries of primary, community and secondary care. There are six Integration Joint Boards within the NHSGGC Board area and each has in place a strategic plan and supporting commissioning intentions.

In its first report on Health and Social Care Integration in 2015, Audit Scotland emphasised the significant opportunities associated with integration for improving outcomes for individuals and communities and argued that a measure of success would be the extent to

which integration provides a vehicle for Health Boards, Councils and IJBs to move to a more sustainable health and social care service, with a greater emphasis on anticipatory care and less reliance on emergency care.

In 2016, Audit Scotland set out a range of findings and recommendations for Scottish Government and for NHS Boards and Health and Social Care Integration Joint Boards, summarised (by Audit Scotland) as below.

"The NHS is going through a period of major reform. A number of wide ranging strategies propose significant change, including the National Clinical Strategy, integration of health and social care services and a new GP contract. These need to be underpinned by a clear plan for change. Some progress is being made in developing new models of care, but this has yet to translate to widespread change in local areas and major health inequalities remain.

Recommendations

The Scottish Government should:

• provide a clear written plan for implementing the 2020 Vision and National Clinical Strategy, including: – immediate and longer-term priorities, including a public health strategy to help NHS boards focus on preventing ill health and tackle health inequalities – support for new ways of working and learning at a national level – long-term funding plans for implementing the policies – a workforce plan outlining the workforce required, and how it will be developed – ongoing discussion with the public about the way services will be provided in the future to manage expectations

• set measures of success by which progress in delivering its national strategies can be monitored, including its overall aim to shift from hospital to more community-based care. These should link with the review of national targets and align with the outcomes and indicators for health and social care integration

• consider providing NHS boards with more financial flexibility, such as three-year rolling budgets rather than annual financial targets, to allow better longer-term planning

The Scottish Government, in partnership with NHS boards and integration authorities, should:

• model the cost of implementing its National Clinical Strategy and how this will be funded, including the capital investment required

• share good practice about health and social care integration, including effective governance arrangements, budget-setting, and strategic and workforce planning

• in line with the national policy on realistic medicine: – work to reduce over-investigation and variation in treatment – ensure patients are involved in making decisions and receive better information about potential treatments

NHS boards, in partnership with integration authorities, should:

• take ownership of changing and improving services in their local area, working with all relevant partner organisations

In response the Scottish Government published the Health and Social Care Delivery Plan (HSCDP) which is predicated on a "Triple Aim" of Better Health, Better Care and Better Value. It also described these aims in terms of reducing inappropriate use of hospital services**;** shifting resources to primary and community care and supporting capacity of community care.

It is against this national strategic background that this Programme – Moving Forward Together - is proposed so as to ensure NHSGGC health and social care services keep pace with best available evidence and ongoing transformational change nationally and regionally to meet the needs of the people of Scotland, ultimately delivering the Triple Aim set out in the HSCDP – Better Health, Better Care, Better Value.

The Aim and Objectives of the Moving Forward Together Programme

The aim of this transformational strategic programme is:

- to develop and deliver a transformational change programme, aligned to National and Regional policies and strategies that describes NHSGGC's delivery plan across the health and social care services provided by our staff, which is optimised for safe, effective, person centred and sustainable care to meet the current and future needs of our population.

The objectives are:

- to update the projections and predictions for the future health and social care needs of our population
- to produce a clinical case for change
- to review existing National, Regional and NHSGGC published strategies and model the impact of their delivery on our population
- taking the information above, to develop new models of care delivery which provide safe, effective and person centred care which maximises our available resource, provides care in the most efficient and effective way and makes the best use of innovation and the opportunities presented by new technology and the digital age
- to support the subsequent development of delivery plans for these new models of care, which describe the required changes in workforce, capital infrastructure and procedures and processes which ensure the intended and projected benefits are realised.

A detailed description of the programme is set out in the accompanying paper. The Board is invited to consider and confirm its approval to proceed to develop Moving Forward Together as outlined. This will see the delivery of a comprehensive transformational change plan to come forward to the Board by June 2018.

MOVING FORWARD TOGETHER: A TRANSFORMATIONAL STRATEGY FOR HEALTH AND SOCIAL CARE SERVICES ACROSS NHS GREATER GLASGOW AND CLYDE

PART ONE: National Policy Strategic Context

The strategic landscape set for NHS Scotland in which NHSGGC must operate can best be described as an agreed and supported direction of travel which is founded on evidence based good practice and sound principles. Audit Scotland highlighted both the imperative to continue to pursue this direction of travel, but also recognised the challenges which face us in delivering the changes which are required to move us forward together.

The high level picture for our nation is one of changes to the demographic composition of our population and the challenges which that brings. It is to be celebrated that our people are generally living longer and healthier lives due to the range and quality of past and present prevention programmes and the care services that the NHS in Scotland has and is delivering.

It is also recognised, however, that these positive changes place increasing demands on health and social care services, who in turn work within allocated resources to provide the care needed for local residents. This has resulted in the need to look at the future needs of our population and to develop and support the changes needed to keep pace with demand now and over the coming years. Modern health and social care practice is developing through the growing evidence base which describes what best meets those future needs through new and developing technological advances, but also in terms of what our population expect of their health and social care services in the modern world.

This changing and challenging environment drives a requirement to review and where necessary redesign our health and social care services for the future.

2020 Vision

The 2020 Vision remains the pinnacle of NHS Scotland Heath and Social Care policy and it clearly has relevance beyond 2020.

The Vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system where:

- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self management
- When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

The Quality Strategy

If the 2020 Vision is the pinnacle of the policy frameworks then the Quality Strategy is what underpins the frameworks.

The Quality Strategy (2010) is the approach and shared focus for all work to realise the 2020 Vision.

The Quality Strategy aims to deliver the highest quality health and social care to the people of Scotland, to ensure that the NHS, Local Authorities and the Third Sector work together and with patients, carers and the public, towards a shared goal of world leading healthcare.

The Quality Strategy is based on the Institute of Medicine's six dimensions of Quality.

It is also shaped by the patient engagement feedback received from the people of Scotland when asked what they wanted from their healthcare system.

This is summarised as a system which is caring and compassionate and has good communication and collaboration. A system where care is delivered in a clean environment and that gives continuity of care and achieves clinical excellence.

Out of these criteria three Quality Ambitions were developed:

- **Safe**
  There will be no avoidable injury or harm to people from healthcare and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all time
- **Person Centred**
  Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision making
- **Effective**
  The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit and wasteful or harmful variation will be eradicated.

Integration and the National Health and Social Care Outcomes

Legislation requiring the integration of Health and Social care came into effect in April 2016 and the new Integration Authorities now have responsibility for over £8 billion of funding across Scotland for the delivery of services which was previously managed separately by NHS Boards and Local Authorities. The Scottish Government considers this to be the most significant change to the way care is provided for people in their communities since the creation of the NHS.

In addition to the Public Bodies (Joint Working) Act, Health and Social Care Services are required to develop in response to other legislation, including:

- The Social Care (Self Directed Support) Act 2013, which makes legislative provisions relating to the arranging of care and support, community care services and children's services to provide a range of choices to people for how they are provided with support.
- The Children and Young People (Scotland) Act 2014, which reinforces the United Nations Convention on the Rights of the Child; and the principles of Getting It Right For Every Child.

- The Community Empowerment (Scotland) Act 2015, which provides a legal framework that promotes and encourages community empowerment and participation; and outlines how public bodies will work together and with the local community to plan for, resource and provides services which improve outcomes in the local authority area.
- The Carers (Scotland) Act 2016, which aims to ensure better and more consistent support for both adult and young carers so that they can continue to care in better health and to have a life alongside caring.

The measure of success in integration is making the necessary changes which put people at the centre of decisions about their care and improves and brings closer together the range of services available to make them near seamless and more responsive to the people who use them.

Hospitals should and will provide clinical care that cannot be provided anywhere else, but most people need care that can be provided in settings other than hospitals which are more appropriate to the specific individual needs and are better placed to support health and wellbeing. This thinking meets the expectation that people would rather receive support and care at home or in a homely setting when they do not require the acute care that can only be delivered in a hospital.

Integration aims to provide care built around the needs of the person, which can support them to remain at home or closer to home, connected to their families and their communities. At a strategic level the benefits of Integration are founded on delivery of 9 outcomes, which are monitored through a range of measureable indicators. These are:

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

What does this mean for NHSGGC?

Metrics to monitor the delivery and impact of these nine outcomes have been described separately by Scottish Government. In terms of impact for NHSGGC, taking outcome 5 as an example, the Board will wish, in due course, to be able to define its contribution to reducing health inequalities across its population, particularly as there is continuing evidence of a widening gap in health inequalities within the City of Glasgow.

We will

- ensure that appropriate health inequalities impact assessments are a core component of the Moving Forward Together programme proposals for change

The National Clinical Strategy

The National Clinical Strategy (NCS) was published in February 2016. It is evidence based and sets out the drivers for the required transformational change in the delivery of clinical services. It follows an approach that looks across the whole patient pathway from primary care, community care, to secondary/tertiary care and includes palliative and end of life care and the approach to Realistic Medicine. It uses the known projections and predictions in terms of changes in demographic profile, technological advances available resource to consider the wider implications of those changes for NHS Scotland for the next 10 to 15 years and beyond.

The NCS lists the key drivers for transformational change as:

- demographic changes in Scotland's population
- the changing patterns of illness and disability
- the relatively poor health of the population and persisting inequalities in health
- the need to balance health and social care according to need
- workforce issues
- financial considerations
- changes in the range of possible medical treatments
- remote and rural challenges to high quality healthcare
- opportunities from increasing information technology (e-health)
- a need to reduce waste, harm and variation in treatment

The NCS uses national and worldwide evidence of successful change to indicate the potential impact of such changes in terms of improved outcomes and better experiences for individuals.

The NCS recognises the current challenges to the delivery of these changes in NHS Scotland which are reflective of those facing NHSGGC:

- increasing need for support for an ageing population with increasing levels of multi-morbidity
- multi-morbidity arising approximately a decade earlier in areas of deprivation

- A need to
    - improve care and outcomes via an expanded, multidisciplinary and integrated primary and community care sector, despite current workforce constraints
    - to increase co-production with patients and carers, create high quality anticipatory care plans and to support people in health improvement and self management
    - embrace the changes required for effective integration of health and social care and ensure that it makes a transformational change in the management of patients despite the current demand and supply challenges also faced by social services
    - reduce the avoidable admission of patients to hospital whenever alternatives could provide better outcomes and experiences
    - dramatically reduce the problem of discharge delay and thereby the risk of avoidable harm and adverse impact on the maintenance, or re-establishment of independent living
    - make better use of information and make better informed decisions about both individual and collective care
    - ensure that services become sustainable in the face of considerable workforce and financial constraints by giving careful consideration to planning of more highly specialist provision
    - provide healthcare that is proportionate to people's needs and where possible their preferences, avoiding overtreatment and over medicalisation and at the same time prevent undertreatment and improving access to services in others
    - provide services of greater individual value to patients
    - move to sustainable expenditure so that we maintain high quality services and can also avail ourselves of medical advances as they arise, and
    - integrate the use of technology into service redesign and to consider how IT could transform service delivery and help meet future challenges.

The potential impact for the delivery of health and social care services provided by NHSGGC will cut across the whole range of services from primary through community, acute care and beyond. This programme – Moving Forward Together – is aimed looking forward to the transformational changes that will be required for meeting the assessed future needs of our people. Taking as an example the principles of service planning, these will potentially significantly change in terms of both the "Once for Scotland" approach in, for example, shared diagnostic services and also the changes in planning regionally for populations, across board and geographical boundaries.

In planning regionally for the West of Scotland population of 2.7 million people this will likely lead to changes in the organisation of our hospitals. There will be a need in future to work as joined up networks providing the full range of planned care needed across specialist services, linking to and working alongside, primary care clusters and community care services to ensure a coordinated, seamless experience for those individuals who cannot be cared for at home or in a homely setting.

The NCS sets out evidence based examples of those services best provided locally, regionally and nationally. This evidence based configuration linked to population size will be a foundation principle for both WoS regional planning and Moving Forward Together.

We will

- maintain open dialogue with delivery partners, e.g. HSCPs, National Services Division, WoS Regional Planning leads and our workforce across all services and service sectors to ensure planning is joined up and cohesive across all relevant NHS Boards and partners.
- bring forward a forward plan that is developed together with all such partners and is agreed by them as a sustainable way forward.

Health and Social Care Delivery Plan

The Health and Social Delivery Plan (HSCDP) sets out in greater detail the outcomes required in the delivery of integrated health and social care services. It represents what Scottish Government expects NHS Boards, Local Authorities and IJBs to deliver in partnership with the voluntary sector, patients, carers, families and our wider population.

The HSCDP focuses on three areas, which are referred to as the "Triple Aim" -

Better Care

- To improve the quality of care for people by targeting investment at improving services, which will be organised and delivered to provide the best, most effective support for all

Better Health

- To improve everyone's health and wellbeing by promoting and supporting healthier lives from the earliest years, reducing health inequalities and adopting an approach based on anticipation, prevention and self management

Better Value

- To increase the value from and financial sustainability of care, by making the most effective use of the resources available to us and the most efficient and consistent delivery, ensuring that the balance of resource is spent where it achieves the most and focusing on prevention and early intervention.

The HSCDP goes on to describe how transformed Health and Social Care services will benefit individuals and communities and will impact on regional and national services.

National and Regional Approach to Service Planning

The National Clinical Strategy introduced the requirement to plan services on a population basis whether regionally or nationally (Once for Scotland) determined by evidence of thsope services that can best be delivered at local, regional or national level.

The West of Scotland (WOS) now has a nominated Chief Executive lead and the Director of WOS Regional Planning is building a team of co-opted senior executives from NHSGGC and other boards and seconded managers to take forward the WOS regional planning agenda.

The stated requirement is to develop a regional transformation plan by September 2017 which sets out how the region will support delivering the HSCDP with board local development plans setting out their contribution both to the regional and national plans.

By March 2018 each region is expected to have a plan setting out how services will evolve to deliver the NCS and further develop the efficiency of secondary care.

NHSGGC plays a full part in the leadership of and support to various work streams in the development of the West of Scotland planning process.

The plans will need to consider how services will be evolved over the next 15-20 years to support the transformation of health and social care and ensure the longer term investment in services and estate is committed to the right areas to deliver the aims of the national clinical strategy and HSCDP.

This WOS planning will run alongside the NHSGGC Moving Forward Together Programme and as it develops the interdependency and alignment will be continually monitored and necessary adjustments made through the maintenance of a close working relationship between the two teams.

Primary Care

The national Primary Care Outcomes Framework sets out a clear vision for the future primary care at the heart of the healthcare system, linking to the 2020 Vision, Health and Social Care Integration, the National Clinical Strategy and Health and Social Care Delivery Plan.

This vision applies across the four primary care contractor groups and the wider multi-disciplinary team working in primary care.

General practices are central to this vision for primary care with Scotland's GPs as the *Expert Medical Generalist in the community; focussed on complex care, undifferentiated presentation and local clinical leadership.*

A new GP contract is under development with changes expected from April 2018. The contract, alongside additional focus and investment in the wider context of primary care, is expected to achieve a move towards that vision and the creation of extended multi-disciplinary teams in every locality.

A key part of the vision is the establishment of clusters of GP practices. These are now in place across Scotland with a clear remit to provide leadership on quality improvement across practices and with wider services.

The Scottish Government review of Out of Hours primary care services was published in February 2017. It seeks to ensure that services are

- Person centred, sustainable, high quality, safe and effective
- provide access to relevant urgent care when needed
- deliver the right skill mix of professional support for patients during the out of hours period

Four theme based task groups were set up to examine workforce matters; how data and technology can enable improvements; explore new models of care and explore what a quality out of hours service would look like.

The Scottish Government also committed £1m to testing the Review Chair's recommended new model of urgent care with seven pilot sites throughout Scotland testing various aspects of this model.

The results of this Initial Testing Programme will inform the National Delivery Plan for the Transformation of Urgent Care, for which £10 million is committed in 2017. It is intended that this will deliver both national and local initiatives over the immediate and longer term towards enabling improvements in urgent care services.

We will

- continue to support the 39 clusters across NHSGGC as a cornerstone of future developments in primary care.
- work together with primary, community and secondary care partners to drive and support action to put in place the Review recommendations for urgent/out of hours care.

The vision for Pharmaceutical services in Scotland includes a commitment to increasing access to community pharmacy as the first port of call for managing self-limiting illnesses and supporting self-management of stable long term conditions, in-hours and out-of-hours, and to increasing access to GP practice based pharmacy, integrating pharmacists with advanced clinical skills and pharmacy technicians in GP practices to improve pharmaceutical care and contribute to the multidisciplinary team.

The Community Eyecare Services Review sets out a clear role for Community Optometrists in the transformation of primary care and ongoing development of community based care; ensuring that patients see the most appropriate professional and further developing eyecare in the community.

The Oral Health Improvement Plan currently under development will set out the steps to support NHS dental services to have an increasing focus on prevention.

Mental Health

The Scottish Government published a ten year strategy for mental health in March 2017. It is wide ranging and cross cutting across, for example, education, prison, secure care, children, young people and adults, including also measurement and data requirements to fulfil the 40 actions set out. It will be reviewed at the halfway stage – in 2022 – to assess its delivery and impact.

In terms of NHSGGC, it is not the purpose of this document to set out a range of specific actions required. That will take time given the complexity of the overall actions required, but it is vital that this programme considers and sets out the needs for people who need mental health and associated support services, whether provided by the statutory or the voluntary sector.

We will

- Work with health and social care partnerships and relevant sectors, including education and secure sector as required, to ensure that NHSGGC is prepared for and will deliver a range of services necessary to meet the needs of our population both in Greater Glasgow and across the WoS as required. These plans will be an important part of the final proposals to be brought forward to the Board in June 2018.

Maternity and Neonatal

The Review of Maternity and Neonatal Services in Scotland was published by Scottish Government in January 2017. Its aim was to ensure that every mother and baby continues to get the best possible care from Scotland's health service, giving all children the best start in life. The Review examined choice, quality and safety of maternity and neonatal services, in consultation with the workforce, NHS Boards and service users.

A summary of the recommendations:

- Continuity of Carer: all women will have continuity of carer from a primary midwife, and midwives and obstetric teams will be aligned with a caseload of women and co-located for the provision of community and hospital based services.
- Mother and baby at the centre of care: Maternity and Neonatal care should be co-designed with women and families from the outset, and put mother and baby together at the centre of service planning and delivery as one entity.
- Multi-professional working: Improved and seamless multi-professional working.
- Safe, high quality, accessible care, including local delivery of services, availability of choice, high quality postnatal care, colocation of specialist maternity and neonatal care, services for vulnerable women and perinatal mental health services.
- Neonatal Services: proposes a move to a new model of neonatal intensive care services in Scotland in the short and long term.
- Supporting the service changes: recommendations about transport services, remote and rural care, telehealth and telemedicine, workforce, education and training, quality improvement and data and IT.

Implementation of these recommendations is overseen by a national Implementation Group chaired by Jane Grant, Chief Executive, NHSGGC.

As is the case with mental health services, the NHSGGC plans for the future in this area are being developed and it is intended that the Moving Forward Together Programme assesses the impact of these recommendations and necessary changes and brings forward appropriate actions to address any changes required in line with the national requirements both in terms of the women and babies within NHSGGC but also as required across WoS as well as any actions taken so far and their impact.

Major Trauma Services

In January 2017 a new National Trauma Network was launched which sees four major trauma centres backed up by a range of co-ordinated trauma units across Scotland. One of these major trauma centres is based in Glasgow, at the QEUH. The national trauma network is commissioned and run by National Services Division while the local configuration of hospitals and, vitally, the clinical pathways for people suffering trauma are determined regionally and locally to best support and meet need. NHSGGC and WoS planning leads are working together to ensure the most appropriate configuration of trauma units and, along with Scottish Ambulance Service (SAS) and NHS 24, among others, to see necessary changes made so as to save more lives.

This work will continue to be driven by the Major Trauma Network and associated partners, however it is essential that the clinical needs of people with trauma are taken into account in determining the future patterns and pathways of care across NHSGGC.

We will

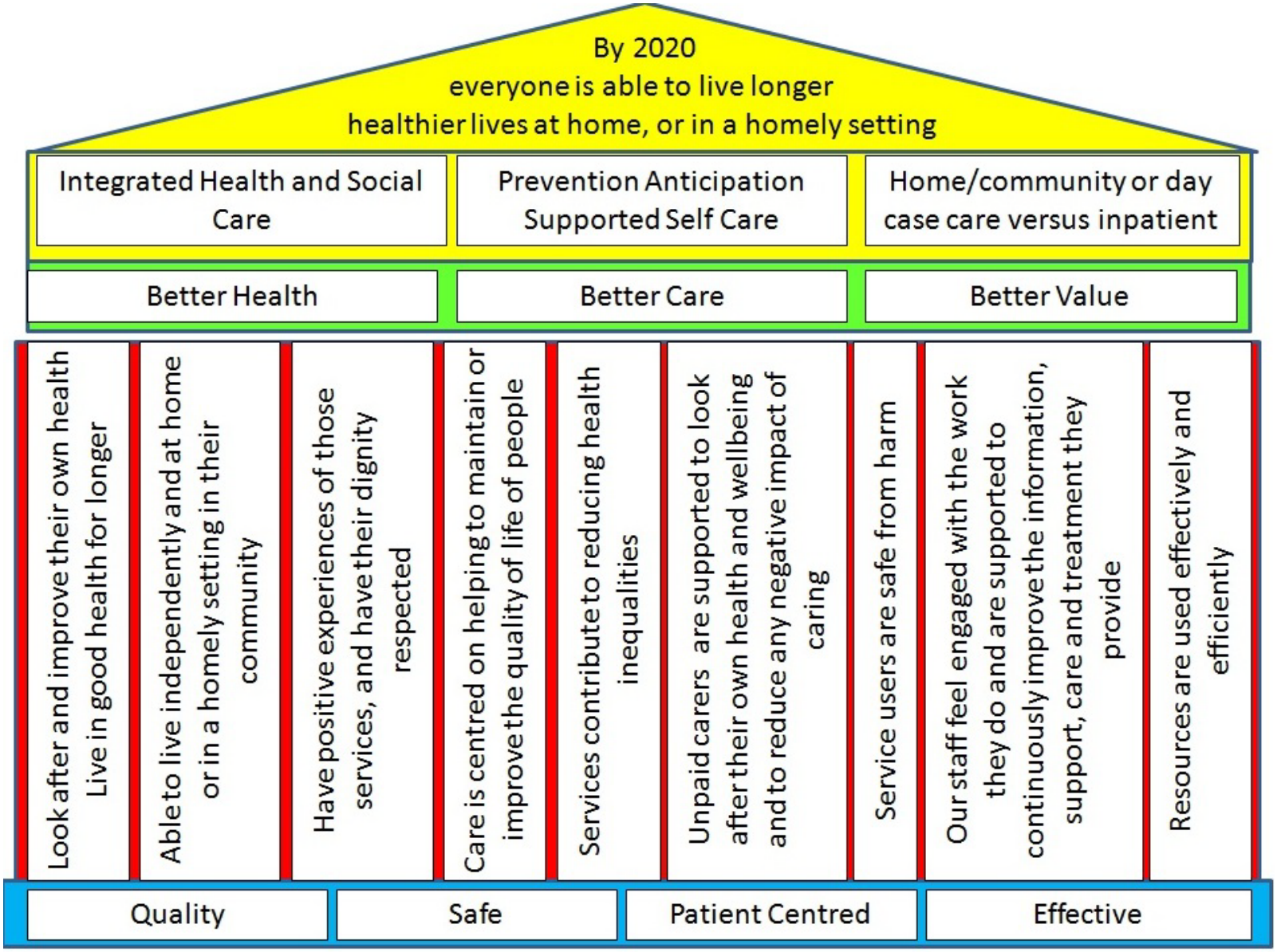
- ensure that the Major Trauma Network and planning for the appropriate configuration of Trauma Units is taken into account in planning for the future needs of our population.

Summary of the National Strategic Context

As highlighted in this section there are a number of national and regional policies, strategies and influences which will shape the NHSGGC Health and Social Care Transformational Strategy. However there is a coherent and clear direction set out across the documents. The diagram below seeks to summarise this direction.

The 2020 Vision is the pinnacle of the strategic framework. Its delivery for our population rests on the triple aim and the success of the integration agenda which is supported by the 9 pillars of the National Health and Social care outcomes and the Primary Care outcomes. Everything is underpinned by the Quality Strategy. Clinical services will be developed in line with the National Clinical Strategy and other relevant Scottish Government strategies.

Pictorially we are representing this as a “Cathedral of Care” – set out below.


By 2020
everyone is able to live longer
healthier lives at home, or in a homely setting
Integrated Health and Social Care
Prevention Anticipation Supported Self Care
Home/community or day case care versus inpatient
Better Health
Better Care
Better Value
Look after and improve their own health Live in good health for longer
Able to live independently and at home or in a homely setting in their community
Have positive experiences of those services, and have their dignity respected
Care is centred on helping to maintain or improve the quality of life of people
Services contribute to reducing health inequalities
Unpaid carers are supported to look after their own health and wellbeing and to reduce any negative impact of caring
Service users are safe from harm
Our staff feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
Resources are used effectively and efficiently
Quality
Safe
Patient Centred
Effective

PART TWO: NHSGGC Strategic Background and the Clinical Services Strategy (CSS)

NHSGGC Clinical Services Strategy

The 2015 CSS provides the extant framework within which NHSGGC plans and delivers health and social care.

Although it predates the National Clinical Strategy the two documents are coherent in terms of the overall principles and the direction of travel across primary, secondary and tertiary care and the shift in care from an emphasis on hospital care towards care provided at home or in a homely setting via primary and community care planned and delivered via health and social care partnerships and, for example, clusters of GP practices working cohesively as a multi-disciplinary team to meet the needs of patients.

The CSS Case for Change

As with the NCS the CSS first identified the case for change based on an evidential review and predictions of our future population needs.

The summary of the final case for change is described by 9 key themes shown below.

- The health needs of our population are significant and changing;
- We need to do more to support people to manage their own health and prevent crisis;
- Our services are not always organised in the best way for patients;
- We need to do more to make sure that care is always provided in the most appropriate setting;
- There is growing pressure on primary care and community services;
- We need to provide the highest quality specialist care;
- Increasing specialisation needs to be balanced with the need for coordinated care which takes an overview of the patient;
- Healthcare is changing and we need to keep pace with best practice and standards;
- We need to support our workforce to meet future changes.

CSS System Wide Challenge

The CSS recognised the challenging demand pressures across a system in which 'hospital' and 'community' services were largely seen as separate, with often poor communication and lack of joint planning across the system. It was recognised that the future demand pressures could not be met by continuing to work in that way.

The CSS proposed a new system of care showed a significant change focusing on providing care where it is most appropriate for the patient. This was based on strengthened 24/7 community services, acute services focused on assessment and management of acute episodes, and a range of services being developed at the interface including shared management of high risk patients and a range of alternatives to face to face hospital visits.

The CSS proposed working differently at the interface between community and hospital which may involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system.

Enablers

The CSS identified that changing the system at scale would require a series of enabling changes to support delivery of the new health care system.

- supported leadership and strong clinical engagement across the system to develop and implement the new models.
- building on the clinical portal to enable shared IT systems and records which are accessible to different professionals across the care system.
- jointly agreed protocols and care pathways, supported by IT tools.
- stratification of the patient population to ensure that care is targeted at the appropriate level with supporting anticipatory care plans in place.
- ensuring that access arrangements enable all patients to access and benefit from services.
- increasing the education and information shared with patients and the public to support people to take more responsibility for their own care.
- involvement of patients and carers in care planning and self management.
- shared learning and education across primary, community and acute services.
- governance and performance systems which support new ways of working.
- information systems which enable us to gather the information we need to monitor whether the changes are working, including disaggregated data on activity and outcomes for equality groups.
- integrated planning of services and resources.
- ensuring that contractual arrangements with independent contractors support the changes required.

CSS projected benefits

It was anticipated that the successful achievement of the new system of health care would result in:

- Patients being in control of their care and empowered to share decisions about it;
- A system of care which is easier to navigate for patients and professionals.
- Clinicians and other staff at all stages having the necessary information about the patient, with care better tailored to the patient's needs.
- Better patient experience and patient safety, and improved health outcomes with a particular improvement for patients with multi-morbidity.
- A reduction in health inequalities as the most vulnerable patients receive better access to holistic person centred care.
- Care which is provided in the most appropriate setting, relative to the patients needs.
- More cost effective use of resources with care focused on early intervention, better management of complex multi morbidity and a reduction in duplication of care.

Moving Forward Together – making it happen

The Moving Forward Together Programme will be delivered by a central hub of a core project team from across NHSGGC and with skills and experience coving all aspects of health and social care. The core team will work using the spokes of their various clinical and managerial networks in order to fully utilise the experience innovation and drive of the full range of staff who deliver health and social care services. The core team report into a cross system programme board populated by our most senior executives.

The Moving Forward Together Programme is not starting from first principles. Rather it builds on and drives forward known actions and commitments already recognised as necessary – but it will also update and supplement these in light of more recent evidence and national strategic needs.

The CSS Future Health System described a series of key characteristics of clinical services. These are also key features of the future for NHS Scotland and NHSGGC in particular in terms of the national strategic picture.

Much of the proposed change in the CSS remains what needs to be and must be done to deliver sustainable high quality health and social care which meets the future needs of our population.

However, if NHSGGC is to continue to meet the needs of our population, this Transformational Programme needs to take the CSS principles and the national context requirements on to a transformational delivery platform . It needs to describe transformational change in the context of integration and bring together health and social care to deliver a new health and social care system that not only provides the best quality of care possible but also supports people to manage their own care where appropriate, through maximising the use of digital technology and community support to improve access for advice and support, such as through community pharmacists. We need to develop the actions which will deliver the changes described in the National context but delivered locally, regionally and nationally for our population.

The actions that this programme recommends will need to:

- Support and empower people to improve their own health
- Support people to live independently at home for longer
- Empower and support people to manage their own long term conditions
- Enable people to stay in their communities accessing the care they need
- Enable people to access high quality primary and community care services close to home
- Provide access to world class hospital based care when the required level of care or treatment cannot be provided in the community
- Deliver hospital care on an ambulatory or day case basis whenever possible
- Provide highly specialist hospital services for the people of Greater Glasgow and Clyde and for some services, the West of Scotland

Delivery of the Moving Forward Together Programme will see improvements in care and outcomes for everyone.

What does the future look like?

- **In Primary Care**

A system underpinned by timely access to high quality primary care both in and out of hours, providing a comprehensive service that deals with the whole person in the context of their socio-economic environment:

- building on universal access to primary care.
- focal point for prevention, anticipatory care and early intervention.
- management where possible within a primary care setting.
- focus for continuity of care, and co-ordination of care for multiple conditions.

- **In Community Care**

A comprehensive range of community services, integrated across health and social care and working with the third sector to provide increased support at home as well as support for self management:

- single point of access, accessible 24/7 from acute and community settings.
- focused on preventing deterioration and supporting independence.
- multi-disciplinary care plans in place to respond in a timely way to crisis.
- working as part of a team with primary care providers for a defined patient population.

- **In Unscheduled Care**

Co-ordinated care at crisis/transition points, and for those most at risk:

- access to specialist advice by phone, in community settings or through rapid access to outpatients.
- jointly agreed care plans with input from GPs, community teams, specialist nurses and consultants, with shared responsibility for implementation.
- rapid escalation of support, on a 24 / 7 basis.

Hospital assessment which focuses on early comprehensive assessment driving care in the right setting:

- senior clinical decision makers at the front door.
- specialist care available 24/7 where required.
- rapid transfer to appropriate place of care, following assessment.
- In-patient stay for the acute period of care only
- early supported discharge to home or step down care.
- early involvement of primary and community care team in planning for discharge.

- **In Scheduled (Planned) Care**

Planned care which is locally accessible on an outpatient and ambulatory care or day case basis where possible, with:

- wider range of specialist clinics in the community, working as part of a team with primary care and community services.
- appropriate follow up.
- diagnostic services organised around assessed individual needs.
- interventions provided as day case where possible.
- rapid access as an alternative to emergency admission or to facilitate discharge.

Aligned with regional and national direction our service planning will cater for the needs of our population, as well as for the wider regional or national population as required. In this planning highly specialised and complex care will be provided in relevant properly equipped specialised units with an appropriately skilled workforce. These services will be designed to meet the current and projected needs based on population and the planning will be shaped by clear evidence on the relationship between outcomes for patients and activity volume when delivered by collocated multi disciplinary teams.

- **In e-Health**

Since 2012 when the Clinical Services Strategic review was commissioned NHSGGC has already achieved considerable benefit from e-Health investment which has transformed many aspects of healthcare already. The main themes in the past five years have been:

- implementing board-wide cornerstone electronic health record systems (Trakcare, Clinical Portal and EMISWeb), including a single patient index across the Health Board using CHI as the main identifier.
- making a wide range of clinical and care information available for clinicians and social care practitioners at the point of need within and increasingly across social care and Health Board boundaries
- digitising incoming hospital and community referrals with SCI Gateway and sending return correspondence with EDT, replacing postal letters (2.5 million items annually)
- centralising laboratory and radiology information systems
- replacing paper notes in outpatient clinics with access to digital patient information
- digitising in-patient workflow and support services

NHSGGC eHealth has an ambitious work plan for the next 12 months which is focussed on patient safety and care integration.

- finalise Full Business Case and, subject to approval, begin implementation planning for a Board-wide Hospital Electronic Prescribing and Medicines Administration system
- implement a new medicines reconciliation system and discharge letter process, creating a single patient-centred medication list
- complete roll out of a single Board-wide maternity electronic record system
- complete data sharing in Portal between all HSCPs and health board
- improve interoperability between key EPR systems such as document sharing from EMISWeb into portal and GP data summary into Portal
- develop a Patient Portal proof of concept digital platform and associated business case that will inform national strategy

Strategic aims of e-health that will help transform care by 2025 include

- Improved healthcare safety for medicines and deteriorating patients giving better situational awareness for clinicians
- Better interoperability of and workflow between cornerstone systems right across community and primary care helping break down professional and organisational silos
- Support for virtual consultations and care coordination reducing need for patients to travel, improving oversight of long term conditions and maximising clinic utilisation
- Digital patient engagement including patient portals to help self care, multimodal access for patients with text or webchat
- Better use of smart informatics at the clinical front line to help decision making by summarising the large amount of health and care data that now exists on individuals
- Providing technology such as the Microsoft Office 365 collaboration suite that will enable more agile and flexible working

Our Starting Point and Transformation in Action

Although there has not been the transformational change since 2015 that would have seen the full implementation of the CSS new health care system, NHSGGC has not stood still.

There are a number of service reviews currently under way which will produce transformational change proposals which may be delivered during this programme or will be incorporated into the final change proposals in the new clinical and service models coming out of this programme and the wider West of Scotland regional approach to planning.

These reviews include:

GP Contract Arrangements
Out of Hours Services
Mental Health Services
Unscheduled Care
Older People's Services
Planned Care Capacity
Beatson West of Scotland Cancer Centre
Modern Outpatient Programme
Stroke Services
Orthopaedic Services
Breast Services
Urology Services
Gynaecology Services

There are also a great number of changes which showcase the opportunities and benefits that can be realised if transformational change is achieved at scale across our health and social care services.

Annex A to this paper highlights small scale but transformational change that has been achieved and which clearly aligns to the direction set out by the CSS.

The challenge of the Moving Forward Together Programme is to take these advances from isolated demonstrations of success on to where they become common practice and then on to become business as usual across NHSGGC.

PART THREE: Proposed Approach: Moving Forward Together

Our Approach

The Moving Forward Together Programme takes a phased approach to delivery.

There is a central Core Team who have dedicated time each week to take forward the work of the Programme. It is composed of senior managers and clinicians from across the HSCPs and Acute Sectors.

The Programme plan has been divided into 4 phases which are described below.

Phase 1 – October to November 2017 - Establishing baseline and modelling known changes

The Core Team members reach back to their base networks to ensure engagement and to use the knowledge and experience base of those networks in a hub and spoke methodology.

We will

- Review the current range of relevant National and Regional Strategic Documents;
    - eg National Clinical Strategy , Health and Social Care Delivery Plan (2016) Cancer and Mental Health Strategies
- Review the outputs of the GGC Clinical Services Strategy for comparison with National and Regional Guidance to create and amalgamated set of principles on which Transformation Strategy will be based
- Update the predictions on population changes to develop a demand picture up to 2025
    - Using the same methodology as WOS work with ISD to ensure alignment
    - Work at a specialty and condition level using population based approach
    - Include primary and community care demand
- Review and quantify the impact of the delivery of the IJB strategic plans and commissioning intentions
- Carry out a stakeholder analysis and develop engagement plan
- Highlight the gaps where further work should be commissioned.

Phase 2 – December 2017 to February 2018 - Clinical discussion on principles leading to the development of plans to implement new models of care and the quantification of the impact of those changes

We will

- Prepare the Phase 1 principles framework, case for change, care stratification model and evidence base to enable a structured discussion with small clinical groups from and then across primary community secondary and tertiary care
- Prepare a review of all local and regional work on clinical services, as well as the GGC Clinical Services Review (CSR) and national strategies and model the predicted impact on the current services in GGC for discussion in clinical groups
- Commission either SLWG or current groups to review Phase 1 predicted service demand and produce proposals for future service requirements, the impact of which can be modelled.
- With clinical groups produce a matrix of stratified clinical interdependencies for each service which will inform options development and a plan for enabling changes and/or supporting services which are required to sustain the new service models
- Model the impact of these proposed changes on the demand and activity profile to inform the options development
- Commission further evidence base reviews and review other service models as required to support the development of options

Phase 3 – March to April 2018 - Drawing together and quantifying the impact of predicted demand changes and new models of care to describe options for a new service configuration across primary community secondary and tertiary care

The Core Team will draw together all of the various pieces of work from Phase 1 and 2 and analyse the outputs of the commissioned work streams.

We will

- review current WOS planning, GJNH and other Health Board strategic intentions and assess the impact on GGC options
- describe the required changes, supporting and enabling work and outline delivery plans with options where relevant
- use this basis to prepare an outline of the strategic delivery plan with options to be discussed during the wider clinical and public engagement programme through an open and transparent effective dialogue process supported by a series of wide ranging conversations

Phase 4 – May to June 2018) Amendments following engagement and Approval

The outcomes of the engagement process following the initial options proposal at the end of Phase 3 will be used to finalise proposals. The details of this Phase will be determined by the guidance given by the NHSGGC Board, IJBs and Scottish Government.

We will

- bring forward finalised proposals for the future of health and social care services delivered by NHSGGC for their population to the Board for approval in June 2018.

Communication and Engagement

It is proposed that during the programme there is a comprehensive and transparent engagement process with the widest possible range of stakeholders.

This will include wide spread staff and partnership engagement and inclusion through the hub and spoke methodology for clinical engagement following the principles of Facing the Future Together.

We will

- engage with and take advice from all the various Board advisory groups and committees
- work together with the WOS Regional Planning Team.
- engage with neighbouring health boards and national partner Boards including the Scottish Ambulance Service, NHS24 and the Golden Jubilee Foundation
- engage with patients and carers at the earliest opportunity and throughout the process by establishing a Stakeholder Reference Group with wide representation across the demography and the geography of our population.
- produce and implement an inward and outward facing communications programme which supports the delivery of our key messages to our staff, partners and population using the range of available effective means.

SUMMARY

The Moving Forward Together Programme is NHSGGC's seminal transformational programme to deliver the National Clinical Strategy, Health and Social Care Delivery Plan and other associated National Strategies.

The Programme will describe a new health and social care system that is optimised for safe, effective, person centred and sustainable care to meet the current and future needs of our population.

The Programme will develop in cooperation and cohesion with the developing work in the West of Scotland for planning of a Regional basis.

The Programme will provide an overarching framework for change across primary, community and secondary care both in the short term during the conduct of the programme and thereafter as a result of it's recommendations.

The Programme will support the subsequent development of delivery plans for the developed new models of care, which describe the required changes in workforce, capital infrastructure and procedures and processes which ensure the intended and projected benefits are realised.

NHSGGC Examples of Transformation in Action

The following section highlights small scale but transformational change that has been achieved and which clearly aligns to the direction set out by the NCS HSCDP and CSS.

The challenge of the Moving Forward Together Programme is to take these advances from isolated demonstrations of success on to where they become common practice and then on to become business as usual across NHSGGC.

Primary Care: Transformation in Action

<table>
<tr><th colspan="2">House of Care
CSS New System Characteristic</th></tr>
<tr><td colspan="2">Building on universal access to primary care.
Focal point for prevention, anticipatory care and early intervention.
Management where possible within a primary care setting.
Focus for continuity of care, and co-ordination of care for multiple conditions.</td></tr>
<tr><td>Previous State:
Disease specific task based review in primary care for patients with Long Term Conditions guided by former Quality and Outcomes Framework; limited patient empowerment.</td><td>Transformed State:
Participating GP practices use the ‘House of Care’ process and framework when recalling patients for their annual review. The House of Care (HoC) ethos places the person at the centre of their care supporting a collaborative conversation between the individual and the professional. Changes in the process include a two-step review:
• The first is to gather information and carry out disease specific surveillance and to prepare the patient for the second appointment (carried out by the HCSW where possible).
• The second, a longer time with the clinician to have a conversation about the impact of the condition and reflect on what matters to the individual (carried out by the Practice Nurse in most cases).

A further change is that the patient receives the results from their tests in between the two appointments. They also receive information and are asked to think about/note what matters to them and given prompts for discussion. The second appointment is then intended as a meeting of equals and experts to review how things are going; consider what's important; share ideas; discuss options; set goals; develop a care and support plan. A ‘More than Medicine’ approach is considered and local services to support this are identified.</td></tr>
<tr><td colspan="2">Benefit Realised
Patients being in control of their care and empowered to share decisions about it. The person is more likely to act upon the decisions they make themselves, rather than those made for them by a professional. Clinicians and other staff at all stages having the necessary information about the patient, with care better tailored to the patient’s needs.

Biomedical impact - in 19 trials involving 10,856 participants, care planning has led to:
• Better physical health (blood glucose, blood pressure)
• Better emotional health (depression)
• Better capabilities for self-management (self-efficacy)</td></tr>
</table>

New Ways Inverclyde – Transforming Primary Care Programme

CSS New System Characteristic

Building on universal access to primary care.
Focal point for prevention, anticipatory care and early intervention.
Management where possible within a primary care setting.
Focus for continuity of care, and co-ordination of care for multiple conditions.

Previous State	Transformed State
16 practices in Inverclyde working to standard national GMS contract within a context of significant pressures on primary care, including rising workload and complexity.	In September 2015, Inverclyde HSCP was approached to consider the opportunity to work in partnership with NHSGGC, Scottish Government and the British Medical Association (BMA) to explore new ways of working and inform the development of the new GP contract; and devise the future role of the GP, envisaged to be that of a senior clinical decision-maker in the community who will focus upon: • Complex Care in the Community. • Undifferentiated Presentations. • Whole System Quality Improvement and Clinical Leadership. Following initial engagement sessions led by Inverclyde HSCP, NHSGGC, Scottish Government and the BMA, all 16 Practices in Inverclyde (at that time) signed up to participate in the pilot. A number of tests of change were developed: • Aiming to reduce musculoskeletal presentations to the GP by making an advanced physiotherapist practitioner available. • Introduced a Drop-In Community Phlebotomy (drawing blood for testing) clinic. • Introduced Advanced Nurse Practitioners (ANP) working within the Community Nursing Service and responding to exacerbations of chronic illness and minor illness/injuries as well as undertaking Home visits. • Having Specialist Paramedics to reduce home visits for GPs by using this role to deal with unscheduled requests. • Piloting an extension of the Prescribing Team's clinical and medicines management activities to embed Pharmacists and technicians in GP practices doing pharmacist led clinics, the authorisation of special requests for prescribed medicines and review of immediate discharge letters from acute hospital and outpatient letters. • Pharmacy First Pilot - Inverclyde Pharmacy First Service is a test service that extends the Minor Ailments Service (MAS) to all patients and adds a small range of common clinical conditions. The objective is to provide timely and appropriate assessment and treatment of these common conditions and identify patients who require onward referral to other services.

Benefit Realised

There is now an expanded multi-disciplinary team in primary care; conditions for further change, due to development of relationships and new ways of working; and increased resilience.

<table>
<tr><td colspan="2">GP Cluster working
CSS New System Characteristic
Building on universal access to primary care.
Focal point for prevention, anticipatory care and early intervention.
Management where possible within a primary care setting.
Focus for continuity of care, and co-ordination of care for multiple conditions.</td></tr>
<tr><td>Previous State:
238 individual GP practices across NHSGGC area, often working in isolation. Quality improvement approaches focused on contractual mechanisms e.g quality and outcomes framework and enhanced services.</td><td>Transformed State:
238 GP practices across NHSGGC area now grouped into 39 clusters each with a cluster quality lead. Clusters have a role in identifying and driving quality improvement both within clusters and practices and in the wider system. The roles are defined as:

<u>Intrinsic</u>
Learning network, local solutions, peer support.
Consider clinical priorities for collective population.
Transparent use of data, techniques and tools to drive quality improvement - will, ideas, execution.
Improve wellbeing, health and reduce health inequalities.

<u>Extrinsic</u>

Collaboration and practice systems working with Community MDT and third sector partners.
Participate in and influence priorities and strategic plans of IJBs.
Provide critical opinion to aid transparency and oversight of managed services.
Ensure relentless focus on improving clinical outcomes and addressing health inequalities.

HSCPs have aligned several existing and new teams to clusters to improve co-ordination of care and multi-disciplinary working: for example neighbourhood older people’s teams.
Clusters are at an early stage of development and there is significant further potential.</td></tr>
<tr><td colspan="2">Benefit Realised
Supports better joint working between practices and with wider community services.
Has enabled alignment of community teams to groups of practices.</td></tr>
</table>

<table>
<tr><td colspan="2">Optometry First Port of Call and Acute Referral Centre
CSS New System Characteristic
Building on universal access to primary care.
Focal point for prevention, anticipatory care and early intervention.
Management where possible within a primary care setting.
Focus for continuity of care, and co-ordination of care for multiple conditions.</td></tr>
<tr><td>Previous State:
Patient with eye problems routinely attending GP practices.
For urgent care patients went to eye casualty and waited to be seen by ophthalmology staff.</td><td>Transformed State:
Optometry practices now first port of call for eye problems including urgent issues. GPs signposting to optometrists, and optometrists can refer to secondary care using SCI gateway if required.

Urgent care now triaged first by optometrist in the community and then by telephone triage by a specialist nurse at the hospital. The patient is then given a next day planned appointment or advised to attend the hospital immediately if triaged as urgent</td></tr>
<tr><td colspan="2">Benefit Realised
Patients going to the service with the most appropriate skills and equipment directly, resulting in a reduction in steps in the pathway and unnecessary referral though GP practice; faster appropriate response and treatment. Patients access care according to urgency on a semi planned basis.
Optometrists are able to ascertain the status of electronic SCI Gateway referrals.
Utilisation of existing systems (SCI Gateway) maximises benefit of previous investment in people, systems and equipment.</td></tr>
</table>

<table>
<tr><td colspan="2">Enhanced Anticipatory Care Planning
CSS New System Characteristic
Comprehensive Primary Care Service
Community Services and care planning in place to respond to crisis</td></tr>
<tr><td>Previous State:
Anticipatory Care Plans should be in place for 30% of GP patients at highest risk of emergency admission.</td><td>Transformed State:
Extension of anticipatory care planning to a larger number of patients than that required within target groups. Practices were paid an item of service for each ACP completed or updated. Additional work was undertaken to improve awareness and use of eKIS among health care colleagues involved in emergency care and home care, for example training junior hospital doctors and extending access to eKIS to Community Nurses</td></tr>
<tr><td colspan="2">Benefits Realised
• 700+ new KIS and 400+ updates performed on vulnerable groups.
• Care homes, dementia and learning disabilities targeted.
• Information in ACP supported decision making for patients admitted as an emergency</td></tr>
</table>

Revised Heart Failure Diagnostic including direct access for GPs to BNP blood tests **CSS New System Characteristic** High Quality Primary Care Management where possible within a primary care setting Diagnostic services organised around patient needs	
Previous State: Patients with suspected Heart Failure were referred to the Heart Failure diagnostic pathway where they went through a serious of investigations. Over 90% of patients referred were found not to have HF. The volume of patients referred into secondary care drove delays in patients with confirmed HF going through the diagnostic pathway and being given an appropriate treatment plan	**Transformed State:** There was a successful pilot, in the Renfrewshire area, in which GPs were given direct access to BNP blood tests for patients with suspected Heart Failure. It is now planned to roll out this access to all GP practices in the Greater Glasgow and Clyde NHS board area from September 2017. This will mean a change in the Heart Failure diagnostic Pathway that before referring a patient with suspected heart failure a GP will be able to request the relevant blood test from primary care
Benefit Realised Providing access to BNP blood testing in primary care improves the patient journey, immediately reduces delays in excluding HF as a diagnosis and reduces referrals and the number of secondary care attendances for these patients. It reduces waiting times for echo, cardiology diagnosis, improves the diagnosis of heart failure and other cardiac pathology for these patients and reduces the risk of emergency admission prior to commencing treatment	

Community Care: Transformation in Action

<table>
<tr><td colspan="2">West Dunbartonshire Care at Home
CSS New System Characteristic:
Single point of access, accessible 24/7 from acute and community settings.
Focused on preventing deterioration and supporting independence.
Multi-disciplinary care plans in place to respond in a timely way to crisis.
Working as part of a team with primary care providers for a defined patient population.</td></tr>
<tr><td>Previous State

The traditional model of care at involved separate referral routes and care planning, contributing to unnecessary delays in the right assessment and service being provided, with a propensity for duplication of service provision.</td><td>Transformed State

West Dunbartonshire HSCP has established an integrated care at home service, bringing together the co-ordinated provision of Care at Home and District Nursing services to more timeously and effectively identify and respond to risk and avoid unnecessary admissions to hospital, both “in” and out-of-hours. This community service links directly to out-of-hours GP services and all HSCP-managed and independent sector care homes.

The multi-disciplinary work together to ensure improved shared information and communication at an earlier stage. Single sharable assessments and information sharing leads to better targeting of resources, more skilled and confident staff working towards shared objectives.

In addition, the innovative use of Technology Enable Care (TEC) and dedicated reablement services support better outcomes, by maximising the individual’s long term independence and quality of life; and appropriately minimising structured supports.

The team consistently receives unsolicited excellent feedback from services users; and encourages a culture where all feedback is used to - including challenge - provides an opportunity to critically review and improve services.</td></tr>
<tr><td colspan="2">Benefit Realised

People living in West Dunbartonshire are better able to live independently at home, recover well from hospital stay or injury and are safer and more independent through the dedicated work of West Dunbartonshire’s Care at Home Team.

The West Dunbartonshire HSCP Care at Home Service was awarded the Scottish Association of Social Work (SASW) Award 2017 for the ‘Best example of collaboration in an integrated setting’.</td></tr>
</table>

Reconfiguration of rehabilitation services in North East Glasgow CSS New System Characteristic Rapid transfer to appropriate place of care, following assessment. In-patient stay for the acute period of care only Early supported discharge to home or step down care.	
Previous State:	**Transformed State:**
Older people had extended stays in acute hospitals which were not seen as a homely setting. Patients attended day hospital for regular but infrequent appointments over long periods Patients attended for clinic appointments on sites without access to the full range of supporting services	Early intervention from specialists in the acute care of older people focussed on immediate multidisciplinary assessment of frailty and clinical need; Rapid commencement of multidisciplinary rehabilitation within acute facilities for patients who require immediate access to the full range of investigations and specialist advice; New HSCP inpatient and community services to enable patients who do not require care in a full acute hospital to:- Be discharged directly home after assessment or a short stay in a full acute hospital; Access local intermediate care in community rehabilitation beds provided in a homely local setting; Have rehabilitation at home with support from additional community rehabilitation services; Acute day hospital services, which deliver assessment and intervention on a more focussed and intense one stop basis, to enable the discharge of patients home or to the ongoing care of local HSCP services; Outpatient services in a setting where there is access to other clinical services enabling a one stop approach.
Benefit Realised	
Patients benefit from shorter periods in acute hospitals and a more focussed period of rehabilitation and re-ablement with a focus on returning them to their home. When they are not ready to return home but do not require acute care they can access community based intermediate care nearer to home and family	

Hepatitis C Outreach CSS New System Characteristic Planned Care Locally Accessible; Hospital Assessment – Right Time Right Place; Coordinated Care at Time of Crisis	
Previous State:	**Transformed State:**
Patients with Hep C Infection have high rates of non-attendance at hospital clinics	Community outreach clinic established at Bridgeton Health Centre combining Liver Clinics with Community Addiction Services and Opiate Substitution Therapy Prescription Management
Benefit Realised	
Better access to services, promoting better health through a joined up approach across relevant acute and community services supporting the patient. Higher levels of attendance at new patient appointments. Reduces barriers to healthcare for historically hard to engage patients	

East Renfrewshire Medicines Reconciliation and Support Service

CSS New System Characteristic:

Focused on preventing deterioration and supporting independence.
Working as part of a team with primary care providers for a defined patient population.

Previous State	**Transformed State**
Individuals and families/carers unclear about medicine failure to comply, leading to exacerbation of condition and re-admission to hospital.	The East Renfrewshire HSCP's Medicines Reconciliation and Support Service is a pharmacy technician led service which: • Provides medication advice and support for patients and carers upon return home after hospital discharge to ensure any medication changes are understood and actioned. • Assessed compliance with medication and offers support where compliance issues are known. • Completes an enhanced medicines reconciliation liaising with relevant members of the multi-disciplinary team to ensure current medication is correct. • Rationalises dosing times to minimise need for unnecessary homecare input for medicines prompts. .

Benefit Realised

By understanding their medication better and by having interventions such as compliance aids and inhaler technique provided, patients have been able to get better results from their prescribed medication.

Reduction in additional medication prompts also supports other HSCP community services, as reduced homecare prompts consequently reduces pressure on the homecare service. The Medicines Reconciliation and Support Service has improved patients' healthcare journeys; promoted a joined up approach to patient care; and by close working with the voluntary sector, provided links to local community supports and opportunities.

East Dunbartonshire Health and Social Care
Intermediate Care Unit (ICU)
CSS New System Characteristic:
Focused on preventing deterioration and supporting independence.
Working as part of a team with primary care providers for a defined patient population.

Previous State	Transformed State
No opportunity for services users to have additional assessment and rehabilitation post discharge from hospital.	East Dunbartonshire HSCP commissioned a pilot step down intermediate care unit within Westerton Care Home in November 2016. The pilot incorporated a model of GP provision, care management and rehabilitation. Eight beds were planned to allow service users to transition from the hospital setting when medically fit for discharge to a homely environment, allowing them time for additional recovery; rehabilitation; and to enable a comprehensive assessment of their longer term health and social care support needs. The skill mix for the unit comprised: • Social workers from the Hospital Assessment Team (HAT) and Allied Health Professionals from the Rehabilitation Assessment Link Service (RAL) who are part of the Community Rehabilitation Team employed from the HSCP. • A nursing/support worker component from the care home. • GP contracted to do 2-3 clinical sessions weekly.

Benefit Realised

There was improvement in delayed discharge figures against heavy demographic demands for admissions to hospital. The unit offered a new service for East Dunbartonshire HSCP's portfolio of services for people who had complex needs who required an opportunity for further interventions and time to reflect on future plans. The pilot consolidated the essential role of rehabilitation in the interface between the acute and the community.

The unit has been very beneficial to clients and their families as it provides opportunities for further assessment and rehabilitation. The service helped to get people out of hospital whilst also giving them breathing space to make decisions for the longer term.

<table>
<tr><td colspan="2">Out of Hours Community In-reach Service:
CSS New System Characteristic
A comprehensive range of community services, integrated across health and social care
Early supported discharge to home or step down care.
Early involvement of primary and community care team in planning for discharge</td></tr>
<tr><td>Previous State:
The Rapid Response team of the Renfrewshire Rehabilitation and Enablement Service (RES) offered access to Physiotherapy Occupational therapy, nursing, dietetic and technical assessment and support to patients referred urgently by their GP or hospital. It operated 0830-1900 Mon-Fri.</td><td>Transformed State:
The Out of Hours Community Inreach Service aimed to support key points of transition both in and out of hours. Community social workers coordinated a range of supports to prevent admission and support discharge, working alongside the Rapid Response team. Key additions were the provision of a transport and resettlement service (including transport of equipment) and the extension of hours of working (1330-2000 Mon-Fri and 0900-1700 weekends). The team worked within the multi-agency discharge hub following its establishment in Feb 2015.</td></tr>
<tr><td colspan="2">Benefit Realised
Provided assistance to Older Adults Assessment Unit, Emergency complex and wards with discharges. This was an essential component for OAAU in terms of facilitating early discharge and reducing length of stay. Consultant estimated reduction to length of stay for patients discharged from OAAU is 1.75 days.
Delivered benefits of joint working between health and social care and co-location</td></tr>
</table>

<table>
<tr><td colspan="2">Renfrewshire Development Programme
CSS New System Characteristic:
Single point of access, accessible 24/7 from acute and community settings.
Focused on preventing deterioration and supporting independence.
Multi-disciplinary care plans in place to respond in a timely way to crisis.
Working as part of a team with primary care providers for a defined patient population.</td></tr>
<tr><td>Previous State:
Traditional models of working and relationships between acute, primary and community care in Renfrewshire.</td><td>Transformed State:
The purpose of the Renfrewshire Development Programme (RDP) was to develop and test new service models proposed by the NHSGGC Clinical Services Strategy. It involved Renfrewshire HSCP, the 13 GP practices in Paisley and the Royal Alexandria Hospital. Its aims were to:
• Improve quality, including patient experience.
• Improve care at interface between hospital and community.
• Reduce avoidable admissions.
• Maintain/improve re-admission rates.

There were six component parts:
• Chest Pain Assessment Unit.
• Older Adults Assessment Unit.
• Out of Hours Community Inreach Services.
• Enhanced Pharmacy Service.
• Enhanced Anticipatory Care Planning.</td></tr>
<tr><td colspan="2">Benefit Realised
There were reduced lengths of stay associated with Chest Pain Assessment Unit and Older Adults Assessment Unit, with fewer patients requiring overnight stay and high patient satisfaction.

There were Increased numbers of Anticipatory Care Plans completed for patients in target groups.</td></tr>
</table>

<table>
<tr><td colspan="2">Glasgow City Home is Best
CSS New System Characteristic:
Focused on preventing deterioration and supporting independence.
Multi-disciplinary care plans in place to respond in a timely way to crisis.
Working as part of a team with primary care providers for a defined patient population</td></tr>
<tr><td>Previous State
Hospital facing social work and community health resources organised and managed separately across the NHS and Social Work and the 3 geographical localities within the city.</td><td>Transformed State
Development of a singularly managed, multi-disciplinary hospital facing community health and social work team for the whole city, with separate hubs facing into north and south acute sectors.

This team will have an unequivocal responsibility for improving HSCP performance in relation to diversion from admission (front door focus), delayed discharges (back door focus) and utilisation of HSCP beds management (e.g. intermediate care, former HBCC, and AWI). The team will co-ordinate activity across all relevant HSCP teams/ disciplines, including social work, rehabilitation and occupational therapy. Essential to its success will be effective interfaces with the Acute system at both front door and discharge points. It will also work closely with Cordia, HSCP integrated neighbourhood teams (as above) and independent service providers (such as care homes).</td></tr>
<tr><td colspan="2">Benefit Realised
More coherent and efficient deployment of hospital facing HSCP resources. A singular community health and social work team, managed by one Service Manager across the city (rather than multiple managers as at present). Simplified accountability and system performance management arrangements. Simplified interface with the HSCP for the acute system. Ultimately the intention is that this team will perform a key role in meeting whole system unscheduled care performance targets and further improvement in Glasgow’s delayed discharge performance. It is also expected to lead to more efficient utilisation of expensive HSCP resources such as intermediate care.</td></tr>
</table>

Unscheduled Care: Transformation in Action

Dedicated Frailty Units and Comprehensive Geriatric Assessment **CSS New System Characteristic** In-patient stay for the acute period of care only	
Previous State:	**Transformed State:**
Elderly patients were admitted to emergency medical wards without routine access to geriatric assessment of their rehabilitation needs.	Dedicated frailty units have been established to deliver a consistent Comprehensive Geriatric Assessment to patients who have been identified as frailty positive using the standard ED Frailty triage tool. Early identification for appropriate patients provides fast track access to elderly care assessment nurses and geriatricians. With targeted specialist resource provided by the frailty team, which consists of Acute Community and Social Care services, can ensure that wherever possible the patients needs can be met and are returned home or to their place of care within 24-48 hours and avoid extended periods of inpatient care that can result in further deterioration for frail elderly patients.
Benefit Realised	
Patients gain rapid access to an integrated multi skilled specialist team focussed on supporting the patients safe return to home or a homely setting as soon as possible, thus avoiding unnecessary extended hospital stays	

Ambulatory Emergency Care Pathways **CSS New System Characteristic** In-patient stay for the acute period of care only	
Previous State:	**Transformed State:**
Patients presenting with conditions which did not require an extended stay were admitted in order to assess and access diagnostic tests as there was no appropriate alternative to admission. This resulted in short stays which took bed capacity and prevented patient flow through the emergency receiving beds.	A number of high volume pathways have now been established for ambulatory care pathways. For COPD the community respiratory team provides support at home to manage and respond to exacerbations and provide alternatives to hospital care. For chest pain there is now a consistent pathway which has been adopted by both EDs and AUs across all sites and enables streaming of patients based on clinical scoring algorithm to avoid unnecessary admission. There is a DVT clinic delivered by specialist nurses via an appointment based system triggered after first referral to complete the treatment plan and educate of condition management There is now a cellulitis pathway that reviews patients after first episode of admission and identifies those suitable to have their treatment converted to planned care delivered by the medical day units
Benefit Realised	
Patients avoid admission to hospital and are treated either on a planned basis or on an ambulatory basis through the hospital or in a day hospital or community based service	

Acute Assessment Units CSS New System Characteristic Senior clinical decision makers at the front door In-patient stay for the acute period of care only	
Previous State: Acute departments were not routinely manned by specialty consultants. These senior decision makers were available but on request and decisions were routed through junior staff.	**Transformed State:** The establishment of Assessment Units with access to professional advice either via senior nurse or specialty specific telephone systems. Work undertaken to improve access to specialty advice with the option to review management plan and/or defer patient attendance to the following day to a hot clinic.
Benefit Realised More rapid access to senior specialist opinion allows treatment plans to be established more rapidly	

Discharge Flow Hubs CSS New System Characteristic Better coordination of patient flow	
Previous State: The elements which are required for discharge; medicines, transport and care packages were not well coordinated and put pressure on ward staff	**Transformed State:** The Flow Hub concept brings together the combination of discharge lounges and transport hubs. The most advanced version of this is in the RAH with HALO (hospital ambulance liaison officer) supporting patient transport management and discharges, working alongside pharmacy service provision for patients awaiting medication/scripts which are provided in the hub rather than the ward areas. These hubs also manage outpatient transport services Pharmacy provision to the hub is being rolled out across sites.
Benefit Realised Discharge is better coordinated and is earlier in the day, improving patient flow and bed availability	

Exemplar Wards CSS New System Characteristic Better coordination of discharge planning	
Previous State: Patient discharge planning dependent on senior medical review. Decisions often taken later in the day resulted in delays.	**Transformed State:** More frequent and earlier decision making with the use of daily 'board rounds'. Discharge decisions delegated to nursing staff where appropriate. Better systems for coordination of Immediate Discharge Letters and Pharmacy.
Benefit Realised More patients discharged earlier in the day allowing beds to be available when needed for acute admissions	

Planned Care: Transformation in Action

Ortho Opt-in **CSS New System Characteristic** Hospital Assessment – Right Time Right Place	
Previous State: All patients referred by their GP with a specific range of joint related conditions would be sent a hospital outpatient appointment and seen in a consultant clinic.	**Transformed State:** Patients referred by their GP with that specific range of conditions go through an extended triage carried out by Specialist Nurses and Physiotherapists/ Podiatrists. Patients are sent information about their condition and asked to phone in for advice or to opt-into an outpatient appointment.
Benefit Realised To date 156 patients have been through this opt-in process. 67% made no contact with the department following the information being sent out. 30% requested a face to face clinic appointment and 3% called for advice in self care. This system reduces unnecessary outpatient appointments and empowers the individual to make a more informed decision about their referral into the department	

Virtual Lung Cancer Clinic **CSS New System Characteristic** Hospital Assessment – Right Time Right Place	
Previous State: All patients referred by their GP with Urgent Suspicion of Cancer (USOC) would be sent a hospital outpatient appointment for a fast track consultant clinic. A significant proportion of patients attending fast track clinic appointments were found to not have a diagnosis of cancer.	**Transformed State:** USOC referrals are now vetted by a Respiratory Consultant and directed to either a fast track outpatient clinic or to a Virtual Lung Cancer Clinic. In the Virtual Lung Cancer clinic referral information, lung functions test results and CT results are reviewed by two Respiratory Consultants resulting in either a routine clinic appointment or a fast track appointment, referral to another specialty or discharge. Written communication is provided to the patient after the virtual clinic.
Benefit Realised Of 354 patients referred for a USOC appointment, 144 were seen by Virtreduced clinic times, or required no physical appointment and were given early reassurance and discharge, allowing resource to be focused on the management of cancer cases. 81% of patients who responded to a questionnaire evaluation of the Virtual Lung Clinic were satisfied with receiving their results by letter. Benefits – timely reassurance of results; improved time to first face to face appointment for those needing one; better use of fast track USOC appointments for patients needing this type of service.	

Virtual clinics in Clyde Gastroenterology CSS New System Characteristic Coordinated care at crisis/transition points and for those most at risk	
Previous State: Inflammatory Bowel Disease Patients attended at regular interviews for Consultant Return appointment putting pressure on the return demand of the service	**Transformed State:** Virtual consultations - review of all 174 IBD patients on Biologics undertaken with Gastro Consultant, IBD Specialist Nurses over 3 x weeks resulted in an individual care plan in place for each patient on a Biologic drug
Benefits Realised No longer required to attend secondary care for appointment Individual care plan in place – shared with IBD specialist nurse team and General Practice Suite of patient self management support materials developed for use Biologic tapering / withdrawal – medicines review – not taking medicines unnecessarily IBD patients and relatives have telephone / email access to IBD Clinical Nurse Specialist Advice in event of a flare Protocols defined for CNS use – Nurse Led Return Clinics established for IBD IBD Consultant – aim is to see patient once then discharge with a clear care plan Reduced unnecessary OP returns to clinic Some require 2 or 5 Yearly scans – discharged in between Detailed Plan provided to GP for each patient Agreed pathway to enable quick access back into service if necessary	

Redesign of Bowel Screening Processes CSS New System Characteristic Diagnostic services organised around patient needs	
Previous State: Bowel screening (national programme) 3 samples required limited uptake	**Transformed State:** Introduction of more specific test requiring only 1 sample anticipated increased uptake (starting Oct 2017)
Benefit Realised Improved update for bowel screening therefore earlier diagnosis and better outcomes in bowel cancer treatment	

Access to Stroke Diagnostics CSS New System Characteristic Diagnostic services organised around patient needs	
Previous State: Limited ability/delay in patients receiving Imaging whilst attending a TIA clinic	**Transformed State:** Ring fenced slots for CT/MR where possible for patients attending TIA clinics
Benefit Realised Patients receive a diagnosis as part of a one stop clinic	

Primary Care Access to Lab Testing CSS New System Characteristic Diagnostic services organised around patient needs	
Previous State: Primary care did not order or receive test results electronically	**Transformed State:** Introduction of GP ordercoms (ICE) for Laboratory Medicine
Benefit Realised All Lab tests ordered electronically and reports available directly to GPs, faster response and more robust system.	

GP direct access to MRI CSS New System Characteristic Diagnostic services organised around patient needs	
Previous State: GP could not refer patients directly for MRI	**Transformed State:** GPs can now refer patients for MRI knee following the approved protocol
Benefit Realised Reduced need for patients to be referred to secondary care	

Mental Health: Transformation in Action

Redesign of Matched Care in Primary Care MH Teams **CSS New System Characteristic** Routine Patient Outcomes Monitoring	
Previous State: Primary Care Mental Health Teams are designed to provide brief, prompt care for people with common mental health problems. Patient "flow" in such systems is critical, but there was no agreed system for tracking care which patients required.	**Transformed State:** CORE-Net (Clinical Outcomes in Routine Evaluation) is an electronic patient outcome measure suitable for PCMHT use, and is completed electronically. Scores are entered by patients or their clinicians and the system visualises progress over time.
Benefit Realised Outcomes for patients, clinicians and teams can now be readily visualised, and support not only individual care plans, but also assist teams in managing overall demand, and team capacity. CORE-net is being rolled out to other community teams in MH.	

Redesign of provision of Cognitive Behavioural Therapy (CBT) **CSS New System Characteristic** Introduction of Computerised CBT (cCBT) across NHS GGC & Partnerships from Nov 2017	
Previous State: CBT is a fundamental mode of evidence-based psychological treatment in MH, but typically requires intensive therapist input. cCBT is recommended by NICE and SIGN and the program used (*Beating the Blues*) has a strong evidence base and has been proven to work in Scotland.	**Transformed State:** cCBT is used for the treatment of patients suffering from mild to moderate depression and/or anxiety. Treatment consists of 8 x 1 hour sessions completed weekly via the internet either in the patient's home or at a community location such as a library.
Benefit Realised Referrals can be made via SCI Gateway from primary care with only minimal contact information required. Patients will typically be provided with access to the cCBT program within 5 working days from receipt of referral. NHS GGC/Partnerships has a target of 980 referrals in the first year, and this will increase treatment options for GPs, reduce referrals to secondary care MH services and support continued delivery of the Psychological Therapies HEAT target.	

E-health: Transformation in Action

<table>
<tr><th colspan="2">West of Scotland Portal to Portal Development</th></tr>
<tr><td colspan="2">The West of Scotland portal to portal project has provided a technical solution built in Clinical Portal to enable boards to launch their respective portal systems seamlessly without requirement to enter an additional username and password.</td></tr>
<tr><td>Previous State:

Patient care is increasingly being delivered in regional models across the West of Scotland. This is due to large populations located across NHS Board boundaries

The viewing of patient records and clinical information across Health Boards within the West of Scotland involved accessing multiple sources of information from different systems, may have required telephone contact or even the transfer of paper case notes between Boards.</td><td>Transformed State:

The project set out to make it simple for clinicians to find the information they wanted, while also addressing security and confidentiality issues.

NHSGGC now has 2 way portal to portal with the following boards:

NHS Lanarkshire

Golden Jubilee National Hospital

NHS Ayrshire & Arran

NHS Dumfries and Galloway

This functionality is available to all clinical staff in GGC and the participating boards. It will be extended to GGC administrative staff in November 2017

Information governance and other key documentation was created once and then agreed by each of the heath boards. A minimum data set was agreed that included demographics, GP details, lab results, encounter history and clinical documentation. A full audit trail is available of all user activity in each portal system.</td></tr>
<tr><th colspan="2">Benefit Realised</th></tr>
<tr><td colspan="2">Data sharing is immediate and safe using the patient CHI number to identify and match the patient. Clinical risk is reduced significantly as up to date information can now be queried at source which further assists decision making.

Obtaining patient information is efficient and simple, which is a significant time saving for clinical staff. Baseline analysis completed ahead of the project underlines this point. It found that doctors could spend 70 minutes per day looking for information about patients

Feedback from clinicians is overwhelmingly positive, the regional portal is being well-used; already, clinicians are accessing 3-4,000 cross board records every week, and there have been more than 50,000 log-ons so far this year.</td></tr>
</table>

Community Nursing System Integration

Ability to view the following data sets from the community nursing information system (CNIS and EmisWeb) within Clinical Portal.

- Risks
- Allergies
- Open Referral Information
- Associated Professionals (GP, named nurse)
- Associated People (Next of Kin, Carer)
- Malnutrition Universal Screening Tool (MUST) data
- Summary of last 10 Visits
- Care Plans

The Community Nursing service will move to EMIS Web in 2018/19 this data will transfer from being viewed from CNIS to EMIS Web, further consultation will be undertaken to look at sharing additional fields.

Previous State:	**Transformed State:**
District Nurses have regular contact with patients often seeing them on a daily basis this means the data they record in the electronic patient record is the most up to date. Previously this was not viewable to anyone other than Community Nurses. When a patient was admitted to hospital there was a lack of information on any community care they were receiving. These patients are often elderly and may be confused at the time of admission restricting their ability to provide accurate medical information.	With the above data fields now being viewed in Clinical Portal other directorates can view important data relating to community nursing patients. The ability to see contact details for patient's district nurse and next of kin is particularly useful when patients cannot provide this information themselves or for when a patient being discharged from hospital and will require district nursing care. GP's can view when the patient was last visited by a district nurse rather than contacting the district nurse in person. Other Specialist Nurses, eg Tissue Viability nurses can see view care plan data relating to any pressure ulcers the patient may have.

Benefit Realised

Improved sharing of patient information and more effective communication between primary, secondary and community care staff leading to patient safety benefits and improved care.

Community Care HSCP Partnership Information Access across partner agencies to patient/client information via an adapted version of Clinical Portal.	
Previous State: No electronic means for two-way sharing of shared patient/client information between social work and NHS staff. Their only option was to phone round/message often multiple partnership colleagues to get what they needed. Clear impact on efficiency, and potential impact on patient/client safety.	**Transformed State:** Portal links created for each of the two social work IT systems in use. Depending on the access rights of a user, information accessible can include demographics, key contact details, alerts/ concerns, encounter summary and a variety of assessments. Piloted and now live between NHSGGC and West Dunbartonshire. Good early reviews from users. Feedback is that they want to implement wider. Roll-out now underway, plus planning for possible future extension.
Benefit Realised Availability and sharing of information between partner agencies leading to improved patient safety and quality of care benefiting patients and carers. More efficiency for staff involved in patient's care as information is available and relevant.	

Neurology Advice Only Headache Pilot Pilot of advice referral using SCI Gateway from Primary to Secondary care.	
Previous State: Patients presenting to GP's with symptoms routinely referred to Neurology and placed on waiting list until seen by the Service.	**Transformed State:** Early intervention with the service via the Advice referral highlighted 25% of the pilot referrals were dealt appropriately through this process which negated the need for the patient to attend an outpatient appointment. 16% of referrals resulted in an urgent referral being made to the patient. While the project was taken forward as a pilot, the system and process has been left on, with wider communication to GP practices due to the potential benefits to patients and to the service. Further work will be undertaken to assess what developments are required to support a full scale implementation for other services.
Benefit Realised Primary care clinicians in requesting advice for patients to decide on best treatment plan, and if a referral is required to secondary care. Secondary care clinicians in being able to vet an advice only referral and upgrade this to an outpatient appointment if appropriate, therefore reducing the number of appointments required. Copy of advice message placed into the EPR to form part of the patient record. Structured advice message within SCI Gateway utilising agreed terminology, allowing appropriate triage. Patient benefits from triaged advise and avoiding an unnecessary appointment.	

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 18

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	Springfield House Podiatry Service relocation, Bishopbriggs
Report By	Paul Higgins, Podiatry Manager, East Quadrant
Contact Officer	Chris Bancroft Podiatry Team Leader Chris.bancroft@ggc.scot.nhs.uk 01415316730

Purpose of Report	The attached report describes the processes and actions undertaken to engage with patients and service users on the relocation of the Podiatry Service from Springfield house through a timeline of events described through an engagement planning timeline and outcomes, detailed within 'gant chart' describing the progress to date; see Table 1at the foot of this report.

Recommendations	For the board to note content

Relevance to HSCP Board Strategic Plan	Closure of this locality is pivotal in adherence to the service WFP and required savings element for the service 2017-18. Closure of this locality is coherent with the Quality strategy in terms of providing a safe effective and efficient service for both staff and patients Closure of this locality is congruent with The Active and Independent living Programme in Scotland in adherence to WFP and skill mixed workforce Closure of this clinic will greatly assist in maintaining the National AHP aspiration of 4 weeks from referral to treatment by maintaining current workforce

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	An assessment of the equalities dimensions will be undertaken as part of the service relocation.

Financial:	Circa £25,000 cost reduction whilst maintaining current service performance locally

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	☐
	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 describes the processes and actions undertaken to engage with patients and service users to participate in the service relocation of the Podiatry Service from Springfield house.

Appendix 1

PURPOSE OF REPORT

The attached report describes the processes and actions undertaken to engage with patients and service users on the relocation of the Podiatry Service from Springfield house through a timeline of events described through an engagement planning timeline and outcomes, detailed within ‘gant chart’ describing the progress to date; see Table 1at the foot of this report.

SUMMARY

Podiatry services have been delivered from accommodation rented from East Dunbartonshire Council for some 10 years. Prior to this the service was delivered from a treatment room in Bishopbriggs High School until no longer fit for purpose. The base cost for the rental of this accommodation is £17k annually with additional costs for utilities and drainage. Podiatry is the only AHP (Allied Health Profession) service that is delivered from this accommodation and all other non domiciliary AHP services are delivered from health centres within the local area.

The current caseload in Springfield House is around 700 patients of which around 65% reside in a Bishopbriggs postcode. Patients call the referral management centre, or are referred as a new patient they are referring to the specialty of Podiatry and not a specific location meaning that regardless of where in the quadrant they reside the individual will be offered first available unless they specify one site. This ensures equity and spread of service provision across all clinical sites. This practice would continue regardless of the Springfield House location change. Podiatry is a Hosted service and therefore all service changes and complaints are managed via Renfrewshire HSCP.

The service negotiated a one year extension to the previous 10 year lease. This Lease comes to an end at the end of March 2018, with notice to quit required 3 month prior (December 2017). The service will liaise with and work with service users and clients up to the notice to quit and to the service location change.

THE CASE FOR CHANGE

The Board has fiscal responsibility for appropriate and thoughtful spending of public monies and therefore to incur unnecessary cost by delivering a service from rented accommodation, particularly when there are reasonable provisions available to provide a safe and effective alternative is no longer viable. As described all other AHP services are delivered from other sites and Podiatry been the exception. Continuity of service from Springfield House is unsustainable for the following reasons;

- Health and Safety - staff are required to unlock and lock the building daily and arm the alarm if last to leave the building.
- On public holidays that are non NHS we can have staff lone working on the site.

- Springfield House site poses IT difficulties due to be a non NHS N3 site and we have an absolute requirement for access to TRAKCARE and clinical portal at all times.
- As a non NHS site there are no pharmacy deliveries meaning stock has to be moved from one site to another by staff and no available uplift of swabs etc raising a clinical risk.
- There have also been serious issues with emergency services (SAS), who have been un-able to locate or access the site.
- Financial pressure that if carried as a cost pressure would result in unnecessary service cuts.

KEY ACTIONS

The service has been actively engaging with patients to work with the service to explain the reasons behind the relocation and the alternative service locations available over the last 3 months.

- We asked each patient; 'Would you be interested in becoming a volunteer to help people with relocation signposting information?'
- This was been done by local staff asking every patient to be involved in a short life working group and by the local team leader calling patients on the caseload to ask for involvement. This has involved over 75 patients being contacted; there has been no uptake by patients to become involved.

The timescale will be to;

- Provide an information stand on the relocation of the service in the local library site (1 morning and 1 afternoon in October 2017).
- Staff will continue to update service users and advise on the various local available service locations.
- Inform Bishopbriggs GP practices of re-location.
- Serve EDC with notice to quit - Dec 2017
- Inform all service users by letter and face to face of notice to quit, timescale and alternative service location up to and by Dec 2017 and onwards to March 2018.

FUTURE SERVICE DELIVERY

- The service will adequately be provided within other ED accommodation i.e. Milngavie, Lennoxtown the KHCC as well as within Glasgow City accommodation namely Stobhill ACH and Springburn Health Centres.
- Patients with active foot disease already attend Stobhill. The sub specialities of Biomechanics, Nail Surgery, Foot & Ankle triage and Rheumatology are not available at Springfield House meaning that onward referral for patients has always been the case.
- There would be no detriment to service delivery and relocation to other sites would protect current podiatry service.
- it will improve access and frequency of podiatry appointments for patients with high medical and/or podiatric needs.
- It will improve outcomes for patients with diabetes in line with Scottish Government guidance. (Personal Footcare Guidance-The Scottish Government-2013)
- It will promote self-care and self-management.

Any comments or suggestions can be directed to;

Chris Bancroft
Podiatry Team Leader
Springburn Health Centre
200 Springburn Way
Glasgow
Tel-01415316730
Email – chris.bancroft@ggc.scot.nhs.uk

TABLE1

The following table sets out a summary of the process and an indicative timetable:				
Tasks and Process			**RAG Report**	
1	End of 10 yr lease with EDC	January 2017		
2	Agreed 1 yr extension of new lease with EDC	January 2017		
3	Reporting to East Dun HSCP board on formal process of engagement to investigate options on the service delivery and location.	March 2017		
4	Entered into formal engagement period of consultation on process of engagement and options with patients, service users and their families	May 2017		
5	Staff to speak to each client and encourage them to comment and to participate, who uses service from Springfield House.	May/Jun/July/Aug		
6	Agree to contact 75 patients (face to face and telephone), inviting them to be involved in a consultation/participation group.	June 2017		
7	Patients and service users contacted in months of July / August 2017 (75)	July / Aug2017		
8	Recruit patients, service users onto consultation group.	Aug 2017		
9	Hold info stall in Bishopbriggs library with explanation on service re-location	Oct 2017		
10	Engage with GP surgeries / posters explaining process of service relocation	Sept / Oct		
11	Serve EDC with notice to quit Dec	Dec 2017		
12	2017Inform all service users by letter and face to face of notice to quit, timescale and alternative service location by end of Dec 17 to March 18	Dec 2017		
13	Lease comes to an end	March 2017		
14	All patients can be seen in Stobhill, Springburn, Kirkintilloch, Lennoxtown, Milngavie etc	March / April 2017		

The following table sets out a summary of the process and an indicative timetable:																
Process		**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Task	**1**															
Task	**2**															
Task	**3**															
Task	**4**															
Task	**5**															
Task	**6**															
Task	**7**															
Task	**8**															
Task	**9**															
Task	**10**															
Task	**11**															
Task	**12**															
Task	**13**															
Task	**14**															

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 19

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	Strategic Planning Group Minutes of 23rd May 2017 and 15th August 2017 (Draft)
Report By	Susan Manion Chief Officer
Contact Officer	Fiona McCulloch, Planning, Performance & Quality Manager fiona.mcculloch@ggc.scot.nhs.uk

Purpose of Report	This report provides the Strategic Planning Group minutes for 23rd May 2017 and 15th August 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.

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 Health & Social Care Partnership

Minutes of

East Dunbartonshire Health & Social Care Partnership Strategic Planning Group Meeting

held at 1:30pm on 23rd of May 2017

East Dunbartonshire Voluntary Action

Unit 4/5, 18 - 20 Townhead, Kirkintilloch, G66 1NL

Present:	**Susan Manion (Chair)**	**(SM)**	**Fiona McCulloch**	**(FM)**
	Barry Sillers	**(BS)**	**Gillian Healey**	**(GH)**
	Gillian Notman	**(GN)**	**Janice Cameron**	**(JC)**
	Diane Meek	**(DM)**	**John McPherson**	**(JM)**
	David Delaney	**(DD)**	**Alison Blair**	**(AB)**
	Sandra Cairney	**(SC)**	**David Aitken**	**(DA)**
	David Radford	**(DR)**	**Jean Campbell**	**(JC)**
	Avril Jamieson	**(AJ)**	**Marion Menzies**	**(MM)**
	Stephen MacIntyre	**(SMac)**	**Fraser Ross**	**(FR)**
In Attendance:	**Christina Burns (Minutes)**	**(CB)**		
	Louise Bickerton	**(LB)**		

No.	Topic	Action by
1.	**Welcome and Apologies**	
	Apologies: Paolo Mazzoncini, Andy Martin	
2.	**Previous Minutes & Matters Arising**	
	Minutes Approved	
3.	**Strategic Plan Draft Outline**	
	FM discussed the strategic plan and asked for feedback around the contents page confirming that feedback from the last SPG had been taken into account. Further to discussions at the last SPG, there will be a comprehensive Glossary to make the document more accessible to users. FM also reiterated that the Strategic Plan will be more focused going forward and that priorities will be properly set out. The old plan will be looked at to see how things have changed. FM suggested that there should be a clearer idea of the final plan by September. FM informed the group that a Brief overview of the population within ED will be included. FM	

	also advised that the Scottish Government had published a Social Care delivery Plan regarding how we shift the balance of care to reduce the impact on Acute Services. FM also went onto discuss the various sections of the Plan and the process around agreeing the Strategic plan. SC asked the group if they thought that a section for Service Users and Carers should be included. The general consensus was that this should be included in the plan. The group went onto discuss Our Vision. SM affirmed the importance of recognizing the difference between consultation and engagement and advised that business planning will be fine tuned going forward. JC suggested that the vision does not accurately reflect the ambition of our plans and feels that there is still some work required around this. DM felt that the vision statement fulfils its purpose and voiced her concerns around a lengthy or over complicated statement. DM feels that a high impact and concise statement is more effective in generating interest. FM discussed Priorities and asked the group for their opinion on the format. The group discussed this and suggested a possible change of wording or more of a table format and the balance between this being a Strategic Document as well as user friendly. SMac felt it may be useful to detail that this is being delivered by the HSCP as there is still some confusion as to who the HSCP are. FR felt that in order to do this we would need to provide the public with more information of who the HSCP are and we do. Consultation will take place on the 20th of September and will allow us to listen to views on the draft which will be more comprehensive by this time.	
4.	**2017-2018 Priorities**	
	The Annual Plan feeds into the 3 year Strategic Plan. This reflects back on the things we are helping to do this year and on Specific parts of the service. SC advised that these are the things that will be worked on and is happy for this to be discussed and brought to the next SPG. SC advised that we would not be able to discuss all of the priorities but rather a small number of items could be discussed at the SPG suggesting that the group first of all concentrate on: LD remodeling Service Review of Mental Health Services Review Home Care or Remodeling Older Peoples Day Care. GH suggested that progress around some of the priorities appear to be stagnant and that the groups must implement those actions. SM suggested that the pace of change will have to increase and that we need to continue to have open discussions to monitor progress.	
5.	**HSCP Contribution to community Planning Local Outcome Improvement Plan (LOIP)**	
	LB provided the group with an overview of the CPPB. Explaining that this is made of local agencies working together to improve outcomes across all aspects of life. LB also discussed the Community Empowerment Act as well as smaller Geographic areas suffering from poorer outcomes. LB then went onto discuss LOIP, advising that this will be evidence based. Locality plans will	

	be looked at as well as Delivery Groups in terms of Economic Growth and Recovery, Community Safety and Employability. SC discussed how this would affect ED HSCP, advising that we will be responsible for a number of outcomes for example Vulnerable Citizens, Older People & Population Health. SC also went onto discuss Children and Young People. Single agency will also be included in our own Strategic Plan on many other areas and we will therefore work with all relevant parties including multi agency to promote collaborative working. These are co-production / collaborative areas that require co-delivery involvement. SC requested the groups' thoughts around Vulnerable Citizens, Older People and Population Health and whether the SPG should be the Local Outcome Delivery Group for this. SC advised that if not that this will mean another multi agency group meeting will have to be heard. SM advised that this would be a good idea and is keen that the SPG are involved. (Local Outcome Improvement for Outcome 6) FM asked that members of the group send any additional point or suggestions to FM or CB	
6.	**Integrated Children's Plan**	
	SC discussed the Children's plan including the demographics, educational outcomes and the SHANARRI indicators. SC also discussed the 2017/2018 priorities. Advising the group that the strategic needs assessment for Children and Young people and a range of action for Mental Health Improvement will be consulted on next week and will subsequently go to the board for approval around the 22nd of June.	
7.	**Locality Panning Groups**	
	GN updated the group with the challenges and achievements of both the Locality Groups. GN discussed loneliness & Isolation and feels that this has been one of the larger items of work. Again however there are still gaps in the service, specifically with regards to integration. There has also been a sense that people are becoming disheartened because issues have been fully discussed with no great improvement. In addition to maintaining the enthusiasm of the group there has also been a challenge around extending to a wider audience. GN advised that she was impressed with South Lanarkshire's criteria around sustainability and is hoping to emulate this. GN also informed the group that John McPherson will be leaving to go to a practice in Greenock. In light of this there is likely to be a challenge around identifying a chair for the next meeting. GH asked how the membership for this group was agreed and felt that this may be a little health focused. SC suggested that many of the items may be appear to be Health related however this may be around integrating individuals into society. AB also feels that some of the most important things to have come from the meetings have not been health related. AB also suggested that it would be good for GP's to have more awareness of the financial constraints or available funds to tackle and impact change. SM suggested that the Locality Groups should be given a clear undertaking of resources. DM felt that GP's are restricted somewhat and may not have the skills to push through the	

	action taken from the meetings. Also as Localities are still in their infancy as a group some individuals are not sure exactly what the functions of the group are as opposed to the GP Forum which is a well established and long running group. SC advised that she would like to discuss Locality Groups with the Heads of Health. BS advised that he has allocated two Senior Mangers from his areas to attend and that he is happy for them to take forward any actions taken from the groups. FR advised that the nurses attending the locality Groups have advised that they have a greater awareness of what is happening within the locality and feel that the groups has been beneficial to them in this respect. SM discussed the dates of the next meetings and the time scales involved for progressing the work discussed.	
8.	**Intermediate Care Facilities Update**	
	DA & GN explained that there have been 45 admissions to date, of this 30 have been referred to RAL and 10 people have been discharged. This has allowed people to live independently in their home environment rather than being admitted to a Care Home. GN informed the group that this is an 8 bed unit and is working at full capacity.	
9.	**Future Meeting Dates:**	
	Tuesday 15th August Wednesday 20th September Tuesday 14th November	

East Dunbartonshire Health & Social Care Partnership

DRAFT

EAST DUNBARTONSHIRE HSCP

Minute of the **Strategic Planning Group**
Tuesday the 15th of August at 2:00pm at East Dunbartonshire Voluntary Action, Units 4 & 5, 14 Townhead, Kirkintilloch, G66 1NL

Present

Susan Manion	ED HSCP Chief Officer
Sandra Cairney	Head of Strategy, Planning & Health Improvement
Fiona McCulloch	Planning & Performance Manger
Jean Campbell	Chief Finance and Resource Officer
David Delaney	Chief Executive ED Association for Mental Health
Avril Jamieson	Carers Representative
Scott Lafferty	TSI Manager (Core Services)
Andy Martin	Head of Adult & Primary Care Services
Paolo Mazzoncini	Chief Social Work Officer
Stephen McIntyre	Director, Hillhead Housing Association
Frances McLinden	General Manager, Oral Health Directorate
Diane Meek	General Practitioner
Marion Menzies	Service User Representative
David Radford	Health Improvement Lead
Gillian Healey	TL Planning & Service Delivery
Bella Kerr	Development Officer
Fiona Munro	Team Manager CRT, OAM HT
Marjorie Johns	Planning Manager, Acute

In Attendance

Christina Burns	(Minutes)

NHS Greater Glasgow and Clyde

East Dunbartonshire Health & Social Care Partnership

1	**Introductions & Apologies** Apologies: David Aitken, Alison Blair, Janice Cameron, Stephen McDonald, Gillian Notman.	**Action**
2.	**Notes of Previous Meeting & Action Plan Updates** The minutes of the meeting held on 23rd of May 2017 were accepted as an accurate record without amendment. The group reviewed the Action List with SC providing a verbal update on the LOIP and Integrated Children's plan. • The Integrated Children's Plan was recently approved by the HSCP Board. This will now go to the Education Committee for Approval by the Council. Jackie McDonald will be the Senior Officer and will take this to the Council. It is hoped that this will be approved at the Committee and an informal launch of the Strategy put in place. **Actions:** • **The LOIP will be published in October. AM is the lead for outcome 6 and the SPG have a leading role in outcomes 4 and 5. Staff across all areas have been working together to develop priorities for the LOIP.**	**AM** **ALL**
3.	**Annual Performance Report** The Annual Performance Plan was published in July in Accordance with the Public Bodies Act and is now on the HSCP website. FMcC requested feedback from the SPG and suggested that members of the group contact her if they would like to provide feedback out with the group. AM discussed the performance figures for outcome 4 and suggested that there were other factors that contributed to the overall figures FM is expecting that there will be substantial improvement in the next few months. FM also discussed the potential implications of the new Dementia Strategy which has now been published. SMcI asked if the SPG would have a role in reviewing targets and who currently set targets. SC clarified that the SPG would have a role in reviewing priorities and discussed the range of sources involved in setting targets. FMcC confirmed that there will be room to develop future Annual Performance Reports in terms of benchmarking against other HSCP's, rather than focusing on targets as a means to identify trends. Many of these improvements will be incorporated into the next annual performance reports. **Actions:** • **SPG to provide feedback to FMc on the Annual Performance Report.** • **SC/FMcC to consider including the source of the targets in the next Annual**	**ALL** **SC/FMcC**

NHS Greater Glasgow and Clyde

Performance Plan.

4. Strategic Plan 2018-2021 Development Process

FMcC advised that the **update on the development of the** Strategic Plan 2018-2021 would be going to the HSCP Board for approval next week. This paper provides the outline of how the HSCP plans to approach the engagement and consultation process required for the development of the Strategic Plan.

DR discussed the upcoming engagement events and advised that there had already been a press release in the local news paper as well as social media links and flyers across various areas to create awareness.

FMcC explained that there will be 4 engagement events for staff. These events will be used to gather the views and opinions of staff in relation to the Plan's priorities as well as how we can improve and develop this.

The engagement event on the 20th of September is the next stage in the engagement and consultation process. This event will bring together the SPG, Locality Planning Group and the PSU&C group. At this stage the information and feedback from the other events will be available for review and will inform further development of the priorities in the Strategic Plan. The SMT will then receive reports for each of the events to assist in developing the plan and a draft will be prepared for wider circulation. This will be a relatively comprehensive draft which will be put on the website to allow people to give their opinions with the final plan written and submitted for approval in March.

The group had a brief discussion around the Housing Contribution Statement which is updated every 3 years along with the Strategic Plan.

5. Priorities 2017-2018

SM explained that she had hoped to bring along some of the key priorities to discuss at the meeting however this is still being shaped and formatted. In addition to the Strategic Plan, the intention is to formulate an Annual Business Plan to outline the key prioritises and objectives for the year; this will be monitored by the HSCP Board.

SM advised that this Annual Business Plan will outline key priorities including our work to improve unscheduled Care , support Care Homes, review the public health dental service and take forward our work to review the Learning Disability service , improve transitions between childrens and adults services and look at the balance of care between for children to ensure more are supported in a local environment, rather than being placed elsewhere.

Actions:

- **SM suggested that the time and duration of future SPG meetings are reviewed due to a direct clash with the Health Board Meeting.** **SM/SC/ FMc/CB**

Locality Planning Group

DM provided a brief update advising that the last meeting took place on the 21st of June. Dr

Ashley Fergie attended this meeting to discuss Dementia Services, Dementia Pathways and CEARTAS as well as the gaps in dealing with young Dementia Sufferers. DM explained that this is one of the priorities that the LPG has been working on. There have also been various discussions regarding obesity in adolescents between the ages of 12 to 18 years old and the mechanisms of support for these young people for example the "way to go initiative".

DR added that Jenny Proctor from the Service Users and Carers group also attended this meeting and that the information that Dr Fergie provided was very well received by the PSU&C group and has generated a lot of discussion.

AM advised that there was generally good attendance at the group with some very vibrant and important issues on the agenda. AM and GN have discussed funding to dedicate to small scale priorities and this will be considered at some point dependent upon key priorities. AM also suggested that there does not appear to be a framework to take issues forward however feels that there are opportunities within the LPG that are not present within other groups in terms of the attendees and the knowledge they bring. .

SM discussed potentially developing budgets for localities however suggested that there needs to be clarity around exactly what will be achieved and the level of funding required to accomplish this.

Actions:

SM requested that specific proposals be discussed at the next meeting to determine how locality groups could be further developed on the 20th September. **ALL**

6. GP Cluster Update & Discussion

AM advised that these meetings are very effective and are regarded as useful and informative by those individuals that attend
FMcC informed the group that there is now ISD support for Cluster Groups to look at the various data including patient flow.

Action:

SM suggested that the mechanism of feedback should be looked at for both the Locality Groups and the GP clusters. **ALL**

7. PSU&C

DR advised that the last meeting of the PSU&C took place on the 8th of August and that the familiarisation between the PSU&C and the Senior HSCP management team is currently still ongoing. Paolo Mazzoncini attended the last meeting which generated substantial interest around children's services.

DR also informed the group that Jenny Proctor had been nominated for the Board as a Carers Representative. A potential replacement has already been identified and will attend the Locality Group in Jenny's place. The PSU&C will also receive an induction pack Aide Memoire with the full background of the HSCP. Service users have been asked to attend the event on the 20th of

September with funding available to reimburse Carers.

8. Preparation for the Introduction of the Carers Act.

The Carers Act will go live in April next 2018. A Carers working group is in place to oversee and help develop the various areas of work for the implementation of the Carers Act. FMc is currently writing an implementation plan which the group will review. The Eligibility criteria must be published by the 31st of March along with an Adult Support Plan and Young Carers Statement. There will be significant work to increase our identification of Carers, offering support plans and young Carers statements as well as creating an overall awareness that support is available. The 3rd Sector will also be heavily involved in this.

Actions:

- **Preparation for the Introduction of the Carers Act should remain on the Agenda until the act is implemented.** **CB**

AOCB & Future Meetings

9. AOCB

DD asked for more information regarding the planned timescale for the Mental Health Review discussed at the last meeting. SM advised that this would be picked up along with the priorities and would be revisited at the next meeting.

Actions:

- **SM requested a Business Plan to allow the group to look at the areas of focus and discuss in depth along with the priorities.** **ALL**
- **An update on the Mental Health Review should be provided at the next meeting.** **SM**

10. Date of Next Meeting

- 20th September 2017, 2pm, Kirkintilloch Baptist Church, 52 Townhead, Glasgow, G66 1NL
- 14TH November 2017 at EDVA Offices, 18-20 Townhead Kirkintilloch, Glasgow G66 1NL

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 20

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	Position paper and discussion document on a Regional Delivery Plan for the West of Scotland
Report By	Susan Manion, Chief Officer
Contact Officer	Susan Manion, Chief Officer 0141 232 8216 Susan.manion@ggc.scot.nhs.uk

Purpose of Report	To present the Position Paper and Discussion Document submitted to the Scottish Government by the West of Scotland Regional Implementation Lead

Recommendations	The HSCP Board is asked to note the Paper

Relevance to HSCP Board Strategic Plan	Our Strategic Plan will help to inform the Regional Plan implementation. Over time the Regional Plan may influence the next iterations of the HSCP Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	Nil

Equalities:	Nil

Financial:	Nil

Legal:	Nil

Economic Impact:	Nil

Sustainability:	Nil

Risk Implications:	Nil

Implications for East Dunbartonshire Council:	Nil

Implications for NHS Greater Glasgow & Clyde:	The NHS GGC Board Chief Executive is involved in the Regional Planning Delivery Group and the HSCP Chief Officers are also represented on that Group.

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

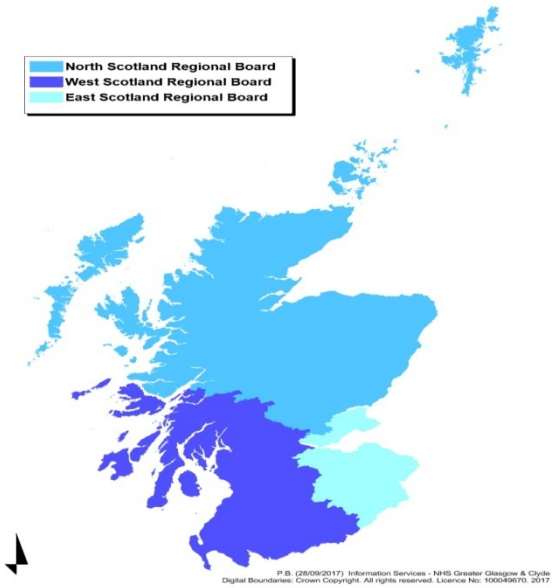
1.1 At the August 2017 meeting the HSCP Board were given an update on the context for the development of Regional Development plans for Health and Social Care for each of the three Regions in NHS Scotland (North, East and West)**.**

1.2 The attached Position Paper and Discussion Document was submitted to the Scottish Government by John Burns CEO for Ayrshire and Arran NHS Board who is the Executive Implementation Lead for the West of Scotland on the 29th September. The final Plan is to be submitted in March 2018.

1.3 There have been a number of engagement events held in September and October for voting HSCP Board members.

1.4 It is recognised that the Health Board, the Council and the HSCP will retain existing governance and accountability but in the context of transparency and collaboration, the parties will work together to facilitate the delivery of the key objectives as they emerge. The GGC Chief Executive and the Chief Officer will continue to be involved in the shaping of the delivery plan.

West of Scotland



Developing a Regional Plan

Position Paper and Discussion Document
September 2017

1. Introduction

This paper describes the collective ambition of the West of Scotland to improve the health and care for people across the Region. It has a particular focus on keeping people well, early intervention and developing better, more integrated care organised around the individual needs of the patients we serve. It builds on the many examples of excellent care already provided across the Region and reflects our local aspiration to deliver the *National Health and Social Care Delivery Plan* providing better health, better care and better value.

The paper is structured as follows:

- Summary of our overall approach
- Our guiding principles
- The leadership of the Programme
- The national policy context
- The regional context
- The case for change
- The emerging common purpose
- Early thinking on new models of care
- The regional plan to take this work forward to March
- Next steps
- Statements of intent

Delivering this vision will require action at every level of the health and care system across the Region. Our starting point is to recognise that circa 90%of care is provided in an out of hospital setting. Our approach will therefore build first and foremost on the needs of local communities whilst also recognising the need to plan for the most seriously ill who will require more specialised hospital based services.

Our approach is to collectively plan to improve the health and wellbeing of our 2.7m population, reducing inequalities and improving health outcomes for our citizens. It will be grounded in effective and meaningful partnership between health care, local authority services, primarily social care, the third sector, patients and communities. The Regional Delivery Plan will support both the Local Delivery and Health and Social Care Strategic Commissioning Plans and taken together with these plans will describe a strategy for the health and social care for the Region's population as a whole.

2. Executive Summary

Regional planning in the West of Scotland with the focus on acute and tertiary services has served us well for many years. These arrangements are no longer fit for purpose, as the task to prepare a Regional Delivery Plan requires a different and more inclusive approach. Therefore, we are putting in place new arrangements to co-ordinate planning across the Region.

The NHS in the West of Scotland has demonstrated significant improvements over the last 20 years; however there is further work to be taken forward to meet the challenges of the next 20years. Preventable illness is widespread and health **inequalities deep-rooted**.

New technologies and treatment options are emerging, and **patients' needs are changing**. We face particular pressures in providing care to an increasingly older population recognising they will need more joined up integrated care to stay well and lead a full life.

In the West of Scotland, we have a shared understanding of the challenges we face and have developed a **compelling Case for Change** as a basis for action.

We have developed a **shared vision and a common purpose** which describes our future offer for our patients and communities. Our ambition is to join up care around the patient breaking down traditional barriers in how care is provided between family doctors and hospitals, between physical and mental health and between health and social care. This future will see far more care delivered locally nearer to people's homes but with some services in specialist centres.

We are committed to **Local Care Models** based on a deep understanding of the different needs of segments of the population, a consistent set of clinical standards and with services integrated and co-ordinated from a patient view.

Whilst most people can be cared for by better more joined up local care, we recognise the most seriously ill need more specialised hospital care. We are committed to developing a region-wide framework to support the development of **New Models of Acute Care** based on a stratified network of services.

To deliver this vision we have put in place comprehensive programme arrangements including **System Leadership through a Regional Programme Board** and have set out a **Forward Programme Plan** (October to March) to deliver the first strategic plan in March 2018.

3. Guiding Principles

In drafting this document and developing the plan, we are proposing to apply the following principles:

- Prevention is better than cure
- Care should be designed around the needs of the whole population removing boundaries in planning and delivering care
- Focus on reducing health inequalities by working together on the wider determinants of health
- Care should be provided as locally as possible and only centralised where absolutely necessary
- Care should be integrated across health and social care working in true partnership with patients, carers and the voluntary sector
- We should make the best possible use of resources achieving value for patients, communities and the tax payer.

4. Leadership of the Programme

The West of Scotland comprises a number of partner organisations supporting the provision of health and care services including 5 Territorial Boards, 15 Health and Social Care Partnerships, 16 Local Authorities, 5 National Boards and a number of Third Sector Organisations.

West of Scotland Partners

Health and Social Care Partnerships (15) / Local Councils (16)[1]	• Inverclyde • East Renfrewshire • West Dunbartonshire • North Ayrshire • North Lanarkshire • Dumfries &Galloway • Falkirk • Glasgow City	• Renfrewshire • East Dunbartonshire • East Ayrshire • South Ayrshire • South Lanarkshire • Stirling & Clackmannanshire[1] • Argyll and Bute
NHS Territorial Boards (5)	• Ayrshire & Arran • Forth Valley • Lanarkshire	• Dumfries & Galloway • Greater Glasgow &Clyde
NHS National Boards (5)	• Scottish Ambulance Service • NHS 24 • Golden Jubilee Foundation	• National Education Scotland • National Shared Services

1 Local Councils are typically 1:1 with HSCPs with the exception of Stirling and Clackmannanshire which has 2 Councils and 1 HSCP
Source: Regional Team

Recognising the importance of all the key stakeholders in developing a plan for the future in the West of Scotland work, we began working with Boards and their executive and non executive members, the Integrated Joint Board chief officers and their voting members, and other senior managers and senior clinical leaders' to begin to create a shared agenda. We recognise that we have further work to do engage with and include Local Authorities, Integration Joint Boards and the third sector in the development of this plan, particularly around the social care element of this work. This will be progressed over the next few months.

Some of this work has been facilitated by external organisations to encourage a more transformational approach both to developing the regional delivery plan and the ways in which we will need to work across the different parts of the system to achieve success, learning from experience both within the United Kingdom and across other parts of the world.

Stakeholder Engagement

Our first set of meetings aimed to set out the question we believe we needed to answer as a region. This can be described as:

How do care services need to be configured in the West of Scotland to be safe, sustainable, equitable, effective and affordable to meet the needs of the 2.7m population going forward to 2035 and support the delivery of the Health and Social Care Plan?

The workshop engaged more than 65 people in shaping approach




An engagement session on the 20th September 2017 saw representatives from the NHS Boards, the Integrated Joint Boards come together to consider the emerging story for the region. The session set out for consideration and discussion:

- the key messages arising from the population needs assessment;
- the key messages from the gap analyses on workforce, demand and performance analyses, finance and infrastructure;
- the case for change;
- the common purpose that unites us as a region
- the potential interventions in care models and a stratified model for designing services
- the programme structure to support the development of the Regional Delivery Plan
- the approaches we need to adopt to communication and co-production as we go forward to prepare the first regional delivery plan for March 2018, including the approach to governance and sign off prior to submitting the plan at the end of March 2018.

This session allowed key regional stakeholders to come together to consider and agree the vision for the region and the guiding principles and behaviours that will be crucial to develop and maintain the relationships across the region and to create the arrangements and necessary conditions to engender a whole system approach to achieve the collective goal.

5. National Policy Context

Over the past eighteen months 2 key documents – the Health and Social Care Delivery Plan and the National Clinical Strategy- have been published providing the policy direction and setting out the way forward in Scotland in terms of health and care of our population on top of the existing Quality Strategy that sets out an ambition for quality.

National Health and Social Care Delivery Plan[1], launched in December 2016, describes the approach to be followed to ensure that Health and Social Care is transformed in the next few years. It is action orientated, and sets out a significant list of deliverable objectives which include a focus on regional and national planning of services where appropriate. The delivery plan draws on preceding strategies, pulling them together and setting out the direction of travel and expectation of a modern health and care system to achieve the aspirations mentioned in the strategies.

- 2020 Vision – people live longer, healthier lives at home or in a homely setting
- Health and Social Care Integration[2] which promotes prevention, anticipation and supported self management; working across health and social care to improve patient care
- Daycase treatment as the norm
- Highest standards of quality and Safety (Quality Strategy 2010)
- Person centred care
- Health and Social Care Workforce Plan[3]– considering workforce planning and development
- Investment - matched to reform and transformation
- Digital Strategy[4] - promoting technology and information supporting both patients and care professionals to provide modern models of care

The National Clinical Strategy[5]published in February 2016 set out areas for change:

- Planning and delivery of primary care services around individuals and their communities
- Planning hospital networks at a national, regional or local level based on a population/ availability of appropriately skilled workforce paradigm
- Providing high value, proportionate, effective and sustainable healthcare (linked with Realistic Medicine)
- Transformational change supported by investment in eHealth and technological Advances

The National Clinical Strategy also calls for regional planning of many hospital services to improve patient outcomes; to make maximal use of highly trained clinicians; to fully utilise complex services supported by expensive technology such as robotic surgery; to standardise care to avoid unwarranted variation; and to make services financially sustainable for the future.

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[1] http://www.gov.scot/Resource/0051/00511950.pdf
[2] www.shiftingthebalance.scot.nhs.uk/downloads/1305042182-Integration(Summary position paper)
[3] Integration across Health and Social Care Services in Scotland – Progress, Evidence and Options: www.gov.scot
[4] http://www.ehealth.nhs.scot/strategies/the-person-centred-ehealth-strategy-and-delivery-planstage-one/
[5] www.gov.scot/Publications/2016/02/8699

The King's Fund has considered the evidence of benefit from reconfiguration of acute services and notes that while reconfiguration can lead to improvements in services:

"Reconfiguration is an important but insufficient approach to improve quality. It should be used alongside other measures to strengthen delivery of care and to instil an organisational culture of improvement."[6]

Other national policies and strategies influencing the development of the regional delivery plan include:

- Best Start *(Maternity and Neonatal Services Strategy – 2017)*
- Primary Care Transformation
- Implementing the GP contract
- Mental Health Strategy
- Cancer Strategy (March 2016)
- Getting it Right for Every Child (GIRFEC)
- Realistic Medicine
- Review of Health and Social Care Targets
- Public Health Strategy

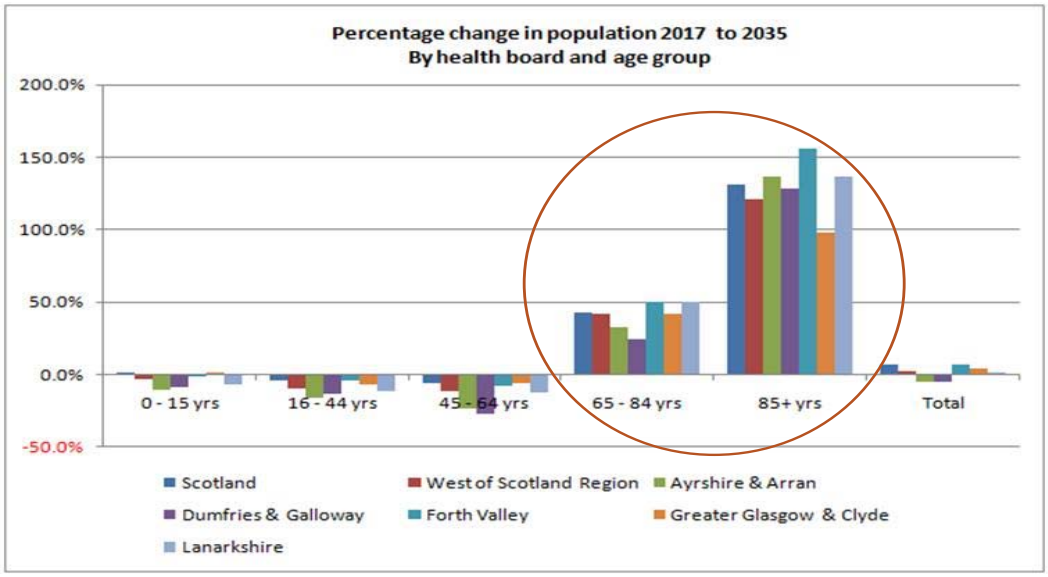
[6] The King's Fund: *Reconfiguration of Clinical Services: What is the evidence?* Candice Imison. November 2014

6. Regional Context

6.1. Understanding the Population

The West of Scotland serves a population of circa 2.7m, covering a wide geographic area of 8,777 square miles, consisting of urban, rural and island communities. A Health Needs Assessment for the West of Scotland is currently being progressed. A significant number of analyses have been identified and undertaken which will support the work over the coming months to consider the service model and provision for health and care services for the region. Beyond the work to consider the population age, gender, deprivation levels and the implications of this both in relation to health and social care provision, use and funding levels, work is considering the use of services, life expectancy and health outcomes; reviewing the trends in this over the last decade or longer.

Population Changes in West of Scotland



Population Needs Assessment: Emerging Findings

- The West of Scotland has some of council areas with highest proportions of oldest residents in terms of population percentage over 65.
- It also has most of the most deprived council areas in terms of summary SIMD score (Glasgow city, West Dunbartonshire, Inverclyde, Renfrewshire, North Lanarkshire, East Ayrshire) and the bulk of the population residing in the most deprived deciles and quintiles.
- Both social deprivation and agedness of the population place major demands on the health and care systems
- The challenges of equitable service provision based on need rather than demand in a geographic area that also has considerable sized areas of affluence results in smaller National Resource Allocation Committee (NRAC) and Scottish Allocation Formula (SAF) shares for hospital & community services.

- Hospital admission rates are observed to be higher in the West of Scotland based on the crude rates. Work is underway to age, sex, deprivation adjust this position to assess the level of over-utilisation. This poses the question - does the proximity to hospital facilities encourage access particularly where they are relatively well provided for in terms of hospital beds and consultant provision?
- Plateauing of the life expectancy at birth is seen for Scotland as a whole, which is particularly clear for Scottish males, and evidence of unexpected downward shifts in the life expectancy trajectory are visible in some areas within the region. Stalling of rises in life expectancy defying the expectation of ongoing improvements in longevity. This is likely to be multi-factorial
  - including the effects of the high prevalence of obesity, the rising prevalence of Type 2 Diabetes, the stalling decline of smoking prevalence, the contribution made by the rise in alcohol-related deaths, etc
  - the role of austerity and level of investment in health and social care may be impacting, as well as the current organisational model that may hinder the achievement of optimal efficiency.
  - falling access to primary and secondary health services, and social care, for some sections of the population in both remote/ rural areas and urban areas.

  All of these threaten to reverse the progress made by improving structural determinants of health over the past century and increased health service provision over the past 15 years.
- Consistently clear improvements in most health parameters, as well as preservation of, or improvement in, the relative position in the national health league table, are being seen for the residents of the most deprived health board in the West of Scotland, namely Greater Glasgow & Clyde, in terms of standardised death rates from all causes, and standardised mortality ratio for all causes, SMR for cancer mortality for all types, and specifically for the commonest cause of death, namely heart disease.
- Despite having less social deprivation than GG&C, Lanarkshire's relative position in the standardised mortality (all causes) league table has worsened somewhat in recent years and its relative position in the cancer mortality league table for all types combined and for lung cancer in females has also worsened.
- Perhaps more surprisingly, more rural areas in the West of Scotland, even those characterised by relative affluence such as Dumfries & Galloway and Argyll & Bute, have unexpectedly lost ground and those with historical health deficits, such as parts of Ayrshire & Arran, appear to have deteriorated further in very recent years. Age/sex standardised death rates (all causes), standardised mortality ratios (all causes of death), and/or SMR for cancer (all types combined) appear to be rising in recent years, for these three board/council areas, the starting points of the rises varying with the area. Even the more affluent Forth Valley, appears to have lost ground with respect to its relative position in the cancer (all types) SMR league table, since its enviable position before 1990.

To ensure that the limited resources available are used equitably, that is, determined by genuine need, and fairly distributed against both geographical and socio-economic gradients, it will be important to consider the service provision across the region.

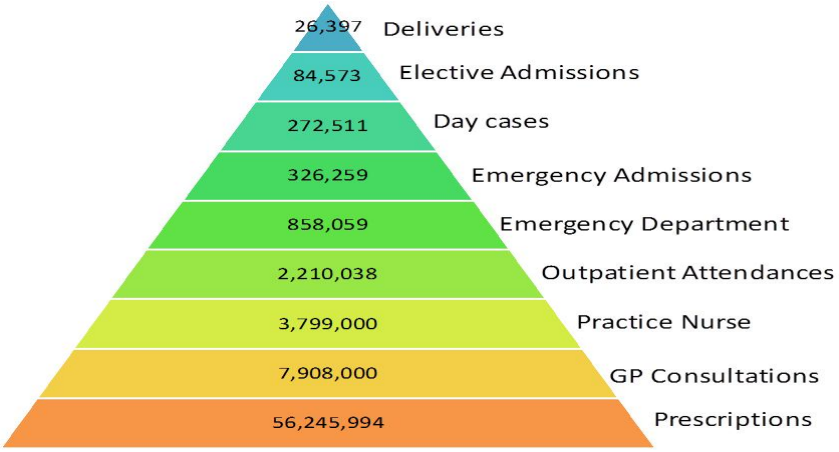
6.2. Demand Capacity Review

As with the Health Needs Assessment, analyses are being undertaken to consider the demand for and use of services. The focus to date has been primarily on health but this will be extended to include the social care provision for the plan submitted in March. This work has been reviewing a number of areas including analyses of: activity by admission category and by specialty; changes in activity; beds, bed days used and length of stay; projected position by 2020, 2025 and 2035; performance data including waiting times and waiting list information, outpatient measures and day case rates.

Information setting out the position for the West of Scotland is available in a supporting paper however some of the high level messages of this work to date are set out below:

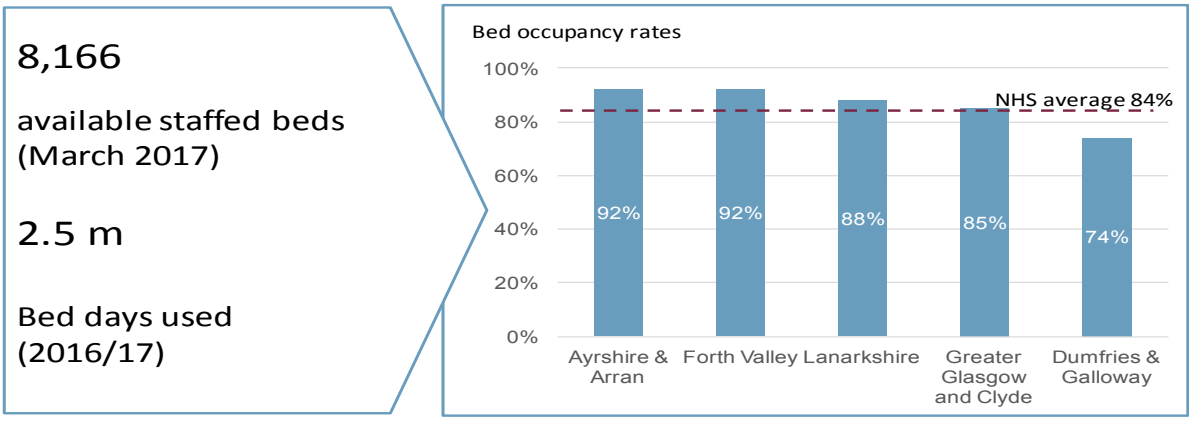
West of Scotland Activity

The diagram below sets out some of the key areas of activity, indicating the different levels of activity, providing some context in terms of where the services are provided.



Work has also been undertaken to consider the bed numbers and bed days being used to support the hospital service provision across the region. The inserted information below shows the current position based on the expected percentage growth of the population based on how the current service is used by different age bands of the population and the potential future scenarios if there is no change.

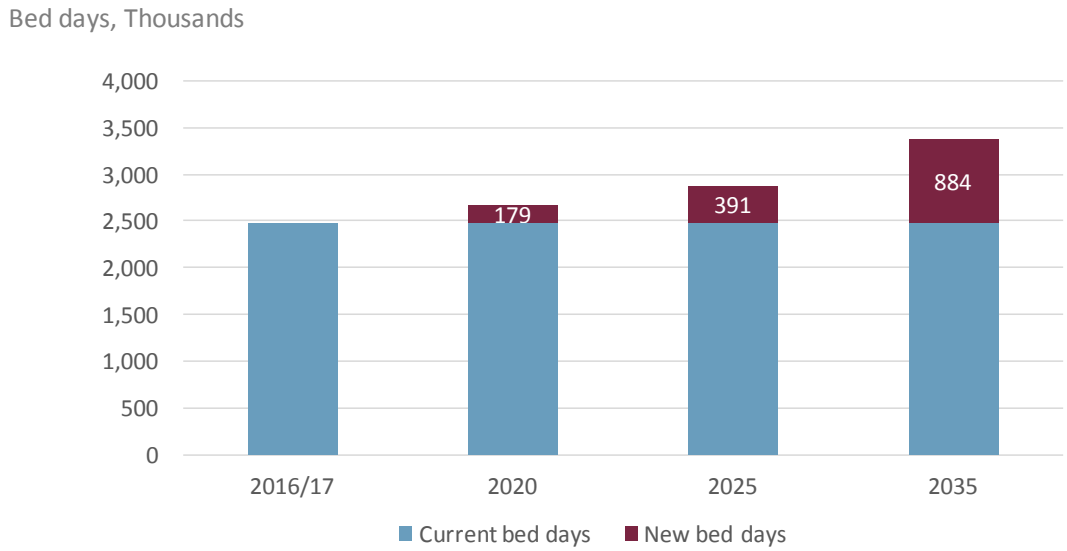
Current acute bed status in West of Scotland



Projected changes in activity and bed days, based on demographic growth only

Of particular note is the rise in bed days in addition to the 200,000 currently to be saved. With the current model of care, we expect there to be demand for an additional 880,000 acute bed days by 2035– 2,850 beds assuming an 85% occupancy rate.

Projected changes in occupied bed days due to demographic changes only



Source: Regional team analysis

6.3. Workforce Challenges

The NHS in Scotland must adapt its workforce models to be in the best position to deliver excellent and sustainable treatment and care in a rapidly changing Health and Social Care landscape. Workforce planning must take account of the national workforce planning work and consider the workforce challenges across the health and social care sector. West of Scotland Health Boards have been working together to develop a position which accurately describes the workforce within the region and identifies the principle workforce issues which must be addressed in order to deliver new regional models of clinical care:

- Workforce availability
- Workforce adaptability

- Workforce affordability

The West of Scotland Health Boards currently employ 62,630 wte / 72,620 head count, which accounts for approximately 45% of the NHS workforce in Scotland. Each Board has reviewed the ISD dataset to identify specific factors, where applicable, in terms of risks and challenges, opportunities and options to create an overall high level regional workforce position.

A supporting paper on the work to date is attached in the appendix. The high level message is that there are five key 'hot spot' job families/professions across the region:

- Medical – challenges in demand, supply and sustainability across a spectrum of grades, specialties and including general practice;
- Nursing – specifically challenges in smaller branches/cohorts associated with the overarching demography of the workforce and the potential risk this presents in terms of retirement profiles e.g. health visitors, district nurses, paediatrics, midwifery, mental health and associated issues with demand and supply. The demand for Advanced Nurse Practitioners (ANPs) was also specifically flagged. This mirrors the medical position both in acute settings but also increasingly within GP practices. There remain questions about the capacity of higher education institutes to meet demand;
- Radiographers – mismatch in supply of radiographers compounded by the increasing demand for services and existing problems with radiology staffing;
- Pharmacy technicians – significant increase in demand not being matched by supply;
- Healthcare science – demographics of the workforce, particularly in senior roles, are influencing the current provision couples with longstanding national issues with supply;

Issues informing the need for change are currently being quantified in terms of medical staffing as this proves challenging in providing equitable access to specialist opinion to support care in a number of Boards and specific specialties within the region. Currently there are circa 269 vacancies at consultant level (119 vacant for 6 months or more). This exercise will in time cover all staff groups.

It is recognised that the workforce of the future will not be "more of the same". The workforce will be older and have a greater reliance on Advanced Practitioners and roles with extended scope. All staff groups will be required to work to the "top of their licence" with work aligned to their skills. It is likely that the workforce may require to be re-profiled to match the increased workload demand in the community and the higher acuity in acute care. The Directors of Nursing are leading work through the West of Scotland Advanced Nurse Practitioner Academy to ensure consistency of competency and level of practice across the West of Scotland, sharing resources where appropriate. This is enabling the West of Scotland to get assurance with regard to growth of this important senior group. They are also looking at non-medical care models to develop new and extended Advanced NMAHP roles such as caseload holders, clinical leads as alternatives to medical models for particularly hard to fill specialties.

As part of the development of the first plan for March 2018 work will be undertaken to understand the total workforce supporting health and care services within the West of Scotland.

6.4. Infrastructure

Based on the report prepared by Health Facilities Scotland the West of Scotland faces significant challenges in relation to the infrastructure within health. The Report indicates that around 50% of the estate is modern, offering good functional accommodation however 50% of the estate has significant challenges. This is summarised below:

Modern estate

- Queen Elizabeth University Hospital & Royal Hospital for Children
- Stobhill and Victorla ACHs Glasgow
- New Dumfries and Galloway Hospital
- Forth Valley Royal Hospital
- 2 PFIs / PPP facilities – Hairmyres, Wishaw (Lanarkshire)
- Golden Jubilee Hospital
- New community care estate such as Eastwood Health and Care Centre and other similar primary care facilities

Estate with significant challenges

- Backlog maintenance around 1/3rd of national total
- Physical condition, age and functional suitability challenges a number of sites
- 3 similarly sized hospitals south west of Glasgow, with a growing need for investment RAH, Crosshouse Hospital and Ayr Hospital
- East side of Glasgow - GRI and Monklands will struggle to provide functionally appropriate accommodation. There are also challenges around the need to improve engineering services infrastructure to support these sites.
- Outlying areas of the region need investment in buildings and engineering services; specifically IRH, Vale of Leven and Falkirk Community Hospital
- Some GP practices

The current position offers both a challenge and an opportunity to build the future infrastructure based on the needs of the population organizing care in the most appropriate setting and using the workforce to best effect to provide the right care level within the hospital or community settings.

- £1bn - £2.5bn investment required
- Investment strategy combining replacement, refurbishment and rationalisation likely to offer most effective and affordable solution
- Health and Care Facilities and requirements as well as national work on primary care being undertaken by Health Facilities Scotland will also be included in the March 18 plan
- Medical Equipment and technology investments are currently being reviewed

- Offers new opportunities to consider different infrastructure to support future services

  The Regional Delivery Plan must bring a co-ordination to the planning of and investment in infrastructure that supports the care models developed.

6.5. Finance

The financial plans submitted by the West of Scotland Health Boards for 2017/18 show a combined recurring deficit of £237m.

	Greater Glasgow & Clyde £m	Ayrshire & Arran £m	Forth Valley £m	Lanarkshire £m	Dumfries & Galloway £m	Total £m
New Resources:						
Baseline increase	31.1	10.0	7.3	23.5	4.2	76.1
Social Care Fund	(23.7)	(7.7)	(5.3)	(13.4)	(3.0)	(53.1)
New Medicines Fund	(7.9)	(2.6)	(1.5)	(3.7)	(1.8)	(17.5)
Income from other Boards	2.4					2.4
Other (including NRAC)	0.0	1.5	5.4		1.7	8.6
Total new resources	**1.9**	**1.2**	**5.9**	**6.4**	**1.1**	**16.5**
Additional Expenditure:						
Recurring over/(under) commitment b/fwd	29.6	17.7	7.5	9.5	4.8	69.1
Pay inflation estimate	20.0	4.8	3.3	7.2	3.6	38.9
Other Costs (incl medical staffing)	6.0	3.1	4.4	8.7	4.5	26.7
Supplies inflation estimate	6.0	5.0	4.7	4.8	0.4	20.9
Primary Care prescribing	8.5	5.6	2.9	1.4	1.2	19.6
Acute prescribing	21.0	0.3	2.4	8.6	0.7	33.0
Other prescribing			2.5			2.5
Capital charge inflation	1.0					1.0
Apprentice levy	8.0	1.5		2.0	0.8	12.3
Rates revaluation	11.0	0.3	1.2		0.5	13.0
Pension cost (RRL to AME)	3.5					3.5
National services	1.5	0.4	0.1	0.3		2.3
Premises costs	3.2	0.9				4.1
Out of Hours and other regional costs	5.0	0.4	0.9			6.3
Total additional expenditure	**124.3**	**40.0**	**29.9**	**42.5**	**16.5**	**253.2**
Financial gap to be closed	**(122.4)**	**(38.8)**	**(24.0)**	**(36.1)**	**(15.4)**	**(236.7)**

Work is currently under way to complete a forward look for the next three years but this is difficult given uncertainties around future funding assumptions regarding Scottish Government funding uplifts and pay policy. To set a context for the financial parameters of the regional plan, a three year forward projection is being developed based on the following assumptions:

- **Annual Scottish Budget allocations** – assumes that the basis in which funding was allocated for 2017/18 continues for 2018/19 and 2019/20 (annual uplift to meet cost pressures <1%).
- **Transfer resource** – share of the transfer of £250m from Acute to IJBs in line with national target to reduce bed days by 400,000. This will also provide 50% of the commitment to increase primary care funding by £500m by the end of the current parliamentary term. The other 50% being funded directly by Scottish Government Commitment to 50:50 split between primary / community care and acute costs by end of the current parliamentary term also factored into three year forward projections.
- **Projected Cost Base** – assumes 10% inflationary increase (3%pa) on 2016/17 budgets over the next three years (conservative estimate).

- **Earmarked allocations** – assumes that these will be spent of new commitments and therefore no net benefit to overall financial position.
- **New medicines and diagnostic costs** - assume increase for secondary care medicines and diagnostics in line with recent historic patterns.
- **Capital**– no change in formula funding allocation to be prioritised towards backlog maintenance and essential equipment replacement.
- Changes to pay policy will impact future modelling

7. Case for change

Everyone deserves to lead a full and healthy life and to receive the best possible care when they become ill. The West of Scotland has many areas of excellent care of which we should be proud of but we know that we could do more both to prevent ill health and to improve outcomes.

Over the last few years we have seen improvements in the services and infrastructure for patient care. For example:

- We opened the Queen Elizabeth University Hospital and Royal Children's Hospital in Glasgow. We will shortly open a new hospital in Dumfries and Galloway.
- We have reorganised our community services, placing responsibility for local health and social care services under the joint leadership of the NHS and Local Authorities.
- We have successfully provided a number of regional services such as interventional cardiology, based in 2 facilities at Hairmyres in Lanarkshire and the Heart and Lung Centre at the Golden Jubilee Foundation; Forensic medium-secure care at Rowanbank Clinic, Glasgow. The Beatson West of Scotland Cancer Centre on the Gartnaval Campus in Glasgow which we have recently extended by developing a satellite cancer unit at Monklands in Lanarkshire; and most recently the Regional Robotic Prostatectomy Service at the Queen Elizabeth Hospital.
- There is ongoing work to reorganise and improve specialist services across the West of Scotland including major trauma, systemic anti-cancer therapy, urology and ophthalmology. Each of these services seeks to improve patient outcomes by organising care in the most effective way; providing the timely access to specialist care and through standardising approaches to optimise care.
- Integrated Joint Boards have progressed change in local care through the Integrated Care Fund and Primary Care Transformation.

Staff work hard so that we can continue to care for people under greater and growing pressures on the services. Despite all of this work, there is an emerging set of facts that we believe will not make it possible for the care services to stay on the current path without causing significant issues for our patients and staff as well as circumstances which we believe will make the current service model unsustainable even in the short term. This set of emerging facts, tested with senior colleagues involved in leading care services in the West of Scotland, who have confirmed their support for this, can be grouped around 8 major themes:

- **Our population is changing and so are their care needs** - Our population is getting older quicker, partially as a result of work we have done to improve how long

people live. This brings its own challenges as older people generally need more health and social care. Particularly of significance is the growth in over 85's albeit we are seeing that life expectancy is remaining flat and for some areas reducing.

- **We need to improve people's health** – In the West of Scotland we have high levels of obesity, smoking, drinking and drug use. There is also widespread poverty in parts of the Region. There is strong evidence that these factors contribute significantly to people's need for care, in how long people live and in how many of these years are lived in good health.

- **Hospital is not always the best place for care** – People are currently in hospitals who need care that would be better provided outside of hospitals. There is strong evidence that people staying in hospital longer than necessary makes them deteriorate and lose their independence. In some parts of West of Scotland we lack co-ordination of care for people who require multi professional input, particularly those with long-term conditions, mental health and older people and this also results in unnecessary visits or admissions to hospitals. Our care staff in the community do not have access to specialised services and this means they have no choice but to refer people to hospitals.

- **We want to provide the best possible care**– There are differences in how we deliver care across the region and variation in practice. It is important that we use the learning from each part of the service to support us to deliver the best care models and address variation in morbidity and mortality rates. This is partially because our most experienced and highly specialised staff are spread too thinly across the West of Scotland reducing the experience given to junior staff in the management of complex cases that allow them to build up the skills to provide the most appropriate level of support in emergency care. Hospitals are also struggling with waiting times for operations and treatments. This is in part because due to emergency care pressures which can impact on the provision of planned care in the same hospital resulting in elective cancellations reducing the capacity available to support planed care.

- **We need to use our workforce effectively** - There are difficulties in recruiting and retaining staff at all levels and settings of care making it hard to provide the best levels of care. The age profile of our staffing in some professions and general practice also gives cause for concern in terms of maintaining sustainable services. Some local organisations already have high levels of vacancies and are using temporary staff which is proven to cause clinical risks as well as costing the care services more.

- **Our buildings are not fit for purpose**– About half of the hospital buildings in the West of Scotland need major repair work or replacement that would cost somewhere between £1-2.5 billion. At the same time, much of the care that could be provided in the community does not have suitable locations or accommodation to provide these services.

- **Opportunities afforded by technology** – Technology has changed many industries for the better and there are many opportunities for the West of Scotland to use technology to improve our service, both in terms of how we organise and deliver care and in the interventions we offer.

- **We need to make the best possible use of available health and social care funding –** This year we expect to have a deficit of £237m across the West of

Scotland. Whilst some Boards will manage this in 2017/18 we must address the underlying issues and transform our service model to deliver quality and sustainable services.

In bringing these 8 themes together it is clear that status quo is not an option in terms of providing sustainable and safe services across the region. Leaders of the West of Scotland care systems believe we must make radical changes in how we provide care or we will fail our population and our staff. There is recognition that regional working across Board boundaries with our citizens to develop service models that meet the populations' needs is essential. This approach will be important to make most effective use of the resources, particularly workforce, if we are to ensure the population have access to the appropriate level of care and to use the funding available to best effect.

Evidence from other systems demonstrates the need to have upfront investment to support delivering the service transformation. In considering the way forward the region recognises the importance of: developing digitally enabled services to modernise how care is delivered; and ensuring adequate capital investment is available to create the most effective configuration of facilities across the health and care system to provide the right models of care to support transformation.

Recognising the existing governance arrangements and accountabilities of the NHS Boards, the Health and Social Care Partnerships/ Integrated Joint Boards and Local Authorities, work will be progressed to consider how each of the organisations can work effectively together to deliver their local plans but also to optimise the opportunities from working regionally to create sustainable care models for the local populations. To achieve this ambition a common purpose has been developed. The next section sets out what our common purpose might be as region to address this case for change.

8. Developing the Way Forward

8.1. Shared Vision and Common Purpose

We are working together as a region towards four aims:

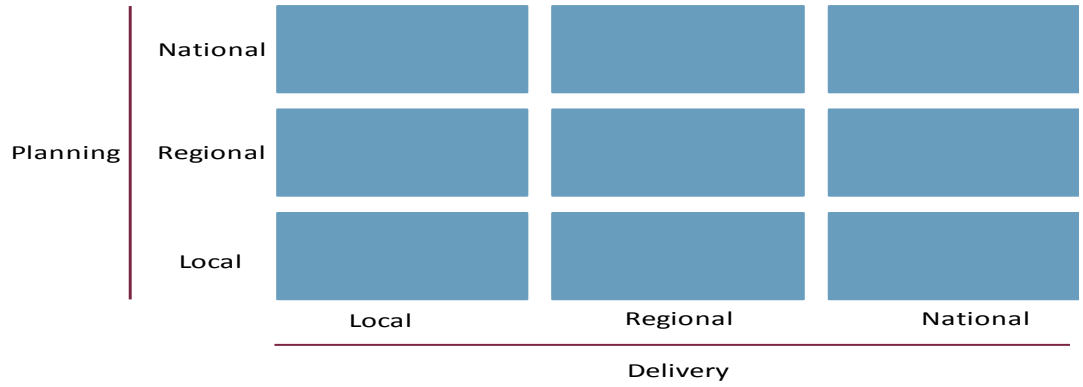
- Improving health and wellbeing;
- Increasing care and quality;
- Delivering on finance and efficiency; and
- Better workplace with a focus on staff.

In the submission in March, we will set out a shared vision and common purpose for the West of Scotland to achieve these aims and directly address our case for change. Our current draft of this is:

Case for change	Common purpose
Our population is changing and so are their care needs	We will design our care around the specific needs of individuals and different segments of our population rather than around existing organisations and services (Population Health Management).
We need to improve people s health	We will proactively engage people to have better lifestyles, develop independence and self care.
Hospital is not always the best place for care	Design and deliver care services me around population segments that are closer to home, particularly those that require joined up care.
We want to provide the best possible hospital care	We will design our future hospital services around the new and expanded local services, with different levels of service provided in different hospitals.
We need to use our precious workforce effectively	Develop regional workforce strategy, which includes addressing key gaps and the ability to flex across region.
Our buildings are not fit for purpose	Create regional estates strategy that makes best use of existing estates to support out of hospital and hospital care models and determines investment needed.
Technology has changed but we are not taking full advantage	We will make better use of the technology we have already invested in and make more investments in technology that allow us to improve care and reduce the cost of the care services.
We need to make the best possible use of tax payers money	Develop comprehensive regional plan that addresses drivers of financial pressure (incl. balance of care, productivity, workforce, back office, estates)

While we will be united as a region in addressing this common purpose, not all of the work to plan or deliver these objectives will be done at a regional level. For example, the Integration Joint Boards (IJBs) have primary responsibility for joining up health and social care in their communities, while there are national programmes who are planning for shared services across the nation. Existing Board Strategies and Health and Social Care Strategic Commissioning Plans set out work that will continue to be progressed locally. This work will influence and be influenced by the development of the regional delivery plan. By March we will define how this common purpose will be planned and delivered at local, regional and

national levels with a guiding principle that we should be as local as possible and as regional as necessary where there is a compelling case for regional or national work.



In developing this plan, one of the challenges will be defining the role of the region in care that is delivered outside of hospital. From discussions amongst leaders of the care system we believe there will be a regional role in facilitating sharing of best practices, developing common and consistent elements of care models across the region, determining how best to ensure the money is available to implement these new ways of care, and making sure the IJBs are supported with the necessary workforce, facilities and technology to do their work.

Inevitably there will be tension between organisations within the region as we try to balance achieving individual organisation goals and regional goals that may sometimes pull in opposite directions. If we are to achieve this common purpose as a region, our service leaders will need to role model behaviours that will support the different organisations to work together successfully. Our workshop participants on the 20th identified behaviours they felt would be important including trust, respect, acting with principle and integrity, acting collegiately and ultimately working for the best interests of all the 2.7m people who live in the West of Scotland.

8.2. Care Models

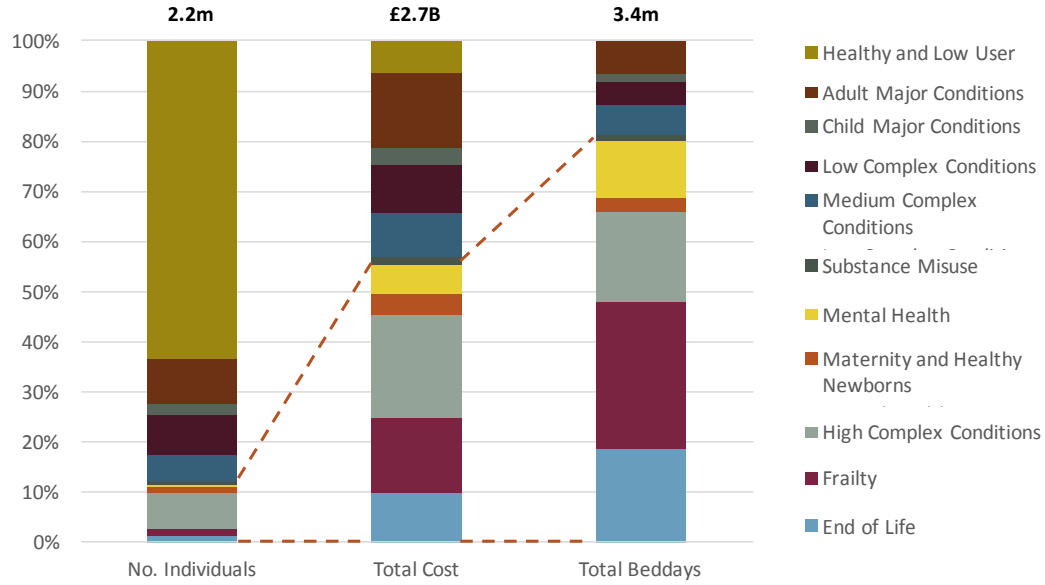
In the West of Scotland we intend to develop our future care models in four ways, outlined in the exhibit below.

Understanding the needs of different segments of the population	Addressing as much care as possible proactively and locally	Designing hospital care to deliver safe and sustainable services	Putting in place the key enablers
• Use ISD data to have fact-based discussion on population segments • Identify specific patients and segments to make targeted interventions to care plans and care models	• Integrated services covering primary care, community care, social care, mental health, access to specialist diagnostics • Services integrated and co-ordinated from patient view • Increased funding and capacity outside hospital • Effective multi-disciplinary team working	• Establishing clear standards for safe delivery of services – Interdependencies – Workforce – Volumes • Establishing different levels of hospital services • Networking hospitals for sustainable high-skilled services	• Digital • Workforce • Estates • Organisational development • Financial Allocation Model • Governance • Communications & engagement

Understanding the needs of different segments on the population

ISD Scotland have developed data that shows how different segments of the population use the care services in very different ways. For example, people with serious mental health needs are estimated to cost £19k in hospital care per person per year, people with frailty issues cost £11K per person per year while mostly healthy people cost £115 per person per year.

In the West of Scotland 12% of the population consume over 55% of the health spend and 80% of beddays



Source: ISD

Individuals and groups of our population clearly have very different needs and we in the West of Scotland are committed to organise the system around these different needs.

Addressing as much care as possible proactively and locally

Integration Joint Boards have primary responsibility for this area and are making progress in developing and delivering on their plans. At a regional level we are exploring the potential for some common elements of care models that can be described regionally and delivered locally. For example, one region in England made this offer of local care to its older population with complex needs:

- **Care planning and navigation** – People will be supported to develop a personalised care and wellbeing plan. Dedicated professionals from a variety of health and social care backgrounds will co-ordinate the care and support from the rest of the multi-disciplinary team (MDT) and the wider health, social care and voluntary sector.

- **Supporting people to improve their health and wellbeing** - Supporting people and carers to improve and maintain health and wellbeing by building knowledge and changing behaviours through proactive prevention / engagement.

- **Healthy living environment** – Ensuring a healthy living environment to preserve long-term health & wellbeing (e.g. falls prevention, housing improvements and alterations).
- **Integrated health and social care multi-disciplinary team** – Providing person-centred, coordinated multi-disciplinary care services, wrapped around GP practices and community services providing care to people who have personalised care plans based on their needs.

- **Single point of access** – A number called by the person, the GP, community services and acute staff, or indeed any other professional, to support people with their care by gaining more efficient, coordinated access to services.

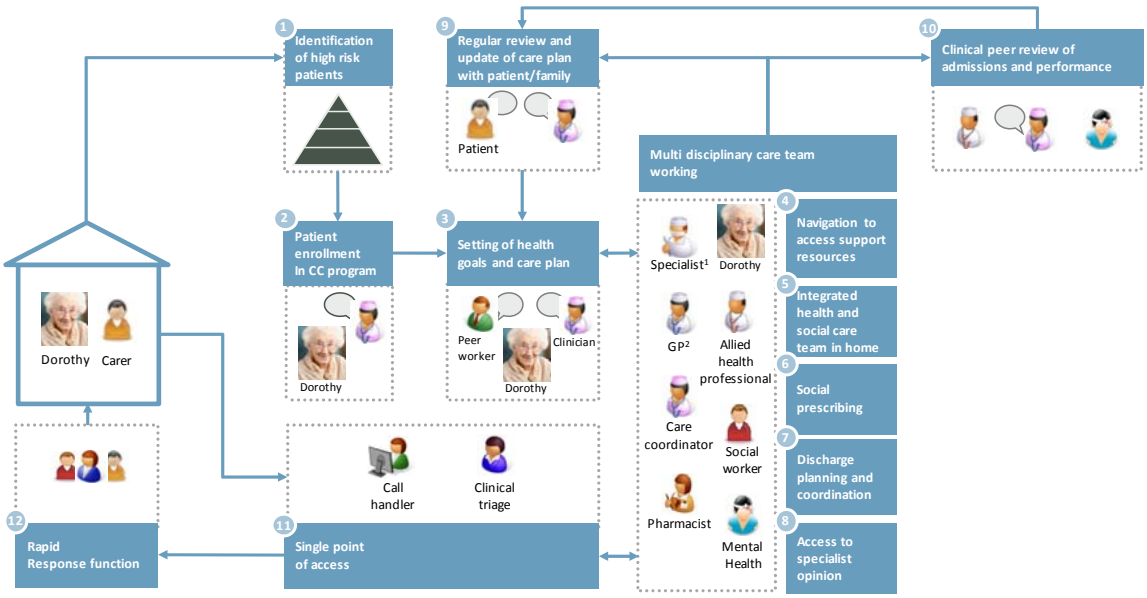
- **Rapid response** – The ability within an MDT to respond rapidly to people with complex needs who are experiencing urgent health or social care needs that left unattended would result in a hospital admission.

- **Discharge planning and reablement** – A pro-active, anticipatory service designed to target those people who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating and to support their recovery.

- **Access to expert opinion and timely access to diagnostics** - The ability for primary care professionals to access a specialist opinion in the community setting and where appropriate, a specialist triage for diagnostics. Access to full and timely diagnostic services and diagnostic results will reduce the need for multiple outpatient appointments.

Such a model for anticipatory care could look like the following chart:

Example flows of an anticipatory Local Care model



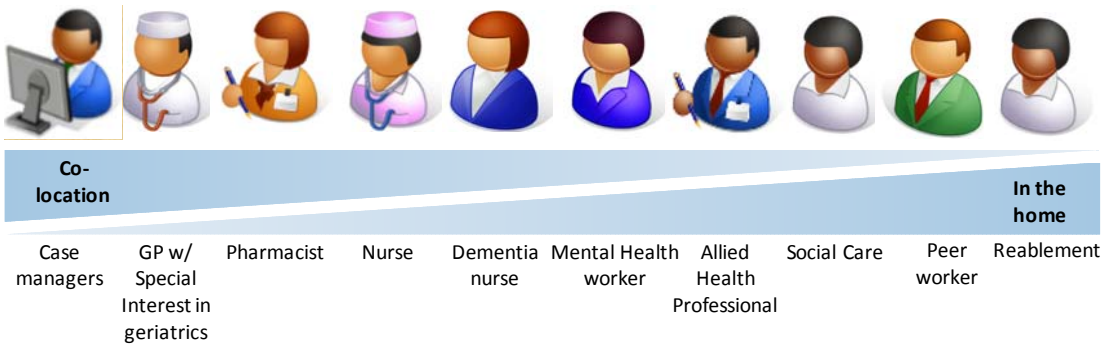
1 Specialists in both inpatient or outpatient settings
2 Includes primary care physicians, advanced practice nurses, physicians assistants
Source: Carnall Farrar

It is important to recognise that this type of local care model will require a mix of different primary care professionals working as a multidisciplinary team and is in part designed to

make best and most sustainable use of the GP as the expert generalist to improve outcomes. The chart below draws out the range of skills that may be needed.

We are exploring ways to strengthen the teams around GPs, particularly for population segments that need coordinated care in the community

Multi-disciplinary team model for older people with complex needs



In the regional workshop, we agreed that we would seek to put a model or models like this in place across the West of Scotland recognising that there could be significant variation in how we might implement it locally. As a region, we intend to as a minimum:

- Share best practice across Integration Joint Boards
- Estimate the impact of local care models so that we can design the future need for beds
- Agree on the regional need for investment to make the business case together
- Ensure the enablers of local care in place, including workforce, technology and facilities
- Communicate to the population of West of Scotland an expectation of what can be provided locally and where hospital care is needed.

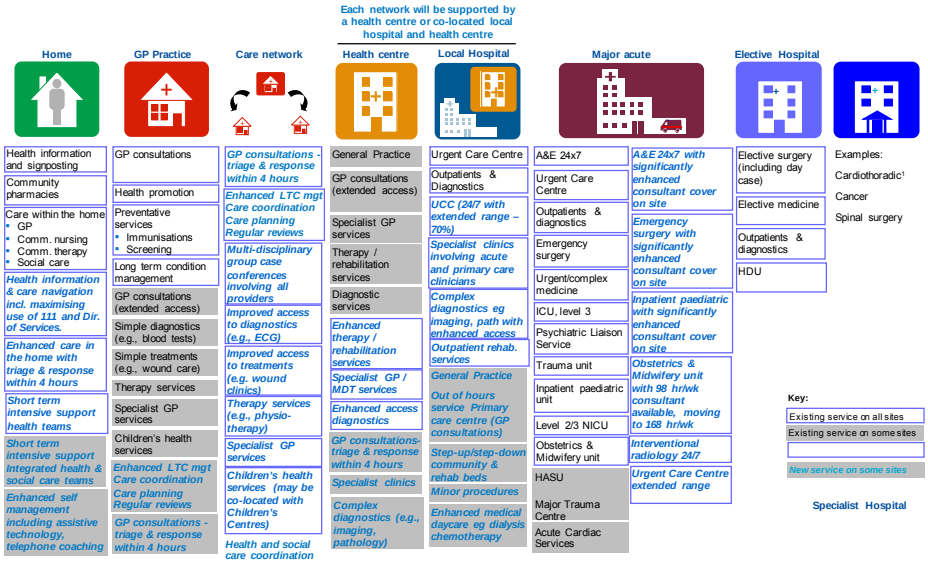
Designing hospital care to deliver safe and sustainable services

As a region, we have explored taking a tiered approach to hospital care, with clearly defined services at each site based on the needs of the population, meeting clinical standards, having the minimum volumes needed to build and maintain staff skills, and the availability of skilled staff for each specialty.

In practice, this would mean moving low volume specialties around different hospital sites; with some higher level hospitals will specialist services. Other hospitals would not have every service but would work through networks.

An example of how a tiered approach might look in the acute sector, as well as how some care services currently provided in acute may move to other models or setting of care models is outlined in the exhibit below.

Illustration of region-wide framework for local and acute care models



In the engagement workshop, it was agreed to explore this approach for the March submission and detail the factors and process that would be considered in such a decision, including assessing different options for clinical safety, availability of workforce, the amount of time it would take patients and families to get to services, capital investment needed, and operating costs.

Putting in place the key enablers

To deliver these care models, many enablers will need to be in place. The exhibit below outlines our early thinking on the different enablers that will need to be planned for in our March plan:

1 Workforce	People will be at the heart of the system that we are building, they are our greatest asset. The new care model will require staff and partners to work differently and will also require new roles to be developed.
2 Organisational development	Training, upskilling and behavioural change are crucial to enable leaders, professionals and teams to work together differently to deliver the new care model.
3 Estates	Estates resources need to be understood. The new care model will be enabled by the creation of a regional capital strategy, considering additional space required; repair, repurposing or disposal of existing space. Exploration of estate and infrastructure for both health and local authorities will be essential to optimise use of facilities and capital funding investment.
4 Information	The new care model will need to be enabled by integrated patient data to allow clinicians and care professionals to plan, and deliver the care needed for our population. Information is also crucial to enable long term, innovative solutions and drive productivity improvements.
5 Financial model	The current financial models and service level agreement arrangements across organisations within the region require to be reviewed as they contribute to the fragmentation in the system, and do not support integrated population based care. A new approach is needed to align organisations around a common purpose, provision of services across the region, nurture collaboration, drive cost savings and support system-wide decision making.
6 Governance	To support the integrated system and achieving a shared vision, appropriate governance is essential to enable the organisations to work together effectively as the system transitions into a new delivery model. This will require clear roles and responsibilities, with engagement from the right stakeholders.
7 Comms and engagement	The public and staff need to be engaged throughout and consulted appropriately. A detailed and robust internal and external communications and engagement plan is required, backed up by the resources to execute it.

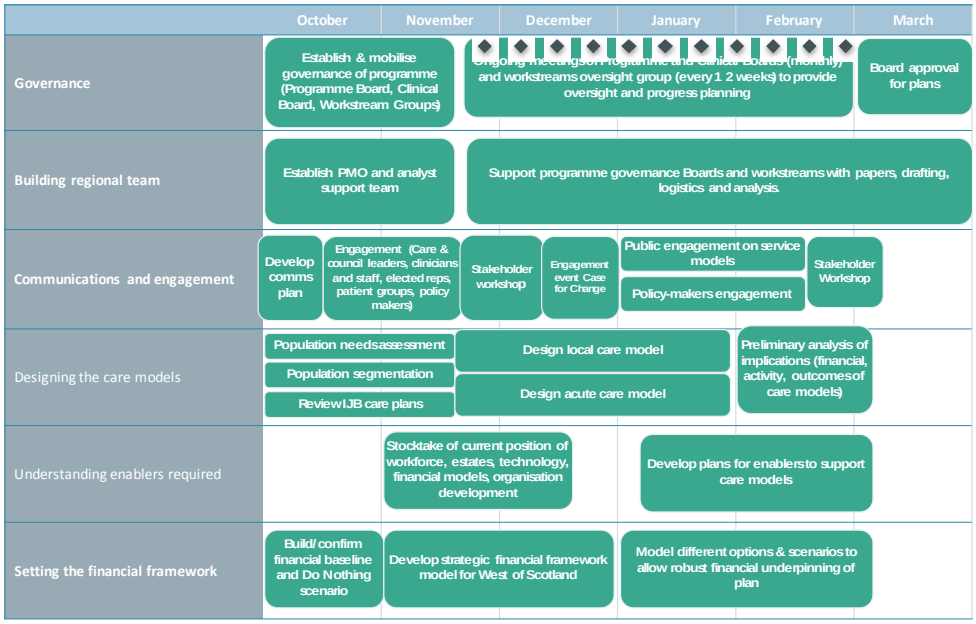
Taken together, we believe these proposals for designing our care models are consistent with the National Clinical strategy, particularly when planning local services around individuals, population segments and their communities, and planning hospital networks at the appropriate level recognising availability of skilled workforce.

9. West of Scotland Structure and Planning Approach to Deliver the Regional Plan

To deliver our regional plan by end-March, we have developed a workplan that covers:

- Governance
- Building the regional team
- Communications and engagement
- Designing the care models
- Understanding enablers required
- Setting the financial framework

This work and the timeline is illustrated below and detailed further in the rest of this section.



9.1. Governance

We are putting in place the following governance arrangements:

- NHS Board Chairs form an assurance and scrutiny group. It is anticipated that this group will develop to include representation from IJB chairs.
- West of Scotland Health and Social Care Delivery Group. This group is chaired by the Regional Implementation Lead. Membership includes CEOs, Chief Officers, Partnership, Employee Director Rep, and leads for Nursing, Medical, HR. We are also engaging with COSLA/SOLACE on including representation from Local Authorities.
- We are exploring the establishment of a Clinical Board/Senate whose scope could include: 1) deepening and owning the case for change, 2) providing clinical input into care model decisions and 3) providing clinical leadership to the process and signal clinical backing of the regional work.

9.2. Building the regional team

Developing the plan and preparing for implementation is going to require building a regional team to support this, the scale of which will depend upon the final scope of work agreed for the region.

The overall effort will be led by the Lead Chief Executive (John Burns) and the Director of Regional Planning (Sharon Adamson). We will be mobilising 5 strategic work streams led by a Chief executive or joint leadership with a Chief Officer to develop detailed plans for each area:

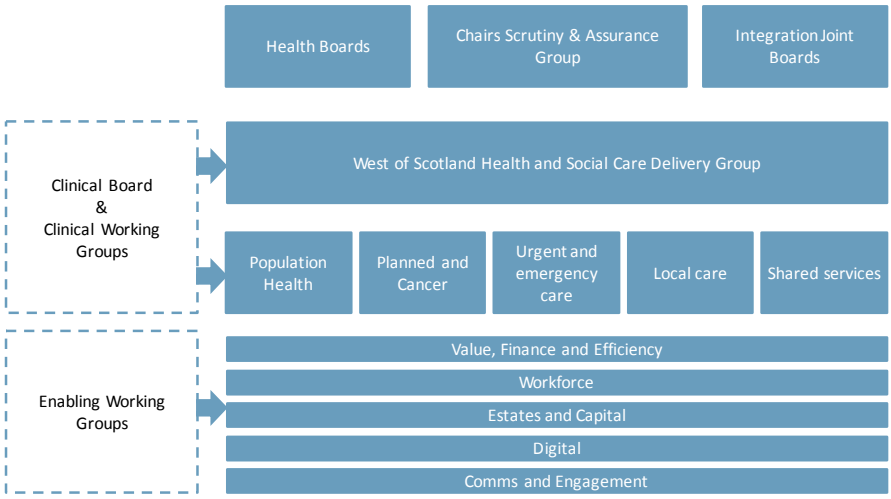
- Population Health
- Planned and Cancer Care
- Urgent and Emergency Care
- Local care
- Shared Services (including links to National Work e.g., Once for Scotland)

Supporting this work is a number of enabling work groups:

- Finance
- Workforce
- Estates and Capital
- Digital
- Communications and Engagement

The chart below maps out our current thinking on the arrangement of governance and workstreams for the West of Scotland:

West of Scotland Region – Programme Structure



Furthermore, there is work underway from the previously agreed regional priorities that will continue and will inform the new regional delivery arrangements, including reviews of:

- Urology
- Ophthalmology
- Trauma and Orthopaedics

- Major Trauma
- Maternity and Neonatal
- Systemic Anti- Cancer Therapy Provision
- Interventional radiology

9.3. Communications and Engagement

All of the areas outlined above need to inform the change in conversations across the system with the public, with the various staff involved, the different organisations and the roles that we all need to play in achieving this, thereby setting the expectations of how we will behave and act to encourage success.

There has been considerable engagement work undertaken by the Health and Social Care Partnerships in developing their Strategic Commissioning Plans. Engagement findings from the National Clinical Strategy and through the National Conversations work also offer views that can inform the approach we are taking and can be built upon as we develop the regional delivery plan.

Critical to success is describing the functional relationships required to progress this and achieve success, recognising the importance of conversations rather than plans in driving change. As part of this we need to provide an environment that supports the enacting of change.

Initial Engagement will look at:

- Developing and sharing key messages around regional planning and the case for change; considering what Scottish Government will lead and what will be regional and local
- Ongoing Engagement
  - Identifying key stakeholders – internal and external, targeting our approaches to support different stakeholders needs
  - Setting out the messages around the population health need, considering service models and the views of the public on service requirements
  - Setting out the emerging thinking on the future service models and implications to provision

9.4. Designing the Care Models and Understanding the Enablers Required

As outlined in section 8.2 above we believe there are four elements to designing interventions that will be transformative and allow us to meet our four aims as a region:

- Understanding the needs of different segments of the population (both now and how it will change over time) in order to identify those that need targeted interventions to care models.

- Addressing as much care as possible proactively and locally in primary, community and social care.
- Designing our acute and community hospitals around the need for safe and sustainable acute care following the local care intervention.
- Putting in place the enablers to allow these interventions to be successfully implemented.

We have quite rich data from ISD around population segmentation and are working with public health colleagues on a population needs assessment for the region. Based on this work, we propose to do a quick effort to prioritise population segments where we would look for better care models to improve their care.

We will then look to produce with IJB colleagues, informed by their existing plans as well as local and international best practice, the common elements of local care models that the population of the West of Scotland can expect to be delivered by IJBs. We expect to have by end-March a clear description of how local care models will be experienced by people in the West of Scotland, an analysis of activity shifts between acute and local care, a business case for the system from these investments, as well as an implementation plan for these models of care.

In parallel with this local care model work, we will be building activity and financial models that will allow us to understand the implications of local care models on the bed requirements and service configuration in the acute sector. By end-March, we expect to have a view on what this will mean in terms of:

- Centres of excellence, particularly for low-volume, high-complexity care
- Organisation of elective and emergency services
- A model for different levels of hospitals and the services they will provide
- An alternative model for providing excellent urgent and emergency care

When designing care models, we will also develop a view on the implications for enablers of these care models, including:

- The implications for estates and infrastructure across the public services, including how best to use the existing estate across hospital sites, primary care and social care.
- Understanding the skills and competencies, as well as numbers, of staff required to support the emerging models, creating a position to influence training and education for the future.
- Understanding of how the future developments in technology might influence the care and models required to better inform the planning beyond 2025 and the potential impact on the different parts of the system. This will consider the opportunities digital health offers, linking with national work.

9.5. Setting the financial framework

In parallel with the care model work, we intend to build a regional financial framework that will:

1) set out the current baseline for the region and the do nothing scenario over a longer period than we have currently projected.
2) allow us to model the impact of care model interventions and changes to key revenue and cost assumptions.
3) Determine a different approach to the finance models to support more effective cross system working
4) outline the business case for interventions at a locality level, board level and regional level.

10. Next steps

With the other regions and the National Boards, we have identified a set of next steps that we should also address collaboratively which the national boards will lead to support the development of the regional delivery plans.

10.1. Collaborative Contribution from the National NHS Boards

As part of developing our regional delivery plans we will also consider the services, functions and support that are best delivered on a national basis; and which can contribute towards the management of demographic financial and workforce pressures. To that end we will work closely with the National Boards over the next few months to refine, develop and prioritise the initial propositions that they have set out.

10.2. Service Transformation – Demand Management

With NHS24 and the Scottish Ambulance Service we will develop plans to

- implement, at scale, the proposals for practice level GP Triage
- reduce the volume of out of hour callers to NHS24 and 999 callers requiring further support from primary and secondary care;
- develop a triage service for return appointment patients and outreach telehealth clinics;
- roll out computerised CBT and improved pathways for those contacting NHS24 and the Scottish Ambulance Service in mental distress.

10.3. Supporting Recruitment, Retention and Improving the Employment Experience

We will work with NES, NSS and others to co-ordinate national and international campaigns to promote careers in health and care in Scotland and to link careers advice and marketing support to the new NHSScotland national recruitment system.

We will also continue to work to improve the employment experience for all our workforce; including rolling out the arrangements to reduce the number of employers of Doctors and Dentists in Training.

We will work with NES, NSS, SSSC, the Care Inspectorate and others to develop an accessible, user designed data platform which provides access to data on the existing and the 'in-training' workforce and to analytical tools which can help to inform the development of different workforce scenarios supporting local, regional and national planning.

10.4. Digital Transformation

It is essential that we transform our digital landscape to enable the public and healthcare staff to access information, resources and services from smart phone technology in the same way as they access retail, transport, and similar services in other spheres of their lives. Part of the work we will progress is to ensure that we can use technological advances in robotics and artificial intelligence to meet the challenges that face us now, and in the future.

Working with the National Boards we will seek to create clarity about technical and usability standards that will support intuitive applications that are capable of delivery across boundaries and which support the scale up and spread of proven innovations to ensure the benefits of technology are accessed across the whole system at pace.

10.5. Once for Scotland

We will continue to work with the National Boards to develop new models of delivery for services such as procurement, radiology, aseptic pharmacy, laboratories and clinical engineering.

We will also work with the National Boards to implement the strategy for NHSScotland Business Systems, which is predicated on moving to Cloud based, Software as a Service models for a joined up approach to Finance, HR and Payroll (moving away from legacy systems and from managing these systems in individual silos). This will provide a core infrastructure which will facilitate the development of shared business services in our regional structures.

11. Statements of Intent

In advance of the submitting the regional delivery plan in March 2018, we intend to:

1. Develop and publish a clinical case for change.
2. Come together as regional leaders of our health and care system and set out a comprehensive programme to deliver our vision and common purpose.
3. Develop a region-wide planning process that will describe what will be planned and delivered by whom at national, regional and local level.
4. Assess the care needs of our population, taking into account the different needs of individuals and segments of the population.
5. Develop local care models for the highest priority population segments and model the impact of these interventions on future acute capacity requirements.
6. Develop a stratified model of local and acute care setting out the different levels of service provision in the different facilities across the region; understanding the implications for future service configuration.
7. Hold engagement sessions with our population, frontline staff and policy-makers to inform them of the regional delivery plan and allow them to shape and coproduce it with us.
8. Develop a view of the impact of this plan on the future capital investment requirements for the region, including hospital and out-of-hospital infrastructure.
9. Assess the impact of this plan on our workforce and outline our future workforce strategy; informing future training and education requirements.
10. Evaluate the impact of the implementation of this strategy on finance and activity and outline a financial plan to support implementation.

Appendices

1. Population Health Needs Assessment Summary Information
2. Demand and activity
3. Workforce
4. Communications and Engagement Plan

Appendix 1

Population Health Needs Assessment Summary Information

Understanding the Population

A Health Needs Assessment for the West of Scotland is currently being progressed; a significant number of analyses have been identified and undertaken which will support the work over the coming months to consider the service model and provision for health and care services for the region. Beyond the work to consider the population age, gender deprivation levels and the implications of this both in relation to health and social care provision, use and funding levels, work is considering the use of services, life expectancy and health outcomes; reviewing the trends in this over the last decade or longer.

Population Needs Assessment: Emerging Findings

- West of Scotland has some of the council areas with the highest proportions of oldest residents in terms of population percentage over 65; as a whole it differs significantly from the Rest of Scotland (RoS) by having a slightly greater percentage of young people aged 0-15 years and a considerably smaller percentage of the very elderly aged 90+ (appendix Table1).

  Table1: Age distribution for a recent year, 2016, for Scotland, NWoS, RoS, and component areas of the NWoS. Source: NRS.

	% of population by age group				
	0-15 yrs	16-64 yrs	65+ yrs	75+ yrs	90+ yrs
Scotland	16.9%	64.6%	18.5%	8.2%	0.76%
GG&C	16.7%	66.8%	16.4%	7.6%	0.72%
FV	17.4%	64.1%	18.5%	8.0%	0.70%
Lan	18.0%	64.3%	17.7%	7.6%	0.59%
D&G	15.8%	59.5%	24.7%	11.0%	0.98%
A&A	16.8%	61.5%	21.7%	9.4%	0.85%
A&B	15.2%	60.1%	24.7%	10.7%	0.99%
NWoS	17.0%	64.6%	18.4%	8.2%	0.73%
RoS	16.9%	64.5%	18.6%	8.2%	0.79%
RoS/NWoS ratio	99.1%	99.9%	101.1%	100.6%	108.9%
NWoS/NoS ratio	**100.9%**	100.1%	98.9%	99.4%	**91.8%**

- It also has most of the most deprived council areas in terms of summary SIMD score (Glasgow city, West Dunbartonshire, Inverclyde, Renfrewshire, North Lanarkshire, East Ayrshire) and the bulk of the population residing in the most deprived deciles and quintiles. Appendix Table 2 and Figure 1.

Figure 1: Map of Scotland, showing the three regions and the distribution of 2016 SIMD quintiles, by datazone. Source: P Barton, NHS GG&C.

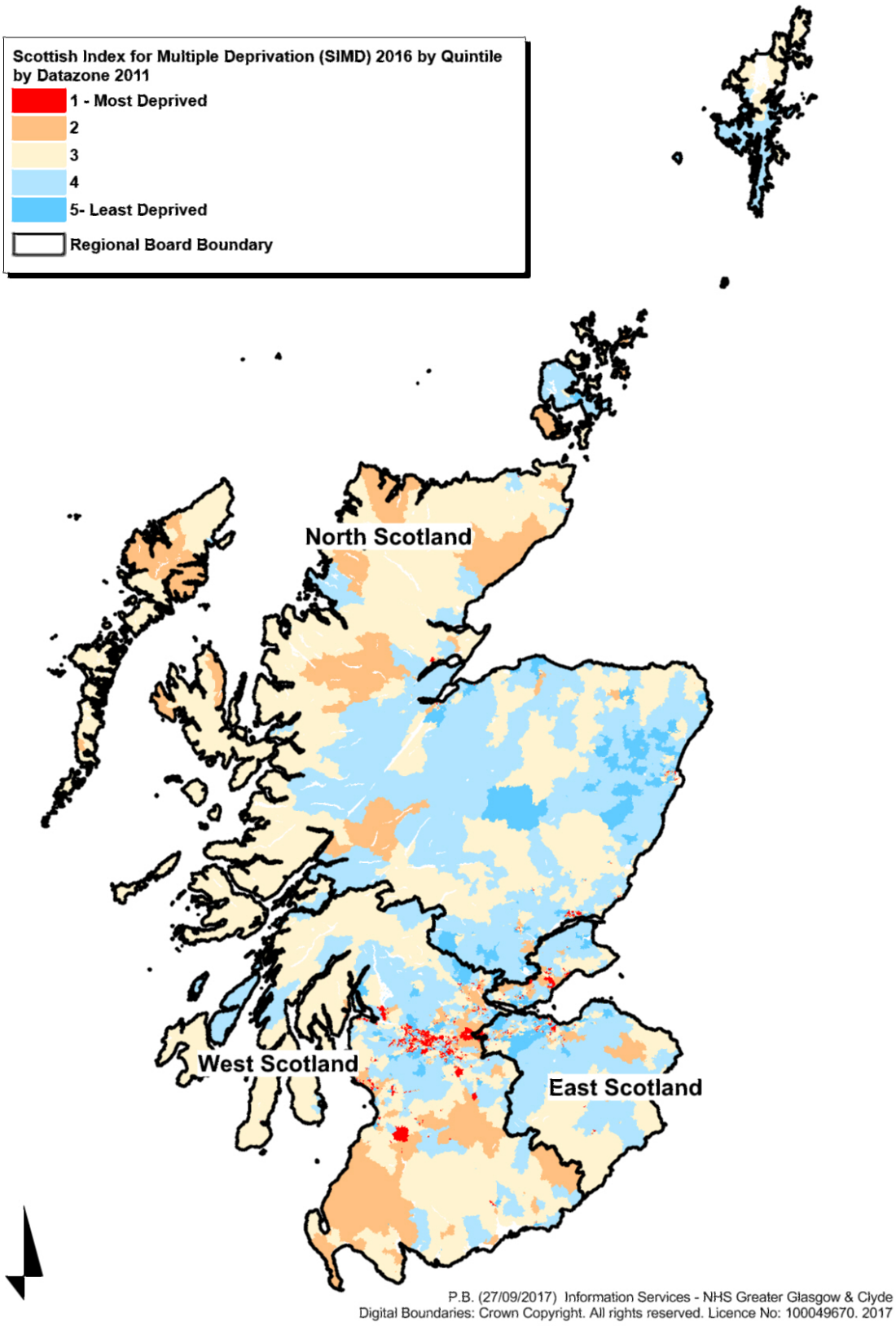


Table 2: Distribution of the Scottish population by SIMD decile and region using ISD weighted population. All figures are based on SAPE 2016 and SIMD 2016. Source: M Grimmer, NHS GG&C.

	Total Population				Percentage of Area Population			
Decile	East Scotland	North Scotland	West Scotland	Scotland	East Scotland	North Scotland	West Scotland	Scotland
1 (most deprived)	72,238	47,996	420,087	540,321	5.3	3.7	15.4	10.0
2	121,262	64,881	352,690	538,833	8.9	5.0	12.9	10.0
3	137,275	93,302	307,082	537,659	10.1	7.1	11.3	9.9
4	136,167	110,211	292,832	539,210	10.0	8.4	10.7	10.0
5	142,166	145,656	249,297	537,119	10.4	11.1	9.1	9.9
6	131,921	167,475	241,106	540,502	9.7	12.8	8.8	10.0
7	141,408	198,350	204,901	544,659	10.4	15.1	7.5	10.1
8	120,668	191,247	230,667	542,582	8.8	14.6	8.5	10.0
9	139,257	149,726	254,340	543,323	10.2	11.4	9.3	10.1
10 (least deprived)	222,498	141,446	176,548	540,492	16.3	10.8	6.5	10.0
Total	1,364,860	1,310,290	2,729,550	5,404,700	100.0	100.0	100.0	100.0

- Both social deprivation and agedness of the population place major demands on the health and care systems. Analysis of the SMR01 dataset for hospital activity shows that the elderly, who are also deprived, are particularly high users of unscheduled services and considerably outnumber the elderly affluent in key board areas such as GG&C.
- The challenges of equitable service uptake and provision, based on need rather than demand in a geographic area that also has considerable sized areas of affluence, results in smaller National Resource Allocation Committee (NRAC) and Scottish Allocation Formula (SAF) shares for hospital & community services and GMS services, respectively. The challenge to meet the level of the need with the level of the service provided will exacerbate the falling historical and projected crude population share of the region as whole and those of the WoS health boards individually to ensure a considerable drop in the equivalent target shares to 2039. Figure 2 shows the projected population estimates for the WoS and the RoS and Figure 3 shows the falling crude population share for the WoS and the rising crude population share for the Rest of Scotland). The WoS is projected to expand only modestly over the next 20 years whereas the percentage rise in the population of the Rest of Scotland will be 6 times greater. ASHD of the SG has agreed to our request to calculate all NRAC parameters, including historical and projected target shares, for the WoS, EoS and NoS.

Figure 2: Projected populations for the NWoS and the RoS, between the baseline, which was 2014, and 2039. Source: NRS. (Breakdown by Board available)

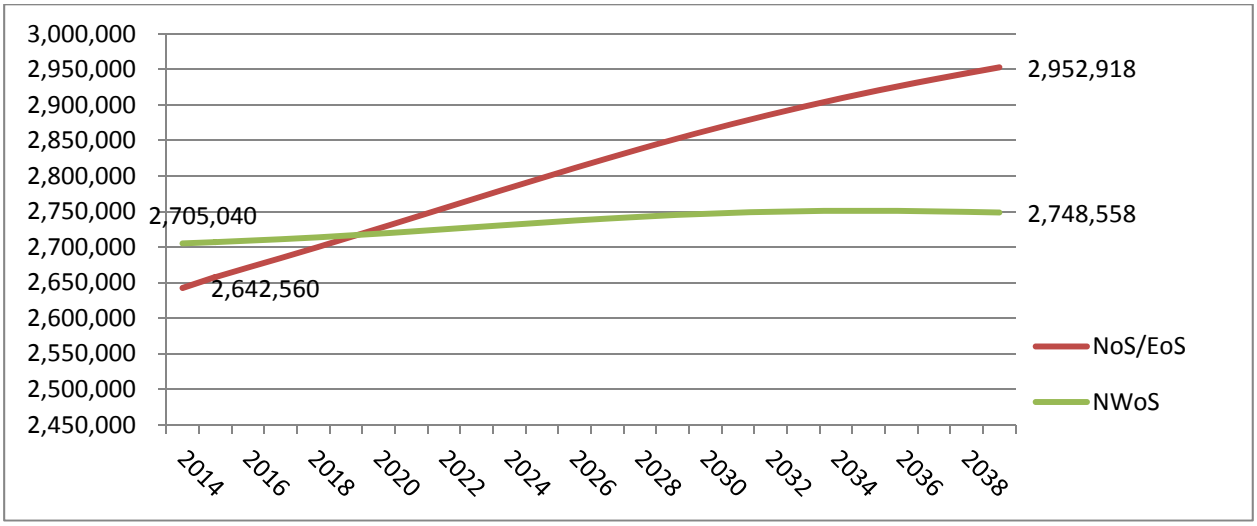
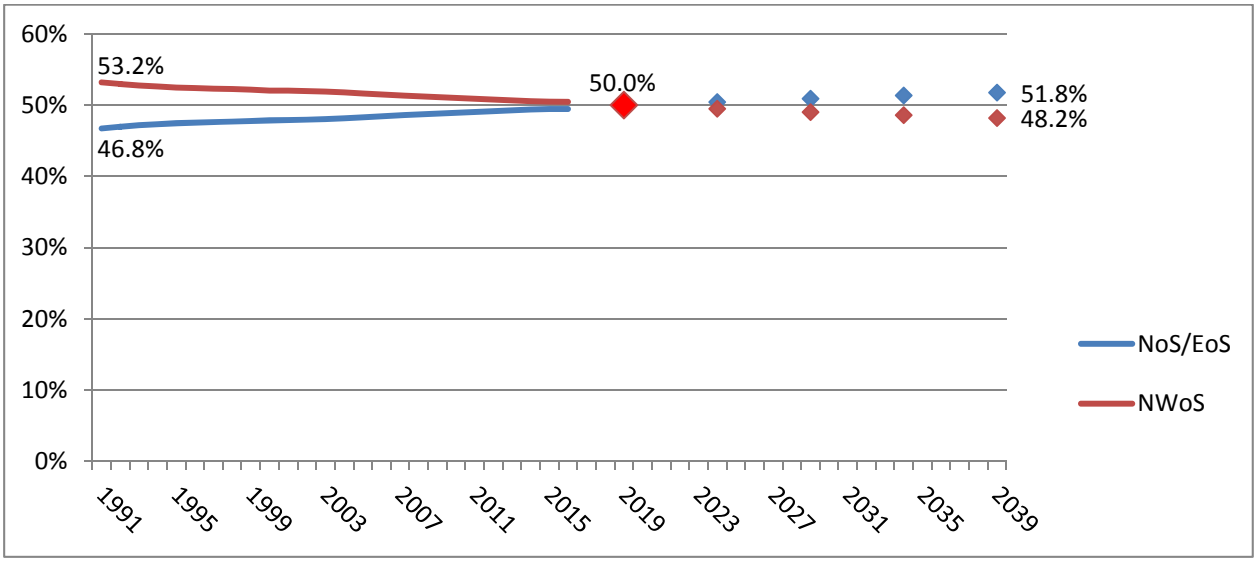


Figure 3: Historical (solid line) and projected (diamond datapoints) for the New West of Scotland Region and the Rest of Scotland (NoS/EoS), 1991-2039. Source: NRS Scotland. (Breakdown by Board available)



- Plateauing of the life expectancy at birth is seen for Scotland as a whole, which is particularly clear for Scottish males (see red arrow in Figure 4), and evidence of unexpected downward shifts in the life expectancy trajectory are visible in some areas within the WoS region (see downward red arrows in Figure 5, which relates to females, which are unprecedented in scale or duration over the entire study period).
- Life expectancy for those who reach 85 years of age appears to have declined since 2009/11, for both genders, but particularly for females (Figure 6). This drop appears to

have occurred earlier for D&G males (after 2009), after 2011 for Lanarkshire males and very recently for A&A, FV and GG&C males (Figure 7).

Figure 4: Life expectancy at birth for Scottish males and females, 2000/2 to 2013/15. Y axis truncated. Source: NRS Scotland.

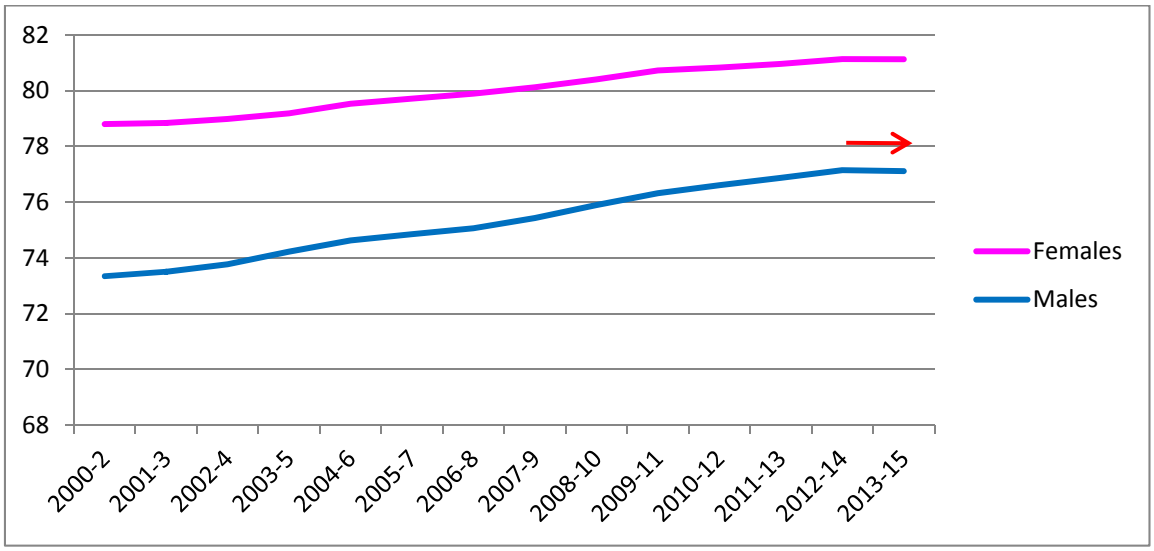


Figure 5: Life expectancy at birth for females by area, 2000/2 to 2013/15. Y axis truncated. Source: NRS Scotland.

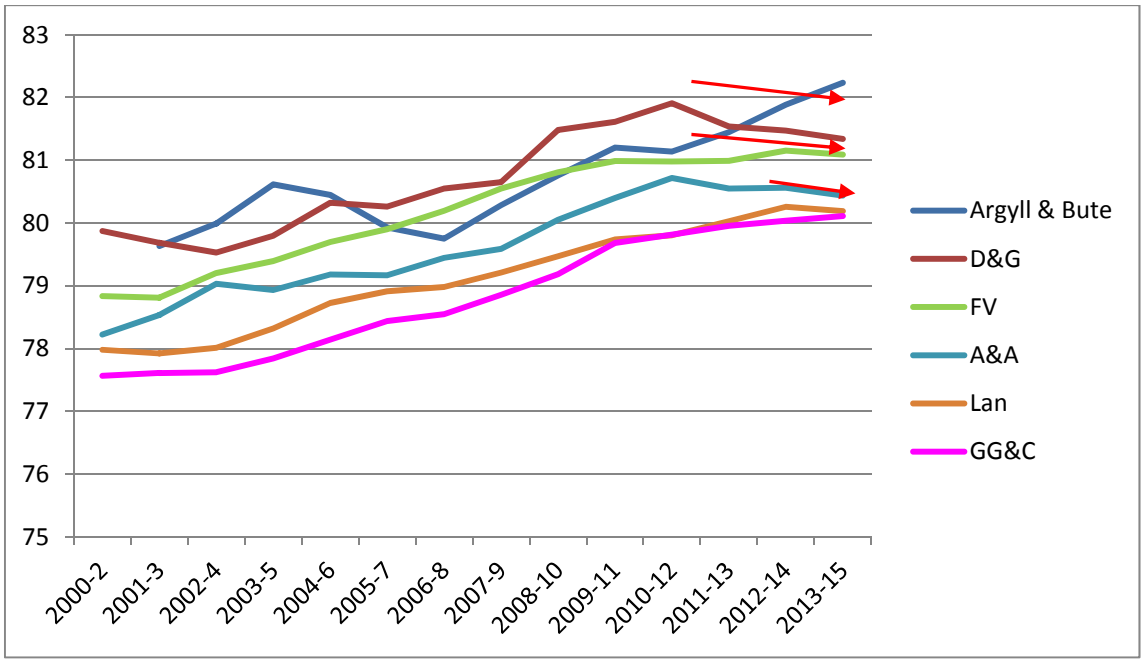


Figure 6: Life expectancy at age 85 years for Scottish males and females, 2000/2 to 2013/15. Y axis truncated. Source: NRS Scotland.

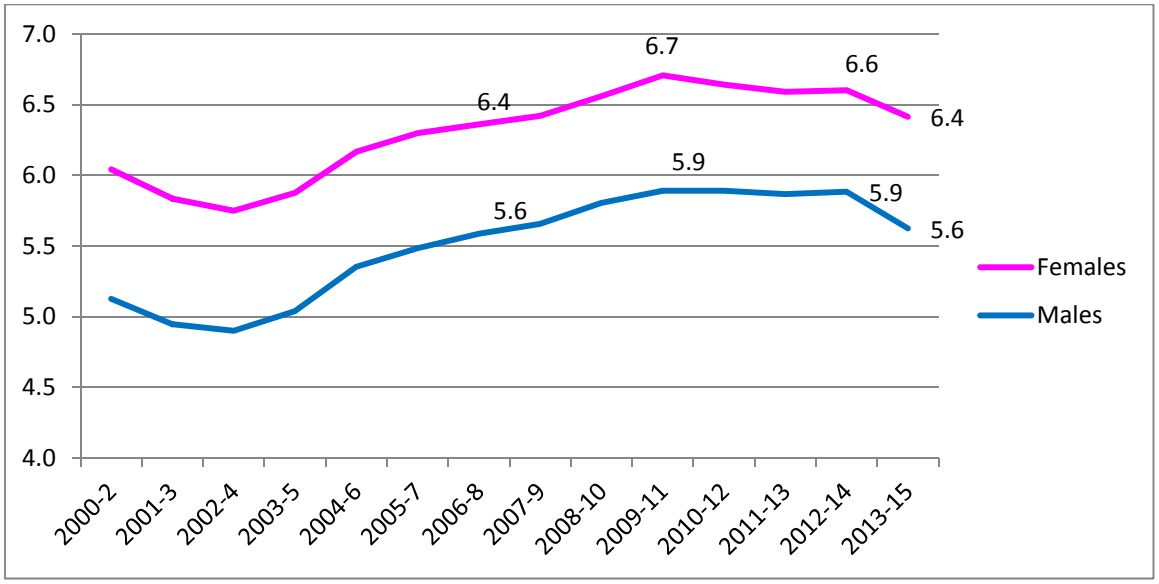
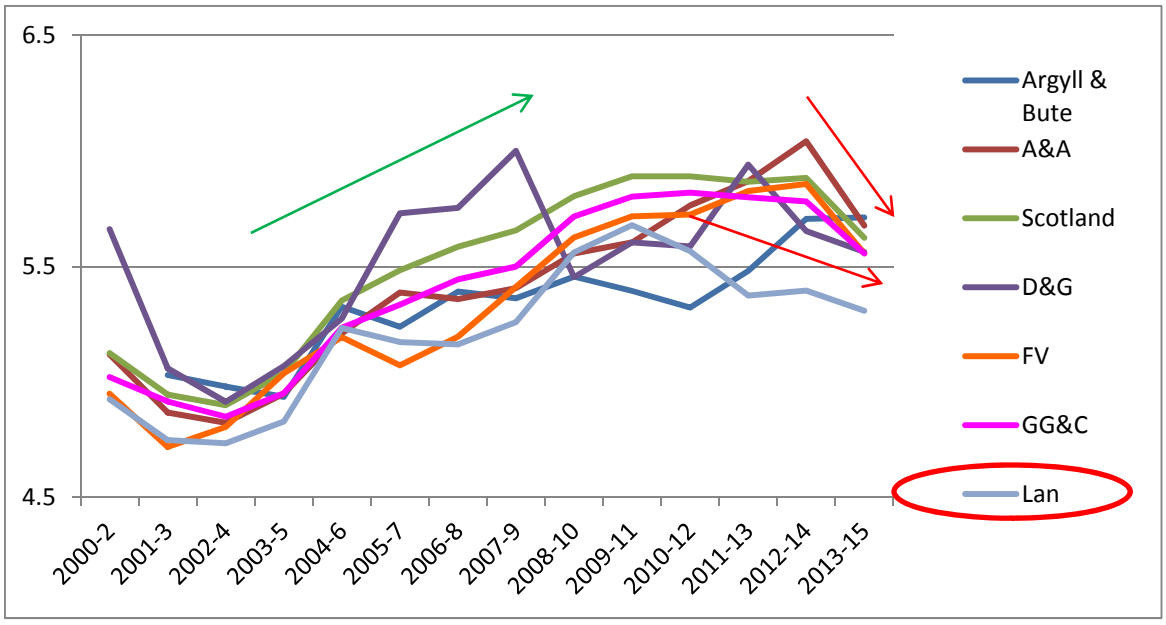


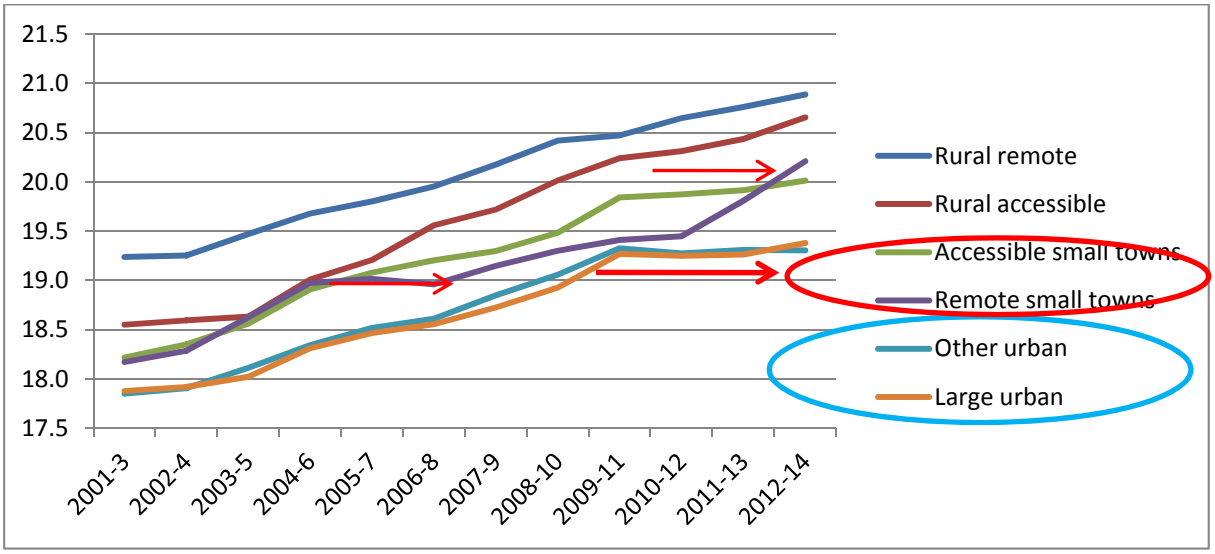
Figure 7: Life expectancy at 85 years for males by area, within the WoS, 2000/2 to 2013/15. Y axis truncated. Source: NRS Scotland.



- Furthermore, when the life expectancy of Scots who reach 65 years of age are categorised using the urban rural classification, some trendlines appear to experience a lengthy plateau including those living in accessible and remote small towns, but also the lines for those living in large and other urban areas, as shown for females at age 65 (Figure 8). This raises the possibility that some of the drop in life expectancy in A&A and D&G as a whole is due to a stalling of LE in older people in accessible (more recent) and remote small towns (after 2004-6). It is interesting to note that the LE is highest and still

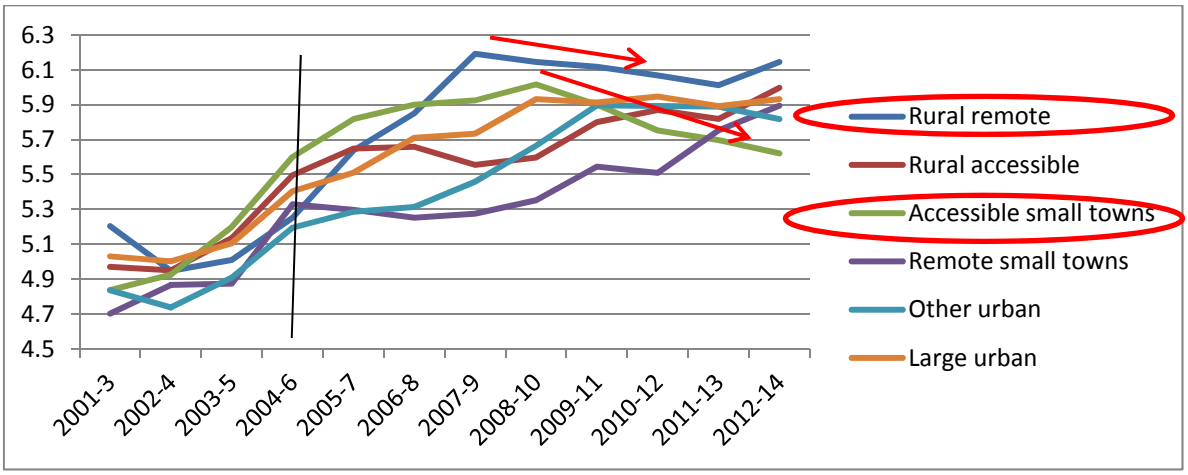
rising for females at age 65 who live in both rural remote and rural accessible areas, suggesting a self-selection effect.

Figure 8: Life expectancy at 65 years, for females, by urban rural classification. Y axis truncated. Source: NRS Scotland.



Nevertheless, any advantage conferred by being elderly and living in rural Scotland appears to diminish for those males in Scotland who reach 85 years of age as shown in Figure 9. There appears to be a prolonged stalling of the previous rise in LE for males at age 85 years living in rural remote areas after 2007-9, despite 7 years of steady improvement.

Figure 9: Life expectancy at 85 years, for males, by urban rural classification. Source: NRS Scotland.



- The stalling of rises, or even clear declines in life expectancy, defy the expectation of ongoing improvements in longevity which are seen in other parts of the world. The cause is likely to be multi-factorial

- the role of the recession in 2008 and exacerbated by recent austerity measures, mediated by
- life style related diseases which include the effects of the high prevalence of obesity, the rising prevalence of Type 2 Diabetes, the stalling decline of smoking prevalence, the contribution made by the rise in alcohol-related deaths, etc
- the relative level of investment in health and social care,
- as well as the current organisational model that may hinder the achievement of optimal efficiency of the current use of resources,
- falling access to primary and secondary health services, and social care, for some sections of the population in both remote/ rural areas and urban areas, as a result of centralisation of acute hospital services, closure/downgrading of community hospitals, falling access to a GP principal who knows the patient (loss of continuity in primary care).

All of these threaten to reverse the progress made by improving structural determinants of health over the past century and increased health service provision over the past 15 years.

- Consistently clear improvements in most health parameters, lesser degree of deterioration, and preservation of, or improvement in, the relative position in the national health league table, are being seen for the residents of the most deprived health board in the West of Scotland, namely Greater Glasgow & Clyde, in terms of standardised death rates from all causes, and standardised mortality ratio for all causes (Figure 10), SMR for cancer mortality for all types (Figure 11a), and specifically for the commonest cause of death, namely heart disease (see Health Needs Assessment report).
- Despite having less social deprivation than GG&C, Lanarkshire's relative position in the standardised mortality (all causes) league table has worsened somewhat in recent years (Figure 10 in Appendix) and its relative position in the cancer mortality league table for all types combined (Figure 11b) and for lung cancer in females has also worsened (Figure 14).
- Perhaps more surprisingly, more rural areas in the West of Scotland, even those characterised by relative affluence such as Dumfries & Galloway (Figure 11c) and Argyll & Bute (Figure 11d), have unexpectedly lost ground and those with historical health deficits, such as parts of Ayrshire & Arran (Figure 11e), appear to have deteriorated further in very recent years. Age/sex standardised death rates (all causes), standardised mortality ratios (all causes of death), and/or SMR for cancer (all types combined) appear to be rising in recent years, for these three board/council areas, the starting points of the rises varying with the area. Even the more affluent Forth Valley, appears to have lost ground with respect to its relative position in the cancer (all types) SMR league table, since its enviable position before 1990 (Figure 11f).

Figure 10: Trends in standardised mortality ratios (all causes of death) for the component parts of the NWoS, 2000 to 2016. Source: NRS Scotland.

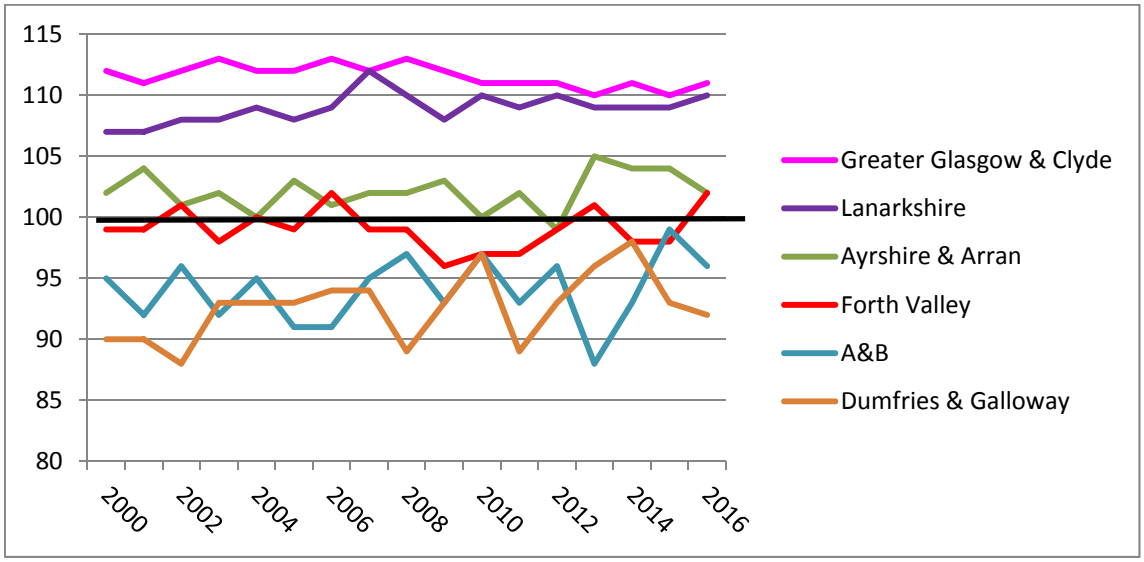
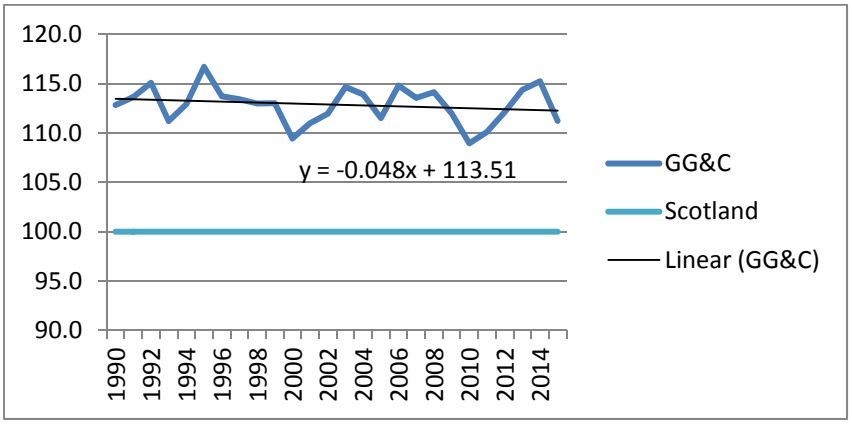
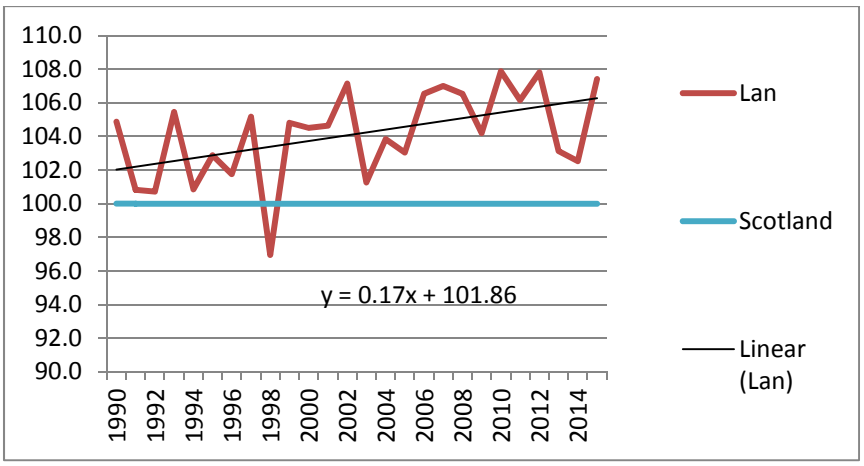


Figure 11: Trends in standardised mortality ratios for cancer (all types combined) for the component parts of the NWoS, 2000 to 2016. Source: NRS Scotland.

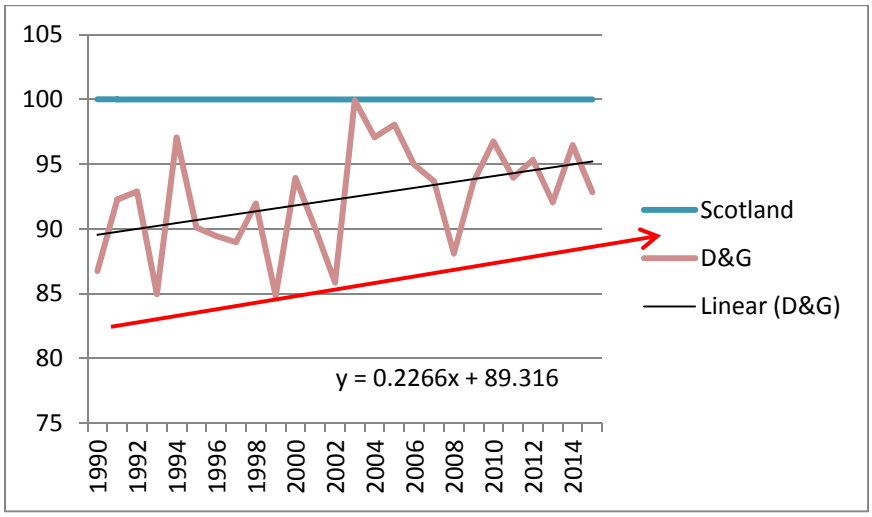
a) GG&C



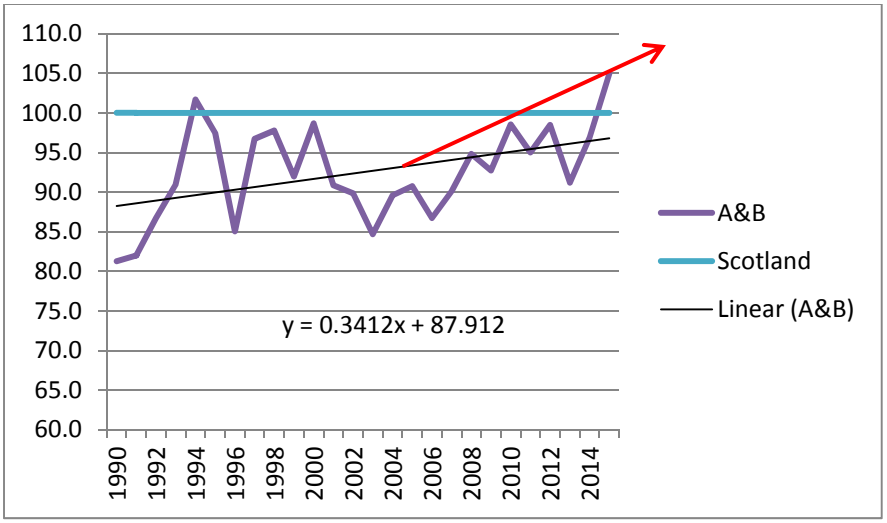
b) Lanarkshire



c) D&G


105
100
95
90
85
80
75
1990
1992
1994
1996
1998
2000
2002
2004
2006
2008
2010
2012
2014
y = 0.2266x + 89.316
Scotland
D&G
Linear (D&G)

d) A&B


110.0
105.0
100.0
95.0
90.0
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80.0
75.0
70.0
65.0
60.0
1990
1992
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1996
1998
2000
2002
2004
2006
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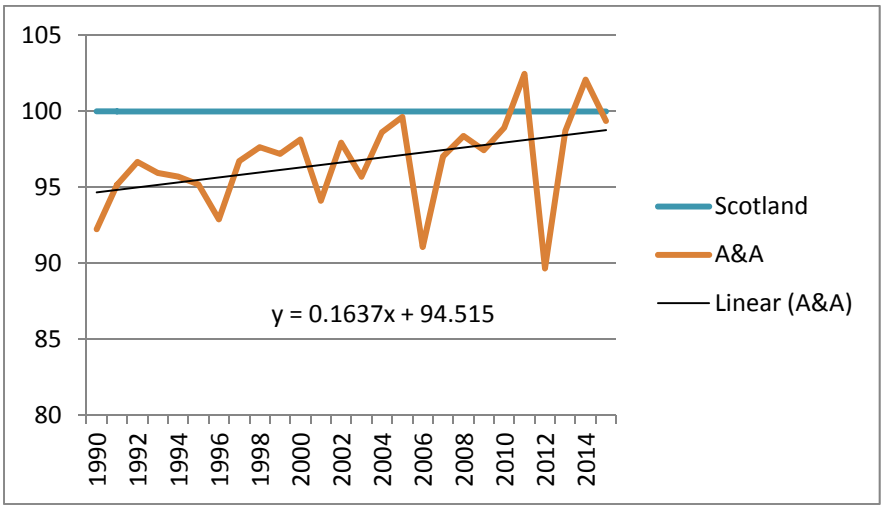
2010
2012
2014
y = 0.3412x + 87.912
A&B
Scotland
Linear (A&B)

e) A&A


105
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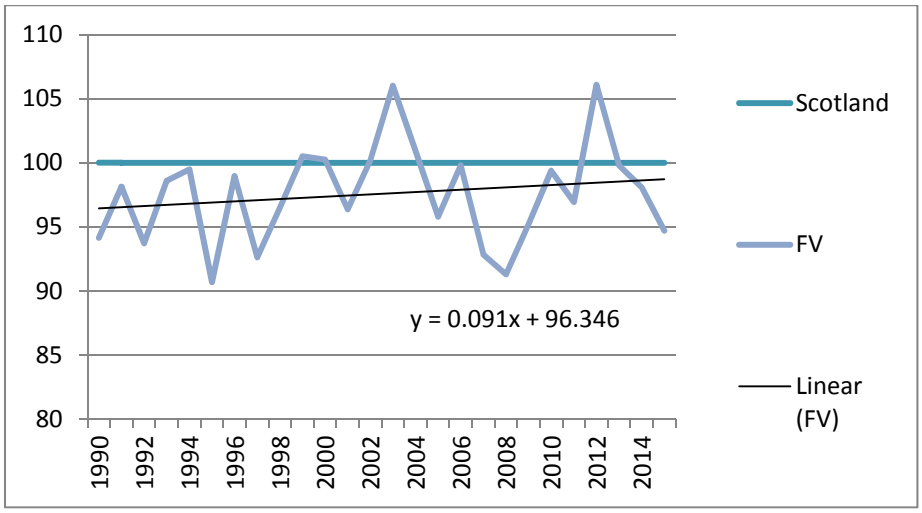
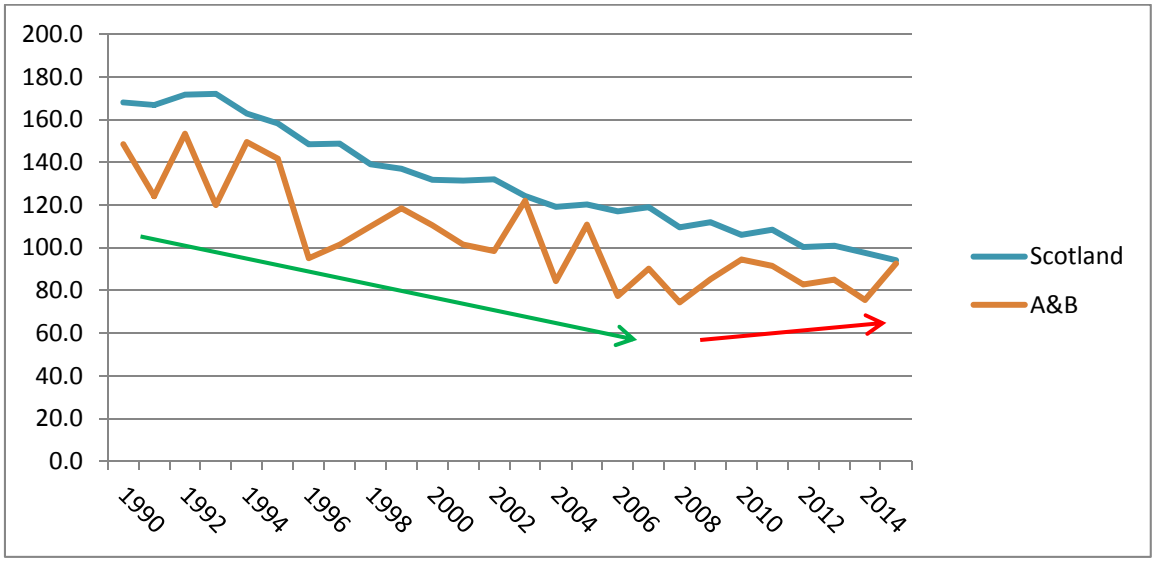
2012
2014
y = 0.1637x + 94.515
Scotland
A&A
Linear (A&A)

f) FV



- For Argyll and Bute males, the age/sex standardised death rate for lung cancer actually increased between 2008 and 2015, at a time when most observers are seeing dramatic declines in such deaths throughout the western world. By 2015, it had reached the national rates, something it had only achieved once before in 26 years (Figure 12).

Figure 12: Trend in age/sex standardised lung cancer mortality per 100,000 person years, in Argyll and Bute males, using the European Standard Population (2013), by year, 1990-2015.



- For Lanarkshire females, the age/sex standardised death rate for lung cancer increased more rapidly than did the Scottish rates such that by 2015, there was a 10.0 point gap opening up between the two trends (shown with the red arrow) (Figure 13). Meanwhile, GG&C females managed to reduce this gap slightly over this time period, emphasising that GG&C either held its ground or improved on it and rarely lost ground regardless of the parameter under study. This converging picture for GG&C vs Lanarkshire, with

respect to lung cancer mortality in females, is highlighted in Figure 14. By 2015, their lines are coming close to touching for the first time (red circle in Figure 14).

Figure 13: Trend in age/sex standardised lung cancer mortality per 100,000 person years, in Lanarkshire females, using the European Standard Population (2013), by year, 1990-2015.

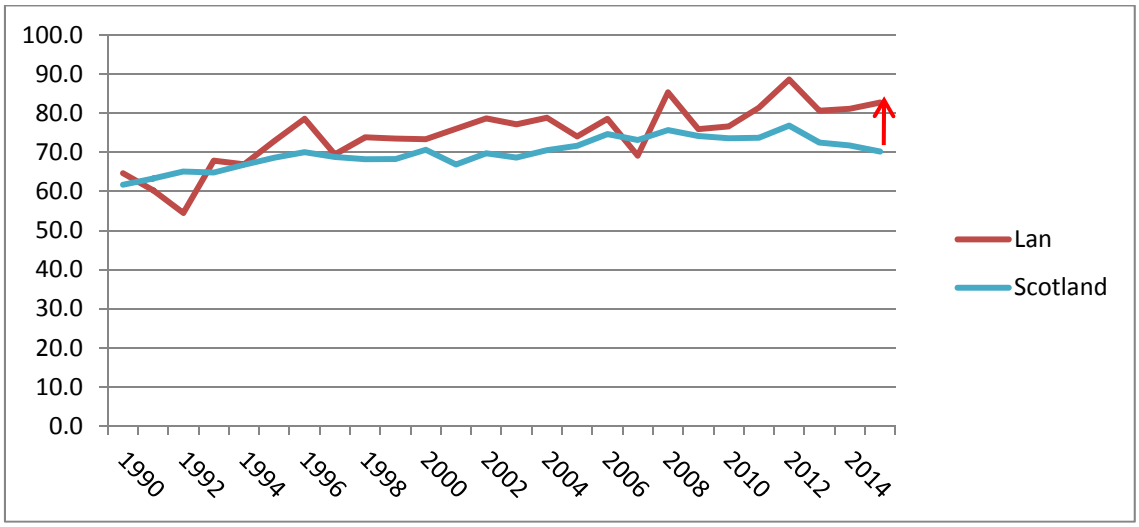
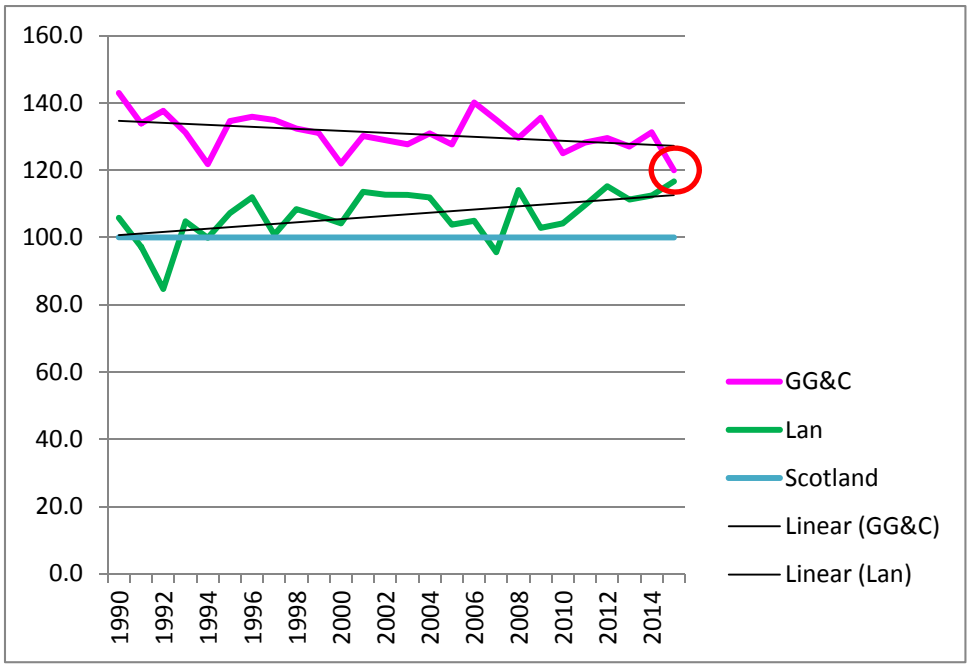


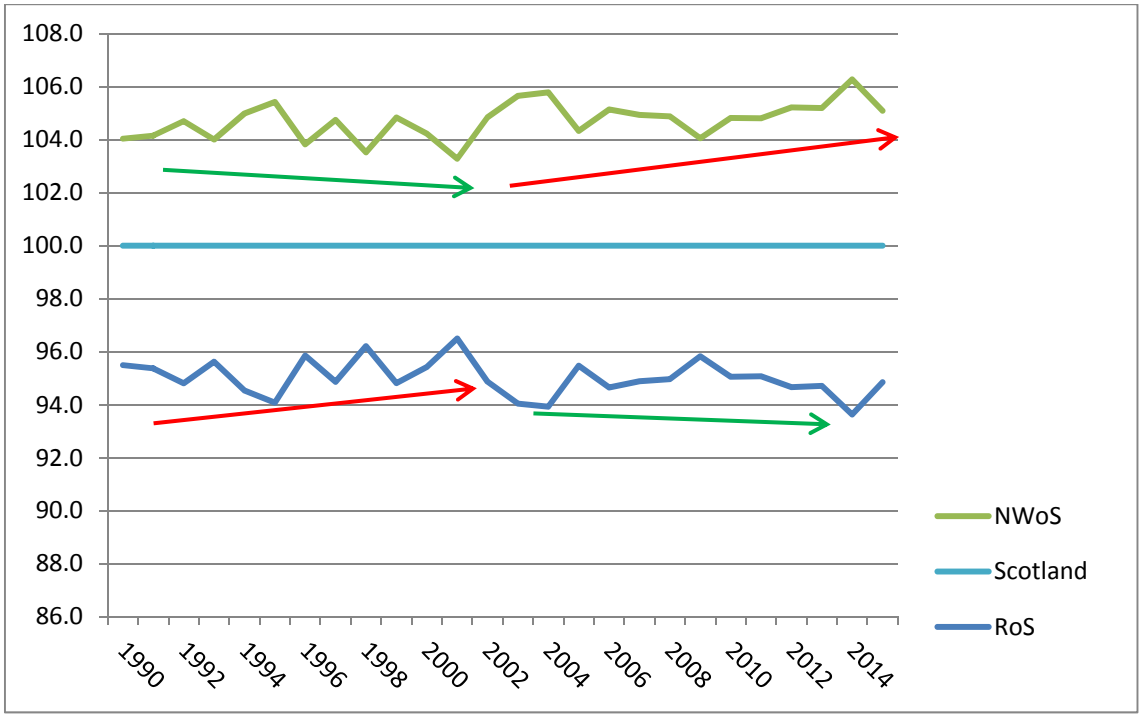
Figure 14: Trend in standardised mortality ratios for lung cancer in females for GG&C and Lanarkshire, showing the relative position compared to the national average (100% for Scotland) by year, 1990-2015.



- A comparative study of the trends of the standardised mortality ratios for cancer (all types combined) for the WoS and the RoS suggests that these changed direction after 2001, starting an upward, worsening trajectory for the NWoS (apart from GG&C

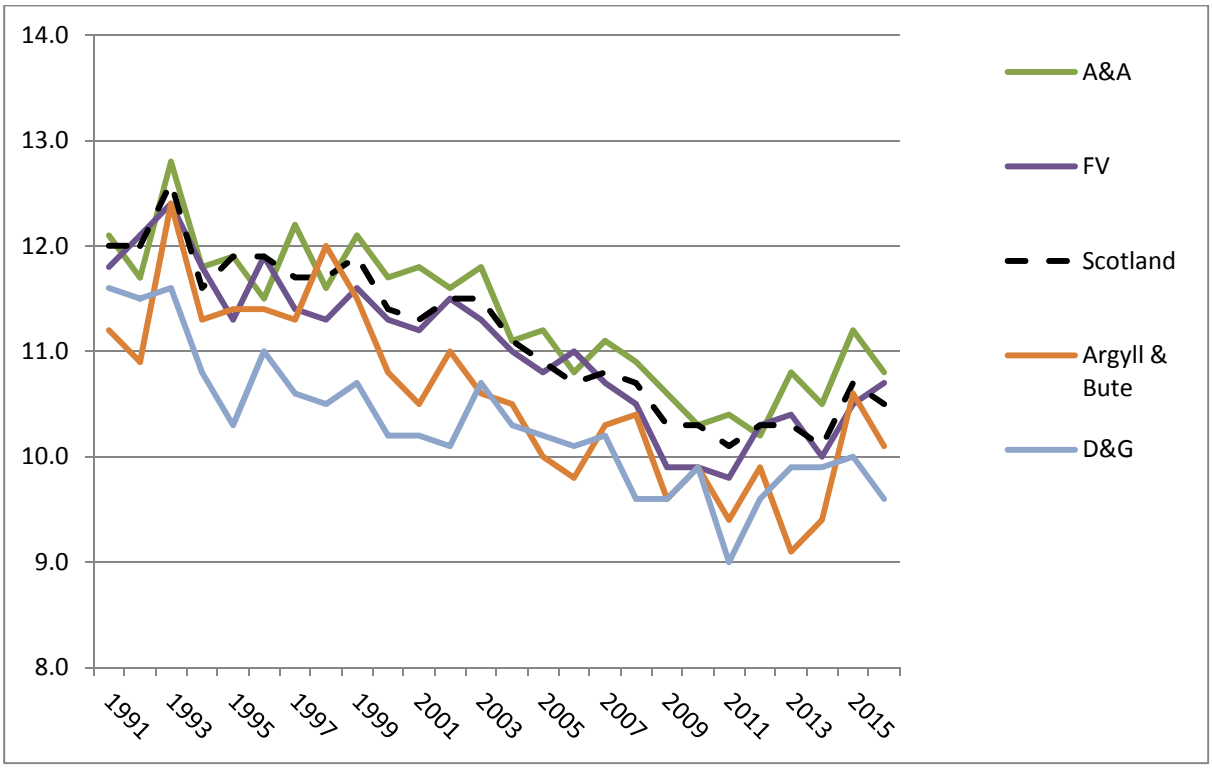
as described above) and a flat or perhaps slightly improving trajectory for the RoS. Identifying what happened after 2001 to cause this worsening relative picture for cancer mortality in 5 of the WoS areas under study is an important aim of the health needs assessment and therefore of any regional plan aimed at improving the targeting and efficiency of service provision (Figure 15).

Figure 15: Trends in standardised mortality ratios for cancer (all types combined) for the NWoS and the RoS, 1990 to 2015. Source: ISD Scotland.



- The only part of the WoS that has improved on virtually every parameter examined is GG&C, well studied for its concentrated social deprivation, and the two obvious mitigating factors to consider are its ability to attract economic investment and its ready access to/supply of health care. The one parameter that showed some loss of ground in GG&C was the age/sex standardised mortality rate for all causes combined, which rose by 2.6% between 2011 and 2016. However, the equivalent rises for the West of Scotland and Rest of Scotland as whole were 4.7% and the 2.1%, suggesting that GG&C behaved more like the Rest of the country (the east half of the country) than its immediate neighbours in the west side of the country . In contrast, the equivalent percentage rises for FV, A&B, D&G, A&A and Lanarkshire for the same 5 year time period were, in decreasing order, 9.2%, 7.4%, 6.7%, 3.8% and 3.6% respectively. The actual trends for the four rural areas that experienced higher percentage rises after 2011 are shown in Figure 16.

Figure 16: Trend in age/sex standardised death rate per 1,000 population, FV, D&G and A&A, both genders combined, using Scotland as the standard population, by year, 1991-2016.



- Extensive analysis (pending) of routinely collected data on the prevalence, incidence, mortality and hospitalisation for both coronary heart disease and all heart disease combined suggests a similar picture, although with ongoing improvements in both GG&C and Lanarkshire and recent small deterioration in the other rural areas under study. The other finding of note is that the overall decline in incidence and mortality for cardiovascular disease in both the WoS and the RoS is only accompanied by a fall in hospitalisation in the RoS. Although higher rates of hospitalisation in the WoS are in keeping with its greater level of social deprivation, a trajectory that is travelling in the opposite direction, ie rising, is difficult to justify.
- Hospital admission rates, for all ICD10 codes (all illnesses and diseases) and types (emergency, elective inpatient and elective day case) are observed to be higher in the West of Scotland than in the Rest of Scotland, based on the crude rates (Figures 17 to 19). The trends are rising for both halves of the country for emergency and elective day case but falling overall for both halves of the country for elective inpatient, in keeping with national directives to move to day case activity. The divergence in the trend lines between the WoS and the RoS over time was greatest for emergency admissions. The temporary plateau in rates for elective inpatient in the RoS between 2011/12 and 2014/15 (Figure 19) was matched with a clear rise in the WoS, which will have exacerbated the ongoing rise in emergency admissions in terms of pressure on what are declining bed numbers.

Figure 17: Emergency inpatient admissions: Crude rate per 100,000 population for NWoS, RoS and Scotland. Source: ISD Scotland.

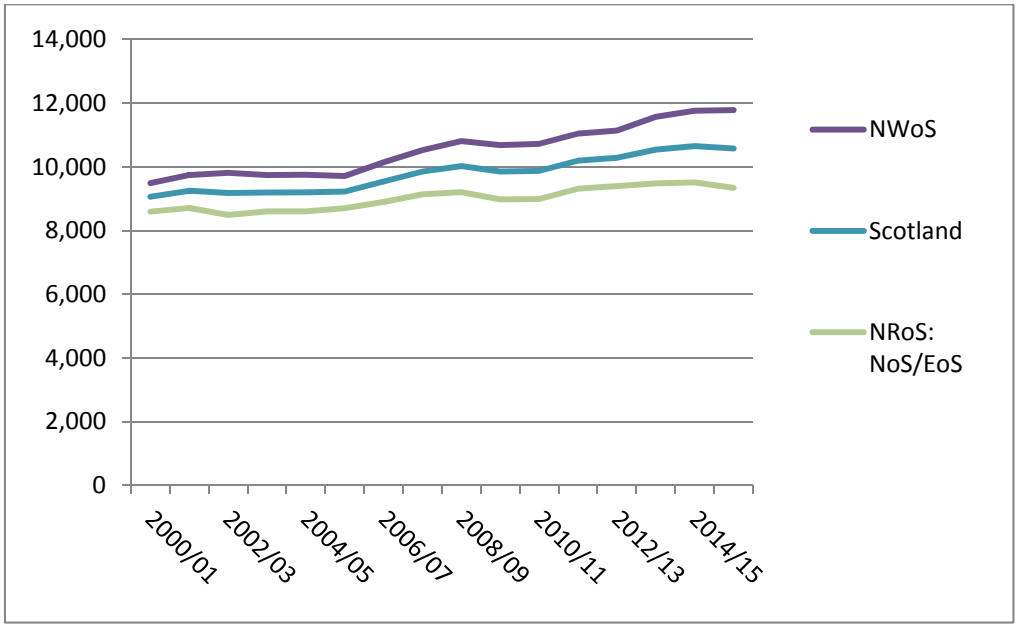


Figure 18: Elective day case activity: Crude rate per 100,000 population, for NWoS, RoS and Scotland. Source: ISD Scotland.

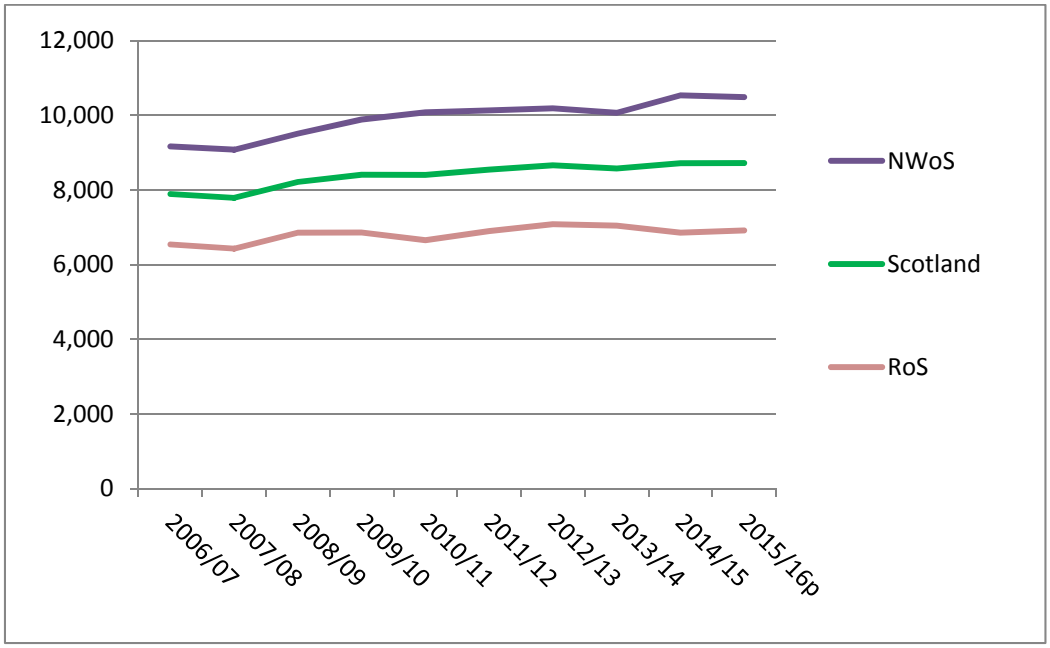
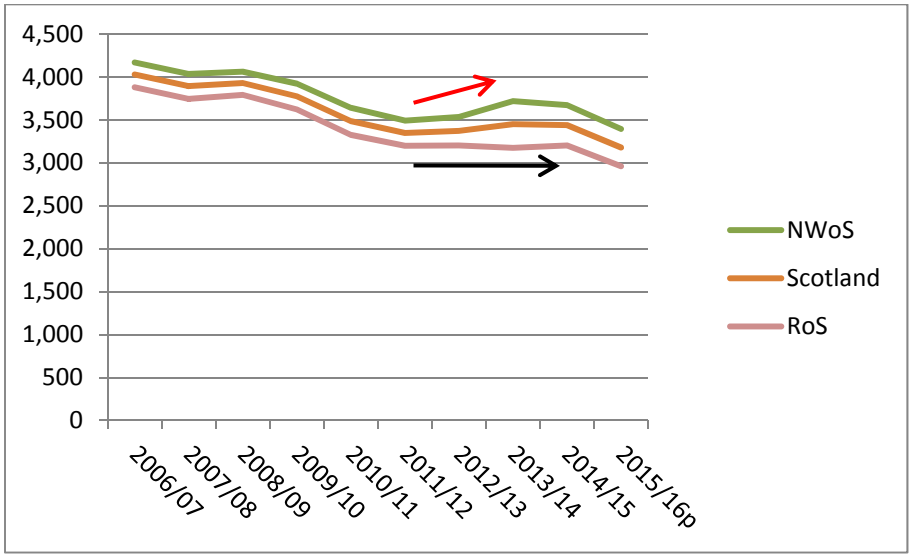
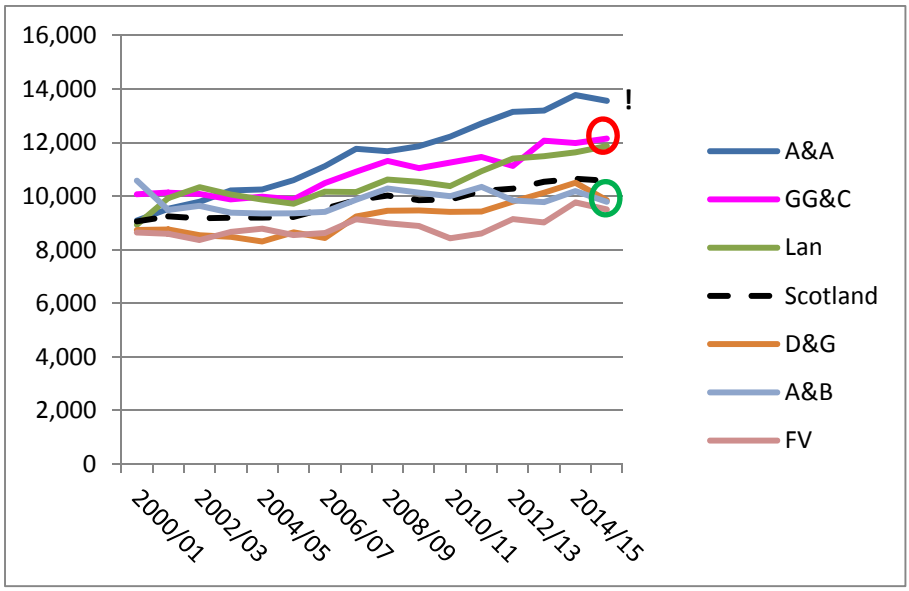


Figure 19: Elective inpatient admissions: Crude rate per 100,000 population, for NWoS, RoS and Scotland. Source: ISD Scotland.



- Furthermore, within the WoS there is considerable variation in rates of emergency inpatient admission with the range expanding significantly over the past 15 years (Figure 20). Work is underway to age, sex, deprivation adjust this position to assess the level of over utilisation in the WoS. This poses several questions - does the proximity to hospital facilities encourage access particularly where they are relatively well provided for in terms of A&E sites, hospital beds and consultant provision? Are there historical cultural factors that lead to increasing dependency on A&E services leading to higher reliance on emergency inpatient admission? Does falling provision of GP principals, and related continuity of care, in primary care have an impact on use of unscheduled hospital care. Do redirection policies at A&E make a real difference to the use of unscheduled care?

Figure 20: Emergency inpatient admissions: Crude rate per 100,000 population, for Scotland and the 6 study areas within the NWoS. Source: ISD Scotland.



- Although the use of elective care varies to a lesser extent within the WoS, based on crude rate trends (Figures 21 and 22), additional questions are raised about why some health board and council areas within that region have such high rates and others have such low rates, even after standardisation for age, sex and deprivation (based on fully adjusted analyses for 2016/17 and age/sex standardised analyses using European standard population for 2013, analyses pending). Why are FV elective day case rates static and equivalent A&A rates falling over time whilst those of the other areas tend to be rising (Figure 21)? Why are A&B rates for elective inpatient admission, though falling, so much higher than elsewhere in the WoS and can this excess be legitimately attributed to its remoteness and rurality, its agedness and the level of deprivation it conceals in its rural neighbourhoods (Figure 22)?

Figure 21: Elective day case activity: Crude rate per 100,000 population for Scotland and the 6 study areas within the NWoS. Source: ISD Scotland.

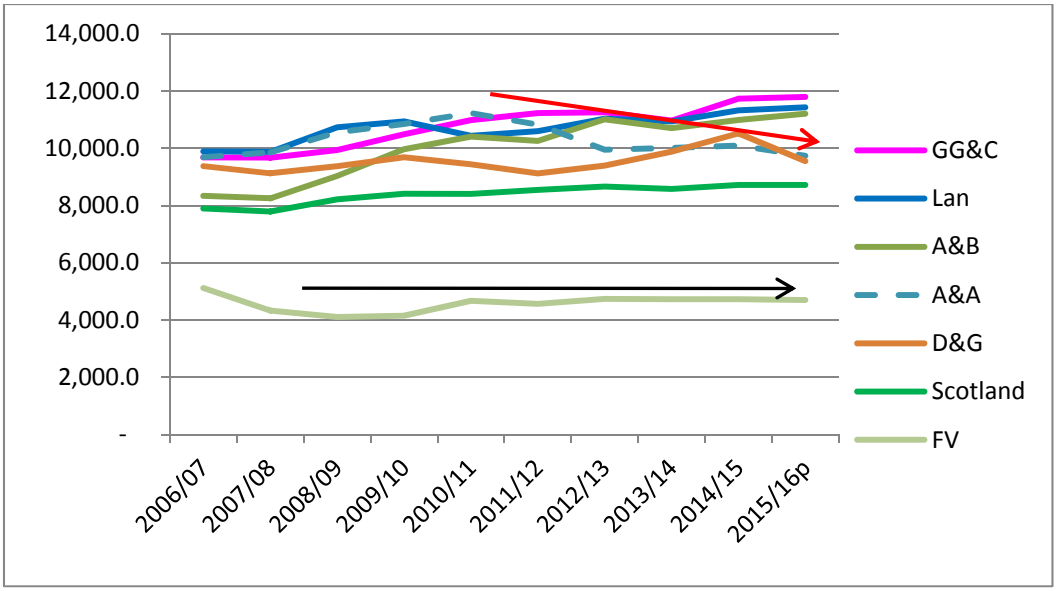
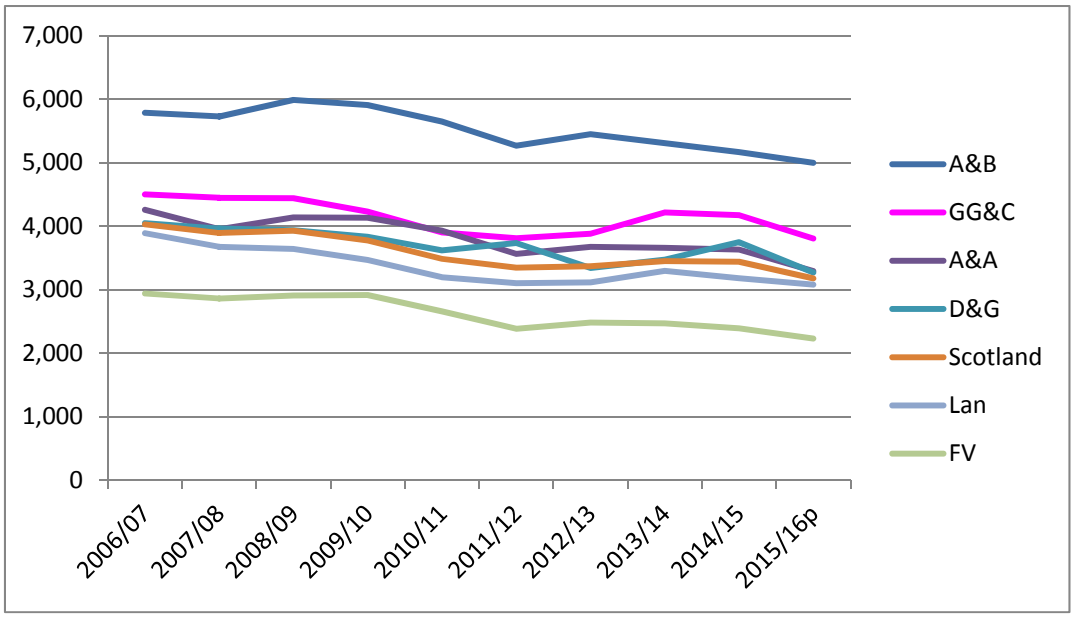


Figure 22: Elective inpatient admissions: Crude rate per 100,000 population for Scotland and the 6 study areas within the NWoS. Source: ISD Scotland.

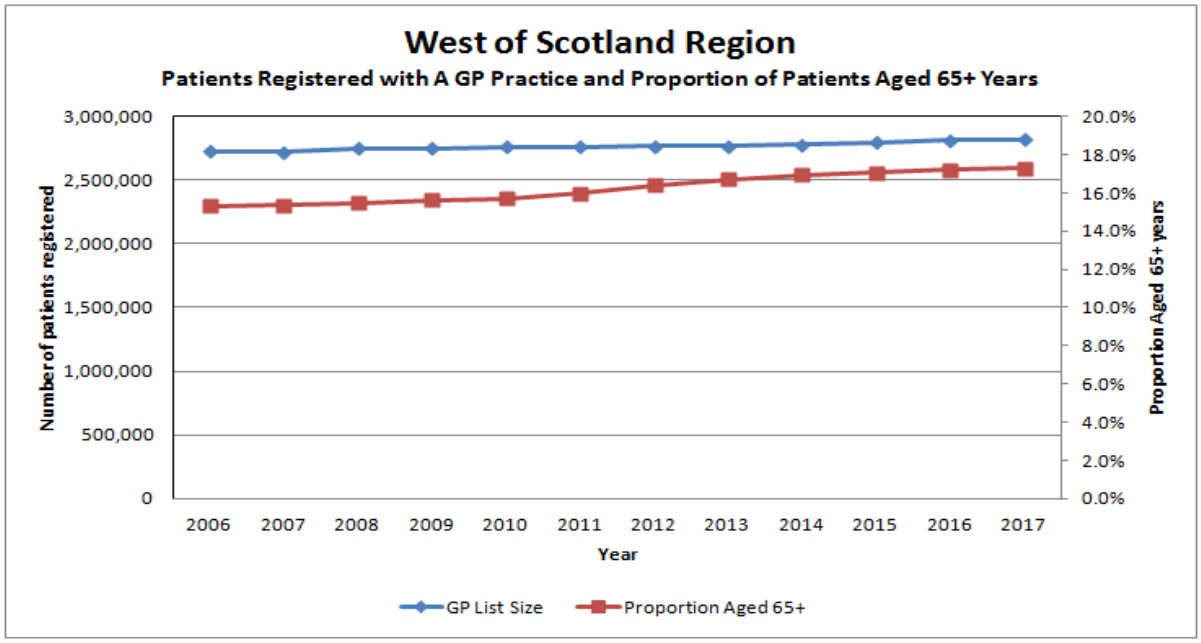


These largely unexplained variations require to be explored with a view to better understanding the drivers of consumption of hospital care and the degree to which current provision is meeting, or indeed exceeding, the needs of the residents of the WoS Region. To ensure that the limited resources available are used equitably, that is, determined by genuine need, and fairly distributed against both geographical and socio-economic gradients, it will be important to consider the service provision and service uptake across the region.

Appendix 2: Demand and Activity

This paper sets out supporting information contained within the West of Scotland Submission. This work was prepared by J Gomez.

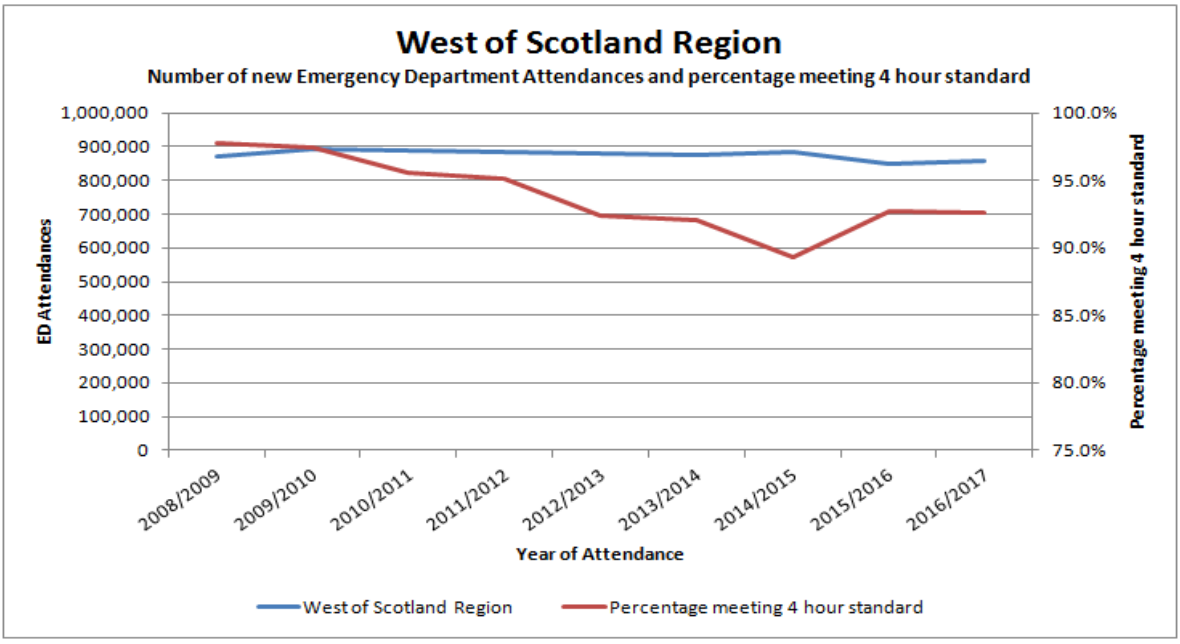
General Practice



- Between 2006 and 2017 the number of patients registered with a West of Scotland GP increased by 3.5 per cent, from 2,725,912 to 2,820,944.
- This represents an average annual increase of 0.3 per cent.
- At the same time the proportion of patients aged 65+ years have increased by 12.9 per cent, an average annual increase of 1.1 per cent.
- ISD have estimated that per annum there would be approximately 7,908,000 GP consultations and 3,799,000 Practice Nurse consultations with 56,245,994 prescriptions dispensed.

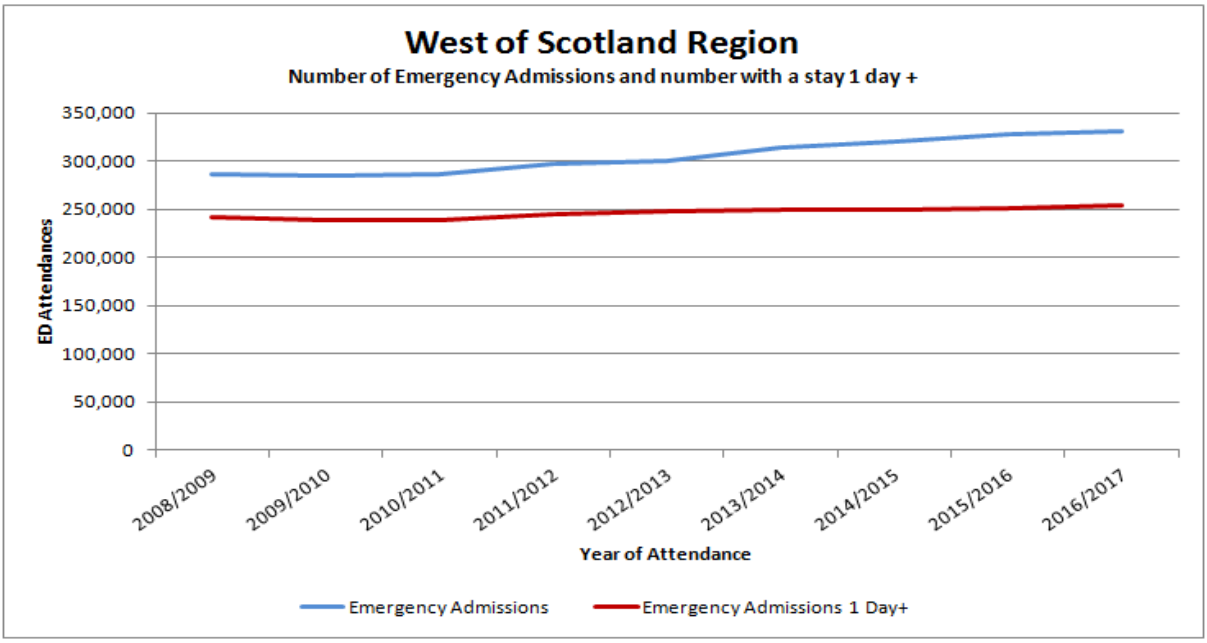
Emergency Care

Emergency Department Attendances



- Between 2008/2009 and 2016/2017 the number of New Emergency department attendances decreased by 1.4 per cent, from 869,960 to 858,059, since 2014/2015 it has decreased by 3.1 per cent.
- This represents an annual average of a 0.2 per cent decrease.
- The percentage of patients meeting the four hour standard decreased by 5.3 per cent, reducing from 97.6 per cent in 2008/2009 to 92.6 per cent in 2016/2017.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population attended Emergency Departments 7.8 per cent more than expected.

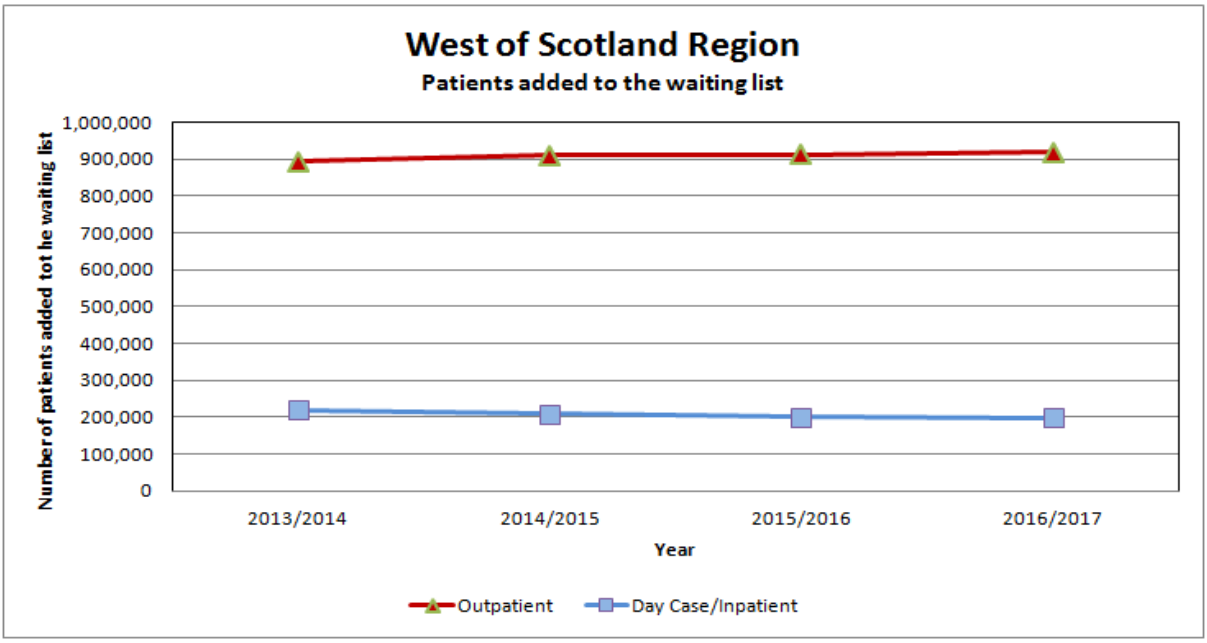
Emergency Admissions



- Between 2008/2009 and 2016/2017 the number of emergency admissions increased by 15.7 per cent, increasing from 286,478 to 331,318, since 2014/2015 it has increased by 3.3 per cent..
- Emergency admissions with a stay of one day or longer increased by 5.1 per cent whilst short stays with no overnight stay increased by 71.8 per cent.
- Zero stay admissions accounted for 15.8 per cent of all emergency admissions in 2008/2009 increasing to 23.4 per cent in 2016/2017.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population were admitted as an emergency 6.3 per cent more than expected.
- In 2016/2017 the case mix adjusted average length of stay was 0.96 which was 0.02 better than NHS Scotland.
- The emergency re-admission rate within 7 days in 2016/2017 was 4.7 per cent compared to NHS Scotland at 4.8 per cent and within 28 days it was 10.1 per cent compared to NHS Scotland at 10.4 per cent.
- Emergency admissions are projected, based on demographic changes alone, to increase by 3.3 per cent (11,250 admissions) by 2020, 8.3 per cent (26,135 admissions) by 2025 and 18.2 per cent (57,494 admissions) by 2035.

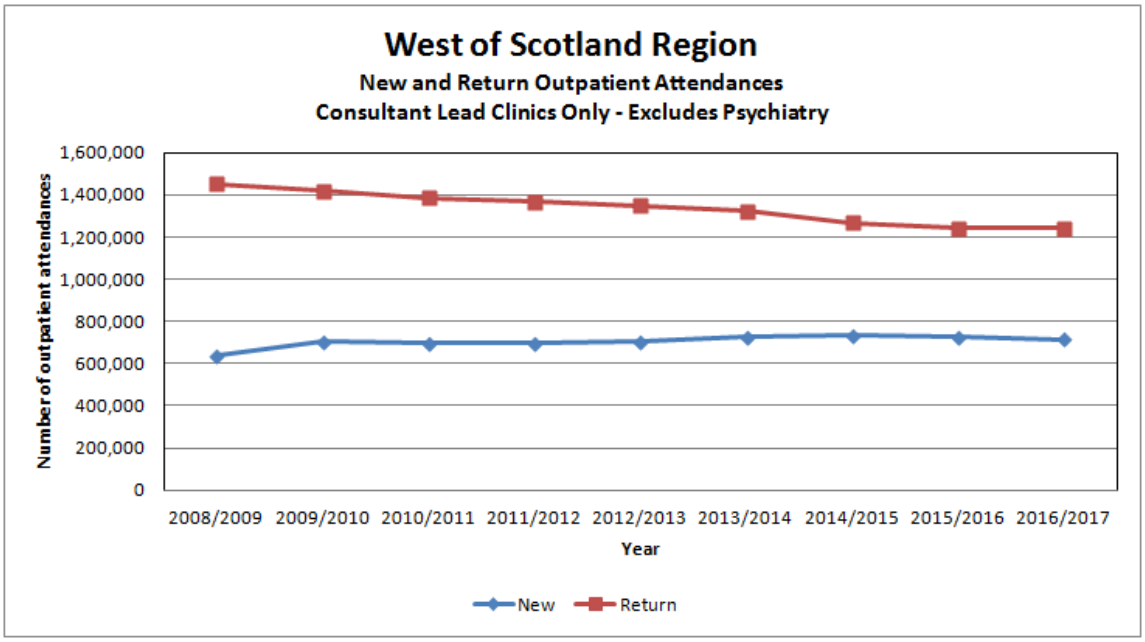
Elective Care

Additions to Waiting Lists



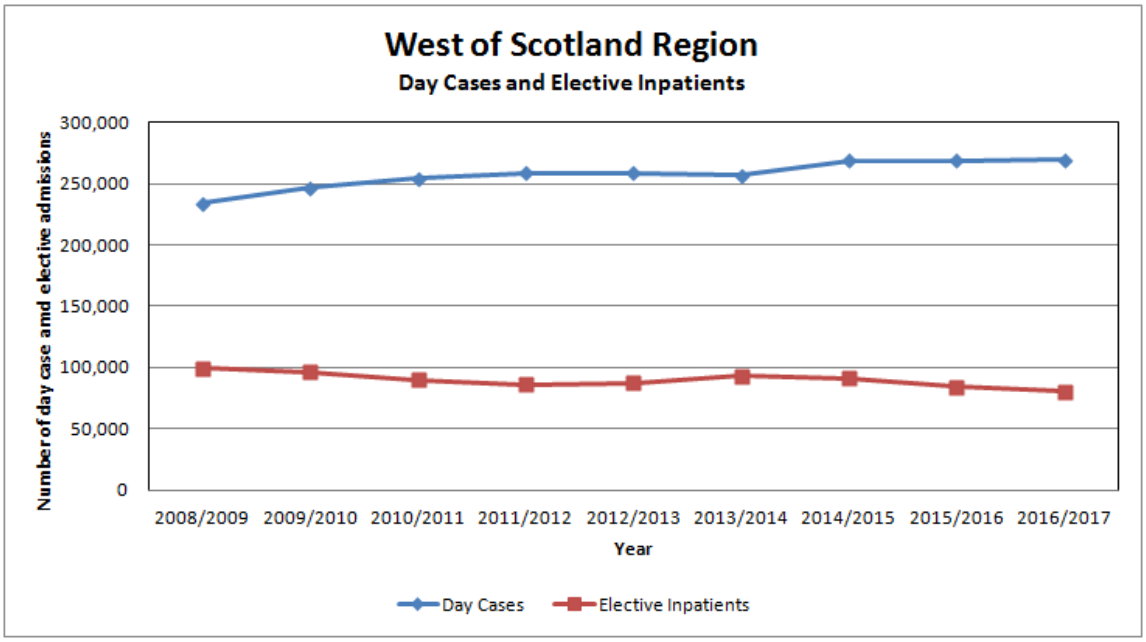
- Between 2013/2014 and 2016/2017 the number of additions to the new outpatient waiting list has increased by 3.0 per cent from 892,805 to 919,244
- This represents an average increase of 1 per cent.
- Patients on the outpatient waiting list have increased by 27.2 per cent from 125,053 in March 2014 to 159,018 in March 2017. Over sixty per cent of this increase occurred in the past year.
- The number of additions to the inpatient or day case waiting list decreased by 9.7 percent, from 219,371 in 2013/2014 to 198,080 in 2016/2017.
- This represents an average annual 3.3 per cent decrease
- Patients on the inpatient or day case list have increased by 37.2 per cent from 24,348 in March 2014 to 33,408 in March 2017. The increase is spread more regularly across the period than the increase in the outpatient waiting list.

Outpatient Attendances



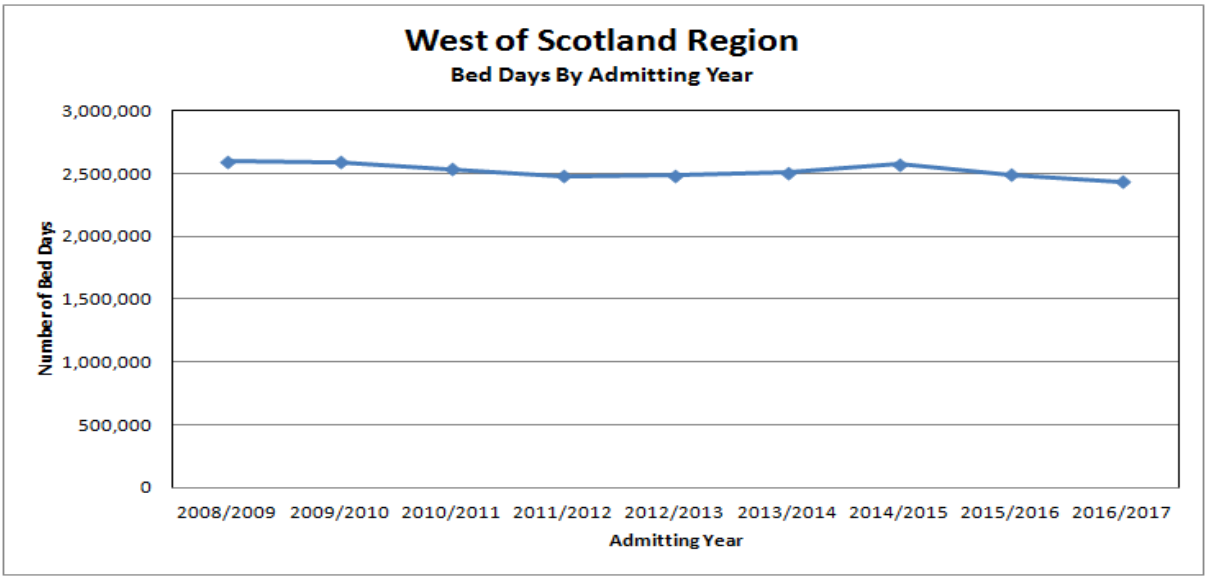
- Between 2008/2009 and 2016/2017 the number of new outpatient attendances at consultant led clinics (excluding psychiatry) increased by 12.1 per cent, increasing from 638,212 to 715,441, since 2014/2015 it has decreased by 2.5 per cent. Over the same period return outpatient attendances decreased by 14.6%.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population attended an outpatient appointment 1 per cent more than expected.
- The percentage of outpatients seen within 12 weeks in 2016/2017 was 83.2 compared to NHS Scotland at 81.5 per cent.
- In 2016/2017 the new outpatient DNA rate was 10.3 per cent compared to NHS Scotland which was 9.4 per cent., the DNA rate for return outpatients was 7.1 per cent for West of Scotland and 8.7 per cent for NHS Scotland.
- The return to new outpatient ratio in 2016/2017 was 1.8 compared to 2.0 for NHS Scotland
- Outpatients are projected, based on demographic changes alone, to increase by 1.9 per cent (14,222 attendances) by 2020, 4.1 per cent (31,105 attendances) by 2025 and 7.4 per cent (56,473 attendances) by 2035.

Elective Admissions



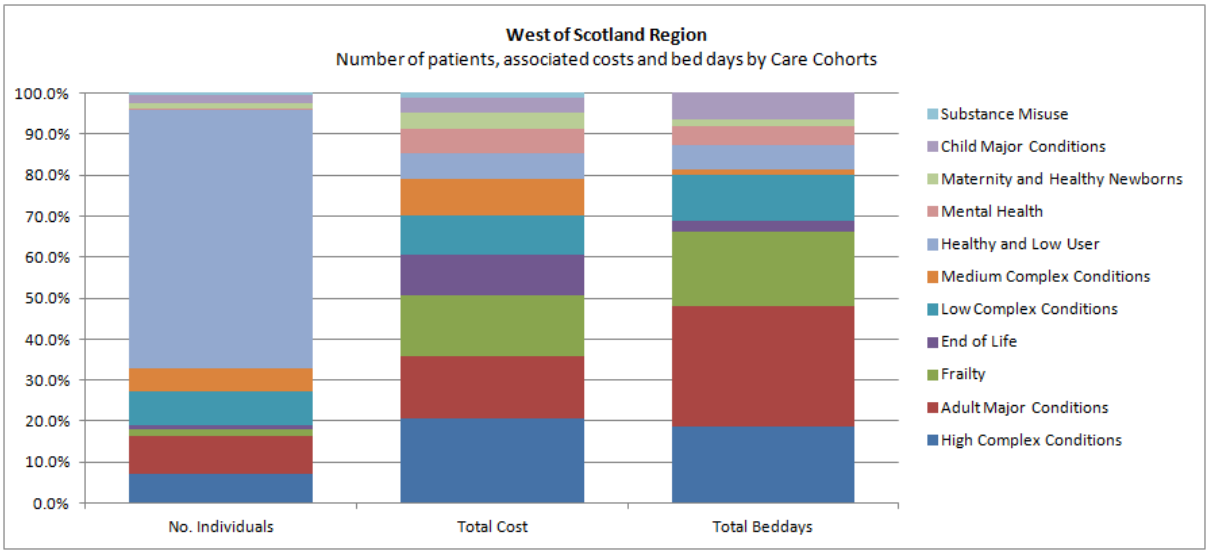
- Between 2008/2009 and 2016/2017 the number of day cases increased by 15.1 per cent, increasing from 233,984 to 269,386, since 2014/2015 it has increased by 0.3 per cent.
- Between 2008/2009 and 2016/2017 the number of elective inpatients decreased by 19.2 per cent, decreasing from 99,530 to 80,437, since 2014/2015 it has decreased by 11.2 per cent.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population were admitted as a day case 16.5 and as an elective inpatient 3.6 per cent more than expected.
- The percentage of day case or inpatients seen within 12 weeks in 2016/2017 was 87.7 compared to NHS Scotland at 87.4 per cent.
- In 2016/2017 the BADS day case rate was 87.0 per cent compared to NHS Scotland which was 85.4 per cent. The overall day case rate for West of Scotland Region was 77.0 per cent and for NHS Scotland 73.9 per cent.
- In 2016/2017 the case mix adjusted average length of stay was 1.03 which was 0.04 poorer than NHS Scotland.
- Day case and elective admissions are projected, based on demographic changes alone, to increase by 3.3 per cent (11,835 admissions) by 2020, 6.9 per cent (24,601 admissions) by 2025 and 12.0 per cent (42,815 admissions) by 2035.

Bed Days



- Between 2008/2009 and 2016/2017 the number of bed days decreased by 6.2 per cent, increasing from 2,597,377 to 2,478,550, since 2014/2015 it has decreased by 5.3 per cent.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population used 3.2 per cent more bed days than expected.
- During the period between 2008/2009 and 2016/2017 the average available staffed bed decreased by 8.7 per cent.
- Bed days are projected, based on demographic changes alone, to increase by 7.2 per cent (178,931 days) by 2020, 16.1 per cent (390,837 days) by 2025 and 36.5 per cent (884,006 days) by 2035.

Activity and Costs for Cohorts of Patients



- Four cohorts, High Complex, Adult Majors, Frailty and End of Life account for 19.1 per cent of individuals but 60.6 per cent of costs and 68.8 per cent of bed days.

West of Scotland

Developing a Regional Workforce

1. Introduction

West Region Workforce size and scope

The NHS West Region employs approximately 62,630 WTE (72,619 headcount) NHS staff, within five territorial Boards (the Golden Jubilee Foundation being a national Board), representing circa 45% of the entire NHS Scotland workforce as illustrated in the charts below:

Chart 1 – Regional workforce contrast

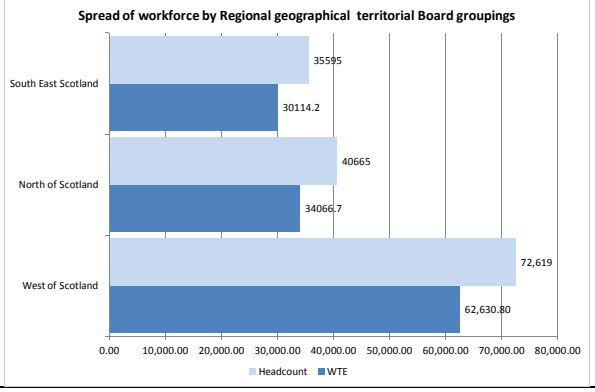
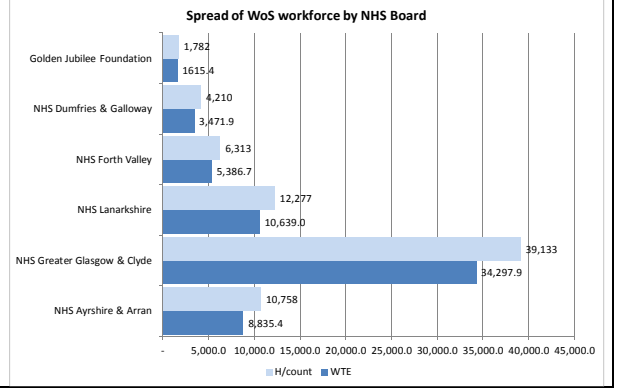


Chart 2 – Workforce within region



In this chapter, the focus is on the NHS workforce as workforce information is more developed. Workforce data from social care will be available from the the Health and Social Care Partnerships as we refine Phase 2 of the national workforce plan.

2. Drivers of Change

2.1. Healthcare treatment and provision is constantly advancing and changing, and our workforce must adapt in order to deliver modern, patient quality focused treatment and care. All staff groups at all levels have an important part to play in shaping and delivering future models of care. Staff need to be supported and developed to ensure they can fully engage and commit to new service delivery models.

2.2. The future workforce cannot be "more of the same". The future workforce will need to be based on multi-skilled teams rather than individual practitioners, this will facilitate skill focused effective multi-disciplinary team working.

2.3. Hospital based staff will work more closely with community teams and both will need to have a clear understanding and appreciation of each other's roles to create a culture which supports people with long term conditions and their carers to be the lead partners in decisions about their health and wellbeing.

2.4. New developments across the West Region, such as the development of a Regional Elective Centre at the Golden Jubilee National Hospital will bring career opportunities and new work environments which are attractive to staff and may potentially destabilise the staffing in existing and established units.

Workforce planning for new developments must include a risk assessment of unintended consequences for workforce supply and demand.

2.5. The ageing population is not the only factor which will impact on service demand; more young people are surviving with long term conditions, the provision of services for people with chronic conditions in mid life, and the increased demand for mental health services for all ages will all impact on the shape of the future workforce.

2.6. Changing treatments, interventions and diagnostics will bring opportunities for brand new roles and career pathways.

2.7. Sustainability and workforce availability in remote and rural settings is a continuing challenge across all job families but particularly medical , nursing and Allied Health Professions.

3. Regional Pressure Points

Boards have already undertaken work to identify pressure points within the West Region. Common themes which have emerged across the West of Scotland are as follows:

- The Medical Workforce – challenges in demand, supply and sustainability across the spectrum of grades and specialities but significantly at Consultant grade within specialties in acute hospital settings; see Appendix 1 case study examples

- Nursing – an ageing workforce, a significant element of which will retire in the next decade presents particular challenges in key job areas e.g. health visitors, district nurses, paediatrics, midwifery and mental health practitioners. The demand for Advanced Nurse Practitioners (ANPs) is likely to increase, as medical recruitment and retention both in acute and primary care creates additional workforce pressures. New educational programmes and pipelines need to be created to supply this workforce, although recruitment of ANPs will come form an increasingly scarce nursing resource .

- Radiology – demand and supply issues connected to the current radiologist/reporting radiographer position in addition to increasing service demand and enhanced technical solutions requiring different ways of working.

- Pharmacy technicians – a significant increase in demand which is not being matched with supply.

- Healthcare science – demography of the workforce, particularly in senior and specialist roles, as well as longstanding national issues with supply.

Further work is required to expand on the detail of these pressure areas and potential solutions. For the purposes of this discussion paper, the focus is on medical workforce.

4. Medical Workforce Availability

Recruitment and retention of medical staff within acute and primary care services is increasingly a challenge across Scotland. The available labour market is competitive at inter/intra regional, national, and international levels.

With a growing elderly population and a consequent increase in complex healthcare needs, it is recognised that the current workforce model, with its heavy reliance on a traditional medical model of care is becoming fragile and in some specialties unsustainable in the long term. New workforce models must consider a mixed economy of professions within the workforce working alongside medical staff i.e. advanced practice roles from varying professional backgrounds e.g. Nursing, Allied Health Professionals, Pharmacy, Healthcare Science and Physician Associates.

The charts below illustrate the age profile of the consultant workforce across the West Region and the gender split:

Chart 3 – WoS Consultant age profile

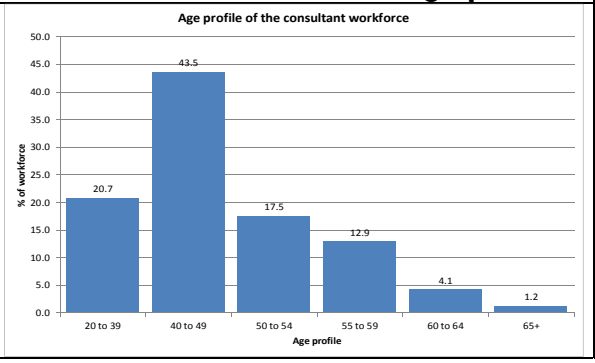
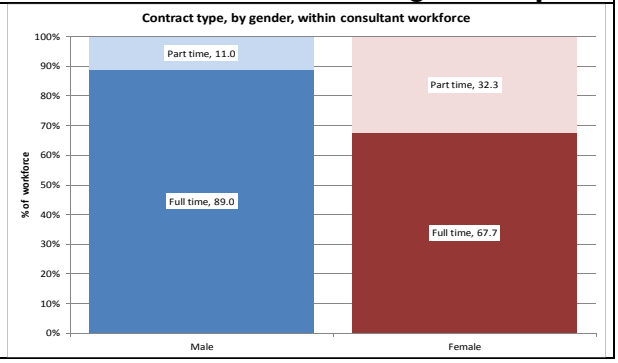


Chart 4 – WoS Consultant gender split



Approximately 126 (headcount) consultants in the West Region are aged over 60. 60.6% of the consultant workforce is male however this is changing as the number of females in the medical workforce continues to expand. This is likely to change the working patterns of the medical workforce as females currently work part time more frequently than males. This will be an important workforce planning consideration in terms of workforce numbers and service capacity.

Table 1, below, illustrates the scale of the challenge faced by the West Region in terms of consultant vacancies, with 46% of all vacancies being vacant 6 months +:

Table 1 – West Region Consultant Vacancies as at 31st March 2017

	Total Vacancies WTE	Vacant 6 months or more
All specialties	**260.0**	**119.8**
All medical specialties	**254.9**	**117.8**
Emergency medicine	9.0	6.0
Anaesthetics	26.0	9.0
Intensive care medicine	2.0	-
Clinical laboratory specialties	**53.0**	**25.0**
Histopathology	13.0	5.0
Chemical pathology	2.0	-
Haematology	5.0	2.0
Medical microbiology & virology	2.0	1.0
Clinical radiology	31.0	17.0
Medical specialties[R]	**78.5**	**41.4**
General (internal) medicine	12.0	9.0
Cardiology[R]	3.0	3.0
Infectious diseases	3.0	1.0
Dermatology	7.9	2.0
Endocrinology & diabetes	4.0	3.0
Gastroenterology	13.0	7.0
Genito - urinary medicine	3.6	0.6
Geriatric medicine	7.0	3.0
Renal medicine	2.0	1.0
Neurology	5.8	4.8
Palliative medicine	1.0	-
Rehabilitation medicine	2.6	1.0
Respiratory medicine	8.0	5.0
Rheumatology	2.6	-
Clinical neurophysiology	1.0	-
Clinical oncology	2.0	1.0
Public health medicine	1.3	1.3
Occupational medicine	2.0	2.0
Psychiatric specialties	**30.4**	**9.1**
General psychiatry	23.7	6.8
Child & adolescent psychiatry	1.8	-
Old age psychiatry	3.3	2.3
Psychiatry of learning disability	0.6	-
Psychotherapy	1.0	-
Surgical specialties	**35.7**	**19.0**
General surgery	3.7	1.0
Otolaryngology	6.0	5.0
Neurosurgery	1.0	-
Ophthalmology	8.0	6.0
Trauma & orthopaedic surgery	6.0	1.0
Plastic surgery	2.0	-
Urology	8.0	5.0
Oral & maxillofacial surgery	1.0	1.0
Obstetrics & gynaecology	4.0	-
Paediatrics specialties	**13.0**	**5.0**
Paediatrics	13.0	5.0

Attached at Appendix 1 is a case study analysis of three medical specialties with significant staffing challenges for illustrative purposes – clinical radiology, histopathology and gastroenterology.

Across all Boards there are also significant supply challenges at the Trainee doctor level, resulting in either trainee vacancies or appointments of less senior trainee doctors, which present real challenges to Boards across the region to sustain current services and plan for future service provision and contributes to the wider Scotland wide challenges of a lack of future supply of trained doctor for both the secondary and primary sectors.. The changing demography of the medical workforce coupled

with individuals wanting to improve work life balance and/or work part time means that for many it takes longer to complete training, which compounds current fragility of rotas and longer term supply challenges. This will be a key element of the March 2018 Workforce Plan.

Recruitment & Retention

The West Region health boards recognise the importance of being an Employer of Choice which attracts and retains staff, supported by robust implementation of the Staff Governance Standards and the implementation of the Everyone Matters 20/20 Workforce Vision with its five priorities (A Healthy Organisational Culture, A Sustainable Workforce, A Capable Workforce, An Integrated Workforce and Effective Leadership & Management). All health boards have local action plans in place which support the priorities and ensure ongoing engagement with staff.
All boards remain committed to reducing expenditure on agency, bank and locum staff and a number of strategies are currently in place in boards to support this aim.

5. Workforce Affordability

Improve efficiency

To maximise the efficiency of service delivery, several factors should be taken into account in designing the workforce of the future:

- **Avoid duplication** – opportunities to integrate and streamline patient pathways will be considered and where possible generic support workers introduced both across health and health / social care (AHP, nursing, social care).

- **Reduce utilisation of high cost agency staff** – all Boards are committed as far as practicably possible to reduce/eliminate the utilisation of high cost agency staff within nursing and medical job families. The West Region continues to develop its medical bank to not only attract doctors in training but also those seeking additional work at retirement.

- **Work to "top of licence"** (registered and support staff) – roles require to be reviewed with staff supported and developed to work to the "top of their licence". This offers the potential to increase staff numbers and redistribute the workload to lower banded but appropriately trained staff, thus avoiding an increase in cost.

- **Extended scope** – to streamline the patient journey, certain roles will extend their scope to provide additional care elements and avoid referral to a different healthcare provider or into acute services e.g. community nurses developing Intravenous (IV) therapy skills to allow patients to be cared for in the community; extending psychological care approaches, growing the resilience of people using services to effectively self-care and supporting

concordance with agreed personalised treatment plans reducing demands on unscheduled care.

- **Roles appropriate to skill** – to ensure efficiency, appropriately skilled staff should undertake roles e.g. admin staff undertaking admin roles, not clinicians. Staff developed to conduct proactive engagement with patients, their families and carers about what matters to them and how they feel better supported to access services and to self care when they are able; staff empowered to promote healthy lifestyles and provide support to patients and carers to meet social challenges such as financial security and employment.

In addition, there are other opportunities for efficiency which will support the workforce of the future:

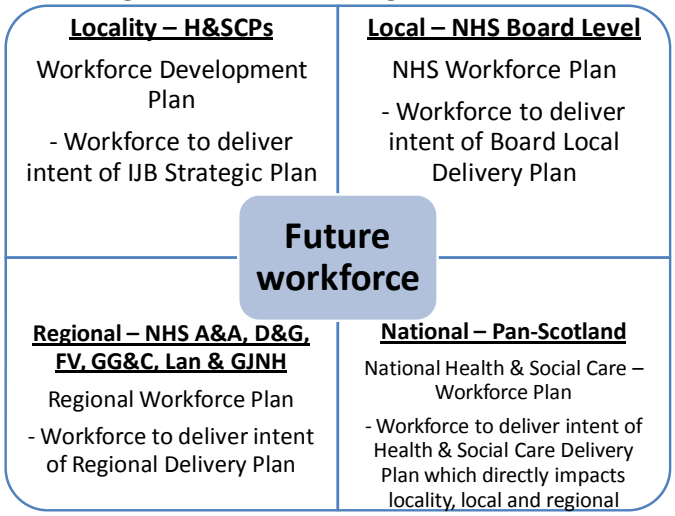
- Agile working arrangements which will support and enable the concept of working across boundaries
- Improvements in technology such as electronic patient records, mobile technology (tablet computers), etc. would support greater workforce productivity and efficiency and will require the workforce to work differently
- Innovative practice using existing technology based platforms (e.g. NHS Inform MATS) and developing other web-based access to services for early advice and self management, influencing a culture of self-efficacy which deflects demand away from healthcare services and into upstream services e.g. leisure, voluntary and third sector services.
- West Region health boards and their partner HSCPs will continue to work with third sector colleagues to focus on supporting and testing out new approaches for the delivery of community-based support for people with complex and multiple conditions.
- Integrate more closely all contractor disciplines such as community pharmacists, dentists, optometrists and care providers to enable patients to better access appropriate care and advice
- Introduce pharmacists in GP practices with advanced clinical assessment skills to support the care of patients with long term conditions and better manage their medications

The workforce of the future will not be “more of the same”. The workforce will be older and have a greater reliance on Advanced Practitioners and roles with extended scope. All staff groups will work to the “top of their licence” with work aligned to their skills. The workforce may require to be re-profiled to match the increased workload demand in the community and the higher acuity in acute care.

6. Regional Workforce Planning

All NHS Boards within the West Region have extant Workforce Plans at required by CEL32(2011) and the new regional approach should robustly complement existing plans as illustrated in Figure 1 below:

Figure 1 – Planning continuum



Critical will be balancing the unique, but mutually dependent, workforce requirements and needs arising from each of the four levels. The key workforce planning considerations required at all levels are the same:

- Detailed qualitative and quantitative profile the current workforce
- Skill profile of current workforce
- Need for a current and future service profile
- Labour market intelligence for staff group/speciality/geographic distribution

The Regional Delivery Plan will present the profile of the West of Scotland population and will recognises significant cross boundary flow from areas of Highland and the Island Boards, and Scotland as a whole due to the provision of some specialist tertiary services for NHS Scotland as a whole within the West Region.

7. Regional Workforce Planning – Way Forward

7.1. Standardised data collection – workforce information and numerical data should be gathered in a consistent regional format to allow for aggregation into regional documents.

7.2. Additional workforce planning capacity – additional resources should be identified for Regional workforce planning, identifying the limitations of the current Board workforce planning capacity.

7.3. Quantitative data needs to be augmented with soft, qualitative data to enable decision making and risk assessment to be made with a full picture including gathering information from the frontline.

7.4. There is a need for work at national level, via NES and NSS, in partnership and collaboration with the regions to ensure appropriate information and

intelligence is sourced, used and understood consistently in a 'Once for Scotland' manner.

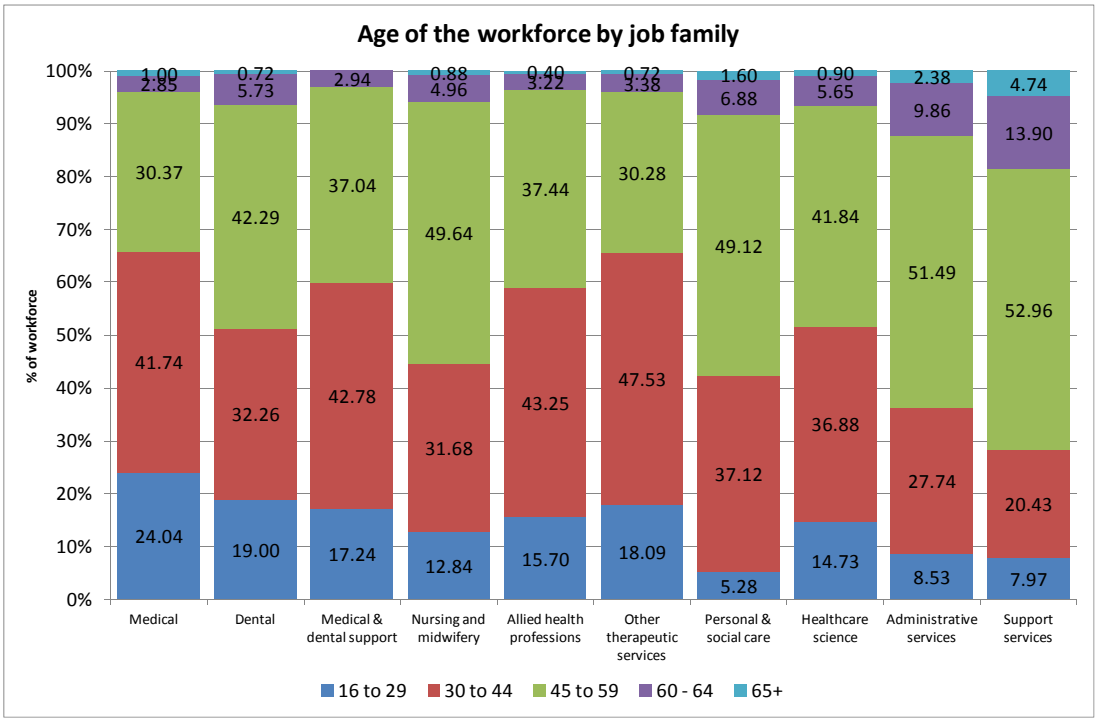
7.5. HR Recruitment teams should establish real time labour market intelligence at Board, Regional and National level, which will enable recruitment processes to be intelligence driven and will help inform education need.

7.6. Interventions to develop the West Region workforce should be skill focused and matched to the SCQF Framework so each intervention is matched to an education level.

7.7. West Region should undertake detailed multi-professional workload and workforce planning to support service redesign and change. Effective use of existing resources will be essential as will gaining an understanding of current utilisation of the workforce and the ongoing implications of retaining and up skilling the existing workforce, many of whom will remain part of the workforce for the next 5-10 years.

The age of the West Region workforce, by job family, is shown in Chart 5:

Chart 5 – Age of WoS Workforce by Job Family



7.7.1. The older population is also reflected in our workforce profile, this will affect the availability and fitness of the West Region workforce. An older workforce will bring both challenges and opportunities and all the West Region health boards are developing new approaches which will support older staff to remain in employment longer e.g. less physically demanding roles, reduced hours and flexible working.

7.7.2. Labour markets are changing, this includes the length of service, of our workforce influenced by changing pension provision; for example an employee born in 1981 will not draw their state pension until they are 68 years old (on the assumption there is no change to the state pension age of 68 being introduced by 2039), if they start work or education at 17 this makes their potential working life 51 years long. There are also now five generations in the workplace, ensuring the strengths and skills of each generation is capitalised on will be a core part of regional planning, whilst acknowledging the changing personal circumstances of such a diverse workforce.

With any intervention planning the length of time to train the required workforce should be factored in to preparation timelines, as well as backfill requirements, location and availability of training.

7.7.3. A similar approach will be required to define the generic support worker role and the education needs of this worker. It may not be possible to determine the exact numbers of each role required and so an initial estimate of need should be agreed and used for the purposes of development. Professions should be able to define their unique professional contribution and identify tasks which can be delegated and carried out effectively by support workers.

7.7.4. In a rapidly changing care environment with continual advances in care, there needs to be a cultural shift to accept that there will be a need for roles which may not have existed before. Listening to the workforce and understanding the detail of challenge will support appropriate intervention on careers, development and education. This further strengthens the need for qualitative and consultative intelligence on workforce and labour market availability, skill requirements and career satisfaction.

7.8. West Region health boards should work with Regulators, Scottish Government and Higher and Further Educational Institutions to ensure that the development of education programmes and curriculum are in line with the future healthcare needs, and have sufficient focus on community care. Future skills and treatment interventions will inform education need.

7.9. It is envisaged that Advanced Practice roles will be an integral part of building capacity and capability within the West Region workforce. The development of extended roles and initiatives such as intravenous therapy, advanced practice, non medical prescribing and the extension of the health care support worker role will require engagement with HEIs and the GP community. West Region health boards are fully engaged in the national agenda to develop the roles of community practitioners, ensuring new models meet the needs of people using services.

End.

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

Radiology

Challenges
Vacancies are a growing trend, with a sustained inability to fill advertised posts, of which in some of the West Region Boards these have been enduring vacancies over many years. This mirrors the position across wider NHS Scotland and the UK as a whole

In terms of sub-specialisation within radiology specific pressure points across the region include: GG&C - Neuro Radiology and Neuro Interventional Radiology; Breast Radiology is flagged as a challenge across all West Region Boards.

Predicted CCT, as illustrated in the charts, for 2018 could be absorbed solely by the West of Scotland Region. Attraction and retention is the key issue across all Boards where there is an inability to replace retirees, without considering additionality arising from service development.

The largest pressures are in D&G, FV and A&A as illustrated in the vacancy charts.

Demand
Radiology services in the UK are described by the Royal College of Radiologists as being in crisis. There is a highly competitive labour market, making job design critical to attraction. The ever increasing role of imaging in modern clinical care has led to a high increase in demand, particularly in complex imaging including CT and MR scans which has outstripped the ability of current services to cope.

Existing models of mitigation
- Plain film reporting contracted out in some Boards
- Retired Consultants providing locum / bank capacity however this is limited by SPPA limitations on hours that may be worked (up to 16 hours per week)
- Collaboration on capacity across Boards

Potential future mitigation of risk
- Expansion of Radiographer clinical reporting and initial commenting – further development of Advanced Practice roles to support the service
- Regional concept of model of delivery
- Networks of expertise supporting the West Region
- National Radiology Shared Services implementation and impact

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

Gastroenterology

Challenges
There is a trend of increasing vacancies, compounded by a number of impending vacancies particularly at a lower retirement than may have been expected (mid-50s) have been reported by some Boards.

There are insufficient numbers going through training; in 2018 there is only one expected CCT, in addition to the current number of 13 wte vacancies, a further 8 wte are expected to retire in 2018.

Demand
There is an increased demand for diagnostic gastroenterology, the rollout of Bowel Screening has been the greatest contributor to the increase, as such this demand could have been anticipated.

Media campaigns have increased public awareness of bowel cancer, increasing referrals. Changes in demography and disease incidence is also attributable

National UK studies anticipate a 40% increase in demand, from 2016 to 2020

Existing models of mitigation

- Nurse Endoscopists / Consultant Nurse Specialists / Specialist Nurses
- Planned care review under taken by Advanced Nurse Practitioners
- Direct to test vetting to improve efficiency
- Specialist Nurses

Potential future mitigation of risk

- Review the model of service delivery across the West Region to best capitalise upon economies of scale with existing resource
- Increase Advanced Nurse Practitioner / range and scope of specialist nursing roles to better support delivery of gastroenterology services
- Physician Associate roles open up a new labour market which has as not yet been systematically utilised within the West of Scotland region unlike other regions. The lead in time for Pas being 2 years.

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

Histopathology

Supply
The vacancy rate has increased significantly with workforce demand currently outstripping supply – a number of Boards have had several rounds of advertising with limited success e.g. A&A have had four rounds of recruitment with only one Consultant recruited

There are currently 13 wte vacancies, with a further 2 wte expected in 2018, this is set against a CCT 2018 supply of 6 headcount, effectively the West Region could subsume the entire CCT output and this would still result in a staffing deficit.

Demand
Pathology is involved in 70% of all diagnostics. Rising disease prevalence and increased incidence of cancer is the primary driver for the demand increase.

The demand is anticipated to steadily increase, with the predicted pattern of retirement there will be a shortage of Consultant Pathologists.

Existing models of mitigation

- Bio-medical scientists undertaking dissection
- Out-sourcing of some reporting

Potential future mitigation of risk

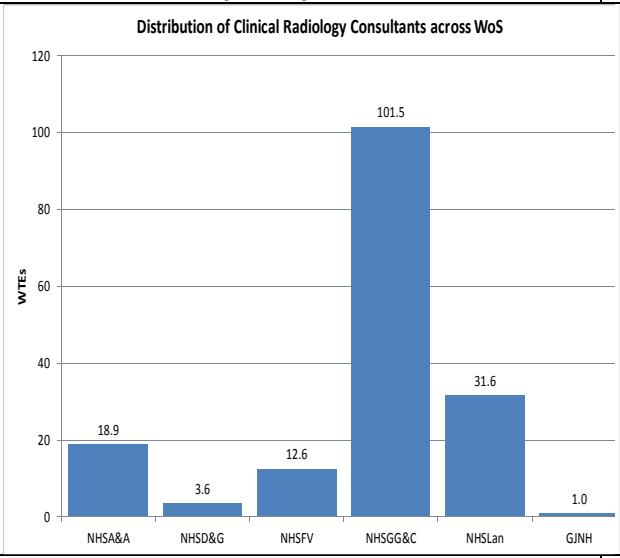
- Out-sourcing of service
- SLA with other Boards in the West Region
- Physician Associate roles open up a new labour market
- Bio-medical science reporting – in its infancy at a national level
- Roles for clinical scientists

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

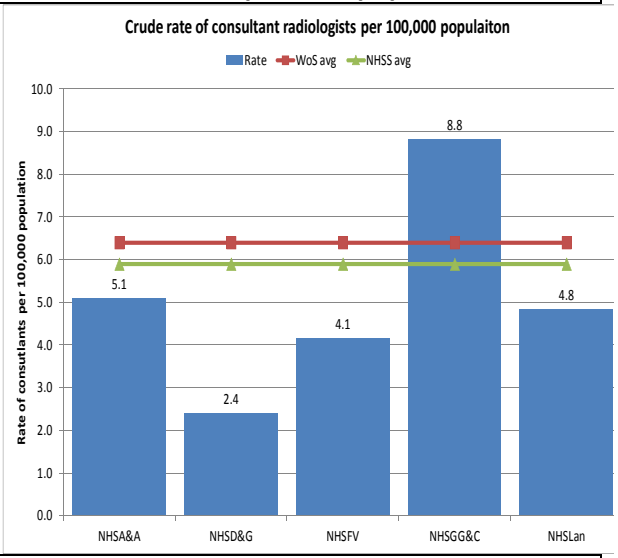
Clinical Radiology detail

Total WoS Radiologists = 169.2 WTE / 179 headcount

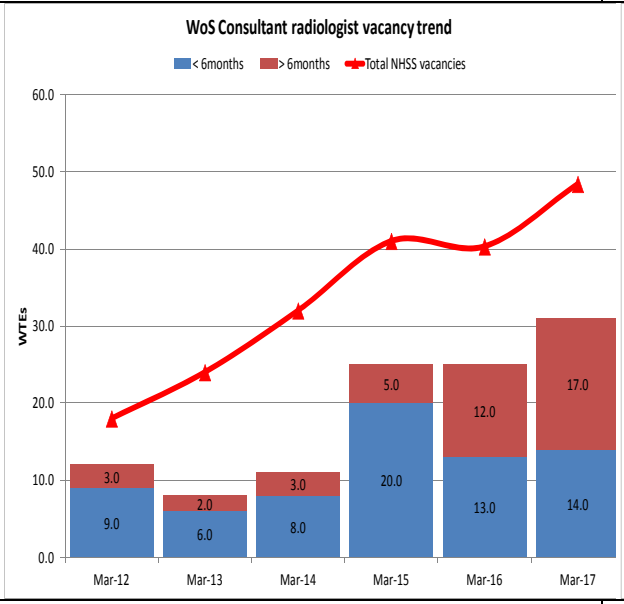
In post by Board



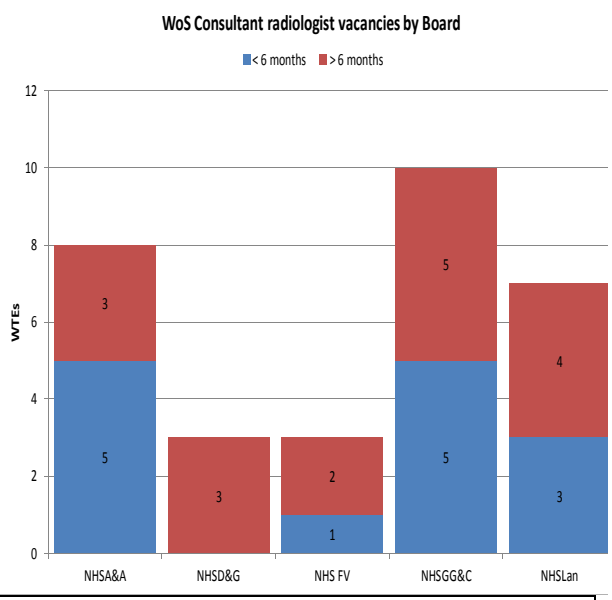
Consultants per 100k population



Vacancy trend - WoS

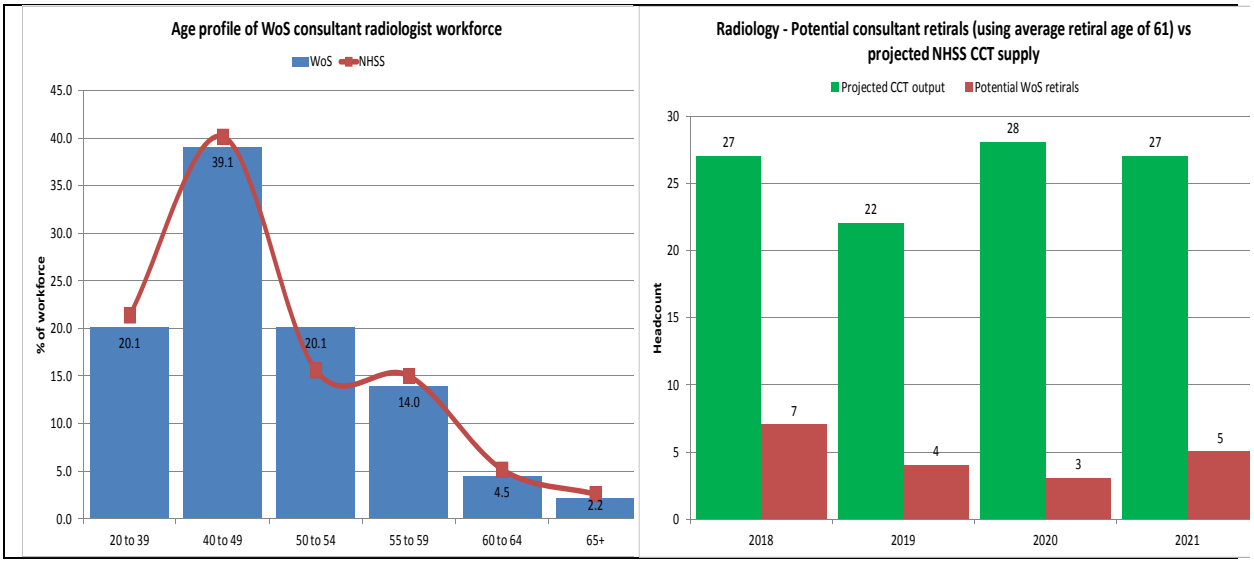


Vacancy distribution by Board



Age profile

Projected retiral v projected CCT output



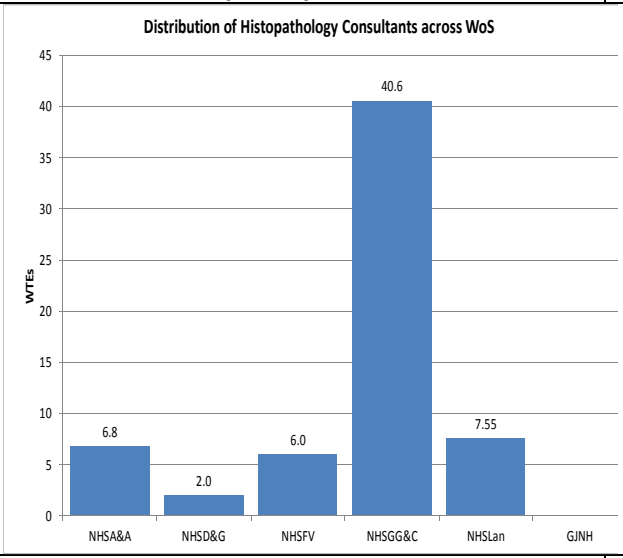
Clinical radiology – narrative summary

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

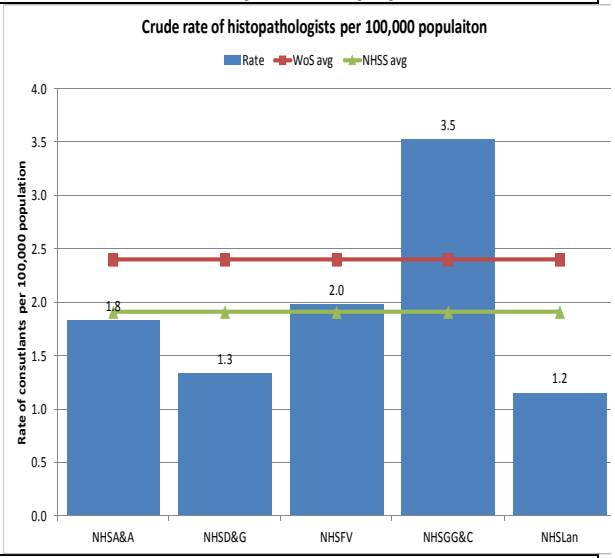
Histopathology detail

Total WoS Histopathologists = 63.0 WTE / 68 headcount

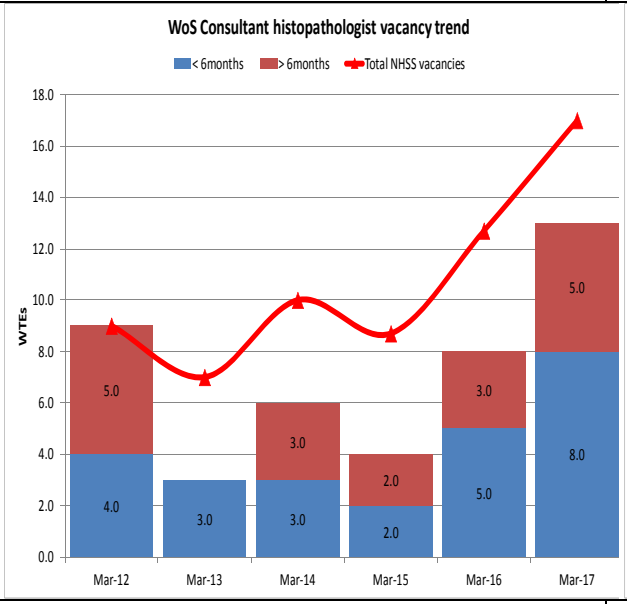
In post by Board



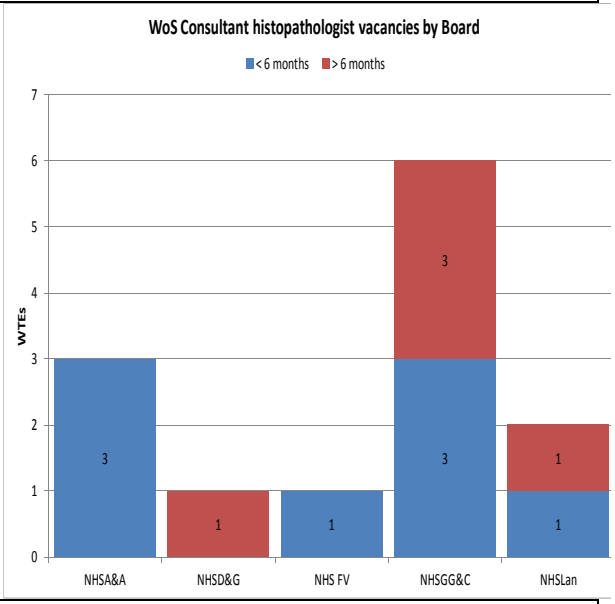
Consultants per 100k population



Vacancy trend - WoS

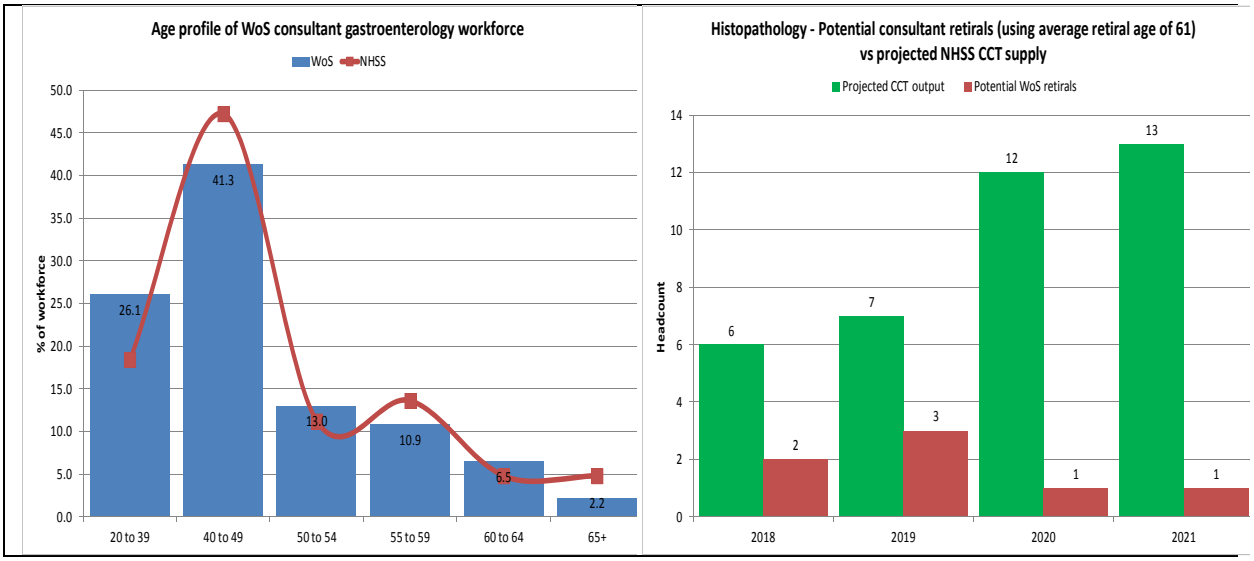


Vacancy distribution by Board



Age profile

Projected retiral v projected CCT output



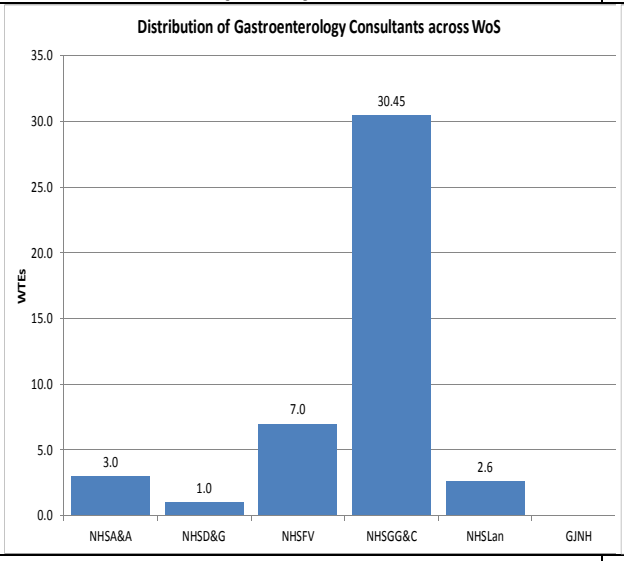
Histopathology – Narrative summary

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

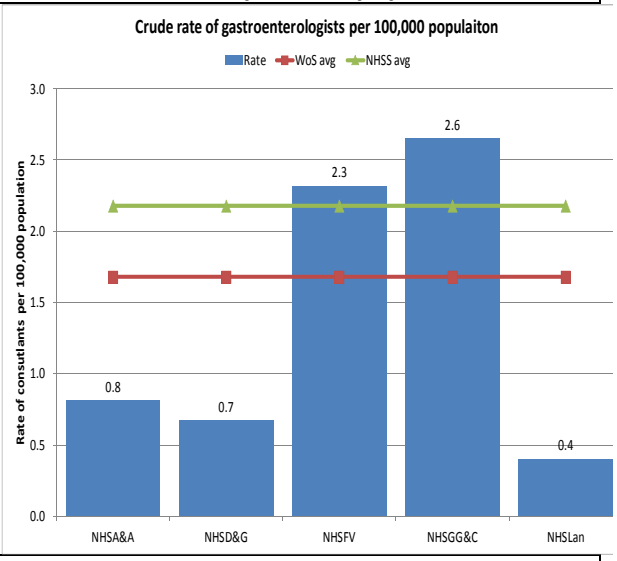
Gastroenterology detail

Total WoS Gastroenterologists = 44.1 WTE / 46 headcount

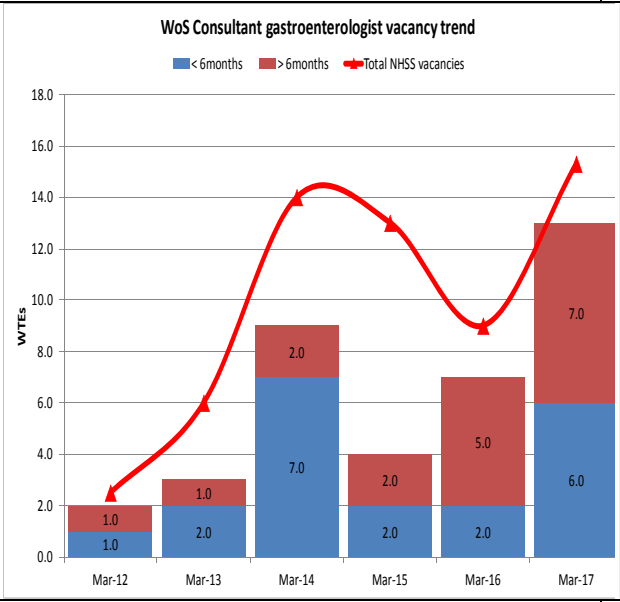
In post by Board



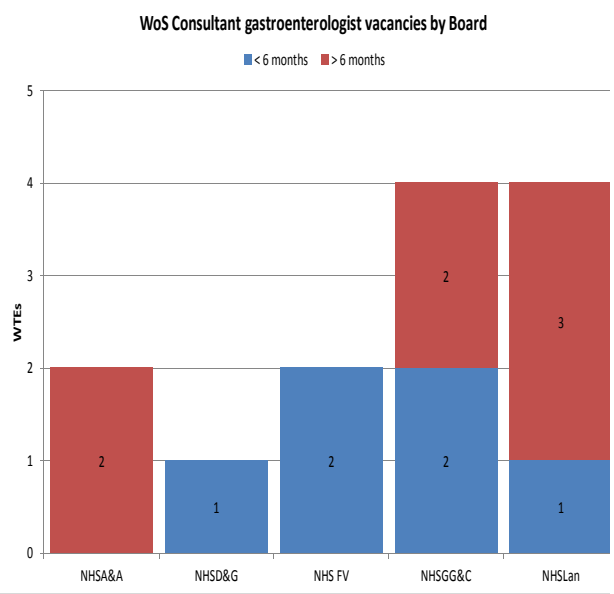
Consultants per 100k population



Vacancy trend - WoS

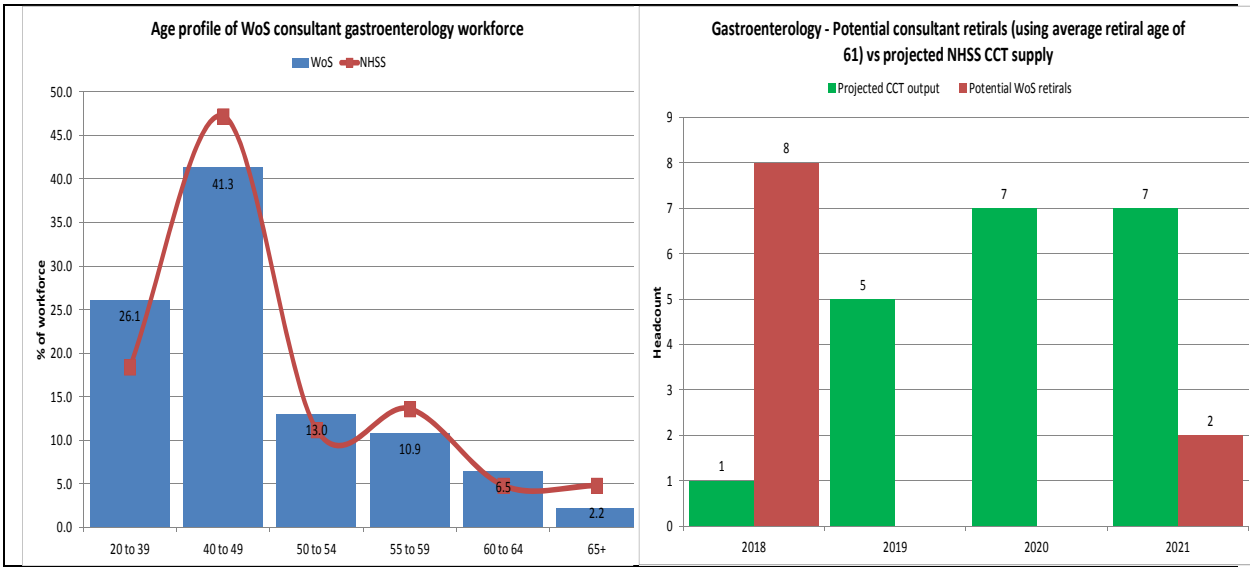


Vacancy distribution by Board



Age profile

Projected retiral v projected CCT output



Gastroentertology – narrative summary

Appendix 4

Planning and delivering care and treatment across the West of Scotland

Communications plan

1. Introduction

1.1 This communications plan has been developed to support the implementation of the West of Scotland Delivery Plan. It sets out the approach that will be taken to engage with key stakeholders on the plan, to communicate the national and historical context within which the plan has been developed and to highlight the benefits that will be realised for patients, communities and staff.

1.2 It also outlines the measures that will be taken by the West of Scotland Communications Teams to ensure consistency of message, co-ordination of timescales and a single 'once for the West of Scotland' approach to maximise effective use of resources and avoid duplication.

2. Background

2.1 The Scottish Government published the Health and Social Care Delivery Plan in December 2016, which sets out the importance of delivering:

- better care;
- better health; and
- better value.

2.2 The Health and Social Care Plan outlines the need to look at services on a population basis and to plan and deliver services that are sustainable, evidence-based and outcome-focussed. By working more collaboratively, NHS Boards, Integration Joint Boards and other partners can plan and deliver services more effectively, so as to provide better patient outcomes and more efficient, consistent and sustainable services.

2.3 At regional level, the Scottish Government has commissioned Regional Delivery Plans to be developed, encompassing a whole-system approach to the delivery of health and social care for each of the three regions (North, East and West).

2.4 For the West of Scotland, this involves planning for the population of 2.7 million, which is covered by five NHS Boards, 16 Local Authorities and 15 Health and Social Care Partnerships, as well as the Golden Jubilee Foundation.

2.5 The national NHS Boards are also developing a single plan that sets out the national services where improvement should be focused, including, where appropriate, a 'Once for Scotland' approach in areas such as digital services, clinical demand management and support services.

2.6 To take forward the national and regional approach, five Chief Executives have been appointed to the role of National or Regional Implementation Lead.

2.7 The West of Scotland partners are required to produce a first Regional Delivery Plan by March 2018, and seek the support of Health Boards and Integrated Joint Boards to work collaboratively to achieve the best outcomes delivered sustainably for everyone across the West of Scotland.

3. Positioning our communications: national and historical context

3.1 The one constant in the NHS is change. The 70th anniversary of the NHS is a fitting backdrop to demonstrate to our communities just how much change has already taken place and how modern healthcare will continue to evolve, providing better care and better outcomes.

3.2 This is a key theme within the communications and engagement strategy created by the Scottish Government to support the delivery of the National Delivery Plan. That strategy provides a national framework to which all regional activity can be aligned.

3.3 All our communications will reflect the language and positioning of change as recommended within the national communications strategy, including:

- the use of language of evolution and development to explain change rather than the terms 'radical' or 'transformational';
- acknowledging people's affection for their NHS and mentioning the things that are important to them;
- emphasis on the benefits/advantages for people; and,
- change and development to be framed within the continuation and improvement of a much loved service.

3.4 The regional plan will also be based on the values and principles of the national strategy:

- Meaningful engagement with our staff - where our staff will be our primary audiences, learning first-hand about the Regional Delivery Plan as it affects them
- Meaningful involvement of our communities from the outset as plans develop
- Inclusiveness – reflecting the full diversity of our workforce and our communities
- Openness and transparency
- Collaborative

3.5 Key messages shared by everyone involved in the dialogue will be essential for clarity. Our key messages are:

- Working so the people of West of Scotland can live longer, healthier lives at home or in a homely setting and we have a health and social care system that:
    - is integrated;
    - focuses on prevention, anticipation and supported self-management;
    - will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
    - focuses on care being provided to the **highest standards of quality and safety, whatever the setting**, with the person at the centre of all decisions; and
    - ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.
- Healthcare / health and social care / the NHS in Scotland has been **continually evolving over the years** as new treatments, technology and service developments have emerged. Our health and social care system **will always evolve to deal with society's health challenges and to provide excellent care**.
- Health and social care provision is different in Scotland. We have found our own solutions to the challenges we face which give us a solid foundation from which to build. We must **continue to develop to provide the highest quality of health and social care** to the people of Scotland.

3.6 These messages will continue to develop as the regional delivery plan evolves.

4. Our audiences

4.1 The following audiences have been identified although this may be further segmented when the messages evolve.

- **Internal:**
  - NHS Boards - Chairs, Non-executive members and Employee Directors
  - Chief Executives and executive teams - Medical Directors, Nursing Directors, Directors of Finance, Directors of Public Health, Chief Operating Officers, HR Directors, Workforce and Planning Directors
  - Integrated Joint Boards
  - Area Partnership Forum, Trades unions,
  - GPs, Pharmacists and Dentists
  - Staff directly affected by the changes
  - All other staff

- **External:**
  - Patients and carers
  - Third sector organisations
  - Elected members: local councillors, MSPs and MPs
  - Community Planning Partners
  - Media
  - General Public

5. Our approach

5.1 Within the West of Scotland we have a well-established Communications Group which works collaboratively to deliver effective communications across a range of issues. This removes duplication and makes best use of the resources available. We will take the same approach with this communications plan. A single point of contact will liaise with the Regional Implementation Lead to develop content and regular updates for use across the region by all boards.

5.2 The Regional Implementation Lead will agree with his fellow Chief Executives on a 'once for the region' approach to communications, with a single authorisation for all communications.

5.3 The Group will collaborate to produce a range of resources that can be used by all boards to help communicate the plan including:

- Case studies – case studies and people stories will be crucial to evidence that changes is constant and successful and is benefitting patients across the west of Scotland
- FAQs
- Digital resources including animations and infographics

- Core content as newsletters and as editorial copy to be used in local communications

5.4 Each board will use its existing and well-established channels to communicate the regional updates with its own audiences:
- Staff communication channels
- External communications channels:
  - Print publications
  - Public websites
  - Social media
  - Third sector organisations
  - Patient groups
  - Media releases, editorial, events

5.5 As far as is practical, all boards will co-ordinate the publication of updates so that information is being shared with audiences within the same timescales.

5.6 Engagement activity with communities will be co-ordinated locally by each board with their established networks and in conjunction with Health and Social Care Partnerships. This will build on the work that the HSCPs have undertaken to inform their Strategic Commissioning Plans which is informing the development of the Regional Delivery Plan. The expectation is that the Boards and HSCPs will be responsible for gathering feedback to inform the draft plan.

5.7 All boards will keep a record of communications activity, including engagement activity, as evidence of engagement and consultation.

6. Budget and costs

This has yet to be determined

7. Timeline

This has yet to be finalised.

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 21

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	9th November 2017
Subject Title	Updated Strategic Management Team arrangements
Report By	Susan Manion, Chief Officer
Contact Officer	Susan Manion, Chief Officer 0141 232 8216 Susan.manion@ggc.scot.nhs.uk

Purpose of Report	The HSCP Integration scheme requires the Chief Officer to assure the HSCP Board that the operational management and governance arrangements are in place for the functions delegated to the Integration Joint Board.

Recommendations	The Partnership Board is asked to: Note the updated management arrangements outlined

Relevance to HSCP Board Strategic Plan	Management arrangements revised to ensure the delivery of the Strategic Plan

Implications for Health & Social Care Partnership

Human Resources	As employing authorities, East Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board have reviewed the change and support the recruitment in line with the agreed practice

Equalities:	Not applicable

Financial:	Not applicable

Legal:	Not applicable

Economic Impact:	Not applicable

Sustainability:	Not applicable

Risk Implications:	Not applicable

Implications for East Dunbartonshire Council:	Management arrangements will support the planning and delivery of Council Social Work Services

Implications for NHS Greater Glasgow & Clyde:	Management arrangements will support the planning and delivery of NHS Board Health 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	☒

MAIN REPORT

1.1 The existing Strategic Management Team (SMT) arrangements for the HSCP were agreed in September 2015. As the organisation has bedded down, it is time to review those arrangements.

1.2 What works well is the operation of the statutory functions including the financial management and reporting arrangements, the strategic planning and performance process and the professional advice and support through the Chief Social Worker, Professional Nurse Advisor and Clinical Director. Operationally much has been achieved as we have improved services particularly in relation to unscheduled care. We have successfully incorporated the children's social work service which, alongside the child health service, is managed by the Head of Children's services/Chief Social Worker.

1.3 In reviewing the existing arrangements, the main concern that has emerged is the capacity in operational leadership for Adult Services. The Head of Adult and Primary Care Services has responsibility for the vast majority of the HSCP operational arrangements both in terms of budgets and whole time equivalent staff responsibilities. However, it is not just the budget and staff that are the issue in terms of capacity; it is the breadth and complexity of responsibilities. The role includes locality work with the third sector and primary care, working with independent contractors and senior staff across GG&C in the areas of mental health, learning disabilities, older people and the acute hospital sector. The complexity refers to the significant service redesign required to meet the future needs of the service. Some of these issues are outlined

below:-

- Supporting the delivery of primary care in the context of the newly emerging GP contract, cluster and locality work all of which requires a change in our relationship with GP practices, dealing with increasing demand and fewer GP numbers. New models to support our plans for unscheduled care are required;

- meeting the changing needs of those with mental health issues and with a learning disability as the current population ages and increasing numbers of transitions from Children's Services requiring updated models of care in the community offering greater choice and meeting increasing expectations from service users and their carers;

- as a commissioner of some acute services including Emergency Care, we need to work closely with acute hospital colleagues and others across neighbouring partnerships to improve pathways of care, therefore supporting more people at home or in a homely setting in their local communities and delivering key priorities set out within our un-scheduled care plan;

- we will have to deliver significant efficiencies and in the context of constrained resources and ever increasing demand we must reconfigure our services. This requires us to work in a very different way and closely with the third and independent sector as well as with local communities;

1.4 The adult health and care services before the establishment of the HSCP in 2015 were managed by three senior posts, a Head of Primary Care, Head of Mental Health Services and a Head of Adult and Community Services. Currently we have one post covering the same management responsibilities, the Head of Adult and Primary Care Services.

1.5 More recently gaps in senior level leadership have emerged in relation to primary care, quality improvement, locality development and a need to increase pace in relation to service redesign. This is due to the lack of capacity in the role as it is currently configured. We will therefore remove the post of Head of Adult services and create one post as Head of Mental Health, Learning Disabilities and Addiction services and another as Head of Community Health and Care.

1.6 This meets our need to ensure that we can drive the necessary change. It is in line with comparable Partnerships. Costs will be met from the existing resource and the new arrangements will create further efficiencies. The existing and revised management arrangements are attached for information.

1.7 The constrained financial environment and increasing demand does not mean that we have to be pessimistic about what it is possible to achieve. In East Dunbartonshire the history of joint working and innovation, the committed and skilled workforce shows us that it is possible to realise the intent behind the legislation. We will do more to join up services for individuals so it is a truly seamless service, we will be ambitious and innovative when it comes to new ways of working. The adjustments to the SMT outlined here are intended to strengthen operational delivery and balance the need to ensure the provision of high quality services every day and also take forward our ambitious programme for change.

1.8	Discussions with staff via the staff forum, the SMT and team leaders have informed this decision. As the employing authorities, the Council and NHS Board have reviewed the arrangements in line with the appropriate employment practices and are supporting recruitment.

Item 21a

East Dunbartonshire Health & Social Care Partnership, Revised Management structure

Table A – Structure at 31 August 2017

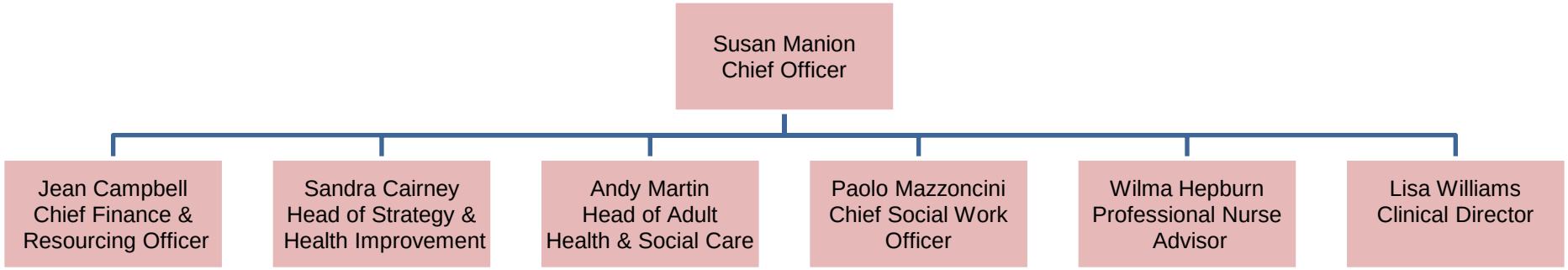


Table B – Updated Structure

Table C – Structure for Head of Community Care

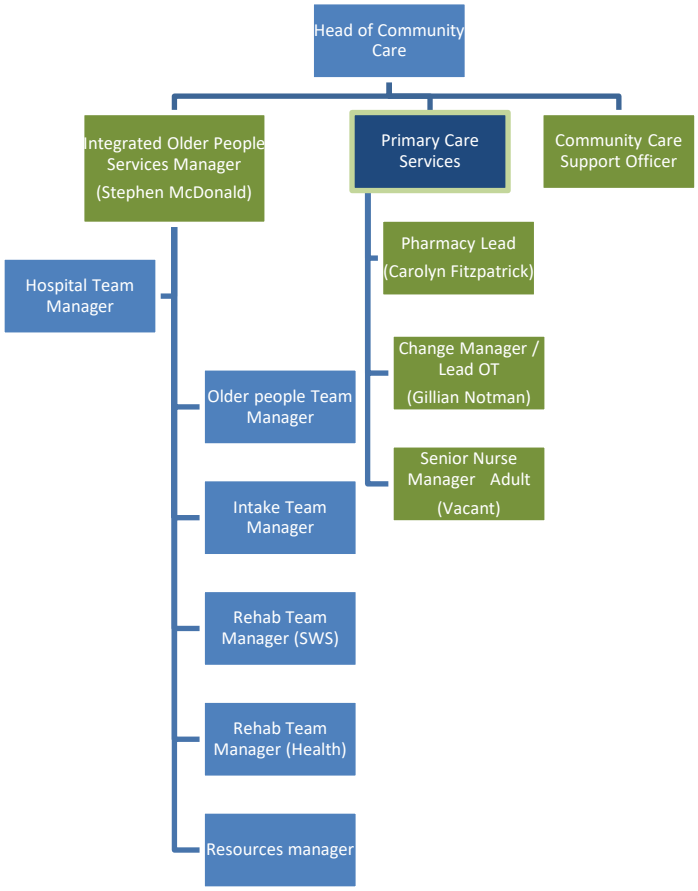
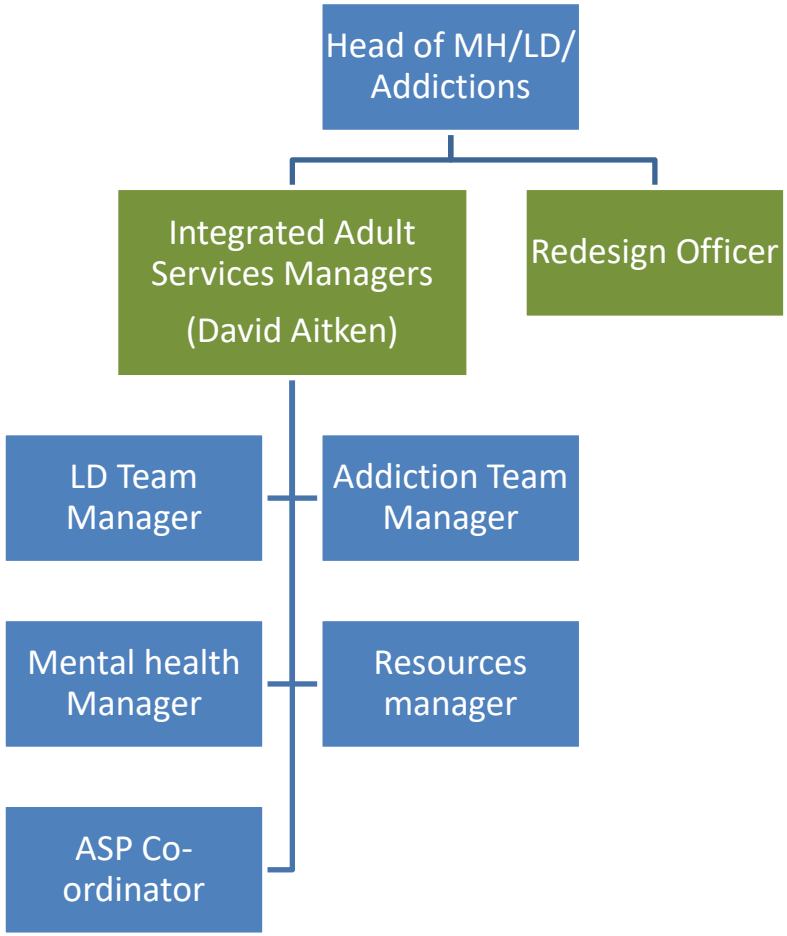


Table D – Structure for Head of Mental Health, Learning Disability & Addictions



East Dunbartonshire Health & Social Care Partnership

Item 22

East Dunbartonshire 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
11th December 2017 – Consultation on the Strategic Plan and how the HSCP supports people to leave hospital safely
4th April 2018 – Children & Families & Criminal Justice
Service Visits – All at 10am to 11.30am
8th January 2018 – Visit to Milngavie Clinic
5th of February 2018 - Visit to Lennoxtown Community Hub
16th April 2018- Visit to Woodlands Resource Centre
HSCP Board Meeting - 11th January 2018
HSCP Board Development: Topic specific seminar on Duty of Candour – 9am to 9.30am.
Performance Improvement Report – Quarter 2
Draft Carer Eligibility Criteria
Draft Strategic Plan
Financial Plan 2018/2019 and 3 years beyond
Local Outcome Improvement Plan – (LOIP per SC)
Records Management Plan
Strategic Needs Assessment - Children & Young People
Carers Act
Chief Social Work Officer report
OHD Performance Report (FMcL)
HSCP Board Meeting - 15th March 2018
Workforce Plan
Annual Governance Documents / Control Lists

Annual Business Plan 2018/19
Performance Improvement Report – Quarter 3
Strategic Plan Final Draft
Draft Joint Health Improvement Plan
HSCP Board Meeting - 10th May 2018
HSCP Board Development – Topic specific seminar on this meeting date on Oral Health Directorate - 9am -930am.
Register of Interests
Business Plan update
iMatter update
HSCP Board Meeting - 28th June 2018
Annual Performance Report
Performance Improvement Report (SC) – Quarter 4
Carer Strategy Draft
OHD Performance Report

East Dunbartonshire Health & Social Care Partnership Board

Distribution List:

	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
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
Gillian McConnachie	Chief Internal Auditor HSCP	e-copy
Karen Donnelly	EDC Chief Solicitor and Monitoring Officer	e-copy
Martin Cunningham	EDC Corporate Governance Manager	3
John Hamilton	Head of NHS Board Administration	e-copy
Louise Martin	Head of Administration, ED HSCP	e-copy
Frances McLinden	General Manager, Oral Health Directorate	e-copy
Tom Quinn	Head of Human Resources	e-copy
Sharon Bradshaw	Human Resources	e-copy
	For information only (Substitutes)	
Councillor Mohrag Fischer	EDC Elected member	e-copy
Councillor Graeme McGinnigle	EDC Elected member	e-copy
Councillor Rosie O'Neil	EDC Elected member	e-copy
A. Jamieson	Carers Representative	e-copy
I Twaddle	Service User Representative	e-copy