For meeting on

28 MAY 2019

Agenda 2019

East Dunbartonshire Health & Social Care Partnership Board

East Dunbartonshire
Health & Social Care
Partnership

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 **Tuesday, 28th May 2019 at 9.30am** to consider the undernoted business.

Chair: Jacqueline Forbes
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 for the HSCP Board held on; 21st March 2019

Seminar: Children's Services, commencing 9am.

Item	Contact officer	Description	Page
		STANDING ITEMS	
1.	Martin Cunningham	Minute of HSCP Board held on 21st March 2019	**Paper to follow**
2.	Susan Manion	Chief Officers Report	**Verbal**
3.	Susan Manion	Ministerial Steering Group Review of Integration – Self Assessment	**Paper**
4.	Jean Campbell	Transformational Board Business Plan	**Paper**
5.	Derrick Pearce	East Dunbartonshire HSCP Primary Care Improvement Plan – Implementation	**Paper**
6.	Derrick Pearce	Review of Winter	**Paper**
7.	Derrick Pearce	Out of Hours review	**Paper**
8.	Susan Manion	Chairing arrangements	**Verbal**

9.	Susan Manion	HSCP Agenda Planner	**Paper**
10.	Chair	Any other competent business	
FUTURE HSCP BOARD AGENDA ITEMS			
		Date (s) of next meeting (s) – 09.30am to 1pm if Seminar schedule start time will be 9am. **Thursday 27 June 2019** **Thursday 5th September 2019** **Thursday 14th November 2019** **Thursday 23rd January 2020** **Thursday 26th March 2020** All held in the Council Committee Room, 12 Strathkelvin Place, Kirkintilloch, G66 1XT	

Minute of meeting of the Health & Social Care Partnership Board held within the Committee Room, 12 Strathkelvin Place, Kirkintilloch on **Thursday, 21 March 2019.**

Voting Members Present:	EDC Councillors **MECHAN, MOIR & MURRAY**
	NHSGGC Non-Executive Directors **FORBES, McGUIRE & RITCHIE**

Non-Voting Members present:

S. **Manion**	Chief Officer - East Dunbartonshire HSCP
M. **Brickley**	Service Users Representative
J. **Campbell**	Chief Finance and Resource Officer
A. **McCready**	Trades Union Representative
A. **Meikle**	Third Sector Representative
J. **Proctor**	Carers Representative
C. **Sinclair**	Acting Chief Social Work Officer / Head of Mental Health, Learning Disability & Addictions

Jacqueline Forbes (Chair) presiding

Also Present:	Claire **Carthy**	Interim Head of Children, Families & Criminal Justice
	M. **Cunningham**	EDC - Corporate Governance Manager
	K **Donnelly**	HSCP Board Standards Officer / EDC – Chief Solicitor & Monitoring Officer
	C. **Fitzpatrick**	Prescribing & Clinical Pharmacy Lead
	G. **McConnachie**	Internal Auditor
	A. **O'Donnell**	Criminal Justice Service Manager
	D. **Pearce**	Head of Community Health & Care Services
	L. **Tindall**	Organisational Development Lead

APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Adam Bowman, Lisa Williams, Frances McLinden and Tom Quinn

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.

PRESENTATION – UPDATE ON CRIMINAL JUSTICE

Alex O'Donnell led the Board through a presentation on Criminal Justice service in the East Dunbartonshire area. Following questions from Board members, the Board thanked him for an informative presentation on the progress of Criminal Justice services in the area.

HEALTH & SOCIAL CARE PARTNERSHIP (HSCP) BOARD
21 MARCH 2019

1. MINUTE OF MEETING – 17 JANUARY 2019

There was submitted and approved the minute of the meeting of the HSCP Board held on 17 January 2019.

2. CHIEF OFFICER'S REPORT

The Chief Officer addressed the Board and summarised the national and local developments since the last meeting of the Partnership Board. Details included:-

- "Moving Forward Together – Key issue for the Board – HSCP and NHS GGC will be holding two public engagement events to provide East Dunbartonshire residents, patients, service users and carers with information on the Moving Forward Together (MFT) programme and information on local health and social care services provided by the HSCP – 5 April 2019 – Bishopbriggs and Bearsden.
- GG&C NHS – Staff Governance Meeting - Performance, Absence Rates, Response to questionnaire, joined-up work, values & behaviours, areas for Improvement.
- Delayed Discharge – Complex cases – development session to be arranged and added to the timetable
- Homecare – Update – Taken longer than expected report to next meeting
- Strategic Inspection – Now completed results and feedback expected 15 April 2019 and a report to a future Board.
- Personnel – Jonathan Best – Chief Operations Officer managing acute services GG&C NHS
  Frances McLinden – 6 months secondment Head of Regional Services – Acute Division
  Replacement for Wilma Hepburn, Chief Nurse – Val Tierney formerly of East Renfrewshire HSCP

Following consideration, the Board noted the information.

3. FINANCIAL PERFORMANCE BUDGET 2018/19 – PERIOD 10

The Chief Finance and Resources Officer updated the Board on the financial performance of the Partnership as at period 10 of 2018/19.

Following discussion and questions regarding: Management Actions to mitigate overspends; the numbers of care homes customers and associated budget lines for respite and supported living; the general pattern of the use of reserves by HSCP Boards the Board agreed as follows:-

a. To note the projected Out turn position is reporting an over spend of £0.67m as at period 10 of 2018/19.

b. To note the progress to date on achievement of the approved savings plan for 2018/19 as detailed in **Appendix 1**.

c. To note and approve the updated reserves position as detailed in paragraph 1.19 of the report.

d. To note the risks associated with the delivery of a balanced budget as detailed in paragraph 2.0 of the report.

4. FINANCIAL PLANNING 2019/2020 - UPDATE

A Report by the Chief Finance & Resources Officer, copies of which had been circulated separately, updated the Board on financial planning for the Partnership and furthermore to agree the Revenue Budget for 2019/20.

Following questions and discussion on the basis of the planning assumptions outlined within the report and the impact this would have on the Partnership's ability to deliver both the functions delegated to it under the integration scheme and the strategic priorities set out for the HSCP, the Board then agreed as follows:-

a. To note the position on the financial planning assumptions for the partnership based on discussion and collaboration with representatives from the constituent bodies and the latest known position for both the Council and the NHS Board for 2019/20.
b. To confirm acceptance of the improved offer in line with the Scottish Government uplift to NHS GG&C.
c. To conditionally accept the indicative budget settlement for 2019/20 subject to the Council formally approving its budget on the 21st March 2019.
d. To note the management actions outlined in Appendix 4 to mitigate the financial challenges to the partnership.
e. To approve the transformation programme for 2019/20 to deliver a balanced budget position for the partnership outlined in Appendix 5.
f. To note the anticipated reserves position for the partnership moving into 2019/20,
g. To note the risks to the Partnership in meeting the service demands for health & social care functions and in the delivery of the strategic priorities set out in the Strategic Plan

5. HSCP EQUALITY AND DIVERSITY INTERIM PROGRESS REPORT - 2019

A Report by the Head of Mental Health, Learning Disability, Addictions and Health Improvement / Interim Chief Social Work Officer, updated the HSCP Board on the mid-term progress against the activities contained within the East Dunbartonshire HSCP's Equalities Mainstream Report 2017 – 2021.

The Board noted the report.

6. DRAFT RECORDS MANAGEMENT PLAN AND UPDATE ON GENERAL DATA PROTECTION RULES (GDPR)

A Report by the Chief Finance & Resources Officer, copies of which had been circulated separately, introduced the IJB's Records Management Plan (RMP) and sought the IJB's approval for its content as well as onward submission to the Keeper of the Records of Scotland for agreement. The report also provided an update on the changes to the Data Protection Laws as they apply to the HSCP.

Thereafter the HSCP Board approved the content of the Draft Records Management Plan and approved the plan to be formally submitted to the Keeper of the Records of Scotland for their agreement by 19th April 2019, subject to any further minor amendments. The Board also noted the implications to the partnership in relation to changes to the Data Protection Laws.

7. MINISTERIAL STRATEGIC GROUP (MSG) TARGETS 2019/20

A Report by the Head of Community Health and Care Services, copies of which had previously been circulated, presented the Board with the proposed 2019/20 Ministerial Strategic Group (MSG) targets for East Dunbartonshire HSCP and outlined the high level actions intended to facilitate delivery of these targets.

Following discussion and having heard from the Head of Community Health & Care Services regarding revised targets for unscheduled care, unscheduled emergency admissions and the level of A&E attendances, the HSCP Board:

a) Approved the 2019/20 Ministerial Strategic Group (MSG) targets
b) Noted the actions intended to deliver on the targets and the development of an Unscheduled Care Work Plan for 2019/20.

8. EAST DUNBARTONSHIRE HSCP CORPORATE RISK REGISTER

A Report by the Chief Finance and Resources Officer, copies of which had previously been circulated, updated the Corporate Risks Register and how these Risks were managed.

Following discussion, the HSCP Board having reviewed the Corporate Risk Register approved the content of the report.

9. PUBLIC, SERVICE USER & CARER (PSUC) REPRESENTATIVE SUPPORT GROUP

A verbal Report by the Service User Representative and the Carers Representative, outlined the processes and actions undertaken in the development of the Public, Service User & Carer Representatives Support Group (PSUCRSG)

The Board heard from the Service User and Carers Representative with further details, particularly in relation to the adjusted format of these meetings, designed to increase member engagement and knowledge and of the subject matters of recent presentations.

Thereafter the Board noted the Report.

10. EAST DUNBARTONSHIRE HSCP CLINICAL & CARE GOVERNANCE SUB GROUP MINUTES OF MEETING HELD ON 30 JANUARY 2019

The Board heard from the Chief Officer in response to concerns regarding the areas of risk not summarised in the minutes. The Board then noted the draft Minutes of the Clinical Care & Governance Group meeting of 30 January 2019 and agreed that future wording would be considered for future minutes.

11. EAST DUNBARTONSHIRE HSCP STAFF PARTNERSHIP FORUM MINUTES OF MEETING HELD ON 21 JANUARY 2019

The Board noted the Minutes of the ED HSCP Staff Partnership Forum meeting of 21 January 2019.

12. EAST DUNBARTONSHIRE PERFORMANCE, AUDIT & RISK COMMITTEE MINUTES OF 19TH DECEMBER 2018 AND DRAFT MINUTES OF 1ST MARCH 2019

The Board noted the Minutes of the Performance, Audit & Risk Committee held on the 19th December 2018 and 1st March 2019.

13. CARERS (SCOTLAND) ACT 2016 – CARERS STRATEGY 2019-22

A Report by the Head of Mental Health, Learning Disability, Addictions and Health Improvement / Interim Chief Social Work Officer, copies of which had previously been circulated, provided the Board with a summary briefing on the updated Carers Strategy 2019-22.

Following discussion the Board commended the report which considered the strategic direction and implications of the Strategy and thereafter noted the Report.

14. PRESCRIBING UPDATE

A Report by the Head of Community Health & Care Services, copies of which had previously been circulated, updated the Board on prescribing within the East Dunbartonshire HSCP area.

Following questions and discussion, the Board heard from the Lead for Prescribing and Clinical Pharmacy with further details, agreed that a future development session would consider the patterns of prescribing over a period of time and thereafter noted the report.

15. UPDATE ON INTEGRATION; ANALYSIS OF IMPLICATIONS OF THE MINISTERIAL STRATEGIC GROUP (MSG) FOR HEALTH AND COMMUNITY CARE REPORT AND AUDIT SCOTLAND.

A Report by the Chief Officer, copies of which had previously been circulated, presented the MSG Review and outlined how it was proposed to take forward the proposals

Following discussion the Board noted the report and agreed to consider future reports on the proposals. The Board also noted that these proposals would be considered alongside the Audit Scotland Report "Health and Social Care Integration; Update on progress" which was reported to the Board on 17 January 2019.

16. LEARNING DISABILITY DAY SERVICES – VISION AND REDESIGN PRINCIPLES: PROPOSAL TO CONSULT

A Report by the Head of Mental Health, Learning Disability, Addictions and Health Improvement / Interim Chief Social Work Officer, copies of which had previously been circulated, updated the Board on progress of the Learning Disability Strategic Review, including the vision and proposed principles for day service redesign and sought approval to consult on these proposals.

Following discussion the Board agreed as follows:-

- To note the progress of the overall Learning Disability Review process;
- To note the proposed day services vision and redesign principles;
- To engage with the public and stakeholders on these initial proposals, in line with the processes set out in this report including the intention to involve service users, carers and other stakeholders in developing the detail of new services; and
- To request a further report to a future meeting of the Board at the conclusion of the consultative process, outlining responses and recommendations for further action.

17. FAIR ACCESS TO COMMUNITY CARE (ADULTS) AND ASSOCIATED ELIGIBILITY CRITERIA POLICIES

A Report by the Interim Chief Social Work Officer / Head of Mental Health, Learning Disability, Addictions and Health Improvement, copies of which had previously been circulated, advised the HSCP Board of the outcome of consultation on the proposed new Fair Access to Community Care (Adults) Policy, including a revised Eligibility Criteria for Community Care (Adults).

Thereafter the Board:

a. Noted the process and impact of the consultative process undertaken to support the development of the new Fair Access to Community Care (Adults) Policy and the revised Eligibility Criteria for Community Care (Adults) Policy attached at Appendix 1 of the report;
b. Approved the Fair Access to Community Care (Adults) Policy and the revised Eligibility Criteria for Community Care (Adults) Policy, as set out at Appendices 2 and 3 respectively for implementation;
c. Approved the phasing of implementation over a three year period, commencing 3 June 2019 and proceeding as outlined in section 1.24 of the report; and
d. Noted the implementation plan as outlined at section 1.25 of the report.

18. AGENDA ITEMS FOR HSCP BOARD MEETINGS - MAY 2019 – JANUARY 2020

The Chief Officer provided an updated schedule of topics for HSCP Board meetings 2019/20 which was duly noted by the Board

19. DATE OF NEXT MEETING – 10 MAY 2019

The HSCP Board noted that the next meeting was scheduled to be held on Thursday 10 May 2019 in the Council Chambers, however due to the circumstances which led to the European Elections being held, it was agreed to hold the meeting on 28 May 2019

Agenda Item Number: 3

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	**28 May 2019**
Subject Title	**Ministerial Strategic Group for Health And Community Care Review of Integration – Self Assessment**
Report By	**Susan Manion, Chief Officer**
Contact Officer	**Caroline Sinclair, Interim Chief Social Work Officer,** **Head of Mental Health, Learning Disability, Addiction & Health Improvement Services** **Tel: 0141 304 7435**

Purpose of Report	This report makes members aware of the completed self-evaluation of progress under integration which has been submitted to the Scottish Government for consideration by the Ministerial Strategic Group for Health and Community Care, in line with required timescales.

Recommendations	Board members are asked to a) note the content of this report and; b) note that an action plan outlining how identified improvement areas will be taken forward will be reported to a future meeting of the HSCP Board.

Relevance to HSCP Board Strategic Plan	This report relates to progress that the partnership, the Local Authority and the Health Board have made in embedding and supporting integration in East Dunbartonshire and therefore relates to matters that underpin delivery of the Board's 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:	The action plan outlining how identified improvement areas will be taken forward requires to be developed in collaboration with East Dunbartonshire Council.

Implications for NHS Greater Glasgow & Clyde:	The action plan outlining how identified improvement areas will be taken forward requires to be developed in collaboration with NHS Greater Glasgow and Clyde.

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 For a number of years now work has been underway across Scotland to integrate health and social care services in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. The Scottish Government focused on four key objectives to be achieved through integration, which remain central to this day:

- Health and social care services should be firmly integrated around the needs of individuals, their carers and other family members;
- Health and social care services should be characterised by strong and consistent clinical and care professional leadership;
- The providers of services should be held to account jointly and effectively for improved delivery; and
- Services should be underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve, rather than the organisations through which they are delivered.

1.2 At a debate in the Scottish Parliament on 2 May 2018, the then Cabinet Secretary for Health and Sport undertook that a review of progress by Integration Authorities would be taken forward with the Ministerial Strategic Group for Health and Community Care (hereafter referred to as the MSG), and that outputs arising from any further action stemming from that review would be shared with the Health and Sport Committee of the Scottish Parliament.

1.3 On 15 November 2018 Audit Scotland published their most recent report on integration which highlighted areas of good practice and positive developments. However, it also highlighted a series of challenges that remain to be addressed. A particular focus was placed on the need to continue to work on financial planning, governance and strategic planning arrangements, and leadership capacity. The report emphasised that the pace and effectiveness of integration both needed to increase.

1.4 The MSG review of integration was published on 4 February 2019 (**Appendix 1**). Following publication it was agreed that the MSG will take on a new role 'driving forward and supporting implementation of the review'. On 6 March 2019 the MSG wrote to Local Authority and Health Board Chief Executives and Chief Officers of Integration Authorities to advise that a self-evaluation tool would be developed for completion by local area partners. This tool would be based around 25 proposals themed under the six 'features supporting integration' identified by Audit Scotland in their November 2018 report, which the MSG considered to provide a helpful framework within which to understand the issues and identify ways to make progress. The six areas are: Collaborative Leadership and Building Relationships;

- Integrated Finances and Financial Planning;
- Effective Strategic Planning for Improvement;
- Agree Governance and Accountability Arrangements;
- Ability and Willingness to Share Information; and
- Meaningful and Sustained Engagement.

1.5 The MSG group opted to set out "proposals" in their report, rather than "recommendations". The intention of the MSG was to underline that the commitments are to be considered a shared endeavour.

2. COMPLETING OUR SELF-ASSESSMENT

2.1 The MSG self-evaluation template was received on 25 March 2019 with a clear outline as to expectations for completion and submission. The MSG review report notes an expectation that "every Health Board, Local Authority and Integration Joint Board will evaluate their current position in relation to this report and the Audit Scotland report, and take action to make progress." It was also made clear that the expectation is that each Integration Authority area will submit a single joint response. Submission timescales are as follows:

- Confirmation to Scottish Government of processes underway to complete the template – 17 April 2019;
- Completed template to Scottish Government - 15 May 2019; and
- One-year-on follow up expected to measure progress against the improvement areas identified – April 2020

2.2 East Dunbartonshire Council, NHS Greater Glasgow and Clyde and the East Dunbartonshire Health and Social Care Partnership have worked together on the text of a joint response. This was submitted to the Scottish Government on 15 May 2019 in line with required timescales. The completed self-evaluation is attached as **appendix 2** to this report.

2.3 In completing the self-evaluation there are key themes emerging around progress towards integration in the East Dunbartonshire area. It is frequently noted that progress in the self-assessment areas has been a journey of improvement, and one that all involved are still on. The self-assessment highlights positive practice in a number of areas and where room for improvement has been identified it has usually also been possible to articulate what is required to achieve that. Overall, it is felt that a great deal of progress has been made to date.

2.4 The partnership will now work to develop an action plan to take forward the improvement areas identified. This will be developed in collaboration with East Dunbartonshire Council and NHS Greater Glasgow and Clyde. The action plan will be presented to a future meeting of the HSCP Board as will delivery updates in the run up to the one year follow on self-assessment process expected to take place in April 2020.

3.0 APPENDICES

3.1 Ministerial Strategic Group for Health and Community Care – Self-Evaluation of The Review Of Progress With Integration Of Health And Social Care

3.2 East Dunbartonshire Self-Evaluation

Ministerial Strategic Group for Health and Community Care

Review of Progress with Integration of Health and Social Care

Final Report

February 2019

COSLA

Scottish Government
Riaghaltas na h-Alba
gov.scot

REVIEW OF PROGRESS WITH INTEGRATION OF HEALTH AND SOCIAL CARE

Introduction

Since 2016, work has been underway across Scotland to integrate health and social care services in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. By integrating the planning and provision of care, partners in the public, third and independent sectors are improving people's experience of care along with its quality and sustainability. Evidence is emerging of good progress in local systems. Audit Scotland's[1] report on integration that was published on 15 November 2018 highlights a series of challenges that nonetheless need to be addressed, in terms particularly of financial planning, governance and strategic planning arrangements and leadership capacity.

The pace and effectiveness of integration need to increase. At a health debate in the Scottish Parliament on 2 May 2018, the then Cabinet Secretary for Health and Sport undertook that a review of progress by Integration Authorities would be taken forward with the Ministerial Strategic Group for Health and Community Care, and that outputs arising from any further action stemming from such a review would be shared with the Health and Sport Committee of the Scottish Parliament.

Why has Scotland integrated health and social care?

We have integrated health and social care so that we can ensure people have access to the services and support they need, so that their care feels seamless to them, and so that they experience good outcomes and high standards of support. We are also looking to the future: integration requires services to be redesigned and improved, with a strong focus on prevention, quality and sustainability, so that we can continue to maintain our focus on reforming and improving people's experience of care. In undertaking this review we have built upon Audit Scotland's observation that integration can work within the current legislative framework, but that Integration Authorities are operating in an extremely challenging environment and there is much more to be done: our focus is on tackling the challenges rather than revisiting the statutory basis for integration.

As part of the review, it is important to acknowledge fully the key importance of staff working across the entirety of health and social care. People working in health and social care services are driving forward many improvements in the experience of care, every day and often in challenging and difficult circumstances. Without the insight, experience and dedication of the health and social care workforce we will simply not be able to deliver on out ambitions for integration. This review does not make recommendations about the health and social care workforce: that work is being undertaken through the National Workforce Plan for health and social care. We nonetheless felt it important to emphasise here the importance of our shared ambitions to develop and support the workforce for integration.

[1] Health and social care integration: update on progress

Reviewing progress with integration

As we have reviewed our progress to date, our approach has been to focus on the key questions that matter most to people who use services and the systems we have put in place in order to better support those priorities. We have asked ourselves where we are making progress and where the barriers are that may prevent professionals and staff across health and social care from using their considerable skills and resources to best effect. When the Scottish Government first consulted upon plans for integration[2], it focused on four key objectives, which remain central to our aims:

- Health and social care services should be firmly integrated around the needs of individuals, their carers and other family members
- Health and social care services should be characterised by strong and consistent clinical and care professional leadership
- The providers of services should be held to account jointly and effectively for improved delivery
- Services should be underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve, rather than the organisations through which they are delivered

The legislation for integration, the Public Bodies (Joint Working) (Scotland) Act 2014, sets out principles and outcomes, which sit at the centre of our ambitions:

Principles of integration: services should[3]:

1. Be integrated from the point of view of service-users
2. Take account of the particular needs of different service-users
3. Take account of the particular needs of service-users in different parts of the area in which the service is being provided
4. Take account of the particular characteristics and circumstances of different service-users
5. Respect the rights of service-users
6. Take account of the dignity of service-users
7. Take account of the participation by service-users in the community in which service-users live
8. Protect and improve the safety of service-users
9. Improve the quality of the service
10. Be planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
11. Best anticipate needs and prevents them arising, and
12. Makes the best use of the available facilities, people and other resources.

[2] Integration of Adult Health and Social Care in Scotland: Consultation on Proposals (May 2012)
[3] http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf

National health and wellbeing outcomes[4]

1. People are able to look after and improve their own health and wellbeing and live in good health for longer
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
3. People who use health and social care services have positive experiences of those services, and have their dignity respected
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5. Health and social care services contribute to reducing health inequalities
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
7. People using health and social care services are safe from harm
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
9. Resources are used effectively and efficiently in the provision of health and social care services

The purpose of this review is to help ensure we increase our pace in delivering all of these objectives.

Review process

At its meeting on 20 June 2018, the Ministerial Strategic Group agreed that the review would be taken forward via a small "leadership" group of senior officers chaired by Paul Gray (Director General Health and Social Care and Chief Executive of NHS Scotland) and Sally Loudon (Chief Executive of COSLA). A larger group of senior stakeholders has acted as a "reference" group to the leadership group.

Membership of the review leadership group is as follows:

- Paul Gray (co-chair) (Director General for Health and Social Care and Chief Executive of NHSScotland)
- Sally Loudon (co-chair) (Chief Executive of COSLA)
- Paul Hawkins (Chief Executive of NHS Fife, representing NHS Chief Executives)
- Andrew Kerr (Chief Executive of Edinburgh City Council, representing SOLACE)
- David Williams (Chief Officer of Glasgow City IJB and Chair of the Chief Officers' network, representing IJB Chief Officers)
- Annie Gunner Logan (Chief Executive of CCPS, representing the third sector)
- Donald MacAskill (Chief Executive of Scottish Care, representing the independent sector)

[4] http://www.legislation.gov.uk/ssi/2014/343/pdfs/ssi_20140343_en.pdf

The work of the review leadership group followed this timetable:

Meeting date	Topics for discussion
24/09/18	Finance: agreeing, delegating and using integrated budgets
23/10/18	Governance and commissioning arrangements, including clinical and care governance
27/11/18	Delivery and improving outcomes including consideration of the Audit Scotland report on integration (published 15/11/18)
19/12/18	Conclusions and agreement on recommendations, to be reported to the MSG on 23/01/19

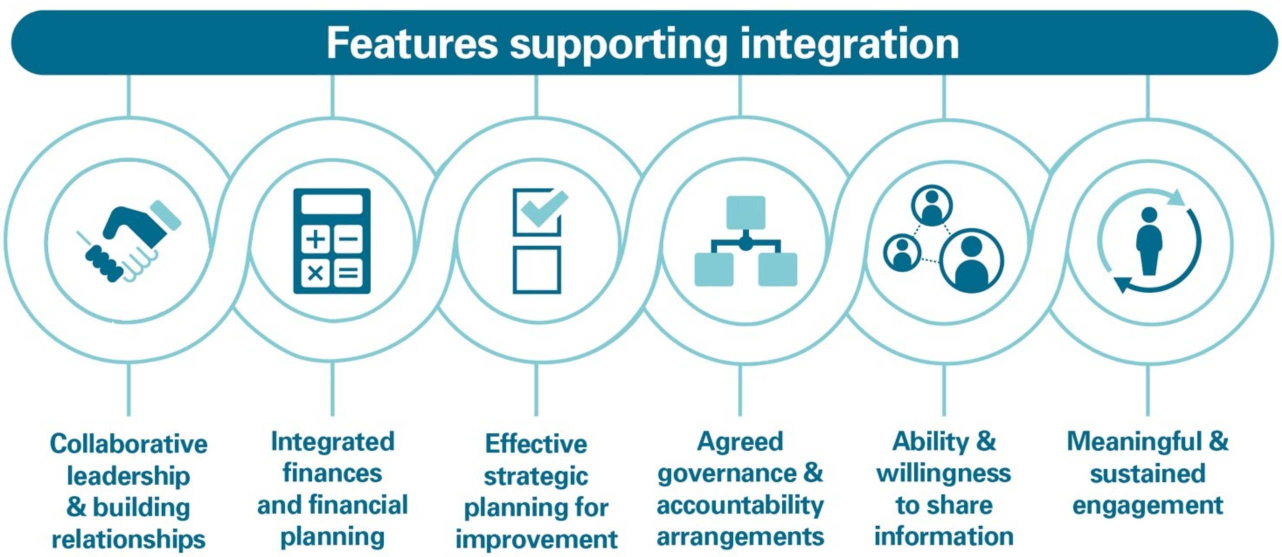
This report draws together the group's proposals for ensuring the success of integration. It builds upon the first output of our review, the joint statement issued on 26 September 2018, which is at Annex A of this report.

Integration Review Leadership Group
4 FEBRUARY 2019

Audit Scotland report

1. The group recognised that the Audit Scotland report on integration that was published in November 2018 provides important evidence for changes that are needed to deliver integration well. The group noted their agreement with Audit Scotland's recommendations. The group recommends that these recommendations should be acted upon in full by the statutory health and social care partners in Scotland. In addition, the group noted that workforce issues were not considered in any detail in the audit, but recommends that those should be a key focus for statutory and non-statutory partners taking forward integration.

2. Within a broad context of focussing on improving outcomes for people who use services and delivering sustainable, high quality services, the group noted specifically that exhibit 7 from the Audit Scotland report, reproduced below, provides a helpful framework within which to make progress. The group agreed to set out its proposals, in this report, under the headings identified in the exhibit, each of which was considered fully in turn.



3. As a group, we decided to set out "proposals" in this report rather than "recommendations" to underline that the commitments our proposals make are a shared endeavour, which we are each signed up to on a personal level as senior leaders and on behalf of our respective organisations. We have used "we" throughout the proposals set out in this document to further emphasise this.

4. In our review work, we recognised, as the Audit Scotland report does, that there is good practice developing, both in terms of how Integration Joint Boards (IJBs) are operating, and in how services are being planned and delivered to ensure better outcomes. However, this is not yet the case in all areas. We know there are challenges we must address and want to make use of good practice to drive forward change and reform to truly deliver integration for the people of Scotland.

Leadership Group Proposals

Our proposals focus on our joint and mutual responsibility to improve outcomes for people using health and social care services in Scotland. They are a reflection of our shared commitment to making integration work, set out in our joint statement from September 2018.

1. **Collaborative leadership and building relationships**

Shared and collaborative leadership must underpin and drive forward integration.

We propose that:

1. (i) **All leadership development will be focused on shared and collaborative practice.** An audit of existing national leadership programmes will be undertaken by the Scottish Government and COSLA to identify gaps and areas of synergy to support integration of health and social care. Further work will be delivered on cross-sectoral leadership development and support.
Timescale: 6 months

1. (ii) **Relationships and collaborative working between partners must improve**. Statutory partners in particular must seek to ensure an improved understanding of pressures, cultures and drivers in different parts of the system in order to promote opportunities for more open, collaborative and partnership working, as required by integration.
Timescale: 12 months

1. (iii) **Relationships and partnership working with the third and independent sectors must improve**. Each partnership will critically evaluate the effectiveness of their working arrangements and relationships with colleagues in the third and independent sectors, and take action to address any issues.
Timescale: 12 months

2. **Integrated finances and financial planning**

Money must be used to maximum benefit across health and social care. Our aim for integration has been to create a system of health and social care in Scotland in which the public pound is always used to best support the individual at the most appropriate point in the system, regardless of whether the support that is required is what we would traditionally have described as a "health" or "social care" service. Our proposals for integrated finances and financial planning focus on the practicalities of ensuring the arrangements for which we have legislated are used fully to achieve that aim, and to support the Scottish Government's Medium Term Framework for Health and Social Care[5].

We propose that:

2. (i) **Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration.** In each partnership area the Chief Executive of the Health Board and the Local Authority, and the Chief Officer of the IJB, while considering the service impact of decisions, should together request consolidated advice on the financial position as it applies to their shared interests under integration from, respectively, the NHS Director of Finance, the Local Authority S95 Officer and the IJB S95 Officer.
Timescale: By 1st April 2019 and thereafter each year by end March.

2. (ii) **Delegated budgets for IJBs must be agreed timeously.** The recently published financial framework for health and social care sets out an expectation of moving away from annual budget planning processes towards more medium term arrangements. To support this requirement for planning ahead by Integration Authorities, a requirement should be placed upon statutory partners that all delegated budgets should be agreed by the Health Board, Local Authority and IJB by the end of March each year.
Timescale: By end of March 2019 and thereafter each year by end March

2. (iii) **Delegated hospital budgets and set aside requirements must be fully implemented**. Each Health Board, in partnership with the Local Authority and IJB, must fully implement the delegated hospital budget and set aside budget requirements of the legislation, in line with the statutory guidance published in June 2015. These arrangements must be in place in time for Integration Authorities to plan their use of their budgets in 2019/20. The Scottish Government Medium Term Financial Framework includes an assumption of efficiencies from reduced variation in hospital care coupled with 50% reinvestment in the community to sustain improvement. The set aside arrangements are key to delivering this commitment.
Timescale: 6 months

2. (iv) **Each IJB must develop a transparent and prudent reserves policy**. This policy will ensure that reserves are identified for a purpose and held against planned expenditure, with timescales identified for their use, or held as a general reserve as a

[5] Scottish Government Medium Term Health and Social Care Financial Framework

contingency to cushion the impact of unexpected events or emergencies. Reserves must not be built up unnecessarily.
Timescale: 3 months

2. (v) **Statutory partners must ensure appropriate support is provided to IJB S95 Officers.** This will include Health Boards and Local Authorities providing staff and resources to provide such support. Measures must be in place to ensure conflicts of interest for IJB S95 Officers are avoided – their role is to provide high quality financial support to the IJB. To ensure a consistent approach across the country, the existing statutory guidance should be amended by removing the last line in paragraph 4.3 recommendation 2, leaving the requirement for such support as follows:

> *It is recommended that the Health Board and Local Authority Directors of Finance and the Integration Joint Board financial officer establish a process of regular in-year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole. It is also recommended that each partnership area moves to a model where both the strategic and operational finance functions are undertaken by the IJB S95 officer: and that these functions are sufficiently resourced to provide effective financial support to the Chief Officer and the IJB.*

Timescale: 6 months

2. (vi) **IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations**. Local audits of the Health Board and Local Authority must take account of the expectation that money will be spent differently. We should be focused on outcomes, not which public body put in which pound to the pot. It is key that the resources held by IJBs lose their original identity and become a single budget on an ongoing basis. This does not take away from the need for the IJB to be accountable for these resources and their use.
Timescale: from 31st March 2019 onwards.

3. Effective strategic planning for improvement

Maximising the benefit of health and social care services, and improving people's experience of care, depends on good planning across all the services that people access, in communities and hospitals, effective scrutiny, and appropriate support for both activities.

We propose that:

3. (i) **Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB.** This will include Health Boards and Local Authorities providing staff and resources to provide such support. The dual role of the Chief Officer makes it both challenging and complex, with competing demands between statutory delivery partners and the business of the IJB. Chief Officers must be recognised as pivotal in providing the leadership needed to make a success of integration and should be recruited, valued and accorded due status by statutory partners in order that they are able to properly fulfil this "mission critical" role. Consideration must be made of the capacity and capability of Chief Officers and their senior teams to support the partnership's range of responsibilities.
Timescale: 12 months

3. (ii) **Improved strategic inspection of health and social care is developed to better reflect integration**. As part of this work, the Care Inspectorate and Healthcare Improvement Scotland will ensure that:

- As well as scrutinising strategic planning and commissioning processes, strategic inspections are fundamentally focused on what integrated arrangements are achieving in terms of outcomes for people.
- Joint strategic inspections examine the performance of the whole partnership – the Health Board, Local Authority and IJB, and the contribution of non-statutory partners – to integrated arrangements, individually and as a partnership.
- There is a more balanced focus across health and social care ensured in strategic inspections.

Timescale: 6 months

3. (iii) **National improvement bodies must work more collaboratively and deliver the improvement support partnerships require to make integration work**. These bodies include Healthcare Improvement Scotland, the Care Inspectorate, the Improvement Service and NHS National Services Scotland. Improvement support will be more streamlined, better targeted and focused on assisting partnerships to implement our proposals. This will include consideration of the models for delivery of improvement support at a national and local level and a requirement to better meet the needs of integration partners.
Timescale: 3 - 6 months

3. (iv) **Improved strategic planning and commissioning arrangements must be put in place.** Partnerships should critically analyse and evaluate the effectiveness of their strategic planning and commissioning arrangements, including establishing capacity and

capability for this. Local Authorities and Health Boards will ensure support is provided for strategic planning and commissioning, including staffing and resourcing for the partnership, recognising this as a key responsibility of Integration Authorities.
Timescale: 12 months

3. (v) **Improved capacity for strategic commissioning of delegated hospital services must be in place.** As implementation of proposal 2 (iii) takes place, a necessary step in achieving full delegation of the delegated hospital budget and set aside arrangements will be the development of strategic commissioning for this purpose. This will focus on planning delegated hospital capacity requirements and will require close working with the acute sector and other partnership areas using the same hospitals. This should evolve from existing capacity and plans for those services.
Timescale: 12 months

4. Governance and accountability arrangements

Governance and accountability must be clear and commonly understood for integrated services.

We propose that:

4. (i) **The understanding of accountabilities and responsibilities between statutory partners must improve**. The responsibility for decisions about the planning and strategic commissioning of all health and social care functions that have been delegated to the IJB sits wholly with the IJB as a statutory public body. Such decisions do not require ratification by the Health Board or the Local Authority, both of which are represented on the IJB. Statutory partners should ensure duplication is avoided and arrangements previously in place for making decisions are reviewed to ensure there is clarity about the decision making responsibilities of the IJB and that decisions are made where responsibility resides. Existing committees and groups should be refocused to share information and support the IJB.
Timescale: 6 months

4. (ii) **Accountability processes across statutory partners will be streamlined.** Current arrangements for each statutory partner should be scoped and opportunities identified for better alignment, with a focus on better supporting integration and transparent public reporting. This will also ensure that different rules are not being applied to different parts of the system particularly in circumstances of shared accountability.
Timescale: 12 months

4. (iii) **IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis.** There are well-functioning IJBs that have adopted an open and inclusive approach to decision making and which have gone beyond statutory requirements in terms of memberships to include representatives of key partners in integration, including the independent and housing sectors. This will assist in improving the effectiveness and inclusivity of decision making and establish IJBs as discrete and distinctive statutory bodies acting decisively to improve outcomes for their populations.
Timescale: 12 months

4. (iv) **Clear directions must be provided by IJBs to Health Boards and Local Authorities.** Revised statutory guidance will be developed on the use of directions in relation to strategic commissioning, emphasising that directions are issued at the end of a process of decision making that has involved partners. Directions must be recognised as a key means of clarifying responsibilities and accountabilities between statutory partners, and for ensuring delivery in line with decisions.
Timescale: 6 months

4. (v) **Effective, coherent and joined up clinical and care governance arrangements must be in place.** Revised statutory guidance will be developed based on wide ranging consultations with local partnerships, identifying good practice and involving all sectors.

The key role of clinical and professional leadership in supporting the IJB to make decisions that are safe and in accordance with required standards and law must be understood, co-ordinated and utilised fully.
Timescale: 6 months

5. Ability and willingness to share information

Understanding where progress and problems are arising is key to implementing learning and delivering better care in different settings.

We propose that:

5. (i) **IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data**. Chief Officers will work together to consider, individually and as a group, whether their IJBs' annual reports can be further developed to improve consistency in reporting, better reflect progress and challenges in local systems, and ensure that, as a minimum, all statutorily required information is reported upon.
Timescale: By publication of next round of annual reports in July 2019

5. (ii) **Identifying and implementing good practice will be systematically undertaken by all partnerships.** Chief Officers will develop IJBs' annual reports to enable partnerships to identify, share and use examples of good practice, and lessons learned from things that have not worked. Inspection findings and reports from strategic inspections and service inspections should also provide a clear means of identifying and sharing good practice, based on implementation of the framework outlined below at 5 (iii) and the national health and social care standards.
Timescale: 6 - 12 months

5. (iii) **A framework for community based health and social care integrated services will be developed**. The framework will be key in identifying and promoting best practice in local systems to clearly illustrate what good looks like in community settings, which is firmly focused on improving outcomes for people. This work will be led by Scottish Government and COSLA, involving Chief Officers and other key partnership staff to inform the framework.
Timescale: 6 months

6. Meaningful and sustained engagement

Integration is all about people: improving the experience of care for people using services, and the experience of people who provide care. Meaningful and sustained engagement has a central role to play in ensuring that the planning and delivery of services is centred on people.

We propose that:

6. (i) **Effective approaches for community engagement and participation must be put in place for integration.** This is critically important to our shared responsibility for ensuring services are fit for purpose, fit for the future, and support better outcomes for people using services, carers and local communities. Revised statutory guidance will be developed by the Scottish Government and COSLA on local community engagement and participation based on existing good practice, to apply across health and social care bodies. Meaningful engagement is central to achieving the scale of change and reform required, and is an ongoing process that is not undertaken only when service change is proposed.
Timescale: 6 months

6. (ii) **Improved understanding of effective working relationships with carers, people using services and local communities is required.** Each partnership should critically evaluate the effectiveness of their working arrangements and relationships with people using services, carers and local communities. A focus on continuously improving and learning from best practice will be adopted in order to maximise meaningful and sustained engagement.
Timescale: 12 months

6. (iii) **We will support carers and representatives of people using services better to enable their full involvement in integration**. Carers and representatives of people using health and social care services will be supported by partnerships to enable meaningful engagement with their constituencies. This will support their input to Integration Joint Boards, strategic planning groups and locality arrangements for integration. This would include, for example, receipt of IJB papers with enough time to engage other carers and people using services in responding to issues raised. It would also include paying reasonable expenses for attending meetings.
Timescale: 6 -12 months

In support of these proposals we will:

- Provide support with implementation;
- Prepare guidance and involve partners in the preparation of these;
- Assist with the identification and implementation of good practice;
- Monitor and evaluate progress in achieving proposals;
- Make the necessary links to other parts of the system, such as workforce planning;
- Continue to provide leadership to making progress with integration;
- Report regularly on progress with implementation to the Ministerial Group for Health and Community care.

In support of these proposals we expect:

- Every Health Board, Local Authority and IJB will evaluate their current position in relation to this report and the Audit Scotland report, and take action to make progress using the support on offer.

- Partnerships to initiate or continue the necessary “tough conversations” to make integration work and to be clear about the risks being taken, and ensure mitigation of these is in place.

- Partnerships to be innovative in progressing integration.

Annex A – Joint Statement

Cabinet Secretary for Health and Sport
Jeane Freeman MSP

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COSLA

NHS SCOTLAND

NHS Board Chairs
Local Authority Leaders
Integration Joint Board Chairs and Vice Chairs
NHS Board Chief Executives
Local Authority Chief Executives
Integration Joint Board Chief Officers
Chief Executive, SCVO
Chief Executive, Health and Social Care Alliance
Chief Executive, CCPS
Chief Executive, Scottish Care

26 September 2018

Dear colleagues

The Scottish Government, NHS Scotland and COSLA share responsibility for ensuring the successful integration of Scotland's health and social care services. We are therefore delighted to send to you today a joint statement, attached to this letter, setting out our shared commitment to integration as leaders in the public sector.

This statement is the first output from our review of integration, which is now underway via the Ministerial Strategic Group for Health and Community Care. It frames our joint ambitions for integration and sets the context for recommendations that will follow from the review.

We look forward to continuing to work with you all to deliver integration, and, through it, better care for people using health and social care services in Scotland.

[redacted]

[redacted]

JEANE FREEMAN
Cabinet Secretary for Health and Sport

COUNCILLOR ALISON EVISON
COSLA President

DELIVERING INTEGRATION

We need to step up the pace of integrating health and social care. Truly integrated services, focused on the needs of citizens – individuals, carers and families, and on the health and wellbeing of local communities – require our leadership and personal commitment. We need to act together and in our individual roles to accelerate progress.

There are challenges that we must address. We will work together, and with our local populations as well as partners in the third and independent sectors, to understand public expectations and better meet needs for health and social care, which go hand-in-hand with improvements in life expectancy and the availability of new medicines and technologies. We are already making progress. We recognise that we are jointly responsible for tackling these challenges and that we need to adapt, compromise and support one another to deliver integration for the people of Scotland.

The Public Bodies (Joint Working) Act 2014 puts in place governance and financial arrangements, and a set of outcomes, for us to work within to achieve integration. We share a duty to empower Integration Authorities, to hold ourselves and one another to account in order to make integration work. We will learn from one another and adopt good practice. We will also work collaboratively and in partnership beyond the statutory sector to deliver improvements.

We commit to delivering together because that is the right way to deliver better services for our citizens.

[redacted]

CABINET SECRETARY FOR HEALTH AND SPORT

[redacted]

COSLA PRESIDENT

[redacted]

DIRECTOR GENERAL, SCOTTISH GOVERNMENT HEALTH AND SOCIAL CARE DIRECTORATES AND CHIEF EXECUTIVE, NHSSCOTLAND

[redacted]

CHIEF EXECUTIVE, COSLA

[redacted]

CHAIR, SOLACE 26 SEPTEMBER 2018

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This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78781-566-7 (web only)

Published by The Scottish Government, February 2019

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS530586 (02/19)

Ministerial Strategic Group for Health and Community Care

Integration Review Leadership Group

Self-evaluation

For the Review of Progress with Integration of Health and Social Care

March 2019

HSCP / EDC Officer composite draft

Purple text = actions that are outside the scope of the local partnership to deliver

COSLA

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MINISTERIAL STRATEGIC GROUP FOR HEALTH AND COMMUNITY CARE (MSG)
REVIEW OF PROGRESS WITH INTEGRATION OF HEALTH AND SOCIAL CARE - SELF EVALUATION

There is an expectation that Health Boards, Local Authorities and Integration Joint Boards should take this important opportunity to collectively evaluate their current position in relation to the findings of the MSG review, which took full account of the Audit Scotland report on integration published in November 2018, and take action to make progress. This evaluation should involve partners in the third and independent sectors and others as appropriate to local circumstances. This template has been designed to assist with this self-evaluation.

To ensure compatibility with other self-evaluations that you may be undertaking such as the Public Services Improvement Framework (PSIF) or those underpinned by the European Foundation for Quality Management (EFQM), we have reviewed examples of local self-evaluation formats and national tools in the development of this template. The template is wholly focused on the 25 proposals made in the MSG report on progress with integration published on 4th February, although it is anticipated that evidence gathered and the self-evaluation itself may provide supporting material for other scrutiny or improvement self-evaluations you are, or will be, involved in.

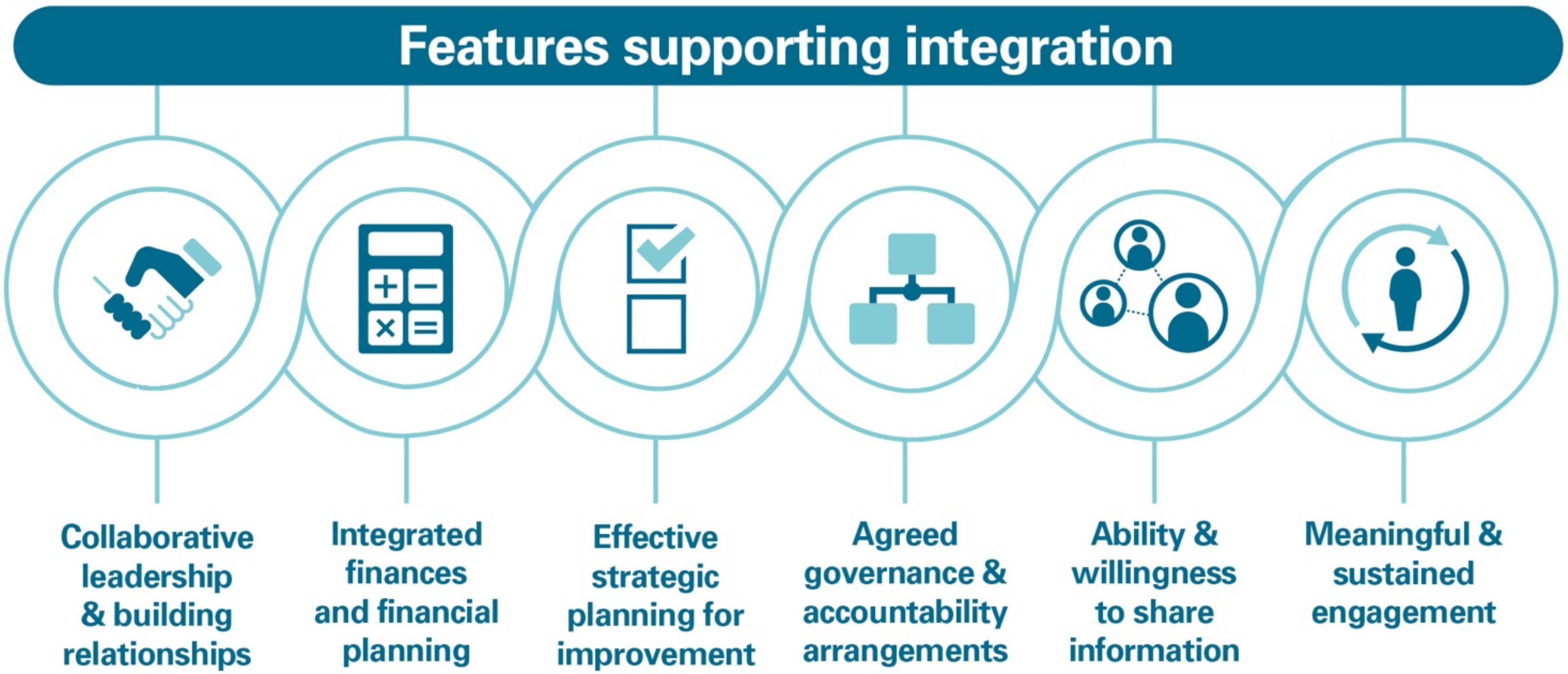
Information from local self-evaluations can support useful discussions in local systems, sharing of good practice between local systems, and enable the Integration Leadership Group, chaired by the Scottish Government and COSLA, to gain an insight into progress locally.

In completing this template please identify your rating against each of the rating descriptors for each of the 25 proposals except where it is clearly marked that that local systems should not enter a rating. Reliable self-evaluation uses a range of evidence to support conclusions, therefore please also identify the evidence or information you have considered in reaching your rating. Finally, to assist with local improvement planning please identify proposed improvement actions in respect of each proposal in the box provided. Once complete, you may consider benchmarking with comparator local systems or by undertaking some form of peer review to confirm your findings.

We greatly appreciate your assistance in ensuring completion of this self-evaluation tool on a collective basis and would emphasise the importance of partnership and joint ownership of the actions taken at a local level. **Please share your completed template with the Integration Review Leadership Group by 15th May 2019 – by sending to Kelly.Martin@gov.scot**

It is our intention to request that we repeat this process towards the end of the 12 month period set for delivery of the all of the proposals in order that we can collectively demonstrate progress across the country.

Thank you.
Integration Review Leadership Group
MARCH 2019



Name of Partnership	East Dunbartonshire HSCP
Contact name and email address	Susan Manion, Chief Officer Susan.manion@ggc.scot.nhs.uk
Date of completion	15th May 2019

Key Feature 1 Collaborative leadership and building relationships				
Proposal 1.1 **All leadership development will be focused on shared and collaborative practice.**				
Rating Descriptor	**Not yet established**	**Partly established**	**Established**	**Exemplary**
Indicator	Lack of clear leadership and support for integration.	Leadership is developing to support integration.	Leadership in place has had the ability to drive change with collaboration evident in a number of key areas. Some shared learning and collaborative practice in place.	Clear collaborative leadership is in place, supported by a range of services including HR, finance, legal advice, improvement and strategic commissioning. All opportunities for shared learning across partners in and across local systems are fully taken up resulting in a clear culture of collaborative practice.
Our Rating			X	
Evidence / Notes	The development of shared leadership and collaborative practice has been evolving since the inception of the HSCPIJB. A range of formal (e.g. training courses) and informal developments (e.g. participation in local service initiatives and senior staff events) have taken place and work has been undertaken to develop a more shared whole system understanding. Positive examples:- • Team managers and team leaders in the HSCP have undertaken the SSSC sponsored Collaborative Leadership in Practice (CLiP) programme. Programmes for Older people's services and Mental Health service teams are in progress. A Workforce and OD Plan is in place that sets out the direction of travel for the HSCP staff. • Regular HSCP senior management and HSCP Board development sessions are held with agendas focussed on a combination of preparation for upcoming strategic and operational business as well as a reflection on progress for the teams and the Board. • Chief Officer and HSCP SMT engage with similar Council and NHS development sessions. Corporate and Senior				

	Management Team joint arrangements have been developed. • HSCP staff are included in the development and delivery of HSCP and Council staff leadership forum sessions • There is good collaboration across the Partnerships as part of GGC. We have hosted management arrangements for some Board wide services and the Chief Officers Group meets regularly and has a team development plan. • There are joint performance management arrangements with the HSCP Chief Officers with specific three way meetings as and when required
Proposed improvement actions	• There are a range of good leadership opportunities delivered across the NHS, HSCP and Council which we will review to look at good practice and assess opportunities for joint learning across the system. We will look to expand the scope across the functions and undertake to review the content and invitation list of further events being developed to ensure they are offered across the NHS,HSCP and Council as appropriate. • Local application of the principles of CLiP across the HSCP more widely – delivered through the OD Plan. • The OD plan will be developed further to collectively share understanding and consider roles and responsibilities across the HSCP professional and leadership arrangements. The aim is to set out a collective approach, to find improved and joined up ways of working focussed on service user and patient care. • We look to create operationally integrated teams as appropriate to the service where we will have leaders being able to manage teams of Health and Social Care staff regardless of their own employment status. • The range and style of different collaborative leadership and development offers available nationally to the NHS, Council and the Partnerships is welcome and would benefit from coordination to ensure maximum and consistency.

Proposal 1.2 **Relationships and collaborative working between partners must improve**				
Rating	**Not yet established**	**Partly established**	**Established**	**Exemplary**
Indicator	Lack of trust and understanding of each other's working practices and business pressures between partners.	Statutory partners are developing trust and understanding of each other's working practices and business pressures.	Statutory partners and other partners have a clear understanding of each other's working practices and business pressures – and are working more collaboratively together.	Partners have a clear understanding of each other's working practices and business pressures and can identify and manage differences and tensions. Partners work collaboratively towards achieving shared outcomes. There is a positive and trusting relationship between statutory partners clearly manifested in all that they do.
Our Rating			X	
Evidence / Notes	Relationships and collaborative working have been developing since the inception of the IJB. A number of regular meetings/forums have been established to support this collaborative working and we expect this to be an ongoing area for further development in the coming years given the increasing service demands, demographic challenges and the financial context ahead. Positive examples:- • Improved approach to collaborative financial planning and monitoring through the establishment of a regular partnership financial discussion forum. This enabled a more effective approach to budget setting for 2019 /20 by enabling those involved to be as well informed as possible to understand the impact of budget decisions on partners, learn from those risks identified in prior years, and work collegiately to set a balanced budget within the HSCP. • Staff within the Partnership are routinely included in, and contribute to, both Council and NHS planning forums. These include Senior Management Team meetings and Programme Boards for specific strategic areas. • The Partnership is closely involved in the delivery of the East Dunbartonshire Community Planning Partnership's Local Outcome Improvement Plans, which form the basis of the Council's planning priorities. The HSCP leads on delivery of three of the total six LOIP outcomes. This demonstrates and ensures good line of sight between Council and HSCP priorities.			

<table>
<tr><td></td><td>
The Partnership is directly involved in the NHSGGC Whole System Planning Group. This is the forum that draws together the work of the various NHSGGC Programme Boards ensuring a joined up approach and participation in this group helps promote the opportunity for joined up and informed planning across the NHSGGC and HSCP agendas.
The Partnership was involved in the development of the NHS Clinical Strategy – Moving Forward Together .The Chief Officer leads on aspects of delivery of this agenda. This supports alignment of priorities across the NHSGGC and HSCP.
There is shared training in place for inducting new board members and local Councillors.
</td></tr>
<tr><td>Proposed improvement actions</td><td>We aim to work to a set of principles:- –

collaboration and involvement across the partners should be focussed on ensuring early awareness of developing priorities involvement across the partners should be effective and proportionate
there should be a focus on collective delivery of improved outcomes
our processes should minimise duplication of efforts
our processes must respect appropriate governance

Improvement areas:-

We recognise that we need to ensure true collaboration across all three agencies. At the moment we probably operate on the basis of working with one agency at a time on specific issues, what we need to do is ensure we really are taking a tripartite approach with a mutual understanding of issues and priorities across all three. This is in the context of NHS GGC supporting the work of six HSCPs. We have already established the ground work to support this including three way meetings between the Chief Executives and the Chief Officer, three way performance and forward planning meetings with the Chief Executives, Chief Officer and HSCP senior managers. Both Chief Executives will attend a future HSCP Board Members' Development Sessions.
We will work to understand how we develop further our integrated approach and achieve early visibility on key strategic and/or operational priorities across the three agencies in support of our individual and collective outcomes.
</td></tr>
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Proposal 1.3
Relationships and partnership working with the third and independent sectors must improve

Rating	Not yet established	Partly established	Established	Exemplary
Indicator	Lack of engagement with third and independent sectors.	Some engagement with the third and independent sectors.	Third and independent sectors routinely engaged in a range of activity and recognised as key partners.	Third and independent sectors fully involved as partners in all strategic planning and commissioning activity focused on achieving best outcomes for people. Their contribution is actively sought and is highly valued by the IJB. They are well represented on a range of groups and involved in all activities of the IJB.
Our Rating		**X**		
Evidence / Notes	The HSCP recognises the third and independent sectors as key partners in delivery of services and achievement of positive outcomes aligned to our Strategic Plan. The HSCP has well established channels and forums for engagement. In practice some are better embedded than others. Engagement with the local third sector is more developed than engagement with the independent sector and the larger national third sector organisations. We look to build on the progress we have made to date in the coming year. Positive examples: • There is an established Strategic Planning Group and two Locality Planning Groups. All have undergone a refresh of role, remit and membership in the past year and all have now developed updated plans and refreshed their membership aligned to the actions in the plans. These groups routinely include third sector representation and will now also routinely include independent sector representation. • There are local provider forums in place with attendance by third and independent sectors. • We are in the process of developing a Commissioning Strategy, co-produced with other stakeholders, including third and independent sector providers, to more clearly outline our future commissioning priorities and market opportunities. This will support effective partnership working. This work has been supported by the NHS iHub.			

	• The local Third Sector Interface is a member of the IJB • The local Third Sector Interface or an appropriate alternative third sector service representative is a member of service planning / development groups as and when these are in place. • Transformational Change led Service Reviews include 'pause points' for consultation and engagement with third and independent sector stakeholders, amongst others. • The East Dunbartonshire Community Planning Partnership includes direct third sector representation and third sector lead on some areas of local service review such as current work on community transport • Moving Forward Together is a developing framework for service change which is evolving at present through a process of community involvement and engagement including third and independent sectors. The Moving Forward Together Team and HSCP delivered these sessions jointly.
Proposed improvement actions	• Involvement of the independent sector in the SPG and LPGs has been less developed than involvement of the third sector. A recent refresh of the action plans and membership aims to address this and progress will be reviewed during 2019. • We will work to further develop our Provider Forums to establish regular attendance and a dialogue on a sustained basis. • We will work with our local Third sector Interface to understand how we can improve our engagement with the larger national third sector providers operating locally, recognising that that we may need to think differently about how this can be achieved and not rely on usual process such as direct attendance at groups and meetings. • We will conclude our work on developing and publishing a Commissioning Strategy • We will review the process for service reviews to ensure early engagement with key stakeholders in the redesign of service delivery models.

Key Feature 2
Integrated finances and financial planning

Proposal 2.1
Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Lack of consolidated advice on the financial position of statutory partners' shared interests under integration.	Working towards providing consolidated advice on the financial position of statutory partners' shared interests under integration.	Consolidated advice on the financial position on shared interests under integration is provided to the NHS/LA Chief Executive and IJB Chief Officer from corresponding financial officers when considering the service impact of decisions.	Fully consolidated advice on the financial position on shared interests under integration is provided to the NHS/LA Chief Executive and IJB Chief Officer from corresponding financial officers when considering the service impact of decisions. Improved longer term financial planning on a whole system basis is in place.
Our Rating		**X**		
Evidence / Notes	This is an area where the Partnership has made considerable progress over the last 12 months. A regular three way forum has been established for HSCP, NHSGGC and EDC finance and transformation tracking and planning and this has supported effective financial planning for the HSCP. Monthly financial reports are provided for all budgets to support real time tracking of spend and early identification of drift. Positive examples: • Three way finance forum in place and working effectively to support year on year planning • Shared understanding of the financial pressures across each partner agency and the transformation activity required to deliver a balanced budget for the partnership. • Budget monitoring reports are provided monthly to all budget holders			

	• Regular and transparent financial reporting to the HSCP Board is in place • The HSCP's CFO is clear as to who within EDC and NHSGGC can provide finance details to support reporting to HSCP
Proposed improvement actions	• We will work to ensure a common understanding of our financial position and establish a monitoring framework to support operational delivery across the NHS, HSCP and the Council. This will mean aligning our arrangements for reporting as is feasible and required by each statutory authority. Partners will work better together to map the timelines for and content of provision of financial information required for monitoring and planning. • We will establish a single set of information, shared in a timely manner, across all necessary reporting forums to ensure consistency and continuity • We will work to ensure we further develop shared narratives to support financial information not only in relation to financial planning but also in the regular financial operational monitoring arrangements.

Proposal 2.2
Delegated budgets for IJBs must be agreed timeously

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Lack of clear financial planning and ability to agree budgets by end of March each year.	Medium term financial planning is in place and working towards delegated budgets being agreed by the Health Board, Local Authority and IJB by end of March each year.	Medium term financial and scenario planning in place and all delegated budgets are agreed by the Health Board, Local Authority and IJB by end of March each year.	Medium to long term financial and scenario planning is fully in place and all delegated budgets are agreed by the Health Board, Local Authority and IJB as part of aligned budget setting processes. Relevant information is shared across partners throughout the year to inform key budget discussions and budget setting processes. There is transparency in budget setting and reporting across the IJB, Health Board and Local Authority.
Our Rating		**X**		
Evidence / Notes	This is an area where we believe we have made good progress with improvements in processes evidence over recent years resulting in an effective process to agree the budgets for 2019 – 2020 before the end of March as required. Positive examples:- • All indicative delegated budgets were agreed by the Health Board, Council and HSCP Board IJB by end of March this year subject to formal approval through the constituent bodies. • We are working to develop medium term financial planning within the HSCP in line with the recommendations of Audit Scotland. • Medium term financial planning in place within the local authority, however not in place within NHS GG&C.			

Proposed improvement actions	• Further work is required in order to effectively transition towards medium term financial and scenario planning. We will work through the IJB CFOs network and through our ongoing local partnership working to learn from best practice elsewhere, offer our learning into the developing national picture and continue to strengthen our local practice • We support the move towards medium to long term financial planning across the NHS and the Council which will positively impact on the HSCP financial planning arrangements. We note that as part of the parliamentary review process there is an aspiration for the next year's budget process to set out multiyear settlements and we are aware of the recent change in arrangements for NHS Board to allow medium term planning and increased flexibility and we welcome these developments.

Proposal 2.3 **Delegated hospital budgets and set aside budget requirements must be fully implemented**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Currently have no plan to allow partners to fully implement the delegated hospital budget and set aside budget requirements.	Working towards developing plans to allow all partners to fully implement the delegated hospital budget and set aside budget requirements, in line with legislation and statutory guidance, to enable budget planning for 2019/20.	Set aside arrangements are in place with all partners implementing the delegated hospital budget and set aside budget requirements. The six steps for establishing hospital budgets, as set out in statutory guidance, are fully implemented.	Fully implemented and effective arrangements for the delegated hospital budget and set aside budget requirements, in line with legislation and statutory guidance. The set aside budget is being fully taken into account in whole system planning and best use of resources.
Our Rating		X		
Evidence / Notes	All involved are aware that this is an area of work that has been progressing relativity slowly due to a range of matters requiring to be clarified / resolved at both local and national levels in order to ensure the resulting actions align with the intentions behind the legislation. We have made progress locally in this area but it is not directly aligned to the budget setting process for the HSCP for 2019 - 2020. Positive examples • Principles and process relating to treatment of the set aside budgets have been discussed and are partly established. A financial framework has been established which reflects actual budgets, performance data in place to support activity planning linked to work around Unscheduled Care through the NHSGGC's Financial Improvement Programme. This work continues.			

Proposed improvement actions	• Work to continue with NHSGGC on process and treatment of set aside budgets with a view to establishing a clear position for 2020 – 2021 budget setting. • Finance and planning work streams to be more clearly aligned to support development of a commissioning plan for unscheduled hospital bed usage going forward. • Due diligence exercise required as part of the overall process of agreeing set aside budgets which addresses the significant financial gap identified in acute budgets based on figures provided by the health board to date. • We will aim to ensure a common understanding as to set aside. We will share this work through the Social Work forum for elected members and HSCP Board development session time will be devoted to supporting understanding of set aside budgets prior to beginning of financial year 2020 – 2021.

Proposal 2.4 Each IJB must develop a transparent and prudent reserves policy				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	There is no reserves policy in place for the IJB and partners are unable to identify reserves easily. Reserves are allowed to build up unnecessarily.	A reserves policy is under development to identify reserves and hold them against planned spend. Timescales for the use of reserves to be agreed.	A reserves policy is in place to identify reserves and hold them against planned spend. Clear timescales for the use of reserves are agreed, and adhered to.	A clear reserves policy for the IJB is in place to identify reserves and hold them against planned spend and contingencies. Timescales for the use of reserves are agreed. Reserves are not allowed to build up unnecessarily. Reserves are used prudently and to best effect to support full implementation the IJB's strategic commissioning plan.
Our Rating			**X**	
Evidence / Notes	Work in this area is well developed in terms of a reserves policy and the planned use of reserves. There is no unnecessary build up of reserves. Positive areas:- • A reserves policy is in place to identify reserves and hold them against planned spend (earmarked for service redesign etc) and hold them for addressing unplanned service demand / issues (un-earmarked). • Clear timescales for the use of earmarked reserves are agreed, monitored, and adhered to. • The HSCP Board is regularly made aware of the reserves position through regular finance reporting.			

Proposed improvement actions	• For 2018 – 2019 and 2019 – 2020 the budget setting process for the HSCP included planned reliance on the HSCPs reserves to achieve financial balance. The HSCP reserves are now at a lower percentage rate than that which would be considered prudent within the partnership reserve policy. This attracted some challenge by the external auditor in their report for 2017/18 in terms of sustainability going forward and our ability to be able to address unexpected demand growth. The Partners will work together to ensure reserves remain reasonable and within policy.

Proposal 2.5
Statutory partners must ensure appropriate support is provided to IJB S95 Officers.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	IJB S95 Officer currently unable to provide high quality advice to the IJB due to a lack of support from staff and resources from the Health Board and Local Authority.	Developments underway to better enable IJB S95 Officer to provide good quality advice to the IJB, with support from staff and resources from the Health Board and Local Authority ensuring conflicts of interest are avoided.	IJB S95 Officer provides high quality advice to the IJB, fully supported by staff and resources from the Health Board and Local Authority and conflicts of interest are avoided. Strategic and operational finance functions are undertaken by the IJB S95 Officer. A regular year-in-year reporting and forecasting process is in place.	IJB S95 Officer provides excellent advice to the IJB and Chief Officer. This is fully supported by staff and resources from the Health Board and Local Authority who report directly to the IJB S95 Officer on financial matters. All strategic and operational finance functions are integrated under the IJB S95 Officer. All conflicts of interest are avoided.
Our Rating		**X**		
Evidence / Notes	As 2.1 The role of the Section 95 Officer (Chief Finance Officer) for the IJB is outlined in the legislation, and to that end, the following progress has been made:- • NHS Finance support has been delegated to the partnership and this works well and fulfils the principle set out above. The CFO has the ability to lead and direct this support and this enables relevant, timeous reporting to the IJB. • Support is provided to the IJB CFO through the work of the Council’s chief internal auditor who has been appointed as the Chief Internal Auditor to the IJB. This supports financial assurance and governance processes. • A finance and planning group has been established which meets regularly, comprising membership from NHS Finance			

	colleagues, Council finance and transformation colleagues and senior management from within the HSCP. This provides a forum for discussion and negotiation on the support requirements to the IJB S95 officer from a Council perspective. • Reports are provided from both the NHS and the local authority on the financial performance of the respective budgets and this is collated into a partnership position by the HSCP S95 CFO and reported on a consolidated basis to the IJB.
Proposed Improvement actions	• Review of the support arrangements to the IJB S95 Officer with a view to streamlining and aligning arrangements and timing of reports where possible • Explore opportunities for joint development sessions for individuals providing finance support.

Proposal 2.6
IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Total delegated resources are not defined for use by the IJB. Decisions about resources may be taken elsewhere and ratified by the IJB.	Total delegated resources have been brought together in an aligned budget but are routinely treated and used as separate health and social care budgets. The totality of the budget is not recognised nor effectively deployed.	Total delegated resources are effectively deployed as a single budget and their use is reflected in directions from the IJB to the Health Board and Local Authority.	Total delegated resources are effectively deployed as a single budget and their use is reflected in directions from the IJB to the Health Board and Local Authority. The IJB's strategic commissioning plan and directions reflect its commitment to ensuring that the original identity of funds loses its identity to best meet the needs of its population. Whole system planning takes account of opportunities to invest in sustainable community services.
Our Rating		**X**		
Evidence / Notes	The existing arrangements in terms of budget deployment are established and support the delivery of the strategic plan. There is a financial plan that supports the strategic plan and there are financial planning and monitoring arrangements that support operational delivery as well as the annual business/transformation plan The CFO and CO meets regularly with the Council and Health Board finance representatives to discuss funding and budget pressures for the coming year. The HSCP works to both the Council and Health Board budget timelines for the respective elements of the budget reflecting the delegated budgets from the Council and NHS, The IJB monitoring reports and budgets contain separate Social Care and Health reports to support the delineation. Positive examples include:- • Staff are empowered to deploy budgets across services to meet identified needs • The budgets are effectively managed as integrated budgets			

	• HSCP Board members are committed to a whole system approach and support the position in operational terms that the resource should lose its identity
Proposed improvement actions	• We will work to review the Council scheme of delegation to ensure HSCP officers are empowered to manage and deploy the resources in their remit directly and effectively • We will review expected future capital requirements for community services and map the potential contribution of agencies to capital programme works to deliver fit for the future facilities in local communities, as far as possible, regardless of ownership of the asset. • Increasingly reporting to the IJB should reflect the totality of partnership resources as opposed to separate reporting information and similarly this should be considered within the constituent body reporting arrangements. • We would support any nationally instigated review of future funding mechanisms for the HSCPs.

Key Feature 3
Effective strategic planning for improvement

Proposal 3.1
Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Lack of recognition of and support for the Chief Officer's role in providing leadership.	The Chief Officer is not fully recognised as pivotal in providing leadership. Health Board and Local Authority partners could do more to provide necessary staff and resources to support Chief Officers and their senior team.	The Chief Officer is recognised as pivotal in providing leadership and is recruited, valued and accorded due status by statutory partners. Health Board and Local Authority partners provide necessary resources to support the Chief Officer and their senior team fulfil the range of responsibilities	The Chief Officer is entirely empowered to act and is recognised as pivotal in providing leadership at a senior level. The Chief Officer is a highly valued leader and accorded due status by statutory partners, the IJB, and all other key partners. There is a clear and shared understanding of the capacity and capability of the Chief Officer and their senior team, which is well resourced and high functioning.
Our Rating			X	
Evidence / Notes	Some key process relating to HR, change management, complaints handling, legal services etc continue to sit with the constituent bodies. However the resource is differentially split. In some instances, the capacity and support is devolved to the HSCP, but for others the service still sit within the constituent body and support is called in as and when required. This, at times, creates a level of imbalance or difference in practice in how the Chief Officer and the HSCPs Senior Management Team are able to operate across the HSCP system as a whole. We aim to better understand the different systems and operational approaches across the Partnership area, so we can develop effective ways to work within these differing systems. Positive examples:- • We have improved our approach to collective allocation of resources over the past 12 months which enabled us to deliver an			

	agreed budget by the end of March 2019 and to establish an agreed transformation programme for the year 2019 - 2020. • The HSCP has access to a range of support functions in the NHS and the Council. In section 3.4 we have highlighted areas where we will look to align process relation to the key functions of performance and planning, in support of the Strategic Planning and Commissioning arrangements. This also applies to HR, legal and finance support for the Chief Officer and senior managers across the system in relation to operational delivery.
Proposed improvement actions	• We will review the scheme of delegation with a view to ensuring the Chief Officer and HSCP Senior Management Team can act within their appropriate areas of authority, in line with relevant legislation and the Scheme of Integration. • We will review our approach to planning to ensure we are able to identify earlier the likely support requirements associated with planned changes and consequent service delivery. We will refresh the operational approaches across the partnership area relating to HR, access to legal services and transformational change support so we can collectively streamline and align arrangements, operationally and in relation to Strategic Planning and performance.

Proposal 3.2
Improved strategic inspection of health and social care is developed to better reflect integration.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator				
Our Rating				
Evidence / Notes	NOT FOR LOCAL COMPLETION - NATIONAL INSPECTORATE BODIES RESPONSIBLE			

Proposal 3.3
National improvement bodies must work more collaboratively and deliver the improvement support partnerships require to make integration work.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator				
Our Rating				
Evidence / Notes	NOT FOR LOCAL COMPLETION - NATIONAL BODIES RESPONSIBLE			

Proposal 3.4
Improved strategic planning and commissioning arrangements must be put in place.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Integration Authority does not analyse and evaluate the effectiveness of strategic planning and commissioning arrangements. There is a lack of support from statutory partners.	Integration Authority developing plans to analyse and evaluate the effectiveness of strategic planning and commissioning arrangements. The Local Authority and Health Board provide some support for strategic planning and commissioning.	Integration Authority has undertaken an analysis and evaluated the effectiveness of strategic planning and commissioning arrangements. The Local Authority and Health Board provide good support for strategic planning and commissioning, including staffing and resources which are managed by the Chief Officer.	Integration Authority regularly critically analyses and evaluates the effectiveness of strategic planning and commissioning arrangements. There are high quality, fully costed strategic plans in place for the full range of delegated services, which are being implemented. As a consequence, sustainable and high quality services and supports are in place that better meet local needs. The Local Authority and Health Board provide full support for strategic planning and commissioning, including staffing and resources for the partnership and recognise this as a key responsibility of the IJB.
Our Rating			**X**	
Evidence / Notes	The HSCP has established much improved strategic planning and performance management arrangements in the last year. These arrangements continue to evolve on the strength of experience. Stronger links have been established between strategic and operational planning and continuous improvement at all levels. The HSCP has strong partner and stakeholder involvement and is in the process of developing a commissioning strategy to support further work in this area. Positive examples • The HSCP has produced and published a three year Strategic Plan 2018 – 2021 based on strategic needs assessment • The HSCP is reviewing its commissioning team arrangements and capacity • The Chief Officer, through the CFO, manages some of the commissioning staff directly.			

	• A commissioning plan in support of the strategic plan is in development • The HSCP has recently reviewed its Strategic Planning and Locality Planning group arrangements and intends to develop locality plans links to the Strategic Plan.
Proposed improvement actions	• Council and Health Board support for strategic planning and commissioning, including staffing and resources, are delivered differently. Direct capacity is provided by the Health Board which is managed by the Chief Officer. Council support for planning and performance functions are accessed through shared corporate support. We will develop arrangements which will align this process as much as possible to support the development and delivery of the strategic plan, annual transformation plan and commissioning plan. The mutual support across the NHS, Council and HSCP will be purposeful and proportionate recognising that both the Council and NHS have to balance the support requirements of the HSCP with those of their other areas of business interests. • We will improve sharing of information early in the strategic thinking process across the Partner agencies, encouraging mutual involvement and an integrated approach to our business.

Proposal 3.5
Improved capacity for strategic commissioning of delegated hospital services must be in place.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	No plans are in place or practical action taken to ensure delegated hospital budget and set aside arrangements form part of strategic commissioning.	Work is ongoing to ensure delegated hospital budgets and set aside arrangements are in place according to the requirements of the statutory guidance.	Delegated hospital budget and set aside arrangements are fully in place and form part of routine strategic commissioning and financial planning arrangements. Plans are developed from existing capacity and service plans, with a focus on planning delegated hospital capacity requirements with close working with acute sector and other partnership areas using the same hospitals.	Delegated hospital budget and set aside arrangements are fully integrated into routine strategic commissioning and financial planning arrangements. There is full alignment of budgets. There is effective whole system planning in place with a high awareness across of pressure, challenges and opportunities.
Our Rating		**X**		
Evidence / Notes	All involved are aware that this is an area of work that has been progressing relativity slowly due to a range of matters requiring to be clarified / resolved at both local and national levels in order to ensure the resulting actions align with the intentions behind the legislation. We have made progress locally in this area and work will continue in 2019 - 2020. Positive examples • Principles and process relating to the set aside budgets have been discussed and are partly established, linked to work around Unscheduled Care and NHSGGC's Financial Improvement Programme. This work continues.			

Proposed improvement actions	• Work to continue with NHSGGC on process and treatment of set aside budgets with a view to establishing a clear position for 2020 – 2021 budget setting. • Establish HSCP Board development time devoted to support the understanding of set aside budgets prior to beginning of financial year 2020 – 2021.

Key Feature 4 Governance and accountability arrangements				
Proposal 4.1 The understanding of accountabilities and responsibilities between statutory partners must improve.				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	No clear governance structure in place, lack of clarity around who is responsible for service performance, and quality of care.	Partners are working together to better understand the governance arrangements under integration to better understand the accountability and responsibilities of all partners.	Clear understanding of accountability and responsibility arrangements across statutory partners. Decisions about the planning and strategic commissioning of delegated health and social care functions sit with the IJB.	Clear understanding of accountability and responsibility arrangements and arrangements are in place to ensure these are reflected in local structures. Decisions about the planning and strategic commissioning of delegated functions sit wholly with the IJB and it is making positive and sustainable decisions about changing the shape of care in its localities. The IJB takes full responsibility for all delegated functions and statutory partners are clear about their own accountabilities.
Our Rating			X	
Evidence / Notes	Through joint working across the system, the NHS, Council and HSCP have all come to understand their roles more clearly in the landscape of health and social care by clarifying roles and responsibilities in development sessions for the elected members, the NHS Board and for HSCP members. This was given particular attention in the first years after the establishment of the Partnership but is refreshed and updated with the change of membership and the new Council administration. The establishment of a Social Work Forum to replace the social work committee was a step forward in sharing understanding and avoiding duplication. The revised joint management arrangements have also helped clarify issues. The joint HSCP/Council senior management team and the inclusive Corporate management arrangements of the NHS have helped officers across the whole system work together to more effectively with a focus on delivery key and interlinked operational objectives, using the integrated governance arrangements to deliver the change rather than be an impediment.			

	Positive examples:- • We have improved support arrangements between the IJB and the constituent bodies in line with the points made at 3.1 • We have re-designated the Council's previous governance committee for social work and social care into an Integrated Social Work Forum for elected member discussion and consultation on matters of interest and concern. This is not a formal decision making forum and allows for full discussion and consideration of all matters relating to health and social care. This has kept clear the governance arrangements for the HSCP while ensuring that elected members are part of the overall discussions. • We have established strong and effective Clinical and Care Governance arrangements that span the totality of integrated functions
Proposed improvement actions	• We have streamlined processes of reporting and governance, to reduce the need for three-way reporting, using a 'once for the partnership' approach where possible with the right decisions taken in the right forums. We will review this to check for clarity of responsibility and accountability as part of the review of the Integration Schemes. • We aim to continue to clarify responsibilities and accountabilities and to avoid duplication in planning, reporting and decision-making across the integrated functions and between the statutory bodies and welcome further consideration at a national level. • We will continue to work to ensure communications and involvement at all levels, as appropriate, with the Officers, elected members and NHS Board members across the Partnership area on key issues. • This is a complex environment so through Board development sessions, Social Work Forums and joint management meetings we will review arrangements to ensure the accountabilities are clear.

Indicator 4.2 **Accountability processes across statutory partners will be streamlined.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Accountability processes unclear, with different rules being applied across the system.	Accountability processes being scoped and opportunities identified for better alignment.	Accountability processes are scoped for better alignment, with a focus on fully supporting integration and transparent public reporting.	Fully transparent and aligned public reporting is in place across the IJB, Health Board and Local Authority.
Our Rating			X	
Evidence / Notes	As 4.1			
Proposed improvement actions				

Proposal 4.3 **IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	IJB lacks support and unable to make effective decisions.	IJB is supported to make effective decisions but more support is needed for the Chair.	The IJB Chair is well supported, and has an open and inclusive approach to decision making, in line with statutory requirements and is seeking to maximise input of key partners.	The IJB Chair and all members are fully supported in their roles, and have an open and inclusive approach to decision making, going beyond statutory requirements. There are regular development sessions for the IJB on variety of topics and a good quality induction programme is in place for new members. The IJB has a clear understanding of its authority, decision making powers and responsibilities.
Our Rating				X
Evidence / Notes	• The HSCP has a Board development programme that is reviewed regularly. This programme comprises of short topic specific seminars that last half an hour and half day development sessions that cover topics in more detail. The Board do attend meetings in other venues. The purpose of these sessions is to provide board members with information to enable them to make informed decisions on key priorities and also to advise them of any new policies or legislation. Board members are consulted on the topics they would like covered as part of the annual programme. • Board members have indicated that they feel this programme and the HSCP Board meetings provide them with a good understanding of our key issues in depth with time to discuss matters in depth. • The HSCP developed an induction programme for new Board members. This programme is given to new Board members who are supported through the process. • The Chair and Vice Chair meet with the Chief Officer to discuss and agree the agendas and for regular updates for all board meetings. This process contributes to succession planning and supports the two yearly change of the IJB chair. • The Chair and Vice Chair attend associated staff and public events. • The Vice Chair , Chairs the Audit, performance and planning sub committee • The Chair is an executive member of the national Chair and Vice Chairs group				

Proposed improvement actions	• The Chair and Vice Chair are keen to look to develop their role, learning from local experience and the experience gained from the work of the national group. • We are reviewing their role in the wider transformational change process. • We are reviewing the visibility of the Board across the organisation

Proposal 4.4
Clear directions must be provided by IJB to Health Boards and Local Authorities.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	No directions have been issued by the IJB.	Work is ongoing to improve the direction issuing process and some are issued at the time of budget making but these are high level, do not direct change and lack detail.	Directions are issued at the end of a decision making process involving statutory partners. Clear directions are issued for all decisions made by the IJB, are focused on change, and take full account of financial implications.	Directions are issued regularly and at the end of a decision making process, involving all partners. There is clarity about what is expected from Health Boards and Local Authorities in their delivery capacity, and they provide information to the IJB on performance, including any issues. Accountability and responsibilities are fully transparent and respected. Directions made to the Health Board in a multi-partnership area are planned on an integrated basis to ensure coherence and take account of the whole system.
Our Rating		**X**		
Evidence / Notes	This continues to be an area of development for the partnership. There is a current process in place and consideration has been given to the recent additional draft guidance. Work on this area will continue and the partnership would welcome Scot Gov advice on particularly positive examples of practice that operate elsewhere, to support continuous improvement in this area. We would also wish to link this to the scoping exercise that seeks to improve accountabilities, as this would help to clarify the technical process of Direction and the respective obligations associated with it. Positive examples • The HSCP has issued directions to support deliver of its strategic plan • The HSCP Board has considered the recently issued draft Scot Gov guidance on Directions and this has informed a revision to our Directions processes.			

Proposed improvement actions	• We aim to have a clear process for the development of and issuing of directions which sees directions as the final stage in a collaborative process i.e. not a source of unexpected instruction. • We will consider exemplar models from elsewhere that are considered to reflect best practice with a view to further refining local processes • We will develop a process for the issuing of directions following each IJB meeting. • We will implement the relevant recommendations from the new statutory guidance once published • We will link the directions issuing processes with the outcomes of the governance/accountability scoping work in order to improve overall Partnership understanding of purpose, process and respective obligations.

Proposal 4.5 **Effective, coherent and joined up clinical and care governance arrangements must be in place.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	There is a lack of understanding of the key role clinical and professional leadership plays in supporting safe and appropriate decision making is not well understood. Necessary clinical and care governance arrangements are not well established.	There is partial understanding of the key role clinical and professional leadership plays in supporting safe and appropriate decision making. Arrangements for clinical and care governance are not clear	The key role clinical and professional leadership plays in supporting safe and appropriate decision making is fully understood. There are fully integrated arrangements in place for clinical and care governance.	The key role clinical and professional leadership plays in supporting safe and appropriate decision making is fully understood. Arrangements for clinical and care governance are well established and providing excellent support to the IJB. Strategic commissioning is well connected to clinical and care governance and there is a robust process for sharing information about, for example, inspection reports findings and adverse events information, and continuous learning is built into the system.
Our Rating				X
Evidence / Our Notes	This is an area where the partnership feels it is well developed. We are aware of the intention to develop national guidance on this area of governance and once this is produced we will further review our arrangements in order to ensure they continue to reflect best practice. Positive examples • A Clinical and Care Governance Group is established • There are clear reporting structures to the HSCP Board, as well as the broader Primary Care and Communities Clinical Governance Forum, and thence up to the Health Board Governance group. Reporting includes regular minutes and also an annual report. • The terms of reference include the schedule of meetings and items to be considered and noted, with a clear message around the responsibility of the group to ensure that safe, effective, person-centred care is delivered with and to the people we support,				

	in pursuance of positive personal outcomes. • Membership is now well established, with good attendance at meetings. Those unable to attend provide written input. • There has been good engagement with service and team leads, with regular updates and feedback to the group. This includes reporting on significant incidents and complaints, as well as Datix reports. • Teams are also encouraged to share innovative work practices, self-evaluations and developments within their service, with regular updates to the meetings from the Clinical Effectiveness Co-ordinator tabling audit, and quality improvement activities. • Inspection reports are shared and lessons learned from these and adverse events. • Quality improvement work is collated and shared
Proposed improvement actions	• We will await the provision of national guidance to support the development of local approaches. • We will further develop our quality improvement framework • Over and above the inspection reports and adverse events etc we will develop a mechanism to ensure the Clinical and Care Governance committee oversee the quality and standards for all of our commissioned services.

Key Feature 5
Ability and willingness to share information

Proposal 5.1
IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Work is required to further develop Integration Authority annual reports to improve consistency in reporting, better reflect progress and challenges in local systems, and ensure all statutory required information is reported on by July 2019.	Work is ongoing to further develop Integration Authority annual reports to improve consistency in reporting, better reflect progress and challenges in local systems, and ensure all statutory required information is reported on, by July 2019.	Integration Authority annual reports are well developed to reflect progress and challenges in local systems, and ensure all statutory required information is reported on, by July 2019. Some benchmarking is underway and assisting consistency and presentation of annual reports.	Integration Authority annual reports are well developed to reflect progress and challenges in local systems, to ensure public accessibility, and to support public understanding of integration and demonstrate its impact. The annual report well exceeds statutory required information is reported on. Reports are consistently well presented and provide information in an informative, accessible and readable format for the public.
Our Rating			**X**	
Evidence / Notes	We believe our performance in this area to be good however we welcome the proposal to develop further benchmarking, sharing and learning opportunities around the annual report. • Our Annual Reports have been delivered as required • The current format was refreshed for 2017-18, which was developed through benchmarking and was well received by local partners. • We would welcome the development of a standardised approach to ensure consistency and with best practice models.			
Proposed improvement actions	Improvement areas • The national Chief Officers Group will work collectively to agree common framework and benchmarking processes. Timescale challenging for July 2019 round of reports.			

Proposal 5.2
Identifying and implementing good practice will be systematically undertaken by all partnerships.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Work is required to improve the Integration Authority annual report to identify, share and use examples of good practice and lessons learned from things that have not worked.	Work is about to commence on development of the annual report to enable other partnerships to identify and use examples of good practice. Better use could be made of inspection findings to identify and share good practice.	The Integration Authority annual report is presented in a way that readily enables other partnerships to identify, share and use examples of good practice and lessons learned from things that have not worked. Inspection findings are routinely used to identify and share good practice.	Annual reports are used by the Integration Authority to identify and implement good practice and lessons are learned from things that have not worked. The IJB's annual report is well developed to ensure other partnerships can easily identify and good practice. Inspection findings and reports from strategic inspections and service inspections are always used to identify and share good practice. All opportunities are taken to collaborate and learn from others on a systematic basis and good practice is routinely adapted and implemented.
Our Rating			**X**	
Evidence / Notes	We believe our performance in this area to be good however we welcome the proposal to develop further benchmarking, sharing and learning opportunities around the annual report. Positive examples • Our annual report presentation format was refreshed for the year end 2018 – 2019 to draw out opportunities to emphasise 'performance at a glance' and case study examples for good practice. This was well received by members. • We have engaged with the support available through the NHS iHub to access learning and sharing opportunities to support ongoing development. • One of the advantages of being part of such a large system as GGC is that we share good practice across all six partnerships, it has becomes part of our business.			

	• The Chief Officers meet monthly across GGC. We have developed hosting arrangements which supports operational delivery as well as strategic planning for those services with a whole system impact across GGC for a range of services including Mental Health, CAMHS and the Healthy Children Programme.
Proposed improvement actions	Improvement areas • The national Chief Officers Group will work collectively to agree common framework and benchmarking processes. • The national Chief Officers Group are also working with the Scottish Government to identify a mechanisms to share good practice and benchmarking information which HSCPs can link to.

Proposal 5.3
A framework for community based health and social care integrated services will be developed.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator				
Our Rating				
Evidence / Notes	NOT FOR LOCAL COMPLETION - NATIONAL BODIES RESPONSIBLE			

Key Feature 6 Meaningful and sustained engagement				
Proposal 6.1 **Effective approaches for community engagement and participation must be put in place for integration.**				
Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	There is a lack of engagement with local communities around integration.	Engagement is usually carried out when a service change is proposed.	Engagement is always carried out when a service change, redesign or development is proposed.	Meaningful engagement is an ongoing process, not just undertaken when service change is proposed. Local communities have the opportunity to contribute meaningfully to locality plans and are engaged in the process of determining local priorities.
Our Rating			X	
Evidence / Notes	We believe this is an area where the partnership performs well however there is scope to develop a more joined up whole system approach to consultation and engagement to assist us to avoid 'consultation fatigue'. Positive examples • The HSCP has a well-established process for community engagement. Engagement is undertaken utilising a range of approaches that range from annual service audits to engagement in determining identified service change, redesign or service development. At all times the approach is designed to be sensitive and proportionate to the nature of the change or level of public interest. • We have a strong, well established and well engaged, Public Service User and Carer group. • We have been building a stronger relationship base with local third sector services through a range of means such as Board, Strategic Planning Group and Locality Planning Group membership and engagement with the local Third Sector Strategic Forum. We will continue to build on this in the coming year.			

<table>
<tr><td>Proposed improvement actions</td><td>Improvement areas
Triangulated evaluation of current processes will continue to be undertaken, to ensure the processes and experiences of engagement are effectively applied as fully as possible.
We will work to identify opportunities for joined up consultation processes across NHS, HSCP and Council.
We will compare our performance against any new standards in relation to health and social care statutory engagement and respond accordingly, in pursuit of continuous improvement.
We will continue to build on the engagement processes noted above re the local 3rd Sector and will seek to build stronger regular engagement with the local independent sector, an area where we recognise there is room for improvement.</td></tr>
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Proposal 6.2
Improved understanding of effective working relationships with carers, people using services and local communities is required.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Work is required to improve effective working relationships with service users, carers and communities.	Work is ongoing to improve effective working relationships with service users, carers and communities. There is some focus on improving and learning from best practice to improve engagement.	Meaningful and sustained engagement with service users, carers and communities is in place. There is a good focus on improving and learning from best practice to maximise engagement and build effective working relationships.	Meaningful and sustained engagement with service users, carers and communities is in place. This is given high priority by the IJB. There is a relentless focus on improving and implementing best practice to maximise engagement. There are well established and recognised effective working relationships that ensure excellent working relationships.
Our Rating			**X**	
Evidence / Notes	We believe this is an area where the partnership performs well however there is scope to further develop this into a more joined up whole system approach. We have a well established Public Service User and Carer (PSUC) Group. Members input has been indispensible in providing perspectives and expertise verbally and in writing and also in making material and highly effective contributions to the work of the Partnership; examples include the Carers and Patient Discharge Experience Report and the Patient Discharge Information Leaflet which were developed by the PSUC members. Members have also directly contributed to the NHS GGC Moving Forward Together Patient Experience programme and resources. Positive examples • The HSCP PSUC representatives group to strengthen accountability, and directly influence and shape the strategic planning of services and outcomes devolved to the HSCP. Outstanding actions at each subsequent meeting. • PSUC representatives are supported and encouraged to effectively participate within and across all the key strategic and planning groups. PSUC representatives currently attend a wide range of HSCP strategic and planning meetings (including the IJB, the Strategic Planning Group, the Locality Planning Groups, the Transformational Board, Primary Care Implementation			

	Group and Service Planning Groups) and are also invited to contribute to short life planning groups on issues such as service redesign. • The PSUC membership is surveyed annually, with the results informing further group and membership development. In its November 2018 survey, 70% of the PSUC members expressed a belief that the group has increased participation in decision-making about HSCP services; 100% feel comfortable contributing at meetings and 80% feel that their views are respected. The impact and opportunities for ongoing and further development is reflected within the PSUC's annual review and action plan.
Proposed improvement actions	Improvement areas • The ambition of the HSPC and of the current PSUC membership is to expand the representation and reach through increased direct and indirect participation. Evaluation of current processes will continue to be undertaken, to ensure the scope, process and experiences of meaningful engagement are operating as well as possible.

Proposal 6.3
We will support carers and representatives of people using services better to enable their full involvement in integration.

Rating	**Not yet established**	**Partly Established**	**Established**	**Exemplary**
Indicator	Work is required to improve involvement of carers and representatives using services.	Work is ongoing to improve involvement of carers and representatives using services.	Carers and representatives on the IJB are supported by the partnership, enabling engagement. Information is shared to allow engagement with other carers and service users in responding to issues raised.	Carers and representatives of people using services on the IJB, strategic planning group and locality groups are fully supported by the partnership, enabling full participation in IJB and other meetings and activities. Information and papers are shared well in advance to allow engagement with other carers and service users in responding to issues raised. Carers and representatives of people using services input and involvement is fully optimised.
Our Rating			X	
Evidence / Notes	As 6.1 and 6.2			
Proposed improvement actions				

Agenda Item Number: 4

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	**28th May 2019**
Subject Title	**HSCP Transformation Plan 2019/20**
Report By	**Jean Campbell, Chief Finance & Resources Officer**
Contact Officer	**Jean Campbell, Chief Finance & Resources Officer (Tel: 601 3221)**

Purpose of Report	To update the Board on the development of the Transformation Plan for the HSCP for 2019/20.

Recommendations	The Partnership Board is asked to: a) Note and approve the HSCP Transformation Plan for 2019/20 b) Remit the Performance, Audit and Risk Committee to oversee and monitor the delivery of the plan with regular updates to the HSCP Board.

Relevance to HSCP Board Strategic Plan	The Strategic Plan sets out the priorities and ambitions to be delivered over the three years 2018 – 2021 to further improve the opportunities for people in East Dunbartonshire to live a long and healthy life. The transformation or annual business plan sets out the priorities which will be delivered during 2019/20 in furtherance of the strategic priorities set out in the Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

Financial:	The Transformation Plan sets out the service redesign, efficiencies and priorities which will support the delivery of a balanced budget for 2019/20 and includes the areas identified as part of the partnerships financial planning agreed as part of the budget setting process.

Legal:	The legal implications of the projects identified as part of the budget setting process have been considered by the constituent bodies who will be involved in supporting their delivery as required. The priorities focussed on the delivery of national legislative requirements will be considered in collaboration with respective legal service teams.

Economic Impact:	None.

Sustainability:	None.

Risk Implications:	The risks associated with each project have been considered in the development of the supporting business cases. The risks associated with the delay or failure to deliver on the priorities set out within the transformation plan are detailed within the Partnership Corporate Risk register and will be documented through the financial monitoring reports throughout the year in terms of impact on the partnership's financial position.

Implications for East Dunbartonshire Council:	The delivery of the transformation plan will be dependent on support from the respective constituent bodies in the form of legal, human resources, transformation and organisational development input. The realisation of savings to balance the budget is challenging and may require recourse to the constituent bodies in the event that these are not fully delivered as expected.

Implications for NHS Greater Glasgow & Clyde:	The delivery of the transformation plan will be dependent on support from the respective constituent bodies in the form of legal, human resources, transformation and organisational development input. The realisation of savings to balance the budget is challenging and may require recourse to the constituent bodies in the event that these are not fully delivered as expected.

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 This Transformation Plan sets out the priorities which will be taken forward during 2019/20 in achievement of the outcomes set out in the Strategic Plan 2018/2021 and the service redesign and efficiency measures to be progressed in delivery of financial balance for 19/20.

1.2 Each Annual Business Development Plan articulates the expected deliverables within each year of the three-year Strategic Plan to achieve service transformation. The priorities detailed within the business plan fall into the three categories:-

- transformative in nature,
- aligned to delivery of financial efficiencies, or
- Arising from the introduction of new national policy or legislation.

1.3 A copy of the Transformation Plan for 2019/20 is attached as **Appendix 1.**

1.4 The partnership has established a Transformation Programme Board to oversee this programme of work involving the partnership's senior management Team (SMT) along with key stakeholders within the constituent bodies.

1.5 The Transformation Board also provides oversight of the savings programme for the partnership in the delivery of a balanced budget for 2019/20.This is further supported by the establishment of an integrated finance & monitoring group in collaboration with Finance and Transformation leads within the partner organisation.

1.6 Progress on the delivery of the programme will be reported through the Strategic Planning Group which includes a range of stakeholders including service user and carer representation, 3rd and independent sector representation, GPs and locality leads.

1.7 The monitoring and delivery of the programme will be overseen by the partnership Performance, Audit and Risk Committee with regular updates to be provided to the HSCP Board.

1.8 The successful delivery of transformation is dependent on working in partnership with our key partners and a number of work streams are aligned to the processes embedded within each constituent body and are supported by Council Transformation teams and wider GG&C teams.

1.9 The priorities have been attributed a BRAG status which at the outset relates to the anticipated difficultly in delivering on these projects. This may be as a result of the timelines for effective engagement, the scales and nature of the proposals which may be the subject of an ongoing formal service review process and /or complexity to deliver:

BLUE	=	Delivered
GREEN	=	On Track / Underway, expected to be delivered in year
AMBER	=	Some anticipated difficulty in delivery expected
RED	=	Significant difficulty expected in delivery of priority area

1.10 There are a total of 54 priorities to be delivered within the transformation plan for 2019/20:-

- 1 is considered blue – delivered
- 28 are considered at Green status – on track / Underway
- 24 are considered Amber status – work is underway with some risk to delivery
- 1 is considered red status – more significant risks to delivery.

Health & Social Care Partnership

ANNUAL BUSINESS DEVELOPMENT PLAN

(Transformation Plan)

2019/20

April 2019

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

NHS
Greater Glasgow and Clyde

INTRODUCTION

The Health &Social Care Partnership (HSCP) is operating within a period of complex and significant service change, spanning multiple specialties and across multiple organisations.

This Business Development Plan aims to strengthen the planning processes that underpin the implementation of priorities outlined in the Strategic Plan (2018/21). The purpose is to ensure that:

- business planning processes are aligned with the strategic principles and operational priorities of quality, efficiency, integration and person centeredness;
- each business change proposal is led by the people who deliver the service to ensure ownership;
- sufficient time is factored in to engage with the wide range of stakeholders internally and externally; and
- each change proposal has a robust decision audit trail.

Each Annual Business Development Plan articulates the expected deliverables within each year of the three-year Strategic Plan to achieve service transformation. The priorities detailed within the business plan fall into the three categories:-

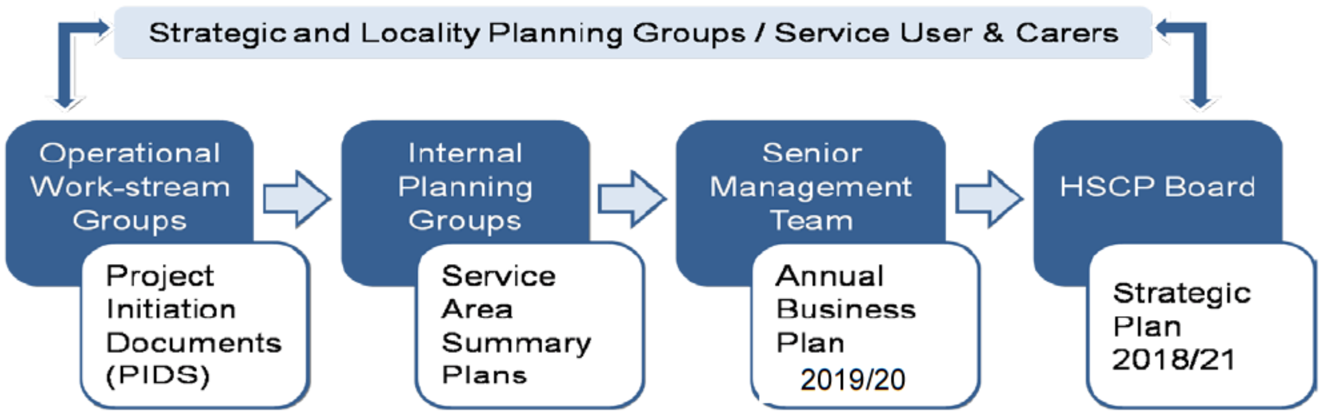
- transformative in nature,
- aligned to delivery of financial efficiencies, or
- Arising from the introduction of new national policy or legislation.

It also supports and/or is aligned with a number of other local and regional strategic plans, for example:

- EDC Business Improvement Plan
- East Dunbartonshire Local Outcome Improvement Plan (LOIP)
- NHSGGC Moving Forward Together Delivery Plan
- NHSGGC Operational Plan (previously LDP)
- Emerging West of Scotland Regional Plan

HSCP PLANNING PROCESSES

The HSCP has developed robust programme management mechanisms to oversee the business planning process and the associated implementation plans and service change delivery. Internal planning groups are being established led by a Head of Service who progresses service area priorities through PIDs developed by operational work-stream groups.



A suite of project management tools have been developed to support work-stream groups in the preparation of Project Initiation Documents. These tools outline the key steps to be considered including:

- making the case for change;
- developing and testing service models;
- undertaking engagement;
- evaluating impact;
- Resource implications;
- securing required decisions
- developing implementation plans; and
- Providing update on progress of priorities.

The priorities have been attributed a BRAG status which at the outset relates to the anticipated difficultly in delivering on these projects. This may be as a result of the timelines for effective engagement, the scales and nature of the proposals which may be the subject of an ongoing formal service review process and /or complexity to deliver.

BLUE	=	Delivered
GREEN	=	On Track / Underway, expected to be delivered in year
AMBER	=	Some anticipated difficulty in delivery expected
RED	=	Significant difficulty expected in delivery of priority area

East Dunbartonshire Health & Social Care Partnership

SUMMARY OF PRIORITIES 2019/20

Project Initiative	Project Code / type	Link to Strategic Plan	Status	Description / Deliverables	Timescales	Financial Implications
Children's & Criminal Justice Services Project						**£412.5k**
▪ Develop sustainable services for school age children in line with national recommendations	CHSP01 / National Policy development	SP1	Green	To ensure the School Nurse service delivers safe, effective and person-centred care based on the principles of Getting It Right for Every Child (GIRFEC) national practice model to the school age population (0-19yrs) of East Dunbartonshire.	March 2020	Financial Efficiency – none expected
▪ Implement the Health Visiting Universal Pathway	CHSP03 / National Policy Development	SP1	Green	Implementation of the universal health visiting programme to promote and safeguard the well being of all pre-school children with a more targeted service dependent on need.	March 2020	Financial Efficiency – none expected
▪ Review of Fostering	BP7 / Management Action	SP8	Amber	Review of externally purchased foster placements and optimise opportunities for delivery through East Dunbartonshire.	30 September 2019	Financial Efficiency – £60k
▪ Review of all LAAC Placements	BP28 / Management Action	SP8	Amber	Review of residential placements for looked after and accommodated children to ensure their needs are met and placements provide best value.	30 September 2019	Financial Efficiency – £150k

▪ Review of Transitions	BP3 / Service Transformation	SP8 LOIP3	Green	Review of processes / procedures and support arrangements for children transitioning into adult services.	30th December 2019	Financial Efficiency – none expected
▪ Review of Children & Families	BP8 / Service Transformation	SP8	Amber	Service Review – Children & Families	30th June 2019	Financial Efficiency – £150k 19/20, £200k F/Y
▪ Review of Transport Policy	BP12 / Service Transformation	SP8	Amber	Review of eligibility to access support with transport arrangements through Social Work services.	30th September 2019	Financial Efficiency – £52.5k 19/20, £105k full year.
▪ Review of Out of School provision	BP20 / Service Transformation	SP8 LOIP3	Amber	Review of after school provision for children with support needs to optimise opportunities for local provision.	31st March 2020	Financial Efficiency - none expected for 2019/20, full year to be scoped.
▪ Develop and implement a Corporate Parenting Strategy	Implement national policy	LOIP3	Green	Develop and implement a Corporate Parenting Strategy and Plan which ensure the HSCP fulfils its duty to all LAC children. This includes the development of a Champions Board, young apprenticeships and advocacy services	31 March 2020	No financial efficiency expected.
▪ Purchase and implement Carefirst CJS Module		SP8	Amber	Purchase and implement Carefirst CJS Module to facilitate improved data interrogation to enable more efficient and effective targeting of resources to identified areas of need in EDC	30 September 2019	No financial efficiency expected.
▪ Implementation of new legislation (Management of Offenders Act 2019 -	Implement national policy	SP4 LOIP4	Green	Respond to the new legislation by increasing robust community based alternatives to create efficient and effective ways to	31 March 2020	No financial efficiency expected.

Presumption Against Short Term Prison Sentences)				manage increased resource demand.		
Adult Services Project						**£598.5k**
▪ Review of Sleepovers	BP1 / Management Action	SP8 MFT – Local Care	Green	Review of current sleepover arrangements in order to ensure appropriate service delivery and to maximise opportunities for use of technological solutions.	31 March 2020	Financial Efficiency - £50k expected for 2019/20.
▪ LD In-house Enhanced Day Services	BP4 / Management Action	SP2 SP4 SP5 LOIP 6 MFT – Local Care	Green	Review of arrangements for day services provision to support adults with learning disabilities and maximise opportunities for delivery through Kelvinbank.	Five additional day care places at Kelvinbank to be offered commencing 30 Sept 2019	Financial Efficiency (avoided spend) - £100k expected for 2019/20.
▪ Fair Access to Community Care Policy	BP13 / Management Action	SP4 LOIP 6 MFT – Local Care, Mental Health and Older People's Care	Amber	Implementation of Fair Access to Community Care policy to ensure resources are fairly distributed to those in need. Amber due to risk of lack of capacity to deliver implementation plan. Mitigation identified and to be implemented.	Implement from 1 June 2019 Complete 31 May 2022	Financial Efficiency - £100k (combined efficiency and avoided spend) expected for 2019/20.
▪ Mental Health / Addictions Commissioning	BP16 / Management Action	SP8 LOIP 6 MFT – Local Care	Green	Review and streamlining of commissioning arrangements across mental health and addiction services based on updated needs assessment and new national and	1 Dec 2019 but dependant on receipt of updated needs assessment due	Financial Efficiency - £30k expected for 2019/20.

				NHS GGC MH Strategies.	Oct 2019	
▪ Mental Health Officer Agency Spend	BP17 / Management Action	SP8	Amber	Develop a means of financially compensating qualified MHOs for undertaking this additional statutory role in order to support recruitment and retention of directly employed MHOs and reduce spend on agency MHOs. Amber due to risk of timescale slippage	1 October 2019 but dependent on agreement with ED Council HR re changes to terms & conditions	Financial Efficiency – cost avoidance expected for 2019/20.
▪ Review of Ordinary Residence – Mental Health	BP23 / Management Action	SP8	Amber	Review of support arrangements for individuals with a mental health condition to ensure costs are being met appropriately within ED. Amber due to risk of timescale slippage	1 October 2019 but dependant on availability of capacity from ED Legal Services and agreement from same to proceed	Financial Efficiency – £100k expected for 2019/20.
▪ ASP Training	BP29 / Management Action	SP8 LOIP 6 MFT – Local Care	Green	Review of delivery mechanism for Adult Support & Protection training across the partnership and wider stakeholders.	1 October 2019 but dependent on agreement with ED Council HR re recruitment	No financial efficiency expected during 2019/20 – cost neutral proposal aimed at increasing capacity within existing spend
▪ Review of Rosebank Allotments	BP31 / Management Action	SP8	Amber	Review of allotment provision to support individuals with mental health and addictions. Amber due to risk of timescale slippage.	1 October 2019 but dependant on HSCPB agreement 28 May 19 followed by 3 month transition period	Financial Efficiency – initially £88.5k expected for 2019/20. Timescale slippage leading to ½ year effect only. £44.25k.

▪ Review of LD Resource Allocation Model	Management Action	SP8	Blue	Review of resource capacity to support learning disability community health function.	1 April 2019	Financial Efficiency - £50k expected for 2019/20. Actual efficiency delivered - £50k
▪ Review of Disabilities function	BP2 / Service Transformation	SP8 MFT – Local Care	Green	Review of disability functions across the partnership from childcare through adult services to older people to promote effective joined up working.	1 December 2019	Financial Efficiency – £80k expected for 2019/20.
• Implement Carers (Scotland) Act 2016	Implement national policy	SP7 LOIP 6 MFT – Local Care	Green	Comply with requirements of new legislation. Required implementation date is 1 April 2019. Performance against requirements to be monitored 2019 - 2020	1 April 2019	No financial efficiency expected. Funding provided from SG for implementation as this represents a cost pressure to the HSCP, and returns required to demonstrate delivery.
• Implement The Community Care (Personal Care and Nursing Care) (Scotland) Amendment (No. 2) Regulations 2018 (Frank's Law)	Implement national policy	SP4 LOIP 6 MFT – Local Care	Green	Comply with requirements of new legislation waiving charges for Free Personal Care for those under 65 years of age. Required implementation date is 1 April 2019. Performance against requirements to be monitored 2019 – 2020	1 April 2019	No financial efficiency expected. Funding provided from SG for implementation as this represents a cost pressure to the HSCP.
• Develop a sustainable approach to services for people with Learning Disabilities	Carried over from 2018 – 2019 Business Plan - ADSP01/ Service Transformation	SP2 SP6 LOIP 6 MFT – Local Care,	Amber	Complete review of Learning Disability Services commenced during 2018 – 2019 progressing through the Council 10 stage process. There are two separate strands to the review	1 June 2019	Current Investment - £14.5m Financial efficiencies to be scoped for 19/20.

		Mental Health		• Day care services • Accommodation with support Amber due to timescale slippage		
Older People's Services Project						**£2.090m**
▪ Review of SMART flat provision / Maximising use of equipment	BP9 / Management Action BP21 / Management Action	SP2 & 5 LOIP6 MFT – Local Care, Planned Care, Unscheduled Care	Green	Review of alternatives for the demonstration of SMART technology. Review of options for the use of technology in the delivery of care and support to individuals within the community.	Review to be completed by June 2019 and Technology Enabled Care Strategy to be in place by Dec 2019 via refresh of Assistive Technology Strategy	Financial Efficiency – £15k expected for 2019/20.
▪ Review of Day Services East	BP10 / 30 Management Action / Service review	SP 1,2 & 4 LOIP6 MFT – Local Care	Amber	Continued implementation of Older People Daycare Strategy across East locality to include ethnic daycare provision.	Review to conclude Sept 2019 with part year savings	Financial Efficiency – £150k expected for 2019/20.
▪ Review of Respite	BP14 / Management Action	SP 7 & 1	Green	Review of entitlement to respite provision to ensure parity across older people's services.	Review commencing August 2019. Financial efficiencies delivered from December 2019	Financial Efficiency – £10k expected for 2019/20.

▪ Review of assessment for Blue Badge	BP15 / Management Action	SP 8	Amber	Review of delivery mechanism for assessment for blue badges with a view to bringing this in house.	Reviewed by September 2019. Financial efficiencies delivered from Dec 2019.	Financial Efficiency – £36k expected for 2019/20.
▪ HAT / Community Care Agency Spend	BP18 / Management Action	SP 5	Amber	Review of agency spend for older people social work teams with a view to identifying a recurring solution within OP structural arrangements.	Financial savings from July 2019 dependant on agreement with ED Council HR re recruitment	Financial Efficiency – cost avoidance expected for 2019/20.
▪ Review of Day Services West	BP19 / Management Action	SP 1,2 & 4 LOIP6 MFT – Local Care	Amber	Continued implementation of Older People Day care Strategy across West locality.	Review completed by December 2019. Part year savings.	Financial Efficiency – £26k expected for 2019/20.
▪ Review of Ordinary Residence – Older People	BP24 / Management Action	SP 1 &4 MFT – Local Care	Amber	Review of support arrangements for older people to ensure costs are being met appropriately within ED.	Terms of reference & process of review developed by Sept. Financial savings in 2021 but dependant on availability of capacity from ED Legal.	No financial efficiency expected during 2019/20
▪ Review of Care Home Placements	BP26 / Management Action	SP 3 & 8	Green	Review and prioritisation of care home referrals from hospital and the community within a set limit.	To be reviewed by June 2019. Part year efficiencies	Financial Efficiency – £300k expected for 2019/20.

					savings	
▪ Review of Staffing Complement in Older People's Mental Health Team	Management Action	SP 2,3 & 5 MFT – Older People	Green	Review of resource capacity to support delivery of older people's mental health services	To be linked to wider review of disabilities (Occupational Therapy). 1 December 2019	Financial Efficiency – £30k expected for 2019/20.
▪ Review of Continuing Care Financial Modelling	Management Action	SP 1,4 & 8 MFT – Older People	Green	Review of resource capacity to support individuals moving on from continuing care settings to supports within their local communities.	Tied to closure of Mearnskirk hospital. NRAC formula used. Finance to be allocated in June 2019.	Financial Efficiency – £260k expected for 2019/20 (one off).
▪ Review of Integrated Care Funding	Management Action	SP 1 & 8	Green	Review of priorities funded through integrated care funding and mainlining of recurring projects.	Review to be completed by September 2019.	Financial Efficiency – £100k expected for 2019/20.
▪ Implementation of CM2000 for externally provided homecare	BP5 / Service Transformation	SP 2 LOIP6 MFT – Older People	Amber	Implementation of time scheduling for externally purchased homecare which move from payment on planned hours to actual service delivery.	Financial efficiencies delivered from Sept 2019.	Financial Efficiency – £300k expected for 2019/20.
▪ Review of Homecare Services	BP6 / Service Transformation	SP 2 & 8 LOIP6 MFT – Older People	Red	Review of care at home services to identify efficiencies in current service delivery model, review balance of internal / external provision, maximise review function and comply with care inspectorate recommendations.	IJB sign off in June 2019. Financial efficiencies delivered from Sept 2019.	Financial Efficiency – £825k expected for 2019/20.
▪ Review of Charging for Community	BP25 / Service Transformation	SP 8	Green	Review of charging levels for community alarms in line with	Financial efficiencies delivered from	Financial Efficiency – £38k expected for 2019/20.

Alarms				benchmarked average.	June 2019.	
▪ Enhance support to primary care by implementing the new GP Contract	Implement national policy	SP1,2,3 &8 LOIP6 MFT – Local Care	Amber	Implement year two of the primary care improvement plan	Annual reporting (including financial spend) to Scottish Government & IJB	Allocated funding £999k
▪ Achieve prescribing financial balance and improve prescribing efficiency	Service Transformation	SP 8	Amber	The Prescribing Team to support each GP practice in the HSCP to make prescribing efficiencies.	Ongoing review of financial efficiencies	No financial efficiencies expected
▪ Further develop supports for those with dementia, and their carers	Service Transformation	SP1,2,3 &7 LOIP6 MFT – Local Care, Older People	Green	Work in partnership with a range of older peoples mental health services to support the delivery of the strategy	31 March 2020	No financial efficiencies expected
▪ Contribute to the national review of Prison Health and Social Care need.	Implement national policy	SP1 & 2 LOIP6 MFT – Local Care	Green	Review current provision and improve accessibility to health and social care services for the aging population in custody through a test for change (hosted by GG&C) to be submitted to Scottish government to explore a model of health and social care within prisons	31 March 2020	No financial efficiencies expected
▪ Achieve the Ministerial Strategic Group targets for	Service Improvement	SP3 & 8 MFT –	Green	Deliver Unscheduled Care Plan key objectives for 2019 – 2020 focussing on frailty, anticipatory	31 March 2020	Potential link to utilisation of set aside budgets

unscheduled care by delivering the 2019 – 2020 East Dunbartonshire Unscheduled care Plan		Unscheduled Care		care and intermediate care at home		
Oral Health Services Project						
▪ Further improve dental services for priority groups	OHSP01/ Service Improvement	LOIP3 LOIP6 SP1	Green	Following production of ED HSCP performance report for dental services, key results areas and recommendations were made which support this project. This links to the Oral Health Improvement Plan launched in Jan 2018 by Scottish Government.	31 March 2020	Current Investment – 3.11 million across GG&C Efficiency of 3.5% per year already given up over last 3 years - none expected for 2019/20.
▪ Review the balance and proportionality of oral health improvement programmes across adult and child services	OHSP02/ Service Improvement	SP1	Green	Ensure resources are targeted to the most appropriate areas in East Dunbartonshire HSCP, addressing health inequalities and ensuring best use of resources available.	31 March 2020	Current investment £3.1 million across GGC. Financial budget increase by 210K as extension to fluoride varnish programme agreed
▪ Develop a Health Board wide premises strategy in relation to PDS services.	OHSP03/ Service Transformation	SP1	Green	Development of a Health Board wide premises strategy in relation to PDS services, including consolidation and possible reduction and relocation of oral health services in relation to the PDS.	31 March 2020	Current Investment - £4.687 million Financial Efficiency – Any savings from budget require to be returned to SG in this year's allocation to GGC.

East Dunbartonshire Health & Social Care Partnership

HSCP Wide						£650k
▪ Review of Charging for Day Services / Transport	BP11 / Service Transformation	SP8	Green	Review of charging levels for day Services and transport in line with benchmarked average.	June 2019	Financial Efficiency – £65k expected for 2019/20.
▪ Review of 3rd Sector Grants	BP22 / Service Transformation	SP8	Amber	Review of payments to 3rd sector organisations to maximise efficiencies from this sector.	June 2019	Financial Efficiency – £185k expected for 2019/20.
▪ Review of Integrated Structures	BP27 / Service Transformation	SP8	Green	Review and maximise opportunities for integrated management structures across the HSCP.	Ongoing	No financial efficiency expected during 2019/20
▪ Vacancy Resourcing	Management Action	SP8	Amber	Review of vacancies across the partnership.	June 2019	Financial Efficiency – £400k expected for 2019/20.
▪ Develop a Health & Care Centre within the west locality	Service Transformation	SP8 MFT – Local Care	Amber	Develop a business case for a new building in the West Locality	March 2020	No financial efficiency expected
▪ Remodelling of the KHCC	Service Transformation	SP8	Amber	Remodel accommodation to support smart working	Completed in March 2020	No financial efficiency expected
▪ Remodelling of Southbank	Service Transformation	SP8	Amber	Remodel accommodation to support smart working	Completed in March 2020	No financial efficiency expected
▪ Development of ICT Strategy	Service Transformation	SP8	Green	Development of a strategy which support integrated working within the HSCP and supports modern, fit for purpose service delivery models.	September 2019	No financial efficiency expected

Agenda Item Number: 5

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	28th May 2019
Subject Title	East Dunbartonshire Primary Care Improvement Plan
Report By	Derrick Pearce, Head of Community Health and Care Services
Contact Officer	Gillian Notman, Change and Redesign Manager

Purpose of Report	The purpose of this report is to, at this stage, ask the Board to **approve** this second year of East Dunbartonshire's Primary Care Improvement Plan (PCIP) associated with the new General Medical Services Contract, pending approval from the LMC and within the context of financial allocation to the HSCP.

Recommendations	• This Primary Care Improvement Plan (currently in draft) outlines the progress achieved in the first year (2018-2019) of the plan with the expected progress for the second year (2019-2020). • Note the attached PCIP is draft because it is subject to further discussion with the HSCP's Local Medical Committee (LMC) rep. This, at the moment, is the position across all GGC Partnerships. • Note that there will be ongoing engagement with key stakeholders to support the transformational changes required to implement the contractual Memorandum of Understanding (MOU). • Note that regular updates will be provided to the HSCP Board on implementation progress and funding usage.

Relevance to HSCP Board Strategic Plan	The new GP contract has a significant impact on the delivery of HSCP services, partly in the redesigning of services, recruitment/training of new staff as well as the management of whole system changes.

Implications for Health & Social Care Partnership

Human Resources	The new Contract supports the development of new roles and extended multidisciplinary teams working both in GP practices and within Clusters. The new General Medical Service (nGMS) Contract also facilitates the transition of the GP role into an Expert Medical Generalist. New members of the extended multidisciplinary team have been, and will continue to be recruited to aligned with each MOU commitment. Some of these healthcare professionals sit within NHS GG&C and are part of board-wide allocation.

Equalities:	There is a phased roll out for the implementation. Patients will not currently receive all the newly configured services, but the plan describes the HSCPs aims for putting extended multi disciplinary teams in to all practices and clusters.

Legal:	There are no legal issues within this report

Financial:	The Scottish Government has provided an allocation of £999,000 funding for 2019/20 from the Primary Care Fund. Our projections in this plan to deliver the MOUs are in excess of the available budget.

Economic Impact:	There are no economic issues within this report

Sustainability:	Refocusing the primary care model will require the HSCP to support and deliver improvements through service redesign.

Implications for East Dunbartonshire Council:	None

Risk Implications:	It is essential that the HSCP gets clarity on funding in relation to the creation of Treatment Rooms. For sustainability reasons, the HSCP must have a permanent solution for treatment room space. Accommodation within practices and the HSCP may challenge deadlines for the delivery of the Community Treatment and Care services. Workforce availability across all Allied Health Professionals and extended roles has been recognised as a challenge nationally. Emerging risks will be managed through the HSCPs Primary Care Implementation Planning group.

Implications for NHS Greater Glasgow & Clyde:	The new GMS contract will impact how community services are delivered throughout the Health Board. Consistent messages on redesign of primary and community services should look to ensure patient population of NHS GG&C have an improved experience

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	☐

MAIN REPORT

1.0 REPORT

1.1 Background information

1.2 The new GMS contract, agreed between Scottish Government and the British Medical Association, was adopted in Scotland on 1st April 2018, covering the initial period from 1st April 2018 – 31st March 2021. The contract refocuses the GP role as Expert Medical Generalist. In doing so it aimed to build on the core strengths and values of General Practice whilst seeking to deliver transformational change to enable sustainability in the face of rising demand, falling primary care workforce numbers and sub-optimal patient experience.

1.3 A Memorandum of Understanding (MOU) has been agreed between the Scottish Government and the British Medical Association (BMA) and has been adopted by Integration Authorities. This MOU sets out the key aspects relevant to facilitating the commissioning of Primary Care Services and service redesign to support the role of the GP as the Expert Medical Generalist.

1.4 Key MOU priorities to be executed are:

- **The Vaccination Transformation Programme (VTP) -** High level deliverable: All services to be Board run by 2021.
- **Pharmacotherapy Services -** High level deliverable: services to be delivered to the patients of every practice by 2021.
- **Community Treatment and Care Services -** High level deliverable: services to be delivered in every area by 2021, starting with Phlebotomy.
- **Urgent Care (Advanced Practitioners) -** High level deliverable: sustainable roles such as Advanced Nurse Practitioner (ANP) services used for urgent unscheduled care as part of the practice or cluster-based team.
- **Additional Professional Roles (MSK Physiotherapy & Mental Health) -** High level deliverable: create a dynamic multidiscipline team consisting of physiotherapists or mental health workers who can act as the first point of contact.

1.5 An initial Primary Care Improvement Plan was submitted to the Scottish Government in April 2018 which laid out our commitments for 2018/2019. A Primary Care Improvement Plan Working Group has been set up by the HSCP which meets bi monthly. This group consists of the Clinical Director, the Head of Community Health and Care services, service leads within the HSCP and representation for the Local Medical Committee (LMC) who provides input from the GP subcommittee. We have worked collaboratively with these partners to progress delivery of the MOU, highlight risks and work to deliver service redesign.

1.6 The Scottish Government has requested a second iteration of the PCIP and a local implementation tracker covering the period July 2018 to March 2019 inclusive. These plans are required to include information on workforce, patient engagement, infrastructure, funding and evaluation. This provides a visual marker on where the HSCP is in relation to delivering the MOUs. There is also an opportunity to describe risks and barriers.

1.7 Both of these plans require to be completed collaboratively with our local GP LMC representative. While there is, and has been, extensive dialogue there are several issues which have still require resolution. These include:-

- Formal reporting and accountability of the PCIP and the HSCP links to the LMC/GP subcommittee.
- The inherent difficulties of utilising PCIP funding for remodelling of premises. This could cause a delay in the roll out of our services or an inability to transfer services away from practices.
- Reporting workforce projection from either a realistic or an aspirational viewpoint.

1.8 The report highlights some success for 2018/2019 including

- All practices have received an additional pharmacotherapy service.
- All relevant patients have received housebound flu vaccinations.
- All practices will have a pre five immunisation service by the end of June.
- All practices have been offered training on signposting and workflow optimisation
- There are good and productive relationships between the HSCP, GPs and practice staff.

1.9 The Primary Care Improvement Plan (2019/2020) and the implementation tracker form are still subject to discussions with our LMC colleagues. At this stage will ask that the Board approve this draft pending agreement from the LMC.

East Dunbartonshire Health & Social Care Partnership

DRAFT
Primary Care Improvement Plan 2019-2020 Update

*****Pending final LMC Agreement*****

Version 1	23rd March	Draft PCIP update
Version 2	11th April	Sent to LMC / GP Sub Committee
Version 2	11th April	Sent to Clinical Director & Associate Clinical Director
Version 3	24th April	Amendments from Head of Community & Care Services Clinical Director & Associate Clinical Director
Version 3	26th April	Sent to CQLs for comment
Version 4	30th April	Sent to LMC / GP Sub Committee Rep
Version 4	1st May	Update of plan with Head of Community & Care Services, Clinical Director & Associate Clinical Director
Version 5	3rd May	Draft PCIP sent to LMC / GP Sub Committee Rep
Version 5	7th May	LMC confirmation of non approval
Version 6	8th May	Update of Plan with LMC / GP Sub Committee Rep
Version 6	20th May	Final draft of plan sent to LMC / GP Sub Committee Rep
Version 6	23rd May	IJB Presentation & approval of draft plan
Final	27th May	Submission to Scottish Government

NHS Greater Glasgow and Clyde

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1. Introduction

The new GMS contract, agreed between Scottish Government and the British Medical Association, was adopted in Scotland on 1st April 2018. This covers an initial period from 1st April 2018 – 31st March 2021. The contract proposed a refocusing of the GP role as Expert Medical Generalist. In doing so it aimed to build on the core strengths and values of General Practice whilst also seeking to deliver transformational change to enable sustainability in the face of rising demand, falling primary care workforce numbers and sub-optimal patient experience.

A Memorandum of Understanding (MOU) has been agreed between the Scottish Government and the British Medical Association (BMA) and has been adopted by Integration Authorities. This MOU sets out the key aspects relevant to facilitating the commissioning of Primary Care Services and service redesign to support the role of the GP as the Expert Medical Generalist.

In July 2018 East Dunbartonshire Health & Social Care Partnership (HSCP) submitted our first Primary Care Improvement Plan to the Scottish Government on our plan to deliver the commitments set out in the new GMS contract.

This is the HSCPs second report which provides an overview of progress against the 2018/19 Primary Care Improvement Plan and articulates plans for 2019/2020. Below are a few examples of the changes made towards our Memorandum of Understanding (MOU) commitments.

2. Aim

Our overall commitment was that:

East Dunbartonshire's HSCP Primary Care Improvement Plan (PCIP) will enable the development of the Expert Medical Generalist role through a reduction in current GP and practice workload. By the end of the three year plans, every practice in East Dunbartonshire HSCP should be supported by expanded teams of health board employed health professionals providing care and support to patients.

3. Our progress to date (April 2018 –March 2019)

- On 24th October 2019 East Dunbartonshire HSCP held an engagement event for practice and community staff to support the implementation of our Primary Care Implementation Plan and to begin to engage with colleagues in the development of the new multidisciplinary teams.
- Recruitment is underway to support the MOU deliverables. To date we have recruited Pharmacists, Advanced Nurse Practitioners (ANP), Phlebotomists and an Advanced Practice Physiotherapist (APP).
- There has been a move towards the creation of extended multi disciplinary teams in every practice within East Dunbartonshire.
- We undertook an accommodation survey of space currently available within our GP Practices. The outcome of the audit showed that 15 out of 16 practices are privately owned with space already at a premium.

- A feasibility study is underway within HSCP premises covering both localities to explore treatment room options. This study will show how the HSCP will accommodate the CTCs. This includes remodeling our current premises.
- A governance structure has been established to report on agreed objectives and milestones.

3.1 Whole System Transformation

Primary care will be part of a whole system approach in which services are and will be delivered by a network of integrated teams across primary, community, specialist and hospital based care. In doing so East Dunbartonshire will be committed to engaging with the principles of Moving Forward Together and are involved in dialogue with our local primary and secondary care interface groups.

Following the development of the HSCPs Strategic Plan, there are a number of transformational programmes underway. Examples of these projects include:-

- The HSCPs portfolio of unscheduled care programmes is developing a range of services which will assist in reducing emergency admissions and moving towards a service which is responsive and not reactive for example Home for Me which will commence summer 2019.
- There is an opportunity to work with Mental Health in relation to the Action 15 Plan. One of the goals of Action 15 is to increase the number of mental health workers to give access to give access to dedicated mental health professionals to all GP practices / Cluster. This should enhance capacity to support people with mental ill health in the community.
- Our self management and social prescribing projects have been designed to support people with a wide range of social, emotional or practical needs, and many of our schemes have been focused on improving mental health and physical well-being.
- Local work on technology enabled care is still in the relatively early stages but it has the potential to transform how people engage and manage their own care.

Some of these transformational workstreams have the potential to increase GP workload. It is therefore essential that the Primary Care Implementation Planning Group have the opportunity to engage and work collaboratively to get the best outcomes and values within current resources.

3.2 Culture Change

We recognise that in order to deliver on the outcomes of the new GP contract, a culture change in how primary care services are used is required. East Dunbartonshire HSCP has developed a communication plan which details how we plan to engage and educate members of the public, ensuring they have an understanding of the new GP contract and services available to them thus enabling them to navigate to the correct service.

Crucial to this is investing time in training staff, particularly within General Practice, to provide appropriate signposting and provide them with the confidence and tools to do so both appropriately and safely. Most East Dunbartonshire practices now have flyers detailing local services available within their reception areas and are actively using signposting to redirect patients to the most appropriate support and/or treatment.

A further element of support to administration and business processes within practices is workflow optimisation. Where practices have implemented this, practice admin, where appropriate, will now read, scan and code all correspondence received within the practice therefore releasing some GP capacity. There are however challenges around implementing this fully in order to release GP time. This requires a strong change management approach within GP reception / admin staff. Initially this will also require a significant amount of direction and leadership from GPs to support these changes in a safe and timely manner.

We have developed a communications and engagement plan. We aim to engage with a wide range of stakeholders and professional groups to inform them of the changes to primary care and in particular to the developments happening locally within East Dunbartonshire. (see Appendix 3).

Specific and focused engagement has and will continue to be through:-

- Clinical Director
- LMC GP-Subgroup representative
- Strategic Planning group
- Primary Care Implement Group
- Profession and care group specific management and leadership groups
- GP forum
- Cluster group meetings
- Practice Managers forum
- NHSGG&C Primary Care Programme Board

We held an engagement event for primary care and HSCP staff on the 24th October 2018 to engage with stakeholders on the implementation of the primary care implementation plan.

We will also engage on a wide scale in relation to the new GP Contract and Primary Care Improvement Plan via community groups and events.

3.3 Transforming Leadership

Significant leadership is required to support the delivery of our MOU commitments. Our approach has been to focus on collective leadership with key stakeholders and representatives.

General Practice
The Local Medical Council (LMC) /General Practitioner Sub Committee (GP Sub) has an integral advisory role in providing support on the implementation of services and approving the Primary Care Improvement Plan. We are starting the process of building a collaborative structure between the Clinical Director, Cluster Quality Leads (CQLs) and the LMC/GP Sub to look at pathways and quality of care. In addition we are sharing views on the progression of the plan including funding allocation and engagement with other professionals, services and with the CQLs. We will invite the

CQLs to our local Primary Care Implementation Planning group. The CQLs role initially focused on 'intrinsic functions' around quality improvement within their clusters. There is now an opportunity for them to become involved in a developing role on the implementation of a core multidisciplinary team within general practice as well as linking in with wider teams built around GP surgeries, clusters and localities.

To allow GPs to function as Expert Medical Generalists, there requires the development of our primary care multi disciplinary teams. We have employed additional Pharmacists and Phlebotomists, created a new role for Advanced Practice Physio (APP) and Advanced Nurse Practitioner (ANP) and also shifted some of the children's immunisation activity directly away from practices. GPs will be the leaders of the new Extended Multi-Disciplinary Teams (eMDTs), however, a Boardwide position is required in relation to payment or backfill for GP time for mentoring eMDT. HSCP managers and service leads will be responsible for making sure that staff are competent to deliver an effective person centered service and to work in collaboration with members of the primary care team.

HSCP

Programme Management

We have appointed a Primary Care Development Officer to lead on implementing our plan to provide programme management skills, to have an overview of all work streams, to ensure there is sufficient capacity to deliver the scale of change involved, to assist with transitions and transformation required and facilitate community engagement and publicity. Key to the success of these changes is the relationship building and cultural adjustments required by all those who access and deliver care. Active involvement in GP related and practice manager fora and other wider networking opportunities within the HSCP and the community are an essential element of this position.

Nursing

Recruitment is underway for a Band 7 leadership role within nursing. Their role will be to co-ordinate and support the delivery of phlebotomy, influenza vaccination work, supervision of the ANP's and to develop and set up the community treatment and care services. This post is crucial to lead the interface between community and primary care nursing.

Pharmacy

A sessional Band 8A Pharmacy Team Leader's post has lead on the recruitment and development of a sustainable pharmacy service to support the implement of the core elements identified within the GMS contract, 2018. This has included the introduction of pharmacy technician support to clusters and interface between the Prescribing Support Pharmacists and Primary Care Invest core tasks.

Framework to support mentorship of eMDTs
There are local arrangements within practices for mentorship and clinical supervision is available as per NHSGG&C policies. Whilst clinical leadership and mentoring has been positively embraced so far, as the sizes and complexities of these teams increase, the demands on GPs and others could challenge these current arrangements. A model of peer supervision will be piloted for ANPs in year 2 to ascertain whether other sustainable options will be productive and efficient. One of our concerns is that the additional leadership functions which we have committed to the delivery of the agreed MOU are temporary positions (e.g. Pharmacy, Project Management). If these posts are lost the ethos of the contract and the momentum for cultural change may not develop within the stated timelines.

4. Summary of position as at 31st March 2019

Whilst the new GMS contract commenced in April 2018, there has been a delay in implementing our planned commitments in year one. This has largely been due to delays in recruitment within the MDT professions. It is too early to have meaningful data on the true impact of change, however within the last six months there has been some progress and feedback. These include:-

What we said we would do	What we have done	Comments	Impact
Vaccination Transformation programme – Phase in the pre-5 VTP in geographical areas. Focus on influenza immunisation for GP housebound patients.	Fully implemented within two clusters. Awaiting final roll out in last cluster. All housebound influenza vaccinations flu's were completed by DNs winter 2018.	Obtaining suitable accommodation has been challenging and has delayed this service from being fully implemented. However suitable premises have now been identified and the final service will be implemented as soon as possible.	
Pharmacotherapy services - We will mainstream 3.2wte Primary Care Pharmacists (PCP) currently funded from the primary care investment fund. We would increase pharmacy resource and skill mix.	A total 4.7wte Pharmacy & technician resource are employed within East Dunbartonshire HSCP. Currently 1wte Technician & 0.5 Pharmacist are in induction training phase & not specifically allocated to specific Practices as at end of March 2019.	Target aspiration for yr 2 will be to achieve 0.1wte per 1,000 patients per practice. This will increase with immediate effect once pharmacy and technician have completed induction phase and allocated into Practices. Target aspiration for yr 3 will be to achieve 0.2wte per 1,000 patients per practice.	<u>PCIP Pharmacist Procedures Audit</u> Within the Bearsden and Milngavie cluster the CQL, Practice Quality Leads (PQL) & the Pharmacists attached to these practices completed a questionnaire to gather ideas on how to standardise processes and communications. Both perspectives were similar in their comments. In the longer term we are hoping this information will be useful to support backfill / flexibility of pharmacists covering

What we said we would do	What we have done	Comments	Impact
	Therefore current allocation at 1st April 2019 was 0.1wte pharmacy support per 2000-3000 per patients per Practice.		other bases during periods of leave.
Pharmacy First	Boardwide programme. Continue to deliver service with same costs from year 1.	Further modeling up Boardwide will inform delivery in year 3.	
Community Treatment and Care We will scope the funding for the required Nursing/Health Care Support Worker capacity, accommodation and supply costs to deliver a community treatment and care service. Once scoping is completed, phase 1 will commence in the Bishopbriggs / Auchinairn cluster.	Year 2-Using the Boardwide model we aim to recruit and commence a CT&C within the next 6 months in the Bishopbriggs / Auchinairn cluster. A feasibility study on treatment rooms is underway in two localities to ascertain options for the roll out of the service.	This will be developed at the pace of available accommodation.	

What we said we would do	What we have done	Comments	Impact
	Domiciliary phlebotomy service which includes simple observations and specimen collections was fully implemented for all surgeries.		
Embed community phlebotomy service by providing 56 hours per week to undertake all GP domiciliary bloods.	Domiciliary phlebotomy service which includes simple observations and specimen collections was fully implemented for all surgeries.	Yr 2 will continue to deliver the current level of domiciliary phlebotomy and implement a clinic based phlebotomy service within Bishopbriggs & Auchinairn. Yr 3 Roll out of Community Treatment & Care Service to all clusters.	
ANP Provision - Implement a model of 2.0wte ANPs within the Kirkintilloch/Lennoxtown cluster	Two ANPs recently appointed. One fully trained and ready to provide full service, second staff member requiring further training, including in-house is being provided within local practices.	Yr 2 Establish ANP within Kirkintilloch & Lennoxtown Cluster. Y3 Roll out ANP service to remaining Clusters	

What we said we would do	What we have done	Comments	Impact
APP Provision - Implement a model of 2.0wte APP within the Bearsden/Milngavie cluster	APP - 1.0wte across 4 practices. Unable to recruit additional APP due to board wide concerns regarding recruitment/destablising of service across the board	Aim for further recruitment in coming year. However, this is dependent on Boardwide position being clarified around recruitment and agreement of model to small Practices.	The APP has been in post for 4 months. An initial audit begins to show the shift from GP appointments to APP from point of referral/first contact. 80-100% of available capacity was utilised and 2 of the 3 practices are already reporting patients being directed to the APP by reception rather than being offered a GP appointment first.
Infrastructure Commit funding towards • programme management, • clinical leadership for nursing, pharmacy and APP • culture change	Project manager recruited and commenced in post December 2018 until March 2020. Additional HSCP leadership resource is allocated to the delivery of the PCIP.	The infrastructure focus in year 2 will be on culture change. Leadership focus for yrs 2 & 3 is on planning, implementation and evaluation.	

What we said we would do	What we have done	Comments	Impact
• QI Cluster Funding	We have committed £5,000 for Quality Improvement activity for each cluster in year 2 (see appendix 2 finance section) Leadership in place for Pharmacy (0.4wte) Physiotherapy (0.1wte) Large engagement event for primary care (24/10/18) Continue to deliver appropriate funding to cluster groups CQLs now part of our tripartite arrangement.	We aim to commit to support quality improvement funding for each cluster as an ongoing commitment e.g. training, PLT events, signposting, posters etc.	

5. Our Priorities for 2019/2020 - refer to Appendix 2.

By applying the knowledge and learning gained in year 1, East Dunbartonshire HSCP will be working on implementing and embedding our year 2 commitments (see appendix 2). We have concerns that our pace of delivery will be influenced by 2 key issues:

- Debate between the HSCP, LMC & Board on source of funding for the creation of treatment rooms. There is a very high risk that the HSCP will be unable to deliver MOU 3, 4 & 5 until a resolution is reached. This will have an impact on reducing GP workload.
- Timely recruitment both locally and Boardwide.

Aims	Constraints / Risks
MOU 1 – Vaccination Transformation Programme	
We will continue with the board wide re-design, planning and implementation/migration of all practice-led immunisation services to alternative models for completion by March 2021.This includes flu vaccination for pre-school, adults under 65 who are deemed 'At Risk' due to a health condition(s), those over 65, all pre-school vaccinations, pregnant women vaccinations . East Dunbartonshire has expressed an interest in taking part in a board pilot considering how to institute this service within a community setting, but further updates are awaited.	Reliance on Boardwide implementation & costs of certain services e.g. VTP, physiotherapy Accommodation in all Clusters will continue to be challenging.
MOU 2 – Pharmacotherapy	
We will introduce more skill mix to the pharmacotherapy services. Continue to monitor and test the role of technicians and support workers doing some of the less complex medication reconciliation activities in practices.	To fulfill the contract commitment in its entirety a scoping exercise took place and revealed that East Dunbartonshire would be required to employ a total of 42 Pharmacists. In discussion with both Boardwide and Local Pharmacy Leads there has been a decision not to go recruit to this level for following reasons:

Aims	Constraints / Risks
MOU 2 – Pharmacotherapy	
We will take part in and provide support to board wide tests for change to explore innovative solutions for a sustainable service model.	• Workforce scoping suggests there is not practicably this amount of Pharmacists available within the system. Early indications have shown there is not enough PSPs/PST to fill the posts without destablising the rest of the NHS. • The above point also impacts on a potential model for part of VTP - Community Pharmacy delivering influenza vaccinations for adults. • We would not have the infrastructure, finance, training support to accommodate for this amount of staff
MOU 3 - Community Treatment and Care Services	
Bishopbriggs/Auchinairn cluster will be a pilot site for the introduction of a community treatment and care/phlebotomy service. Scope alternative ways in which the HSCP can deliver this service given the limited / no accommodation within our local Practices & Health & Care Centers.	It is essential that we receive clarity from the Board on funding in relation to the creation of Treatment Rooms. Moving forward and for sustainability reasons we must have a permanent solution for treatment room space.
MOU 4 - Urgent Care	
We will implement an ANP model within the Kirkintilloch/Lennoxtown cluster. We will map ANP clinical interventions to ascertain whether there is a shift of clinical work within practices. We will roll out ANP model to other clusters.	Practices and HSCPs must work together to redefine the role of urgent care and the management of long term conditions within primary care so that all nursing skills within the eMDT and Practices can be maximised.

Aims	Constraints / Risks
MOU 5 - Additional Professional Roles	
We will undertake a pilot for Community Links Worker service within one cluster to ascertain its effectiveness in providing person centered care and reducing GP workload. With the commitment of an additional APP, we will support the Physiotherapy professional lead to implement an alternative model of delivery so that those practices which have limited treatment room space can have equal access to service. We will work with Mental Health in relation to the Action 15 plan to determine need and appetite for Mental Health Practitioners to be based within Practices.	Locally we refer to Community Links Workers as "Wellbeing Workers". The Wellbeing Workers have the same remit and pivotal role as Community Links Workers delivering on social prescribing. Current APP model does not incorporate for creativity of flexibility in relation to small practices or those who have a small practice list size. This has halted our progression of services. It is essential that there is a solution focused approach. No agreement has been reached on allocation of Mental Health Practitioners directly working within Practices or Cluster model.
Other	
We will implement actions identified in our communication strategy including wider community interface. We will develop a framework for internal and external communications There will be a pilot in one cluster on the use of Trello as a means of sharing information and building on Quality Improvement. We will maximise opportunities to share best practice, news and invite feedback.	Concern around key messages in relation to changes in primary care not being consistently delivered and publicised in the right fora or public spaces to make a difference.

6. Evaluation Impact

Boardwide

There has been an agreement between all HSCP partners that there will be a Boardwide evaluation which will commence in year 2 and will be led by Public Health. This evaluation will explore the following questions:

1. Have we shifted non-complex work to the wider MDT and concentrated complexity on the GP resource?
2. Are the new ways of working improving professional satisfaction and sustainability in primary care?
3. Are patients confident and satisfied in their use of the new primary care system?
4. Are patient outcomes and safety sustained and improved under the new system?
5. Have we improved equity across primary care?
6. What are the impacts of the Scottish GP contract on the wider health and care system?

Local Evaluation - 2019/2020

East Dunbartonshire HSCP will develop and implement an evaluation work plan to capture the pilots and monitoring of services.

Below are suggestions on how the HSCP will monitor the shift and effectiveness of services. This is not an exclusive list and will continue to be developed:

MOU	**Progress**
MOU 1 Pre-school Immunisation	Board wide review of current model. Locally we will assess the impact of this community based model within practices and service users.
MOU 2 Pharmacotherapy	Evaluate shift in GP pressure by Pharmacists doing Medicines reconciliation, IDL's etc Board wide tests for change • Review of practice level repeat prescribing processes • Implementation of serial prescribing • Development of evidence around pharmacy technician competencies, including work on medicine reconciliation, acute prescribing and high risk medicine monitoring.
MOU 3 Community Treatment and Care Services	Scoping current activity against Boardwide specifications and interventions list for community treatment and care services. This will inform our accommodation needs and staffing quota for the East Dunbartonshire CT&C service in the longer term. In year 2 we will start to implement the CT&Cs model based on best available indicators of demand and capacity in Bishopbriggs. This will aid in the implementation of the CT&CS model in the other clusters in year 3.

MOU	Progress
	We will be required to work alongside the MFT programme to scope both what potential work will transfer to CT&Cs in the future and the funding this will require from Secondary Care. This is being overseen by the Boardwide Community Treatment & Care Group.
MOU 4 Urgent Care	Develop role of ANPs working across the HSCPs Community Nursing Team and Practices to inform the most appropriate future model for ANPs as part of the wider emerging continuum in line with the "Changing Nursing Roles" agenda. The initial focus of our ANP development in year 2 is using ANPs to respond to Home Visit demand in the identified practices.
MOU 5 Additional Professional Roles	Undertake a pilot for a Community Link Worker service within one cluster to ascertain its effectiveness in providing person centered care and reducing GP workload. Analyse the current model of APP and support the testing of a cluster based model for practices where accommodation is challenging. Assess numbers of patients seen and assessed by the APPs and outcomes.
Communication	Introduce 'Trello' as a means of testing out a virtual model of communication.

7. Enablers

7.1 Workforce Planning

Boardwide Position
Workforce planning is one of the most significant challenges highlighted in the development and implementation of the Primary Care Improvement Plans, both in terms of availability of workforce at a sufficient scale to support all practices across NHSGG&C and in terms of the change process required to support effective working for new teams. In order to meet all requirements of the new contract and develop the eMDT across all practices in Greater Glasgow and Clyde, an estimated additional workforce of between 800-1000 posts may be required.

Within the NHSGG&C areas HSCPs are committed to the following principles:

- Approaches across NHSGG&C should share consistent principles and pathways, role descriptors and grading, scale (numbers of staff per practice/ patient population)
- Recruitment should be co-ordinated across NHSGG&C where appropriate taking account of existing professional lead and hosting arrangements.

Across NHSGG&C, workforce planning for the Primary Care Improvement Plans is being considered in conjunction with the Board's wider Moving Forward Together strategy which sets a vision and direction for clinical services in the future. Staff Partnership representatives are involved at all levels. Specifically for the PCIPs, the key aspects of the approach include:

- Modeling to identify the work, tasks and skills required for the new roles
- Assessment of the numbers of staff required to fill those roles
- Modeling of the existing workforce including turnover
- Consideration of changes in other services and competing demands
- Reviewing different skill mix models and creative approaches to deliver both within and across professions.
- Developing approaches to supporting eMDT working within practices and between practices and wider community services

This approach is being tested initially within Pharmacy as one of the early priority areas, but will be adapted to other professional groups as part of year 2 and 3 implementation.

The availability of key staff groups continues to require action at national level, particularly to ensure sufficient training places and development of skills for primary care.

Local Position
All partners are committed to support the development of multi disciplinary teams to deliver on the MOU commitments. Scoping of our current workforce is crucial to understand what staffing and models should be implemented. From April 2019, the HSCP will begin the work to review our current workforce plan (2018-21) in line with the expected guidance from Scottish Government. In our revised workforce plan which will take us through to 2021, we will include more statistical data on our wider Primary Care Contractor services, our 3rd and Independent Care partners as well as those directly employed by either East Dunbartonshire Council or NHSGG&C. In this way we will be better able to identify potential recruitment issues and labor market demands. The local engagement for this activity will begin in late April 2019.

The data we are currently aware of reflects a national picture of:-
- A high proportion of GPs approaching retirement.
- More GPs choosing to work part time.
- An ageing nursing workforce.
- Difficulty with recruitment into General Practice at Junior Doctor level.

7.2 Premises & Accommodation
Boardwide position
The NHSGGC Property and Asset Management Strategy includes independent contractor owned and leased premises. Oversight of GP premises developments is provided through the Board's GMS Premises Group which reports to the overarching Primary Care Programme Board.

In year 1 of the PCIPs, existing mechanisms such as improvement grant funding have been used explicitly to support the requirement for additional space as part of PCIPs and this will continue.

There is a comprehensive programme of back scanning underway to free up space within practices to enable more clinical and administrative space to be provided, as well as supporting digital infrastructure through the removal of paper records. HSCPs will fund this through PC funding.

The national survey of GP premises will report shortly and will be used to inform future planning and investment including prioritisation for premises improvement grants and planning for capital developments, and will also support the due diligence and impact assessment process where there is a request for the Board to consider taking on an existing lease or an option to purchase.

Specific challenges have been noted in ensuring sufficient accommodation for services within small practices, and also for services being provided in one location for several practices in a locality. Supporting new developments to create additional space and accommodate Board employed staff is also challenging within independent contractor owned/ leased premises in line with the existing Premises Directions.

During years 2 and 3 of the Primary Care Improvement Plans, there will be a further focus on strategic planning for primary care premises in the medium and long term, in the light of the new GP contract, Primary Care Improvement Plans and the wider context of Moving Forward Together (the Board's long term strategy for clinical services) which sets out ambitions for the development of an extended range of community services based around virtual or actual community hubs. The strategy for GP premises will be developed in conjunction with the wider property strategy for community services and included within the capital plan associated with the Moving Forward Together programme.

Local Position / Accommodation Transformation
The HSCP does not have any existing treatment rooms. In year one, our aim was to scope out how we could deliver the agreed commitments around community treatment and care services across both localities. The result of this is that there are serious limitations in transferring treatment room services from Practices over to the HSCP. Our status in developing clinical services has been limited somewhat due to these constraints e.g. Physiotherapy service roll out was prioritised to those Practices that had suitable treatment accommodation. This has demonstrated an inequality in service for smaller practices where need may be more significant.

15 out of 16 GP premises are privately owned premises, with the majority of these not being purpose built. Following our accommodation survey it highlighted that there are pressures for Practices to have sufficient space for current delivery. Further expansion of the eMDT will create a significant stress on an already strained position. Sustainability Loans are available for all applications subject to finalisation of loan agreement; however, with limited space or capacity to develop existing premises, new premises may be required. This will require a significant amount of funding. This has been discussed locally and suggested that HSCP/PCIP funding should possibly not be used for the creation of new premises and feel this should be the responsibility of Board capital or Scottish Government funding. To date we have not received any significant investment in Health premises compared to other HSCPs within NHSGG&C. We are aware that some HSCPs have access to

treatment rooms and adaptable buildings to provide community treatment services.

With the Moving Forward Together programme commencing in years 2 and 3, there is significant local concern around of competing priorities in relation to the already limited availability of accommodation and financial implications. Clarity is required on scope, demand, accommodation and finance for MFT programme requirements within the community and how this is implemented within Primary Care.

We have significant concerns around delivering MOU 3 due to the following reasons:

- No previous financial support to develop accommodation / space;
- No clarity around financial source for development of accommodation / space;
- Timing around developing accommodation / space within the timescale set out in the contract.

In year 2 (2019/20) East Dunbartonshire is committed to progress in:

- Once clarity has been provided in regards to financial source, the options detailed within the HSCPs feasibility study undertaken within both East & West localities should progress to the next stage of development.
- We will support a programme on back scanning to release space capacity within practices (majority non clinical space)
- Pilot a Practice model of service delivery (community treatment and care) to identify and work through the challenges and issues which will arise, so that we can promote a cluster model for future developments where appropriate.

7.3 Digital Infrastructure

Within NHSGGC, the eHealth team works in conjunction with HSCPs in the introduction of new services and processes within practices. This ensures where possible the standardisation of approach, fit to the Digital Strategy, use of core enterprise systems and minimal cost overhead. Costs have been supplied by EHealth to HSCPs to enable this to be incorporated into overall costs for new MDT members.

In discussions with GP Sub they have recommended that EHealth for the new MDT should not be included within PCIP costs.
eHealth maintain an inventory of IT assets and software deployed to practices and for wider HSCP and Board operations. Development staff and eHealth joint working will ensure that as new services are deployed to support the MOU, and as significant estate changes occur (i.e. GP Practice Back scanning of records, New Premises) that these are reflected in the introduction of new technology solutions and amendments to operational processes and Business As Usual working.

7.4 Data Sharing Agreements

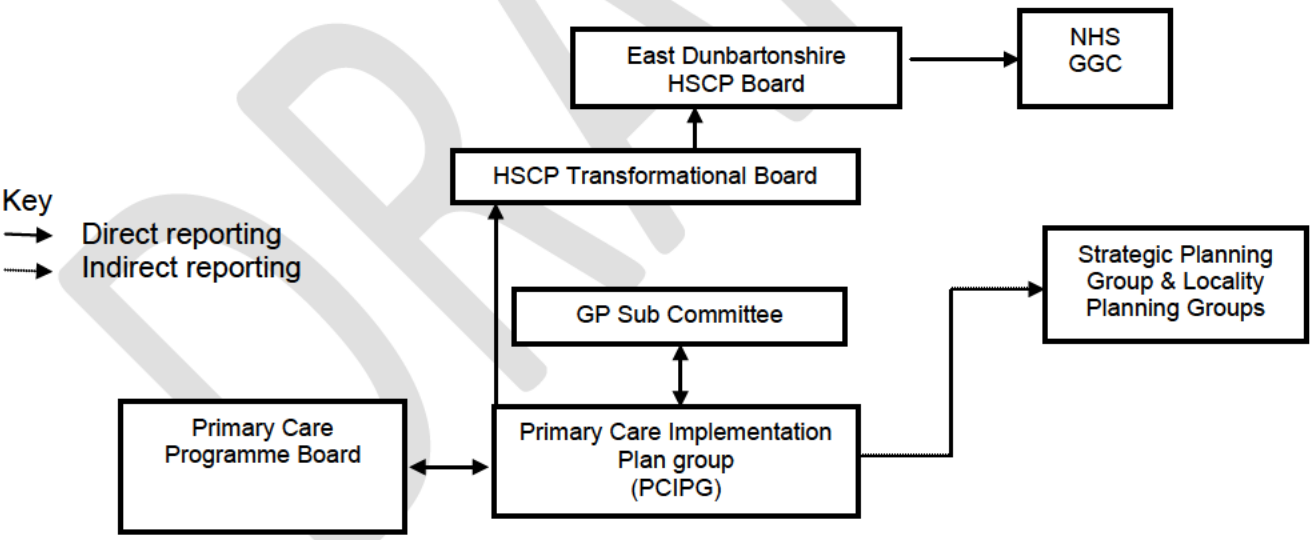
The new GP contract introduced a joint data controller arrangement between Health Boards and GP Contractors relating to personal data contained within GP NHS patient records. Sharing of information between the people who are involved in the care of patients is increasingly important to the safe and effective delivery of health and social care, and to the delivery of services by the new Multi Disciplinary Teams working within and with practices. The PCIP plans for development of MDTs need to be supported by robust information sharing agreements with all practices for the

delivery of clinical care, for audit and review purposes and for service, workforce and public health planning.
An information sharing agreement which outlines the rules to be applied by a Health Board and a GP Contractor when sharing information with each other is being developed. This is a key enabler and is required as a matter of urgency to support the implementation of the PCIPs.
The development of cluster model specific risks requires clarity and a solution focused approach to IT and Governance. We are currently unclear at a local & Boardwide level.

7.5 Infrastructure & Governance

Primary Care Implementation Plan Group (PCIPG)
Throughout the timeframe of the plan, the Primary Care Implementation Group will continue to report to a wide range of stakeholders on milestones, issues and challenges. This group consists of the Clinical Director, Associate Clinical Director, Head of Community Health and Care services, Service Leads & Cluster Quality Leads and GP subcommittee. We have worked collaboratively with these partners to progress delivery of the MOU highlighting risks and work in a solution focused way to support service redesign.

Reporting mechanisms within the HSCP for the PCIPG



Recruitment of staff breakdown
2018 - 2022

Our anticipated workforce required to deliver the extent of the contract has been informed by the Inverclyde “New Ways of Working” programme. Our tracker / workforce template reflects our thinking on our projected workforce need; however, this will be refined and reviewed once our workforce plan is updated following local engagement events and Scottish Government guidance. Early indications shows that by year 3 we would require to employ additional staff as follows in order to fully implement the GP contract (figures include projections from April 2019-March 2021):

	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)		Service 5: Additional professional roles			Service 6: Community link workers	
Financial Year	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other	ANPs	Advanced Paramedics	Mental Health workers	MSK Physios	Other [1]		Other / comment
2018-19***	3.9	1	2	2	1	0	0	0	1	0	0	1
2019-20	4	1	9.2	7.2	1	2	0	0	1	1.5	2	0
2020-21	4	1	12.5	4.3	1	2	0	2	2	0	2	0
2021-22	4.1	1	20.5	7	1	1	0	2	2	0	2	0
TOTAL	16	4	21.1	20.5	1	5	0	4	6	1.5	6	1

*(1.1 inc for sessional / part time)

We will work with the Scottish Government, National Education for Scotland (NES) and the NHS board to develop a work force which can be stable and sustainable in both the short and longer term. In doing so there is a need to have better links with universities, facilitate career progression, understand the future demand and scope out the skills required.

The HSCP are committed to implement the MOUs, however, there is concern around the following:

- The availability of appropriately trained and experienced staff.
- Recruiting without destabilising other services (Acute / Community).
- With the development of cluster model there are specific risk on roles e.g. within the wider nursing team. Clarity and a solution focused approach is required at both a local & Boardwide level
- Challenges around Boardwide recruitment in terms of pace, allocation & flexibility for required need and the national challenges around university recruitment, throughput and retention. There is an opportunity to challenge current working practices by introducing skill mix, explore new ways of working, get better understanding of professional skills and develop new and clearer pathways between primary and community care services.

Below are two examples where we are beginning to explore workforce resources in new ways:-

Pharmacotherapy services
Integral to the delivery of primary care transformation is the establishment of a sustainable pharmacotherapy service in every practice to support the reduction of GP work load and to improve outcomes in medicine's management.

The introduction of the Pharmacy Technician into the team has supported the shift of skill mix within Pharmacy. This will be further consolidated with appointments in year two.

East Dunbartonshire will be involved in board wide innovations/tests for change to inform how to best utilise the skills and the workforce available to support the contract delivery and better outcomes for patients. These include:-

- Review of practice level repeat prescribing processes
- Development of evidence around pharmacy technician competencies, including work on medicine reconciliation, acute prescribing and high risk medicine monitoring.

ANP
Within East Dunbartonshire, this role is in its infancy due to challenges in recruitment. Whilst their role is still evolving and being shaped by active dialogue with the Kirkintilloch / Lennoxtown cluster, initial thoughts are around developing a service to support urgent care needs by offering home visits, triage calls and/or minor ailments clinics within practices.

We will work with Nursing Professional Leads, Practice Development Department, GPs and practice staff to support the national work on refreshing the General Practice nursing role and the wider aligned Excellence in Care programme to ensure consistency and quality across the nursing workforce in primary care settings.

8. Year 3 – Aims & Challenges

We will continue to honor the commitments within the new GMS contract in 2020/21. The delivery of this is dependent on funding available.

Aims	Challenges / Comments
MOU 1 – Vaccination Transformation Programme **In addition to VTP services implemented in 2018/19 & 2019/20.*	
Adult Immunisations Out of Schedule Travel Advice & Vaccinations	Model and costs to be confirmed. Since this is a Boardwide led project the HSCP has no influence over timing of roll out, resource & accommodation requirements.
MOU2 - Pharmacotherapy	
Continue to build skill mix with the introduction of further Pharmacy Technicians and Pharmacy Support Workers	With this introduction of a relatively new skill mix the Pharmacotherapy Leads are devising a competency and skill framework to ensure safe and appropriate practice. The Pharmacy leadership will undertake a careful and measured pilot to provide assurance to GPs that the new skill mix will be effective in delivering some of the acquired tasks related to the Pharmacotherapy service.
Boardwide Pharmacy First	We will continue to contribute to the Boardwide Pharmacy First Strategy.
MOU3 – Community Treatment & Care	
Phlebotomy	Expansions on the foundations delivered in year 1 will continue to enable every practice to have access to phlebotomy service with the capacity to manage all bloods requested by primary care.
Community Treatment & Care service	Learn from Year 2 Practice pilot and roll out preferred model to a second cluster. We aim to know the demand / workload requirements which will also inform our knowledge of how many treatment rooms will be required in each locality.

Aims	Challenges / Comments
MOU4 – Urgent Care	
ANP	Consolidate the ANP service to all Practices within East Dunbartonshire. The HSCP will continue to support Practices to understand new and changing roles identified in the new contract and how practices can evolve, maximise, shape and develop their current Practice Nursing Staff.
MOU 5 – Additional Practice Physiotherapist	
APP	Concern around previous experience in relation to Boardwide blocking of recruitment, allocation & placement of staff. It is essential that we receive adequate activity data & numbers of staff to review evidence that this service has made potential impact on GP workload. In year 3 we aim to expand an additional 2wte.
Mental Health Professionals	In partnership with Mental Health and scoping of demand and appetite in year 2 we aim to pilot a cluster model of Mental Health Professionals. Concerns around primary care funding source from Action 15.
Community Links Workers (Wellbeing Workers)	Following year 2 pilot we aim to implement Community Links Workers across East Dunbartonshire and expand their role to include working with mental health professionals and third sector. The role will also include the roll out the e-frailty toolkit which will support a proactive self management approach within primary care.

The caveat for the above services is dependent on adequate accommodation / funding.

Aims	Challenges / Comments
Other	
Project Management	Delivery of the MOU commitments outlined in the PCIP requires funded project management support throughout the 3 year implementation period. This resource is fully in place to ensure robust governance and financial arrangements, continuous engagement with key stakeholders and pace of change are embedded and maintained.
Engagement & Public Information	By year 3 we will have confidence in the methods we have utilsed in reaching a wide range of stakeholders and can begin to see the change culture and public awareness.
Quality Improvement	Boardwide and local evaluations and small pilots should inform what does or does not add value to the delivery of the MOUs. If there is little evidence to support this shift in GP workload our Primary Care Improvement Group will scruitinise future direction of travel to meet the commitments.

Appendix 1

The following tables show the financial / staffing breakdown. Year 1 update includes actual costings for service provided, however, please note that due to most services commencing mid-year or later there is an underspend which will be carried forward into year 2.

PCI Year 1 Update

Key	
Complete	
In progress	
Not started	

MOU 1 - Vaccination Transformation Programme			
Requirement / Staffing	**Yr 1 Planned Cost**	**Yr 1 Actual Cost**	**Status**
Pre-School Immunisation 4.0WTE Band 5 (2.0wte from existing funding) 1.5wte Band 3 = Share of Band 3, 6 and 7 Leadership & admin = Pharmaceutical fridges =	£92,000	£60,137	
School Based Immunisation Team (From existing funding)	£0	£0	
Housebound Influenza Vaccination 2 months of Band 5 (Nurse) 4 months of Band 3 (admin) Sundries Vax porters Vax and carriage	£18,297	£8,586	
Total	**£110,297**	**£68,723**	
Comments / Narrative Housebound Influenza Vaccinations - All Housebound Influenza vaccinations were carried out by District Nursing Service in			

Year 1

MOU 2 - Pharmacotherapy			
Requirement / Staffing	**Yr 1 Planned Cost**	**Yr 1 Actual Cost**	**Status**
Pilot PCI Pharmacy support 3.2wte Band 7 3.9wte Band 7 1.0wte Band 5 0.4wte Band 8B (leadership) (Fixed term to be reviewed in year 2)	£364,000	£146,520	✔
Boardwide Pharmacy First strategy Redirection of minor ailments to pharmacies instead of using GP appointments	£13,000	£25,199	✔
Total	**£377,000**	**£171,719**	
Comments / Narrative Pharmacy First currently provide medication for UTI's & Impetigo. Scottish Government looking to increase conditions treated by service. Costs for service may also increase.			

MOU 3 - Community Treatment & Care Services			
Requirement / Staffing	**Yr 1 Planned Cost**	**Yr 1 Actual Cost**	**Status**
Establish a centralised phlebotomy service for all housebound patients, including Chronic Disease Monitoring through Adult Community Nursing service. Band 3 = 20hrs pilot from HSCP Budget 36 additional hours from PCIP funding	£48,000	£22,885	✔

Total	**£48,000**	**£22,885**	

MOU 4 - Urgent Care (ANP)			
Requirement / Staffing	**Yr 1 Planned Cost**	**Yr 1 Actual Cost**	**Status**
Explore potential for ANP to respond to urgent care issue and link in more closely with Primary Care. With reference to new ways of working, implement a test for change pilot covering Kirkintilloch / Lennoxtown cluster 2 wte Band 7 ANP	£67,000	£4,300	✓
Total	**£67,000**	**£4,300**	

MOU 5 - Additional Professional Roles (APP)			
Requirement / Staffing	**Yr 1 Planned Cost**	**Yr 1 Actual Cost**	**Status**
APP 1wte Band 7 APP 1 session Band 8A Clinical Leadership	£43,000	£16,768	✓
Programme Management / Communication Band 7 Clinical Leadership (Leadership is for ANP, Phlebotomy & Influenza vaccine work and community care & treatment service). (0.4wte Band 7 commencing 15th April 2019, increasing to 0.8wte July 2019)	£32,000	£0	✓

MOU 5 - Additional Professional Roles (APP) contd.			
Requirement / Staffing	**Yr 1 Planned Cost**	**Yr 1 Actual Cost**	**Status**
Programme management support will help to facilitate a change in culture around service delivery and new ways of working 1wte Project Manager Band 6 3 (yrs 1-2)	£25,000	£11,525	
Engagement	£5,000	£1,489	
Cluster funding (CQL)		£16,600	
Public Information	£10,000	£0	
Test of Change		£1,660	
Total	**£115,000**	**£48,042**	

	Total
Total Year 1 Allocation	**£831,000**
Carry forward from 2017-18	**£159,302**
Total planned cost for Year 1	**£717,297**
Total Actual cost for Year 1	**£315,669**
Carry forward to 2019-20	**£674,633**

Carry forward 2019-20	**Total**
HSCP Reserves	**£527,242**
SG Balance	**£147,391**
TOTAL	**£674,633**

Appendix 2

The following table provides a breakdown of staffing and costs in relation to our second year commitments. The overspend reflects the delivery of the MOU as stated within the contract. If required to stay within budget the HSCP will be unable to fulfill the full GP contract commitments.

Year 2 MOU Commitments

MOU 1 - Vaccination Transformation Programme			
Requirement / Staffing	**Yr 1 ongoing cost**	**Yr 2 new cost**	**Total Yr 2 cost**
Pre-school Immunisation			
2.0wte Band 5 (Plus 2.0 wte existing funding)	£81,748	£0	£81,748
1.5 Band 3 HCSW (GGC total 20.8wte)	£0	£46,307	£46,307
Share of Band 7, 6 and 1wte Admin Band 3	£0	£25,810	£25,810
Pharmaceutical fridges	£0	£5,000	£5,000
Equipment & sundries	£0	£2,000	£2,000
IT Contingency	£0	£22,400	£22,400
School Based Immunisation Team Continue to delivery School Based Immunisation Team (from existing funding)	£0	£0	£0
Housebound Influenza Vaccination 2 months of Band 5 Nurse 4 months of Band 3 (admin) Sundries Vax porters Vax and carriage	£22,244		£22,244
Pregnant Women Vaccination Service Transformation	£0	£13,317	£13,317
Pre-school Flu vaccinations (Mop-up sessions)	£0	£8,745	£8,745

<65 >65 'At Risk' & 65+ Flu Vaccination Service Transformation	£0	£32,605	£32,605
Shingles (70-79) Vaccination Service Transformation	£0	£0	£0
Travel Health Advice & Vaccination Service Transformation	£0	£0	£0
HSCP VTP Planning & Coordination Costs	£0	£20,432	£20,432
Total	**£103,992**	**£176,616**	**£280,608**

MOU 2 - Pharmacotherapy

Requirement / Staffing	Yr 1 ongoing cost	Yr 2 new cost	Total Yr 2 cost
4wte Band 7 Pharmacist (Plus 3.9 wte existing)	£239,410	£184,512	£423,922
1wte Band 5 Technician (Plus 1.0 wte existing)	£45,874	£42,718	£88,592
0.4wte Band 8B (leadership)	£37,575		£37,575
Boardwide Pharmacy First strategy Redirection of minor ailments to pharmacies instead of using GP appointments	£25,199		£25,199
Total	**£348,058**	**£227,230**	**£575,288**

Comments / Narrative
Pharmacy First currently provide medication for UTI's & Impetigo. Scottish Government looking to increase conditions treated by service. Costs for service may also increase.

MOU 3 - Community Treatment & Care

Requirement / Staffing	Yr 1 ongoing cost	Yr 2 new cost	Total Yr 2 cost
Phlebotomy			
Band 3 1.49 wte	£44,035		£44,035
3wte Band 5	£0	£131,154	£131,154
4.5wte Band 3 (Health Care Support workers to work across both services)	£0	£143,920	£143,920
1wte Band 6	£0	£53,557	£53,557
Total	**£44,035**	**£328,631**	**£372,666**

Comment / Narrative
The development of service is contingent on the creation of treatment rooms. Clarity is required on funding stream.

MOU 4 - Urgent Care

Requirement / Staffing	Yr 1 ongoing cost	Yr 2 new cost	Total Yr 2 cost
4wte Band 7 + travel (2 wte existing + 2 wte new)	£132,646	£138,008	£270,654
Participate in GG&C wide learning for Specialist Paramedics	£0	tbc	tbc
Total	**£132,646**	**£138,008**	**£270,654**

Comment / Narrative
The development of service is contingent on the creation of treatment rooms. Clarity is required on funding stream.

MOU 5 - APP

Requirement / Staffing	Yr 1 ongoing cost	Yr 2 new cost	Total Yr 2 cost
APP			
2wte Band 7 (Plus 1 wte existing)	£58,823	£123,008	£181,831
1 session clinical leadership 8a	£0	£13,000	£13,000
Wellbeing Workers			
2wte Band 5	£0	£85,436	£85,436

MOU 5 – APP contd.

Requirement / Staffing	Yr 1 ongoing cost	Yr 2 new cost	Total Yr 2 cost
Programme Management / Communication			£0
Leadership for Nursing Services	£0	£61,504	£61,504
1wte Band 6 (years 1-2)	£52,774		£52,774
Engagement	£0	£5,000	£5,000
Public Information	£0	£10,000	£10,000
Total	**£111,597**	**£297,948**	**£409,545**

Comments / Narrative
Learning to be taken from Glasgow City in relation to Community Clinical Mental Health Professionals
The development of service is contingent on the creation of treatment rooms. Clarity is required on funding stream.

Miscellaneous Year 2 spend

Requirement / Staffing	Yr 1 ongoing cost	Yr 2 new cost	Total Yr 2 cost
Evaluation of Primary Care Improvement Plans (% of Boardwide Cost)	£0	£6,017	£6,017
Back scanning	£0	£130,030	£130,030
Cluster Quality Improvement	£0	£15,000	£15,000
Total	**£0**	**£151,047**	**£151,047**

Total Year 2 Allocation	**£999,000**
Carry forward from 18.19 to 19.20	**£674,633**
Total planned cost for Year 2	**£2,059,807**
Variance	**-£386,174**

Communication Plan

Outcome	Action	Method	Stakeholders	Progress / Comments	Lead Officer/Provider
Engage with our communities to raise awareness and understanding of the campaign	Develop a range of information, engagement events, leaflets & resources to raise awareness of campaign.	Short life working group to be established including PSUC & Primary Care Representation.	PSUC, Primary Care, Locality Planning Reps, HSCP Scope language options and easy read versions of publications.	Not started	Change & Redesign Manager / PCDO
	Develop generic information / resources for GP, HSCP websites / solus screens in line with Know who to Turn to campaign	Short life working group to be established including PSUC & Primary Care Representation.	PSUC, Primary Care, Locality Planning Reps, HSCP	Not started	Change & Redesign Manager / PCDO
	Make information / resources available to our communities	• HSCP website	HSCP, EDC, GP Practice Managers, Royal Mail, Community Resources, PSUC	Not started	Change & Redesign Manger / PCDO
		• GP Practice Websites		Initial discussion has taken place with some Practice Managers re	Change & Redesign Manger / PCDO

Outcome	Action	Method	Stakeholders	Progress / Comments	Lead Officer/Provider
				displays on websites.	
		• Scope Royal Mail drop		Not started	Change & Redesign Manger / PCDO
		• Display in community sites / solus screens		Not started	Change & Redesign Manger / PCDO
		• Display in community resources		Not started	Change & Redesign Manger / PCDO
		• Social Media		Not started	Change & Redesign Manger / PCDO
	Supporting public to understanding reception role & promote campaign	• Develop resources to display in GP practices & community venues • Solus Screens • Recorded telephone message	GPs, Practice Managers, Change & Redesign Manager, PCDO	In progress	
Engage with our children & young people community	Support parents to access right service for them	• Display in community resources	Senor Nurse C&F, OHD, Lead Pharmacist, Lead	In progress – Childsmile / dental registration	

Outcome	Action	Method	Stakeholders	Progress / Comments	Lead Officer/Provider
to raise awareness & understanding of the campaign	and their children	• Oral Health Premises • Pharmacy service • Opticians	Optometrist,		
	Interactive sessions with children & young people (P5>)	Scope possibility of mirroring Inverclyde model	Inverclyde HSCP, HSCP, ED Primary & Secondary Schools, Health Improvement Team, Wellbeing Workers		Health Improvement Team
Engage with our staff to raise awareness and understanding of the campaign	Provide appropriate training for reception teams and HSCP staff to implement a standard approach in East Dunbartonshire to care navigation	• Regular Briefing reports to HSCP staff • Regular Briefing to Primary Care staff • Project Manager & PCDO to attend Team meetings • Signposting training	PSUC, Primary Care, Locality Planning Reps, HSCP	In progress	Change & Redesign Manager, PCDO, Practice Managers
		• Workflow Optimisation		In progress	Change & Redesign Manager, PCDO, Practice Managers
		• Customer Care /		In progress	Change & Redesign

Outcome	Action	Method	Stakeholders	Progress / Comments	Lead Officer/Provider
		Dealing with Difficult situations			Manager, PCDO, Practice Managers
		• Scope e-learning module for all staff		In progress	ED PCDO / Inv PCDO

Appendix 4

Services received by Practice 2018/19 – 2019/20

Practice No.	Practice	APP		ANP		Phlebotomy (Housebound)		Pharmacy		Housebound Influenza		Pre 5 Vaccinations		Wellbeing Workers	
		2018/19	2019/20	2018/19	2019/20	2018/19	2019/20	2018/19	2019/20	2018/19	2019/20	2018/19	2019/20	2018/19	2019/20
40027	Terrace Medical Practice													**	
40101	Kessington Medical Practice		*												
40239	Denbridge Surgery														
40402	Denbridge Surgery														
40385	Kersland House Surgery														
40173	Ashfield Medical Practice														
43030	Regent Gardens Surgery														
43114	Peel View Medical Centre														
43581	Woodhead Medical Practice														
43044	Turret Medical Centre														
43100	Southbank Surgery														
43261	Lennoxtown Medical Practice														
43059	Springfield Medical Practice														
43171	Kenmure Medical Practice														
43222	Auchinairn Medical Practice														
43557	Brackenbrae Surgery														

* Clarification of allocation required prior to placement in clusters

** Wellbeing service in pilot phase

Primary Care Improvement Plans: Implementation Tracker March 2019

Health Board Area: Greater Glasgow & Clyde	**Completed by:**	**Derrick Pearce**	
Health & Social Care Partnership: East Dunbartonshire HSCP	**HSCP/Board**	**East Dunbartonshire HSCP**	
Number of practices: 16	**GP Sub Committee**	**Dr Alastair Taylor**	
	Date:		Mar-19

Implementation period - Year 1
From: August 2018
To : March 2019

Notes for completion

to include consideration of relationships involvement in ongoing structures and

	fully in place / on target	partially in place / some concerns	not in place / not on target
Overview (HSCP)			
MOU – Triumvirate enabled - GP Sub Engaged with Board / HSCPs	R	A	G
Comment / supporting information	GP sub member on PCIP group.		
PCIP Agreed with GP Subcommittee	R	A	G
Comment / supporting information (date of latest agreement)	???? April 2019		
Transparency of PCIF commitments spend and associated funding	R	A	G
Comment / supporting information	Following restructure of Finance Team work is underway to produce local financial reports which will support transparency and		

Primary Care Support to complete

tbc additional quest on on implementation of other processes as per new regulations e.g. list closure area change disputes

Enablers / contract commitments			
BOARD			
Premises			
GP Owned Premises: Sustainability loans supported	R	A	G
comment / supporting information	Applications	No.	51
	Loans approved	No.	51 (provisional)
	narrative:	Funding available for all applications subjection to finalisation of loan agreement. 15 out of 16 East Dunbartonshire practices are privately owned. Space is at a premium in existing premises and many practices may be unable to accommodate the potential increase in staff employed by the HSCP specifically in developing Community & Treatment & Care services.	
GP Leased Premises: Register and process in place	R	A	G
comment / supporting information	Applications	No.	17 expressions of interest
	Leases transferred	No.	0
	narrative:	Process for developing the register under development: 17 expressions of interest from practices seeking assignation of lease.	
Stability agreement adhered to	R	A	G
comment / supporting information	Enhanced Services agreed annual in line with stability agreement; local arrangements developed in relation to vaccination prior to national guidance. Some concerns expressed about changes to wider community services (e.g. Sandyford)		
GP Subcommittee input funded	R	A	G
comment / supporting information	Additional sessions and HSCP reps funded in 18/19 to support new contract and PCIP processes in addition to core GP Subcommittee funding. Final agreement re balance of new 18/19 funding still to be confirmed. To move to a more standardised approach in 19/20 supported by new funding.		
Data Sharing Agreement in Place	R	A	G
comment / supporting information	An information sharing agreement which sets out the rules to be applied by a Health Board and a GP Contractor when sharing information with each other is being developed. This is a key enabler and is required as a matter of urgency to support the implementation of the PCIPs. Awaiting national data sharing agreement. This is required as a matter of urgency to support local agreements.		

consider adding question on long term strategic plan for primary care premises

HSCP			
Programme and project management support in place	R	A	G
comment / supporting info	* 0.4wte Band 8A * 1wte Band 6 (In place as of 3rd December 2018.)		
Support to practices for MDT development and leadership	R	A	G
comment / supporting info	* 0.4wte Pharmacy Leadership in place * 0.4wte Nursing Leadership (Commencing April 19) * 0.2wte Physiotherapy leadership in place. * GP mentorship / leadership in place for current new members of the MDT **Risks** *Framework to support mentorship of MDTs *Additional leadership functions to deliver MOU agreed as temporary contracts		
GPs established as leaders of extended MDT	R	A	G
comment / supporting info	GP's will be the leaders of the new MDT however as size and complexities of these teams increase the demands on GPs and others could jeopardise these current arrangements. (see "Support to practices for MDT development & Leadership". East Dunbartonshire HSCP will support Practices to understand new and changing roles identified in the new contract and how practices can evolve to maximise shape and develop their current existing teams. This will be carried out by sharing consistent principles pathways role descriptors and grading done in partnership with GG&C. **Risks:** *A Boardwide position is required in relation to payment or backfill for GP time for mentoring EMDT. * Framework to support mentorship of MDTs *Additional leadership functions to deliver MOU agreed as temporary contracts		
Workforce Plan reflects PCIPs	R	A	G
comment / supporting info	Workforce Planning is one of the most significant challenges highlighted in the development and implementation of the Primary Care Improvement Plans in terms of availability of workforce at a sufficient scale to support all practices in terms of the change process required to support effective working for new teams. HSCP Workforce Plan only reflects the development of the extended MDT. Further work is required to scope out baseline figures on workforce in community services. This is essential to monitor wider impact of service delivery. Risks: *Recruitment of suitably qualified and experienced practitioners and or leaders within East Dunbartonshire HSCP & Boardwide poses a risk for implementation within the intended timescales *Boardwide delays in actual recruitment processes due to formal authorisation * Lack of wider HSCP Workforce Plan *Development of cluster model specific risks requires clarity and a solution focussed approach to roles. Currently unclear at a local & Boardwide level		
Accommodation identified for new MDT	R	A	G
comment / supporting info	As detailed in section 1 space is at a premium in existing premises and many practices may be unable to accommodate the potential increase in staff employed by the HSCP specifically in the developing Community Treatment & Care Services. So far we have been fortunate in being able to place all staff recruited in year 1 within Practices. In terms of small or single partner practices there has been a notable gap in placement of the physiotherapy service as there were no or insufficient clinical space to allow this service. The HSCP do not currently have any treatment rooms at present and these would need to be developed. We have an initial pilot of a treatment room service within one cluster (based within Practice). However moving forward and for sustainabi ity reasons we must have a permanent solution for treatment room space. In discussions with LMC / GP Sub we have been advised that the PCIF should not be used to create / build space for this service and that the responsibility falls into / under the Board's Property and Asset Management Strategy. East Dunbartonshire wi l escalate this as an urgent matter. It is imperative that the HSCP receive direction from the Board on this funding stream as this could potentially impact on our planned model for community care & treatment within years 2 & 3. Actions to date: * Initial scoping of Practices around available accommodation. This has highlighted extremely limited / appropriate available space. *HSCP have committed to funding Back scanning to allow office / clinical space within practices summer 2019.		
GP Clusters supported in Quality Improvement role	R	A	G
comment / supporting info	3 CQLs have been appointed and fully engaged in meetings with PQL's. Change & Redesign Manager and Pharmacy Lead are available to all Cluster groups when required and invited to provided guidance signposting and support to quality improvement material and training.		
Ehealth and system support for new MDT working	R	A	G
comment / supporting info	Awaiting guidance from Board wide approach to e-health specifically related to MDT implementation. Risks: *Development of cluster model specific risks requires clarity and a solution focussed approach to IT and Governance. Currently unclear at a local & Boardwide level		

MOU PRIORITIES			
Pharmacotherapy			
PCIP pharmacotherapy plans meet contract commitment	R	A	G
Pharmacotherapy implementation on track vs PCIP commitment	R	A	G
Practices with Primary Care Invest service in place	16		
WTE/1 000 patients	0.04wte		
Pharmacist Independent Prescribers (as % of total)	40%		
	Level 1	Level 2	Level 3
Level of Service	All Practices have a part al Level 1 service e.g. Medicine reconciliation Acute Prescriptions.	No. practices	No. practices
comment / narrative	To fulfil the contract commitment in its entirety a scoping exercise took place and revealed that East Dunbartonshire would be required to employ a total of 42 Pharmacists. In discussion with both Boardwide and Local Pharmacy Leads there has been a decision not to go recruit to this level for following reasons: * Workforce scoping suggests there is not practicably this amount of Pharmacists available within the system. Early indications have shown there is not enough PSPs/PST to fill the posts without destabilising the rest of the NHS. *The above point also impacts on a potential model for part of VTP - Community Pharmacy delivering influenza vaccinations for adults * We would not have the infrastructure / finance to train support or accommodate this amount of staff		
Community Treatment and Care Services			
PCIP CTS plans meet contract commitment	R	A	G
Development of CTS on schedule vs PCIP	R	A	G
Practices with access to phlebotomy service	16		
Practices with access to CTS service	0		
Range of services in CTS			
comment / narrative	*Domici iary Phlebotomy service established. *The HSCP do not currently have any treatment rooms at present and these would need to be developed. We have an initial pilot of a treatment room service within one cluster (based within Practice). However moving forward and for sustainab ity reasons we must have a permanent solution for treatment room space. In discussions with LMC / GP Sub we have been advised that the PCIF should not be used to create / build space for this service and that the responsibility falls into / under the Board's Property and Asset Management Strategy. East Dunbartonshire wi l escalate this as an urgent matter.		
Vaccine transformation Program			
PCIP VTP plans meet contract commitment	R	A	G
VTP on schedule vs PCIP	R	A	G
Pre-school: model agreed	R	A	G
practices covered by service	12		
comment / narrative	Roll out of pre-5 immunisation was not possible in 1 cluster due to lack of accommodation. This is an example where acquiring accommodation proved challenging. Discussions were escalated with Public Health at Board level to obtain 1 room for 1 day. These discussions took 2 years before a resolution.		
School age: model agreed	R	A	G
practices covered by service	16		
out of schedule: model agreed	R	A	G
practices covered by service			
comment / narrative	Discussions are ongoing at Board level in relation to new unimmunised residents hard to reach close the gap (mop-up sessions)		
Adult imms: model agreed	R	A	G
practices covered by service	0		
comment / narrative	Discussions taking place at Boardwide. Believe that solutions are being sorted via central team.		
Adult Flu : model agreed	R	A	G
practices covered by service	16		
comment / narrative	All housebound patients within the 16 Practices received their influenza vaccination from the District Nursing service (winter 2018).		
	R	A	G
practices covered by service	Discussions taking place at Boardwide. Believe that solutions are being sorted via central team.		
Travel: model agreed	R	A	G
practices covered by service			
comment / narrative	See comments above.		
Urgent Care Services			
Development of Urgent Care Services on schedule vs PCIP	R	A	G
practices supported with Urgent Care Service	6		
comment / narrative	Appointed x2wte ANPs March 2019. ANPs currently undergoing induction. 1ANP fully qualified and 1 ANP requires 18 months training to be fully qua ified. Appointment of Nursing Leadership Post to commence in April 2019. Model currently scoped out. Currently in Practices providing house calls and some c inics. The ANPs will work with a l Practices to develop the their role pertinent to each Practice.		

Additional Services (complete where relevant)			
APS – Physiotherapy / MSK			
Development of APP roles on track vs PCIP	R	A	G
Practices accessing APP	4 - Denbridge Surgery (40402) Denbridge Surgery (40235) Kessington Surgery Kersland Surgery Risk: *In year 1 the HSCP requested 2wte physiotherapy to be piloted within 1 cluster. Despite multiple requests to Physiotherapy lead for 2wte we were only allocated 1. Current model does not incorporate for creativity of flex bi ity in relation to small practices or those who have a small practice list size. This has halted our progression of services.		
WTE/1 000 patients	0.009wte		
comment / narrative	0.9wte in post from 26/11/18		
Mental health workers		A	
On track vs PCIP	R	A	G
Practices accessing MH workers / support	No. Practices		
WTE/1 000 patients	Not Applicable		
comment / narrative	Not included within Year 1 plan. View to discuss in year 2. We hope Action 15 would contribute funding. No funding has yet been identified so far.		
APS – Community Links Workers		A	
On track vs PCIP	R	A	G
Practices accessing Link workers	No. practices		
WTE/1 000 patients	Not Applicable		
comment / narrative	Scoping model of Link Workers within localities for year 2 implementation. Roll out to other practices after pilot		
Other locally agreed services (insert details)			
Service			
On track vs PCIP	R	A	G
practices accessing service	No. practices		
comment / narrative	A number of fac litated training sessions have been held: *Document workflow management *Signposting *Protected Learning Events All above were for GP Practice staff to relieve pressure on GPs and develop new ways of working. *MFT Engagement across both localities *HSCP to fund Back scanning in year 2.		

* ref to Action 15 where appropriate

Overall assessment of progress against PCIP	R	A	G

Specific Risks

*Recruitment of suitably qualified and experienced practitioners and or leaders within East Dunbartonshire HSCP & Boardwide poses a risk for implementation within the intended timescales. (L + N)
*Boardwide delays in actual recruitment processes due to formal authorisation. (L+N)
* The HSCP asked for 2wte Physiotherapy for 1 cluster in year 1. Our rationale was continually rejected by Boardwide professional leadership for Physiotherapy. This has delayed the implementation of this service. In addit
Boardwide Physiotherapy service up till now has not supported creativity / flexibility in model de ivery to implement APPs in those practices which either have limited accommodation or are a single practice / small practice size.
*Suitable Accommodation wi l impact on delivery of MOUs (N)
*Framework to support mentorship of MDTs (L + N)
*Lack of wider HSCP Workforce Plan (L + N)
*Development of cluster model specific risks requires clarity and a solution focussed approach to IT, Governance & roles. Currently unclear at a local & Boardwide level. (L&N)
*Inequality of access to services to those practice who have little or no suitable accommodation within their current accommodation. (L&N)
*Additional leadership functions to deliver MOU agreed as temporary contracts (L)

include interdependencies
indicate if local or national

Barriers to Progress

*Accommodation, (L&N) For example Roll out of pre-5 immunisation was not possible in 1 cluster due to lack of accommodation. This is an example where acquiring accommodation proved challenging. Discussions were escalated with Public Hea th at Board level to obtain 1 room for 1 day. These discussions took 2 years before a resolution. Expand on barriers in accommodation (use pre school example)
*Financial support sustainable transformational change (N)
*e-health solutions, (N)
*Recruitment (N) for example Boardwide block to further 0.9wte physiotherapy post even though this was identified as a need.
*Understanding impacts of change within Practice (L&N)
*Inability to communicate key messages of the contract changes through to the wide range of stakeholders, including patients. (L)
*Pace of change and expected MOU deliverables within next 2 years (L&N)
*The priority in delivery of MOU's may require less emphasis on creative tests for change. (L)
*GP time for mentorship of extended MDT
*Reliance on Boardwide implementation of certain services e.g. VTP, physiotherapy

Issues FAO National Oversight Group
Priority Areas

*MOU3 - In the absence of treatment room accommodation being available, clarity and resolution of funding source is required (for creation of accommodation in order to deliver the service / MOU commitment).
MOU 2 - Pharmacotherapy Clarity and resolution required between aspirational model ing for completion (referred to above) of Levels 1-3 vs Workforce / service that can be provided within budget available
*MOU 2 - If "aspirational" model is the preferred option for full Pharmacoptherapy service roll out current modelling shows that recruitment of this workforce would not be possible for various reasons including the actual number of Pharmacists / Technicians available and lack of undergraduate placements to keep up with national demand. Insufficient capacity & finance to recruit & train pharmacists, up-skill technicians and support workers w ll delay progress in implementing service. This could also impact on other pressures of current and future services for example MFT / Pharmacy First.

Other Areas

*Still require nationally driven culture change campaign regarding pub ic use of primary care
*Mentorship of staff (L&N)
*IT solutions / Interface (N
*Comprehensive workforce plan (L
*Take learning from pilots in England on electronic prescriptions which could dramatica ly impact pathway flow. (N
* Funding & accommodation required for MFT deliverables require to be clarified. There may be conf icting pressures for local accommodation. (L&N

Funding profile 2018 - 2022

Financial Year	Total Budget (All figures in £000s)	Service 1: Vaccinations Transfer Programme	Service 2: Pharmacotherapy	Service 3: Community Treatment and Care Services	Service 4: Urgent care	Service 5: Additional Professional roles	Service 6: Community link workers	Other / comment	Total Planned Expenditure	Actual Expenditure	(Over) / Under spend	Comments
2018-19*	£831,000	£68,723	£171,719	£22,885	£4,300	£16,768	£0	£31,274	£717,297	£315,669	£674,633	Carry forward from 2017/18 £159,302
2019-20	£999,000	£280,608	£575,288	£372,666	£270,654	£194,831	£85,436	£280,325	£2,059,808		-£386,175	Carry forward from 2018/19 £674,633 (included in over /
2020-21	£1,998,000	Boardwide to confirm. This will include £284,296	£1,474,133	£941,843	£555,032	£482,597	£170,872	£67,557	£3,692,034		-£1,694,034	
2021-22	£2,815,000	Boardwide to confirm. This will include 2020/21	£1,769,017	£1,407,782	£690,040	£728,613	£256,308	£67,557	£4,919,317		-£2,104,317	
Total Expenditure	£6,643,000	£921,611 (approx)	£3,990,157	£2,745,176	£1,520,026	£1,422,809	£512,616	£446,713	£11,388,456			

*** For 2018-19, please include how much you spent in-year and how much unutilised funds you carried over.**

* For 2018-19, please include how much you spent in-year and how much unutilised funds you carried over.
* Staff recruited from April 2019 will receive 6% superannuation paid via PCIF. Staff recruited prior to this - 6% will be topped up from additional board funding.

Financial Year	Services 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment & Care Services			Service 4: Urgent Care (advanced practitioners		Service 5: Additional Professional roles			Service 6: Community Link Workers	Other / comment
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other (admin)	ANPs	Advanced Paramedics	Mental Health Workers	MSK Physios	Other (1)		
2018-19	3.9wte Band 7	1wte Band 5	2wte Band 5	1.5 Band 3	1wte Band 3 (4 months)	0	0	0	1	0	0	**Project Management** 1wte Band 6
2019-20	3.9wte Band 7 4wte Band 7	1wte Band 5 1wte Band 5	2wte Band 5 0.2wte Band 5 6wte Band 5 1wte Band 6	1.5wte Band 3 4.5wte Band 3 (HCSW to work across both services)	1wte Band 3 (4 months)	2wte Band 7	0	Further discussion need to determine need & apetite & negotion around Action 15 and how this will be funded	1wte Band 7 1wte Band 7	**Leadership** MSK - 0.1wte Pharmacotherapy - 0.4wte ANP - 1wte	2wte Band 5	Development Engagement Publicity Bakcscanning Quality Improvement Activity **Project Management** 1wte Band 6 **This does not include costs for development of treatment room accomodation. Further clarity is required from the Board around position of funding.*
2020-21	7.9wte Band 7 4wte Band 7	2wte Band 5 1wte Band 5	8wte Band 5 0.2wte Band 5 1wte Band 6 0.3wte Band 7 Pharmacy Technician 2wte Band 5 2wte Band 6 coordination	6wte Band 3 5wte Band 3 (HCSW)	1wte Band 3 (4 months)	2wte Band 7 2wte Band 7	0	2 (Implement pilot in cluster)	2wte Band 7 2wte Band 7	**Leadership** MSK - 0.1wte Pharmacotherapy - 0.4wte ANP - 1wte	2wte Band 5 2wte Band 5	Engagement Publicity **Project Management** 1wte Band 6
2021-22	11.9wte Band 7 4.1wte Band 7	3wte Band 5 1wte Band 5	10wte Band 5 0.2wte Band 5 3wte Band 6 0.3wte Band 7 Pharmacy Technician 5wte Band 5 2wte Band 6 coordination	11wte Band 3 5wte Band 3 HCSW	1wte Band 3 (4 months)	4wte Band 7 1wte Band 7	0	tbc	4wte Band 7 2wte Band 7		4wte Band 5 2wte Band 5	Engagement Publicity **Project Management** 1wte Band 6
Total	**16**	**4**	**20.5**	**16**	**1**	**5**	**0**	**0**	**6**	**1.5**	**6**	**1**

Key	
Black text	Existing Recruitment
Green text	New Allocation

Workforce profile 2018 - 2022 (WTE)

WTE Table

	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)		Service 5: Additional professional roles				
Financial Year	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other	ANPs	Advanced Paramedics	Mental Health workers	MSK Physios	Other [1]	Service 6: Community link workers	Other / comment
2018-19***	3.9	1	2	2	1	0	0	0	1	0	0	1
2019-20	4	1	9.2	7.2	1	2	0	0	1	1.5	2	0
2020-21	4	1	12.5	4.3	1	2	0	2	2	0	2	0
2021-22	4.1	1	20.5	7	1	1	0	2	2	0	2	0
TOTAL	**16**	**4**	**21.1 (1.1 inc for sessional / part time)**	**20.5**	**1**	**5**	**0**	**4**	**6**	**1.5**	**6**	**1**

*** please include any staffing that were in post at the start of the financial year, as well as any staff recruited in-year

[1] please specify workforce types in the comment field

Chief Officer
Susan Manion

Agenda Item Number: 6

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	**28th May 2019**
Subject Title	**Review of the East Dunbartonshire Winter Plan 2018/2019**
Report By	**Derrick Pearce, Head of Community Health and Care Services**
Contact Officer	**Fiona Munro, Team Manager / Unscheduled Care Lead** **Tel: 0141 232 8233 Email: Fiona.Munro@ggc.scot.nhs.uk**

Purpose of Report	The purpose of this report is to reflect on the East Dunbartonshire HSCP Winter Plan 2018/19; to determine what went well and what can be improved on for Winter 2019/20. The report also includes, at Appendix 1, the full NHS Greater Glasgow and Clyde Review of Winter 2018/19 which was submitted to Scottish Government and reflects the whole system experience.

Recommendations	The Partnership Board is asked to: i) Note the HSCP's reflection on the 2018/19 Winter Plan ii) Note the outcome of the NHSGG&C Board-wide reflection on the 2018/19 winter

Relevance to HSCP Board Strategic Plan	In line with the HSCP Strategic Plan, the HSCP Winter Plan describes our actions in response to potential additional pressures which may affect the delivery of services to those who are vulnerable and at risk of admission to hospital. The Winter Plan is part of a suite of Business Continuity plans that ensure the continued safe delivery of HSCP services to vulnerable service users. Reflecting on the experience of the Winter period informs the plan going forward to Winter 19/20

Implications for Health & Social Care Partnership

Human Resources	Nil

Equalities:	Nil

Financial:	Nil

Legal:	Nil

Economic Impact:	Nil

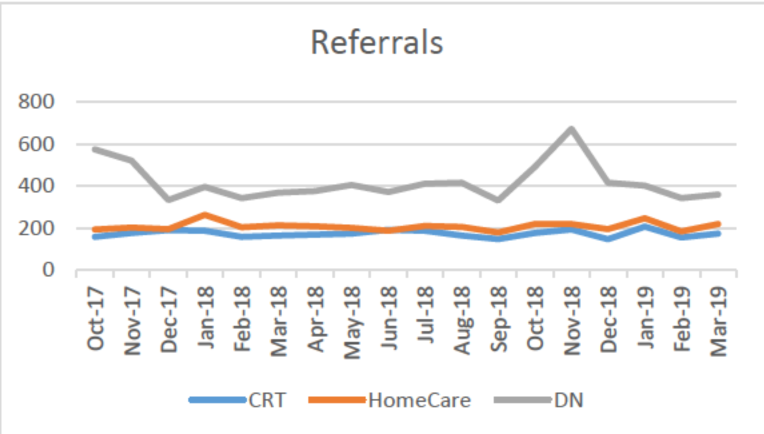
Sustainability:	Nil

Risk Implications:	Nil

Implications for East Dunbartonshire Council:	There is whole system learning for future winters from reflecting on the experience of winter 2018/19.

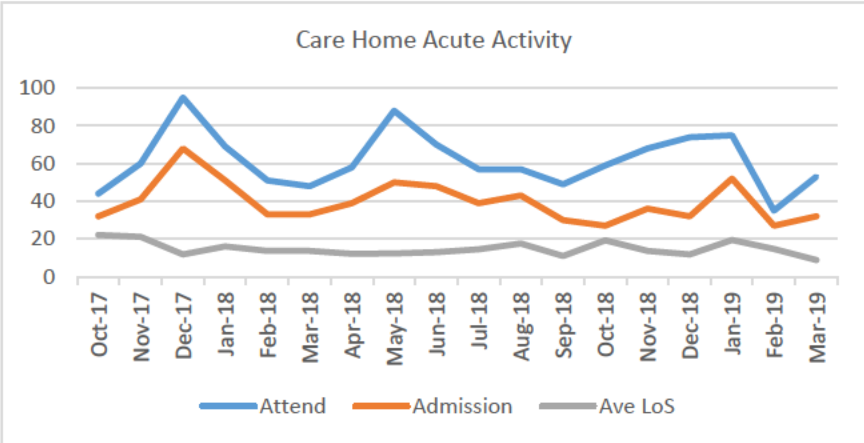
Implications for NHS Greater Glasgow & Clyde:	There is whole system learning for future winters from reflecting on the experience of winter 2018/19.

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 HSCP Winter Plan 2018-19 Plan is part of a suite of HSCP Business Continuity plans and winter contingency arrangements that ensure the continued safe delivery of local services to vulnerable service users and a safe environment for staff. This includes the HSCP contribution to the wider NHS and Council planning processes and the overarching NHSGG&C Winter Plan that was submitted to the Scottish Government on 31 October 2018. The East Dunbartonshire HSCP Winter Plan was signed off by the HSCP Board on 15th November 2018.
1.2	The Winter Plan is based on the Annual Guidance Checklist issued by the Scottish Government and provides assurance of the HSCP's preparations for winter.
1.3	The HSCP Winter Plan identifies and addresses local issues across primary care and community services for which East Dunbartonshire Health and Social Care Partnership is responsible, while also supporting the ongoing whole system delivery of effective unscheduled care. Operational teams have staffing contingencies to cover the festive period to prevent unnecessary admissions, facilitate timeous discharges and respond to pressures resulting from increased secondary care activity and/or severe weather, flu outbreak etc. The HSCP continues to contribute to whole system planning for unscheduled care and participated in a GG&C think tank event that identified a number of projects which were being progressed to better respond to unscheduled care including, but not limited to, the winter period. At the end of winter it is important to reflect on the experiences to help inform future service delivery and planning for 2019/20. The Greater Glasgow and Clyde Board wide reflection is included at Appendix 1 to this report.
1.4	Key headline reflection from the Winter Plan 2018/19 include: • All operational teams have refreshed Business Continuity Plans to ensure sustained service delivery during the winter period. Increased activity was absorbed within community teams. The table below shows the fluctuations in demand for Community Rehabilitation, Homecare and District Nursing  • The Hospital Discharge Team averaged 54 referrals per month with an average of 14 being recorded on Edison (as delayed discharges). These delays were attributed to 'AWI' and 'awaiting Care Home placement'. The Home Care service was able to respond to all referrals to support discharge over the winter period. The

intermediate care facility ran at 90% occupancy over the winter period and facilitated a 33% return to home.

- For Winter 2018/19 there was the introduction of the 'Caring Together' team designed to provide enhanced support to care homes. 'Red Bags' were also included to facilitate early discharge and improve communication between acute and care homes. Early indications would suggest a positive impact in all three areas. The chart below shows attendances at ED/AAU from care homes, admissions to hospital from cares and lengths of stay for care home residents in secondary care.



- Provision was made for the availability of 2 additional beds within a Care Home to be used as an alternative to admission for requiring more social care. These were not required.

1.5 Summary of key reflections

Overall East Dunbartonshire HSCP is consistent with the the experience across the 6 NHSGG&C area HSCP's. Higher activity was noted by services with an increase in the number of unavoidable delayed discharges (AWI mainly). On the whole, however, the increased activity was contained within the contingencies build into service through their Business Continuity Plans. There was high demand on acute services over the period so we need to continue to look at the pressure areas across the whole system to collectively improve performance.

There was recognition across the system that planning for winter should start at an earlier point to ensure the set up of services in a timely manner. We must also review to establish if some of the changes should be embedded across the year.

Planning for Winter 2019/20 will commence for East Dunbartonshire in September to ensure a synchronisation with our Unscheduled Care Plan and timely consideration of options to feed into the GG&C-wide winter Planning. The East Dunbartonshire HSCP Winter Plan 2019/20 will come to the HSCP Board in November 2019.

NHS Greater Glasgow & Clyde

Health & Social Care: Local Review of Winter 2018/19

2/05/19

NHS Greater Glasgow & Clyde
East Dunbartonshire Health & Social Care Partnership
East Renfrewshire Health & Social Care Partnership
Glasgow City Health & Social Care Partnership
Inverclyde Health & Social Care Partnership
Renfrewshire Health & Social Care Partnership
West Dunbartonshire Health & Social Care Partnership

Winter Planning Executive Lead:

Jonathan Best, Chief Operating Officer – Acute Division
David Williams, Chief Officer, Glasgow City HSCP (on behalf of all GGC HSCPs)

Introduction

1. The Winter Plan was developed as a cross-system exercise to anticipate and respond to increased unscheduled care pressure on our health and social care services. It was formulated under the oversight of the Board's Unscheduled Care Steering Group, drawing together input from the three Acute Division Sectors and the six HSCPs in GG&C.

2. Overall, the Winter Plan for 2018/19 identified a potential expenditure of circa £6m to provide the additional capacity across the whole health and social care system to support demand for Unscheduled Care. The expenditure plan was allocated as:

	Potential	Actual
Addressing Demand at the 'front door'	£574k	£827k
Improving Management of patients within Hospital – Patient Flow	£676k	£390k
Safe Discharge without delays, reducing length of stay	£531k	£543k
Managing Higher Patient Numbers	£3,208k	£3,418k
Care Outside Hospital	£785k	£485k
Total	£5,774k	£5,664k

Table 1: Forecast v Actual Spend

3. There has been a consistent and sustained focus on re-design to support improvement in unscheduled care performance across the Board throughout 2018/19. Despite this the Board remains challenged to consistently deliver against the 4 hour wait target and the combined demand on our emergency departments and assessment units has continued to increase rising by 4% over the last year with over 517,000 attendances. We are currently averaging 90% compliance against the target.

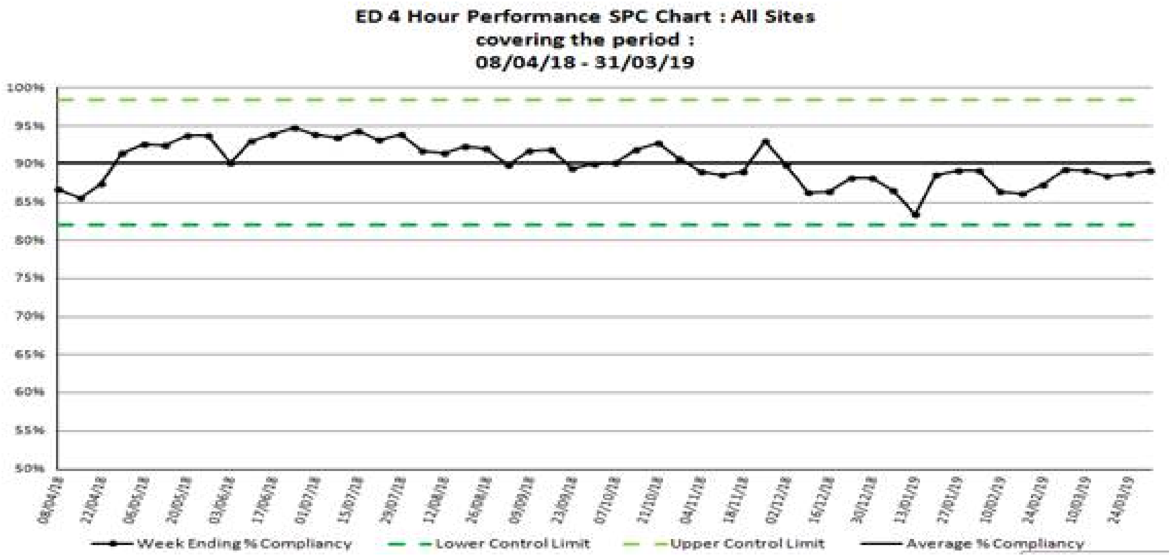


Fig. 1: ED 4 hour performance 2018/19

Section 1: Overview of Winter

Addressing demand at the 'front door'

4. The Winter Plan prioritised potential spend of £574k to strengthen capacity at the 'Front Door'. Actual spend was £827,320. Across the four receiving sites, additional staffing was recruited to extend rostered hours within the Emergency Departments and Assessment Units:

    - Medical staffing: Consultant and middle grades, targeted at early evening and overnight shifts
    - Nursing: Trained to support core shifts at peak times and Untrained (Healthcare Assistants), targeted to assist in taking bloods, ECGs
    - AHPs: to provide rapid response in support of discharge and linkage with community teams
    - Test of change: Specialist MSK Physiotherapist in ED Minors
    - Point of Care Testing to enable rapid diagnosis of Flu Symptoms.
    - At the RAH, additional bed capacity was provided for immediate assessment within Ward 15 (20 Beds) as well as extended opening overnight of beds within the MAU.

5. ED Performance during the winter period was marginally up on 2018 but within a context of increased demand. The weekly average from 2 December to 31 March was 87.8% with weekly attendances averaging at 8486. During the same period last year, average weekly performance and attendances were 85.7% and 8106 respectively.

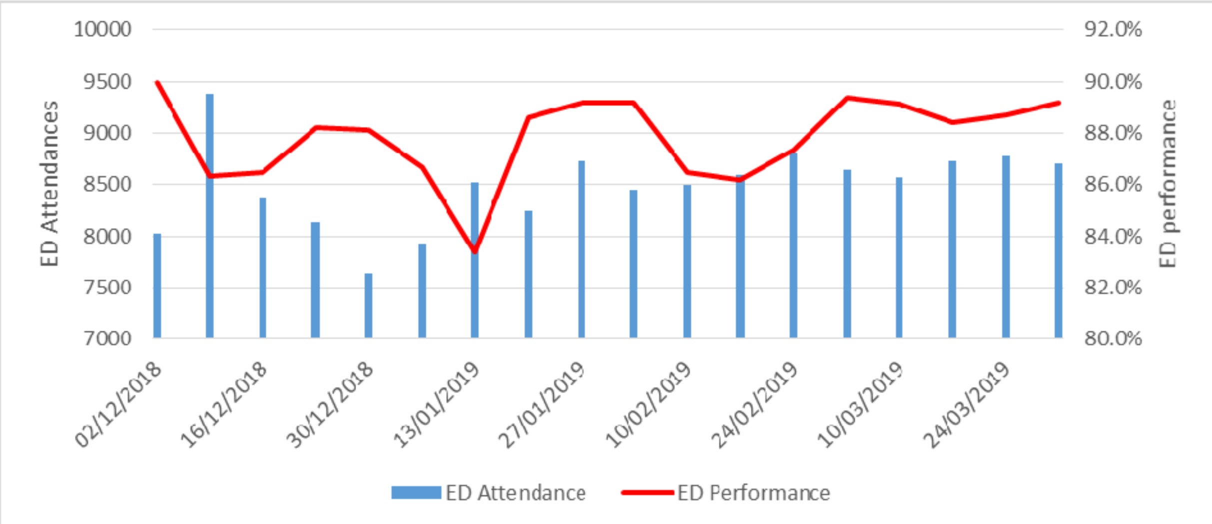


Fig. 2: GGC ED weekly performance & attendances

6. Analysis of breaches across the four receiving sites indicates that "Wait for 1st Assessment" accounted for at least a 25% of all breaches per month but rising to 38% during March. It was consistently the top reason for the GRI (45% Dec-Mar) and IRH (27% Dec-Mar), and either of the top two reasons at the QEUH (the other being Wait for bed – Non Monitored).

		Dec	Jan	Feb	Mar	YTD
Wait for 1st Assessment	Number	1082	1126	1330	1498	10761
	%	26%	25%	33%	38%	27%
Wait for bed - Non Monitored	Number	542	1089	782	478	7893
	%	13%	24%	19%	12%	20%
Clinical exception	Number	539	621	440	470	5425
	%	13%	14%	11%	12%	13%
Total Breaches		**4213**	**4491**	**4028**	**3938**	**40332**

Table 2: Top 3 Reported Reasons for Breaching the 4 hour standard – GGC Aggregate Position

Test of Change – Physiotherapists in Emergency Departments

7. To support the 4 hour unscheduled care access standard within NHS Greater Glasgow and Clyde, Physiotherapists (3 wte @ Bd 7) were deployed within the 3 sites (QEUH,GRI, and RAH) within the ED teams, to support flow 1, specifically MSK presentations, and provide senior decision making support, for 12 weeks over winter.

8. The focus of including Physiotherapy within the ED team, was to ensure we used their professional expertise to support the demand of MSK presentations (30 % of flow one) to provide right professional at the right time, and therefore enhance discharge, and quality of care.

9. The total number of patients seen by the physiotherapist across the 3 sites were 1045 patients, over the 12 week period, 91.7% were discharged directly from ED, and 8% were advised to seek further physio treatment following self management , via the community msk team.

10. A detailed evaluation will be completed, early observations are:

    - The flexible working pattern, inclusive of late shifts and weekends, won support from the ED team.
    - Integrating the physiotherapists within the ED team was important to support flow at times of pressure.
    - Work-plans to include this clinic approach to fast-track MSK patients 'off the clock'
    - Extending the clinical competencies, (eg to include wound closure, ultrasound, injection therapy to include inflammatory conditions) would add value to widen the patient group.
    - Maintain 1 and 2 slots in MSK dairies to directly pass onto treatment mode, rather than referral process, therefore one pathway.
    - Gaining clinical confidence with a number of medical staff within the team, takes time.

Point of Care Testing

11. Point of Care Testing is reported to have had a positive impact, similar to the experience of last year. It enabled determination of need for patient isolation, supporting more effective use of side rooms and assisted with discharge by providing assurance of diagnosis.

12. However it should be noted that the time taken to complete the test increases patient wait in ED/AAU by approx 20mins. We need further work to resolve the inability of the current system to link to clinical portal or Trakcare. Results have to be manually uploaded which is time consuming and has an associated error risk.

Patient Flow

13. A potential spend of £676k was directed at improving patient flow with an actual spend of £390,304. Ensuring that once admitted to hospital, patients are admitted to an inpatient bed quickly and receive the appropriate medical care. Spend was directed primarily at establishment of the 'Flow Hubs' and 'Boarding Teams'.

14. "Wait for Bed – Non Monitored" continues to be the second most frequent reason for delays at the Front Door. Over the last 12 months, it accounts for 24.2% of breaches across GGC. The position is more variable across different sites, it is the predominant reason at the QEUH for delay accounting for 27% over the December to March period.

15. Between December and March saw a marginal reduction in "Wait for bed – Non Monitored" as a cause of breaches across all sites fluctuating between 21.9% and 23.5%. Given the context of increased volumes of admissions, this suggests that the additional staffing capacity supported actions to maintain patient flow.

16. Full implementation of Flow Hubs across sites was stymied by delays in recruitment. As a consequence, the full benefit has not yet been realised. However, all sites reported continued improvements work around daily huddles that enable prioritisation of issues. Pharmacy are now in attendance at the GRI, RAH, IRH and VoL. At the QEUH, pharmacy have staff on each floor hence integration with clinical teams to support patient flow is embedded. In Clyde, greater participation of HSCP staff at both the RAH and IRH strengthened communication and join up between hospital and community services.

17. Investment in Boarding Teams has been more focused and recognised as improving safety and clinical continuity, as well as assisting with patient flow.

Safe Discharge without delays, reducing length of stay

18. The Winter Plan identified potential spend of £531k to improve capacity and capability to ensure that when patients are fit to leave, their discharge proceeds without delay. Actual spend was £543,159. Measures invested in included:

    - Additional Physiotherapy and Occupational Therapy to provide capacity for assessment & treatments across 7 days in medical and orthopaedic wards, expediting decisions on discharge.
    - Additional Consultant ward rounds at weekends – senior clinical decision-making
    - Discharge Lounge facilities for patients waiting on transport and new initiatives such as the "breakfast club" to allow patients who are ready to leave first thing to be supported & prioritised.
    - Additional Festive Public holiday staffing

- Children's services: RSV/Bronchiolitis nurse led discharge pathway
- Extended hours in Pharmacy over evenings/weekends
- Additional Ambulance transport to support discharge & transfer across sites (SAS and Red Cross)

19. Our Winter Plan set an ambition to improve the rate of discharge by 5% before noon and at weekends by December 2018, sustaining this through the winter months. Across GG&C, this was not achieved.

GGC	Target	Nov	Dec	Jan	Feb	Mar	Trend
Weekend	**24%**	18%	19%	17%	17%	17%	
Pre Noon	**23%**	20%	19%	19%	19%	19%	

Table 3: Discharge Rates: Aggregate GGC position

20. This position is variable across sites. The GRI maintained an average of 21% discharges pre noon through the winter period, reflecting improvement work throughout the year resulting in the rate being 4% better than the same period in 2017/18. The QEUH fluctuated between 12% and 18%, January being the most challenging month.

21. Weekend discharge rates experienced similar variations at the QEUH but the RAH saw a deterioration from 30% down in December to 16% between January and March.

22. The IRH had consistently the lowest rates of discharge at weekends and pre noon with averages for the period of 15% and 12% respectively. Patient flows from out with GGC, from Argyll & Bute and Ayrshire & Arran, may be a feature of this rate.

23. All Sectors reported ongoing improvements to process and have Daily Dynamic Discharge (DDD) working groups to align to the Exemplar Ward processes. This is supported by a number of IT improvements to help the ward teams, creating Electronic weekend handover which is targeted to safely track patient tasks and expedite discharges over the weekend and during the out of hours period. Introduction of the 'priority'/'golden' patient process to identify patients for pre 10am discharge has become embedded practice.

24. Proposals to implement a 'Breakfast Club' working from the QEUH Discharge lounge to expedite early discharge were not enacted due to recruitment issues. Funds were diverted to additional Health Care Assistants to releasing junior doctors of routine tasks enabling them to prioritise better. The impact was viewed as positive and is being formally evaluated.

25. Targeting of additional AHP support at priority areas (ARUs & Frailty) rather than attempting to service all wards was a further test of change that is viewed as being more effective. This builds on similar initiatives in Orthopaedics where there is a growing evidence base showing reduced length of stay.

26. Additional funding allowed plans to be implemented to elongate the pharmacy working day on the 3 main receiving hospitals. Staffing was increased to cover the opening of planned winter wards at

GGH and IRH. Clyde sector further invested in pharmacy technicians to facilitate flow to the Discharge Lounge.

27. QEUH pharmacy team implemented a different model on a Saturday, where a pharmacy team are deployed within one surgical and one medical floor this has had the following impact:

- Decreasing medicine supply via discharge (waste)
- Enabled clinical pharmacy input to patients at the weekend
- Shortened discharge waiting times on receipt of IDL's (reduced waits and calls for porters)

Managing higher patient numbers

28. In anticipation of increased demand, the Winter Plan identified potential spend in the region of £3.2m to expand capacity by up to 146 Adult beds, with further provision for children (13 beds) and Medical HDU/Critical Care. Actual spend was £3,417,612.

29. The increase in bed capacity was modelled against scenarios of surge demand of 2%, 5% and 8% increases of admissions. Over the January to March period, the average monthly increase compared to the same period last year was 5.6%.

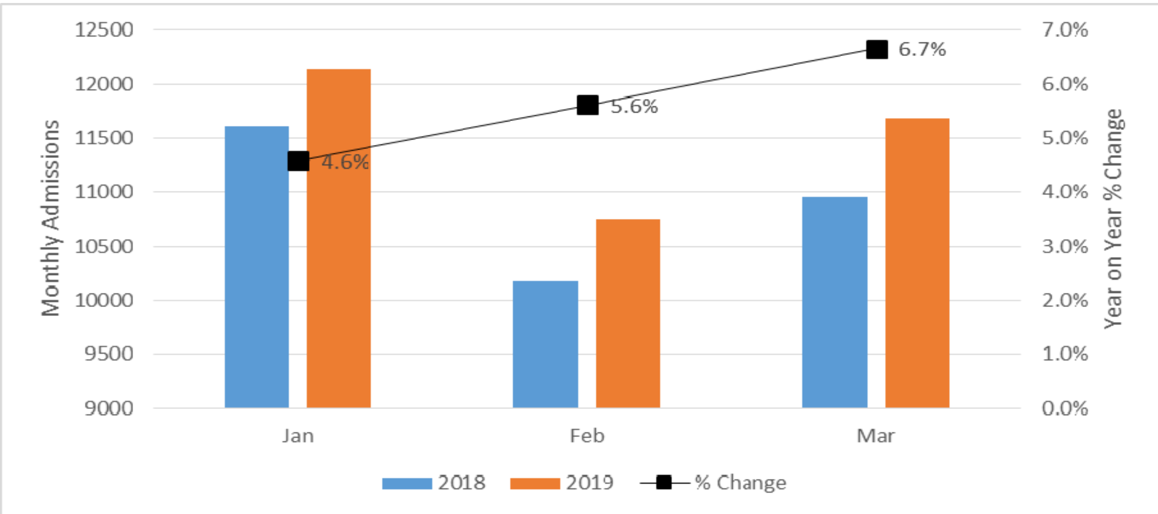


Fig. 3: Monthly Admissions: Comparison Winter 2018/2019

30. The additional bed capacity was scheduled to open from January 2019 however early surges of demand resulted in plans being brought forward into December. Early January experienced higher than anticipated pressures, particularly at the QUEH and RAH leading to further beds being made available. These contingency actions continued throughout the January to March period. In the South Sector, this was more occasional responding to spikes of pressure. At the RAH, this additionality amounting to c.30 beds was more constant.

31. Plans to open 12 beds at the Vale of Leven were not enacted reflecting locality differences in demand.

Care Outside Hospital / Interface between HSCP and Acute services

32. The Winter Plan built upon an HSCP joint action plan to reduce unscheduled care activity by 10% in ED attendances, admissions and occupied bed days. This agenda was shaped around the top 6 conditions and enabling activities which would impact generically across clinical pathways:

    - COPD Pathway
    - Reducing Admissions from Care Homes
    - Frailty
    - Anticipatory Care Plans (ACP)
    - Delayed Discharge

33. A potential spend of £785k was identified as additional provision to strengthen services in the community, reduce hospital admissions and enable early discharge. This included provision for:

    - 15 additional Intermediate Care beds (Glasgow City)
    - Extension of the Community Respiratory Service to 7 days (Glasgow City)
    - Test of "72 hour Supported Time Out" Beds within Care Homes. (Glasgow City)
    - Expansion of community capacity

    Actual spend was £485,353.

34. Extension of the Community Respiratory Service to 7 Days was not fully enacted due to difficulties in recruiting the additional staff and vacancies in the team. The broader programme of initiatives around the COPD is continuing however and includes:

    - Pharmacy First: extension to support access to rescue medicines for patients who require them for Chronic Obstructive Pulmonary Disease (COPD). Community pharmacists in Renfrewshire (via Pharmacy First) prescribe rescue medication to patients with a known diagnosis of COPD within strict clinical parameters. The COPD pilot started in January and all practices and the chest clinic within the Royal Alexandra Hospital and is being fully evaluated.

    - Development of the Shared Respiratory Patient Assessment tool to enable staff based in acute and community settings (Community Respiratory Team, Glasgow City HSCP), to use the same electronic patient record for assessing patients, strengthening appropriate escalation of care at the interface.

35. The "72 Hours Supported Time Out" test of change operated from mid-January to later February 2019 and comprised nine beds in care homes across Glasgow City – three in each locality. In the event demand was not as envisaged, and an evaluation has been undertaken to identify learning for the future planning.

36. HSCPs have reported flexible extension of community support in response to the discharge pressures within the acute system, with specific contingencies for extended hours at weekends and evenings. However, often this surge capacity was not utilised as referrals did not come through from acute services. Further work is need to ensure that this additional capacity is fully utilised.

37. Continuing work on reducing admissions from Care Homes includes the 'Red Bag' scheme and broad adoption of the Care Home Dashboard both of which are enabling community teams to prioritise efforts to reduce admissions and improve the admission process where it can't be avoided.

38. Progress regarding Care Homes accepting discharges at weekends has been an issue. Team Managers and Workers at the Royal Alexandra Hospital maintain a "why not today?" philosophy towards discharge and challenge unnecessary delays and long held attitudes such as "don't discharge on a Friday", pushing Care Homes for earlier admission dates.

39. There is a continuing need to encourage Care Homes to adopt a more urgent and high priority action in assessing patients in hospital who are ready for discharge. Particularly where funding is in place and their Care Home has been identified as a primary choice by family. This at times, can add substantial increases in bed days lost.

Section 2: Response to Scottish Government Questions

Clear alignment between hospital, primary and social care

What went well?

40. On an ongoing basis, there is system wide communication at Director level with daily calls between the Chief Officers of Acute and HSCPs, replicated at locality levels of the systems between operational teams. Each of the Acute Sectors has a Local Delivery Group for Unscheduled Care providing a joint forum for Acute and HSCP operational dialogue. A weekly focus was co-ordinated across the HSCPs with Acute input to drive process developments intended to deliver the MSG Unscheduled Care activity reductions.

41. In addition to this established governance process, the planning was supported by two extended development sessions involving senior clinical leadership from across Primary and Secondary Care, and senior management input from the Acute Sectors, HSCPs, NHS24 and Scottish Ambulance Service. These sessions were intended to provide additional challenge to conventional thinking, recognising heightened demand during the summer months with very high ED attendance rates.

42. The output from the initial development session in September was identification of a number of priority areas of focus with an intention to develop and establish 'Tests of Change'. The follow up session in late November, allowed development work to be considered for implementation and further focus on priorities for collaborative working.

What didn't work well?

43. There is a common perspective that the heightened focus on Winter Planning starts too late to enable new interventions to be adequately developed.

44. Late decisions on additional funding hampers recruitment of key staff, in some areas there was a reliance on locum doctors. Many staff volunteered to do additional hours to help cover winter pressures, this may not be a sustainable approach long term.

Key Lessons/Actions Planned

45. Winter Planning is a specific focus of the Unscheduled Care agenda designed to give assurance or preparedness at times of peak demand. The distinctions between seasons has been less defined in recent years with high demand experienced all year round.

46. Cross-system planning processes need to become more systematic throughout the year to enable implementation timelines and forecasting of workforce, bed and financial requirements.

47. NHS GGC now has a cross-system transformation programme "*Moving Forward Together"* which has as one of six work streams a programme around Unscheduled Care. This will develop change

proposals for demand management including redirection, ED frequent attenders and working with Care Homes.

Appropriate levels of staffing to be in place across the whole system to facilitate consistent discharge rates across weekends and holiday periods

What went well?

48. ED Performance during this period was marginally up on 2018 but within a context of increased demand across all measures of activity.

	2019				% Change from 2018			
	Jan	Feb	Mar	YTD	Jan	Feb	Mar	YTD
ED 4 hours Compliance	87.1%	87.4%	88.9%	90.2%	1.9%	-1.0%	2.5%	0.2%
ED Attendances	37416	34412	38276	444848	10.4%	-0.1%	4.5%	4.0%
Assessment Unit Attendance	6285	5812	6105	72788	-0.4%	4.9%	0.6%	3.0%
Total Emergency Attendances	43701	40224	44381	517636	8.7%	0.6%	3.9%	3.9%
ED Admissions	9092	8106	8894	102464	7.3%	4.0%	3.7%	3.8%
Assessment Unit Admissions	3050	2637	2791	34474	-2.9%	10.8%	1.9%	1.3%

Table 4: Monthly Activity/Performance

49. Workforce planning for the winter period commenced earlier in the year enabling a better appreciation of ward staffing requirements and in anticipation of the expansion of bed capacity. Over 450 newly qualified nurses were recruited in the autumn. Further changes in the recruitment and management of the nurse bank increased the fill rates of consistently over 80%.

What didn't work well

50. Performance still fell short of the 95% ED standard, "delay for 1st assessment" being the most consistent cause of breaches indicating the pressure within ED departments. The 2nd most prevalent cause of breaches was "wait for bed" indicating that further work is necessary to improve patient flow.

51. There was no measurable improvement made in relation to Discharges before noon or at weekends.

52. HSCPs made provision for staff to work extended hours at evenings and weekends and over the bank holidays in anticipation of surges in demand. This was not utilised effectively by acute services with the result that day time numbers rose significantly compromising the ability of all to respond effectively.

53. Decisions on additional resources for staffing and extra capacity were communicated late in the year, as a consequence several initiatives did not proceed as planned due to difficulties with recruitment.

Key Lessons/Actions Planned

54. Services reported a range of improvement actions and tests of change which had a positive impact. Formal evaluation and sharing across sites would facilitate shared learning and consideration of formal adoption within core services/working practices, eg.

- Pharmacy/HSCP representation in huddles
- Targeted AHP teams on specific pathways/areas
- Extended use of Health Care Assistants to support junior doctors

Local systems to have detailed demand and capacity projections to inform their planning assumptions

What went well?

55. The Board has developed a range of analytical tools to understand unscheduled care demand trends and the performance of key processes within the acute setting.

56. A range of dashboards are now available with 'real time' data and their application continues to be extended across the system allowing Acute and HSCP teams to view the same data to support operational decision making and priorities.

57. System Watch is more widely available and is being used on regular basis to set the scene in planning meetings.

What didn't work well?

58. The ability to forecast rates of demand and the implied capacity requirements continues to be challenging.

Key Lessons/Actions Planned

59. Continued work necessary to develop cross-system understanding of the range of data now available, particularly from System Watch.

Maximise elective activity over winter – including protecting same day surgery capacity

60. Surgical activity plans aimed to maintain delivery of planned care during the winter period. Aside from the festive period and early January when cancer and urgent surgery was prioritised, the run rate of planned care was consistent through the winter period.

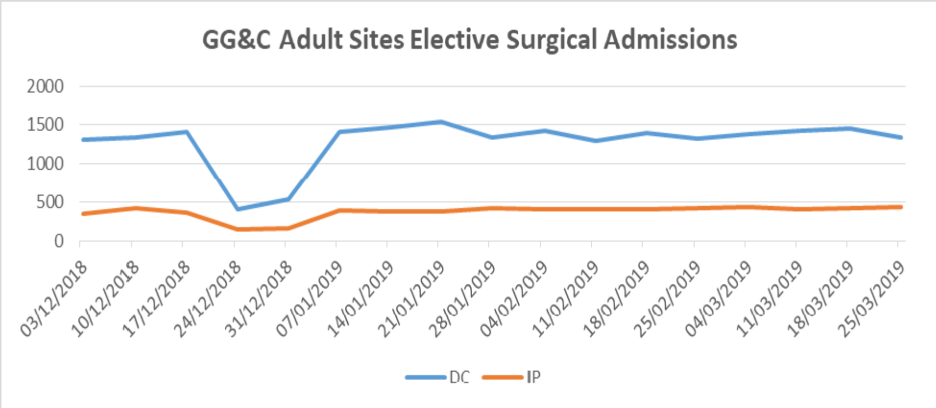


Fig. 4: Weekly Elective Surgical Admissions

What went well?

61. Aside from the festive period from 24th December to 6th January, planned care maintained a weekly average run rate of 1388 day case and 405 inpatient admissions with only two weeks when activity dipped below 5% of this.

What didn't work well?

62. Disruption due to bed availability and trauma activity was managed proactively to minimise cancellation following admission. In practice, operational management were sensitive to the pressures of responding to unscheduled care and tempered rates of planned admissions accordingly on a week by week basis.

63. Residual impact of the Cowlairs disruption in November combined with the focus on the Waiting Times Improvement plan and Cancer Targets has made balancing of priorities challenging.

Key Lessons/Actions Planned

64. The impact of winter demand should be integrated into the Waiting Times Improvement plan with a view to an annual activity plan aligned to delivery expectations.

Escalation plans tested with partners

What went well?

65. The Board Escalation Plan is built on a common framework that has been applied by each Sector to reflect local circumstances. It is now being used across all Sectors, enabling fine tuning of the escalation criteria, learning about how they are applied and the expected impact.

66. As part of the Winter Planning preparations, there was a broader dialogue across the wider system with HSCP partners and SAS. A key focus was on the additional actions that could be taken in the event of spikes of demand. As a consequence, there is greater involvement by HSCP teams in the

huddle processes strengthening links and enabling better anticipation and responsiveness to demand.

What didn't work well?

67. Final formal sign off for the Escalation Plan documentation was delayed hence it was not fully in place by the beginning of the Winter.

68. The flow hubs are an integral part of Escalation Framework infrastructure. More progress would have been made had delays in recruitment to key positions not occurred.

Key Lessons/Actions Planned

69. Escalation processes are essential elements of Business continuity arrangements. They need to be regularly reviewed particularly given their recent introduction.

70. Further extension out with the Acute Division to identify triggers and actions across the broader system (primary, community and ambulance services) should be considered.

Preparing effectively for infection control including norovirus and seasonal influenza in acute and community settings

What worked well?

71. NHS Greater Glasgow and Clyde adheres to Health Protection Scotland 2016 Guidance for the management and prevention of Norovirus and has developed a local Standard Operating Procedure (SOP) which summaries key points for clinical staff. NHSGGC also has a dedicated Norovirus Information Hub which includes guidance, educational presentations, checklists, patient information etc. in a single point of access for staff.

72. Noroviruses spreads effectively in hospital settings. As immunity is short lived, prevention of all norovirus outbreaks in hospitals is challenging. However, it is possible to minimise the incidence of norovirus outbreaks and when they occur to limit their impact on patients and the disruption to services.

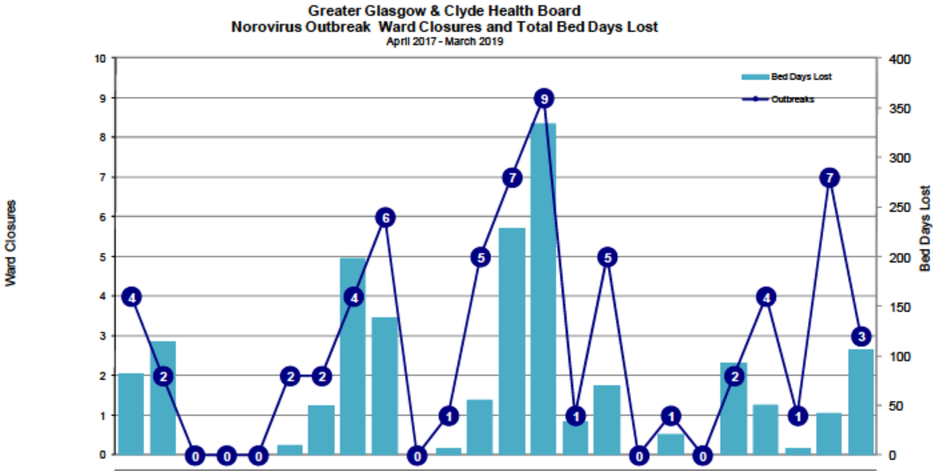
What could have gone better?

73. This year an escalation plan for Norovirus/Influenza was prepared and approved by the Infection Control Committees, however during this season this plan was not required.

74. During the period April 2018 – March 2019, norovirus activity was reported in 9 GGC hospitals, with 40 ward closures. There were 274 patients and 115 staff affected during this period with 983 Bed days lost.

75. In the same period last year (April 2017 – March 2018), norovirus activity was reported in 9 GGC hospitals, with 26 ward closures. There were 156 patients and 38 staff affected during this period

with 653 Bed days lost. It should be noted that most of the activity last year was in April and May, not normally considered peak norovirus season.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Bed Days Lost	82	114	0	0	0	10	49	198	138	0	7	55	228	334	33	69	0	21	0	93	50	7	42	106
Outbreaks	4	2	0	0	0	2	2	4	6	0	1	5	7	9	1	5	0	1	0	2	4	1	7	3

*Bed Days Lost for each outbreak totalled for the month during which the ward first closed.

Fig. 5: Noruvirus Outbreak – Ward closures/Bed days lost

Delivering seasonal flu vaccination to public and staff

What went well?

76. The winter of 18/19 was a relatively quiet ‘flu season within NHSGGC and across the country. The dominant strain seen was flu A H1N1 – otherwise known as swine flu which tends to affect the younger and working age groups (15-64 yrs). The Public Health Protection Unit were on hand to support Primary Care with advice of diagnosis and anti-viral treatment however it was not required to any great extent.

77. The influenza like illness (ILI) rate within primary care remained low and below the baseline threshold level for all but a couple of weeks this winter – in contrast to a peak of activity seen in 2017/18 around the start of the year.

78. No acute respiratory illness (ARI) outbreaks were noted within Care Homes the GGC area.

79. Within secondary care, the swab positivity rate only reached ‘low seasonal activity level’ for a few weeks of the season.

What could have gone better?

80. 2018/19 saw in another increase in the percentage of NHS GGC staff taking up the winter flu vaccination, to 45.1%. This is higher than NHSGGC 2017/18 uptake of 40%, but 15% lower than the Scottish Government target this year of 60%.

81. Overall, the uptake of flu vaccine across the general public winter was very similar to last year. A significant proportion of the vulnerable population in NHSGGC remained unprotected from the risks and complications of influenza this winter. There were some challenges this year for GPs with flu vaccine distribution to practices and a more complicated algorithm indicating which patient gets which vaccine which resulted in many enquiries to PHPU.

Eligible Groups	Average Uptake Rate 2018/19 (2017/18)	Range	National Uptake Target
65 yrs and over	73.7% (73.9%)	55.7 - 86.7%	75%
< 65 yrs & 'at risk'	43.0% (45.6%)	10.5 – 69.9%	75%
Children 2 – 5 yrs	54.3% (54.7%)	11.6 – 111.9%	65%
Pregnant Women (not in another clinical risk group)	52.4% (54.2%)	20.9 – 100%	-

Table 5: Flu Vaccination uptake 2018/19

Key Lessons/Actions Planned

82. To further increase the uptake of flu vaccination next winter (2019/20), work will focus on three linked areas.

- Promoting ownership and responsibility for staff flu vaccination at each and every ward and department;
- Increasing peer immunisation and
- Developing a fit-for-purpose IT system to allow simpler recording of vaccinations and improved reporting by locations and workgroups.

83. The Public Vaccination challenge for next year will be maintaining vaccine uptake as new delivery models are rolled out in year 2 of the Vaccine Transformation Programme.

Local Priorities for Winter Planning 2019/20

84. Action planning to improve unscheduled care performance within the Board is aligned to the National 6 Essential Actions Programme. Key work stream plans are detailed below.

Alternative Pathways to Admission

85. NHSGGC has an established unscheduled care team who continue to support the adoption and implementation of new models of care for high volume conditions. 2019/20 will see the delivery of the eHealth component to managing frailty more proactively at the front door and work will continue to be progressed around the COPD pathway. In 2019/20 work will be progressed by the HSCP's to broaden the number of conditions targeted for improvement and encompassing Heart Failure, Pneumonia and Cellulitis.

86. The overall aim is to achieve a reduction in total admissions, length of stay and attendances in line with the board's ambition to realise a 10% reduction in unscheduled bed days and demand during 2019/20.

Improving the Emergency Departments Processes

87. Within Emergency Departments and Assessment Units we will focus on a number of areas as follows:

    - Time to triage and time to first assessment, which will be reported and discussed at the Unscheduled Care Steering Group.
    - Protection of the minors flow performance in the emergency department. Aim is to deliver performance above 98% in this area.
    - Improvements across all sites to reduce ambulance turnaround times. This is a joint approach developed in collaboration with SAS to reduce delays and improve the accuracy of reporting times.
    - Embedding the board Redirection Policy
    - Reviewing various stages of the 4 hour pathway to identify opportunities to improve the delivery of safe and effective patient centred care.

Management of Current Inpatient Capacity

88. A key focus is the enhancement of the onsite flow hubs. In March 2019 we introduced new Demand and Capacity Flow Managers to lead the flow hubs to improve real time decision making and manage patient movement to improve the four hour standard on our acute sites. Complimentary work continues with the introduction of mandatory Estimated Date of Discharge processes, continual improvement through Daily Dynamic Discharge and the adoption of Ward task sheets. As part of this work we are working with eHealth to create a range of supporting information systems to allow real time patient management.

89. The overall aim of this work is to shift in the discharge curve to the left and to achieve a 40% of patients discharged by noon, 40% of discharges on a weekend, reduction in the number non-acute patients in hospital (captured in Day of Care Survey).

Reduction in Demand

90. We have created a Care Home dashboard allowing care home activity data sharing between acute and HSCPs. This information will be used to ensure that, where clinically appropriate, patients are supported to remain in their place of care. Alternative provision to respond to patient needs can be made within the community and primary care. We are moving forward with a review of high volume attendees supported by HSCP's to ensure that anticipatory care plans (ACPs) and/or agreed treatment plans are developed to respond to individual patient requirements and, where possible, alternatives to acute care agreed. HSCP's will also focus on patients with Frailty using a generic assessment tool and developing community based responses that avoid unnecessary hospital attendance and/or admissions. This work will contribute to reducing emergency attendances and admissions across our hospitals by 10%.

eHealth

91. A series of projects have been identified to support workflow and decision making to improve the management of unscheduled care activity across hospitals and the Board. This includes electronic data capture of NEWS scores on attendance, enhancement of our WardView system to improve ward based information and progression of discharge related tasks to support timely decision making. A key priority this year will be to improve the accuracy of real time system updates either through workflow automation or process change to increase the reliability of information on our patient management IT platforms. This work will significantly contribute to our Flow Hub vision and improve our overall efficiency and effectiveness in the management of unscheduled care demand and capacity within GGC.

Delayed Discharge

92. There has been a real and sustained focus across our HSCPs and Acute teams to minimise patients delayed in hospital. NHSGGC's and its partner HSCPs are the best performing in Scotland in respect of delayed discharges.

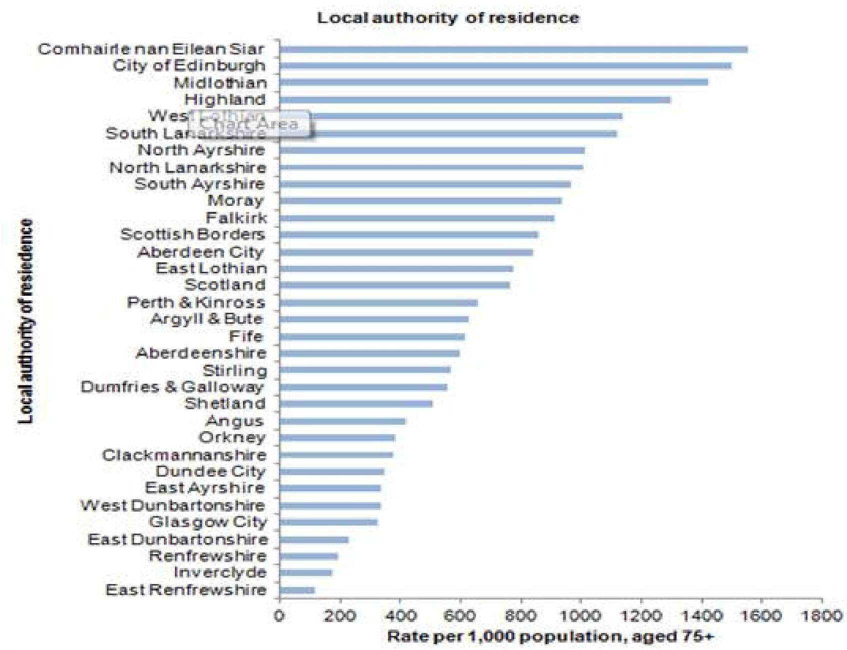


Fig 6: National Delayed Discharge rates

93. There has been a slight deterioration in performance over the last 6 months across Scotland and this is evident across GGC. A range of actions are in place to improve the position into 2019/20 as follows:

- Increase in the capacity of specialist AWI which will deliver a reduction in bed days lost of around 180 per month.
- A continuing programme of improvement in relation to Intermediate Care is being supported by Acute consultants and a range of HSCP professional groups. There is a particular focus on average length of stay in Intermediate Care to create capacity for discharge from hospital. The ALOS trend over time has been driven down by this improvement work, but this will continue to be a priority.

- A continuing programme of improvement in relation to AWI. This programme brings scrutiny to elements the HSCP can improve including timeous completion of reports, local authority guardianship applications etc.
- Increased management focus on everyday activities to achieve:

  - A reduction in same day (as fit for discharge) referrals from Acute
  - Prioritisation of delays by HSCP community staff – these are marginal, as most cases are held by the hospital-facing services (e.g. Home Is Best team in Glasgow, Home First in Inverclyde)
  - Improved communication arrangements between ward staff and the relevant social work team or service
  - Improved performance around the ordering of transport, polypharmacy needs at the point of discharge etc.

Agenda Item Number: 7

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	**28th May 2019**
Subject Title	**Greater Glasgow & Clyde Review of Health and Social Care Out of Hours Services (OOHS) – Urgent Care Resource Hub Proposal**
Report By	**DERRICK PEARCE, Head of Community Health and Care Services**
Contact Officer	Kirsty Orr, Programme Manager – NHSGG&C Review of Out of Hours Services Tel: 0141 287 0391 Email: Kirsty.Orr@ggc.scot.nhs.uk

Purpose of Report	The purpose of this report is to brief East Dunbartonshire HSCP Board on the progress to date of the Review of the Health and Social Care Out of Hours Services and to seek HSCP Board approval on the proposals outlined. It should be noted that the review in inclusive of Emergency Social Work Services in additional to social care and health services.

Recommendations	The HSCP Board is asked to: i) Note progress to date; and ii) Approve the agreed outcome and actions identified by the Programme Board and HSCP Chief Officers.

Relevance to HSCP Board Strategic Plan	The Review of Health and Social Care OOHs Services is a key contributor to the delivery of the HSCP's Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	Staff Partnership and Trades Union colleagues are engaged in the process.

Equalities:	A baseline EQIA has been undertaken for all services in project scope. This will be repeated prior to change or implementation of the proposed model.

Financial:	The financial implications of the proposed model will need to be assessed, including the resources required to support the draft model

Legal:	nil

Economic Impact:	nil

Sustainability:	nil

Risk Implications:	A risk assessment framework has been developed to support the review to date and will be updated the planning phase

Implications for East Dunbartonshire Council:	None at this time.

Implications for NHS Greater Glasgow & Clyde:	None at this time.

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

1. MAIN REPORT

1.0 Background

1.1 A Review of Primary Care Out of Hours Services was commissioned by the Cabinet Secretary for Health, Sport and Wellbeing and led by Professor Sir Lewis Ritchie in January 2015, in light of the challenges being faced in delivering services during the out of hours period.

1.2 Professor Sir Lewis Ritchie's Report advised that a whole system approach to enable a safe, sustainable, patient-centred service model to be developed was central to enhanced joint working across health and social care services during the OOHs period. The approach was described through 28 recommendations.

1.3 The review recommended a model for out of hours and urgent care in the community that is clinician led but delivered by a multi-disciplinary team where patients will be seen by the most appropriate professional to meet their individual needs – that might not always be a GP but could be a nurse, or a physiotherapist or social services worker.

1.4 The review also states that GPs should continue to play a key and essential part of urgent care teams, providing clinical leadership and expertise, particularly for more complex cases.

1.5 Following the publication of that report a local review of Health and Social Care Out of Hours provision has been commissioned across the 6 GG&C Health and Social Care

Partnerships, led by Glasgow City HSCP. A project governance structure was agreed to oversee this work and a Project Manager was appointed in September 2017 to manage and co-ordinate all aspects of the review.

1.6 The OOHs services within that programme scope are:

- GP
- District Nursing
- Community Rehabilitation
- Children’s Social Work Residential Services
- Emergency Social Work Services
- Emergency Dental Services
- Homelessness
- Home Care
- Mental Health
- Community Pharmacy
- Optometry

2.0 Current Issues to Resolve in delivering Health and Social Care OOHs Services

2.1 The present situation for the ongoing provision of Health and Social Care OOHs Services across Greater Glasgow and Clyde is that the current configuration lacks resilience and is probably not sustainable. The reasons for this are multi-factorial and include:

- Lack of work force capacity across parts of the health and social care system as it is challenging to attract and retain staff to work in the OOHs period
- Aging workforce; resulting in the loss of experienced and skilled staff
- Growing numbers of people living with multiple and complex conditions; resulting in an increasing demand on services in an age of austerity which requires us to achieve more through better use of resources
- Expectations of the population in terms of increasing demands for care when convenient rather than a focus on need
- Services needing to work more effectively together in the out of hours period - the current fragmented nature of the health and social care service provision makes communication, day-to-day management and co-ordination of services extremely challenging and resource intensive. The current configuration of provision can result in a number of services working in isolation to provide support to one patient / service user during the OOHs period.

2.2 Within Professor Sir Lewis Ritchie’s review, 28 recommendations had been made which have provided us with a clear framework in which to review our current situation and for the provision of consistent urgent OOHs care that is sustainable over time throughout Greater Glasgow and Clyde.

2.3 This report sets out the proposed model in relation to the wider Health and Social Care OOH. The specific recommendations on the GP OOH will be the subject of a separate report.

3. Process Undertaken to develop an Integrated Health and Social Care OOHs Service Model

3.1 Four half day events were held across May to September 2018 to enable a broad range of staff the opportunity to work through and agree actions and next steps for the proposed new system wide OOHs service model. These events involved members of the Health and Social Care Out of Hours Programme Board, and a range of clinical and managerial colleagues and staff side representatives.

3.2 The central aim of the first three sessions was to develop a finalised position on changes and improvements to the Health and Social Care OOHs models, including changes to the GP OOH model and wider improvements to how other services work together.

3.3 A key output of the sessions was that an Urgent Care Resource Hub (UCRH) approach would be developed to facilitate integrated, person-centred, sustainable, efficient and co-ordinated health and social OOHs services across the GG&C area.

3.4 During these sessions 6 principle elements emerged (for each of the services within the project scope) which required clarity and agreement. These were:

- Service Purpose – defining what the service should do in the OOHs period and defining what patients/carers should expect and what staff can provide;
- Service Access – describing how the service is accessed by a user / patient or other professional service;
- Service Location – confirming the location of service delivery and the numbers of services, sites and staff required;
- Workforce Mix – agreeing the right mix of workers supported with the right training and development to meet the OOH need;
- Service Interfaces – describing and agreeing how services engage and co-ordinate across the health and social care system in hours and out of hours;
- Technology – developing and using technology to enable interfaces and to support care delivery and information sharing across the OOHs Health and Social Care System.

3.5 The fourth session provided the opportunity to robustly test the high level concept of an Urgent Care Resource Hub (UCRH) and the potential to enhance integration, co-ordination and access to Health and Social Care OOHs services by applying patient, service user and professional focused scenarios.

3.6 This paper describes the high level service model with the detail of the service specifications and description of the operational arrangements that now will be subject to further refinement and clarification.

4. Outcomes and Enablers of the Urgent Care Resource Hub

4.1 As the work has progressed, it is clear that we already have a number of services working through the out of hours period that are delivering planned care to a number of patients and services users.

4.2 These services include the OOH District Nursing service who work to provide care to a known and defined list of named patients, often patients who are at or near end of life requiring palliative care. Services also delivering planned care include Care at Home services which will provide care and support throughout the OOH period to a significant number of known service users within a defined assessed care package.

4.3 The creation of an UCRH would primarily have its focus on the delivery of care coordination and a fast response where care needs change in the OOH period for known patients/service users. It would also be to provide a response where a patient/service user contacts NHS24 but they do not require seeing a GP. Their needs can be met through alternative staff including a DN intervention and/or by a Care at Home service or some other intervention from an OOH service delivered through HSCPs. The Hub would also have a role to improve and coordinate the connection of patients/service users back into day time services.

4.4 The UCRH would, therefore, enable a whole system approach to the provision of scheduled (where planned care needs change and require something beyond what the service can provide) and unscheduled (where a patient/service user contacts NHS24) Health and Social Care. OOHs Care provides a vehicle to enhance and develop integration and co-ordination across a wide range of services.

4.5 Through the review process, it has become clear that the co-ordination of a crisis response or complex or multi-sectoral urgent planned or unplanned OOHs care for new or known patients from an UCRH is core to the delivery of well-led, appropriately supported multidisciplinary health and social care team working.

4.6 The delivery of sustainable OOHs care must also involve close working with Third and Voluntary Sector Providers to continue to meet the population's needs.

4.7 It is essential that the UCRH role would not, therefore, be to duplicate NHS 24's role and remit. The key outcome for services coordinated within or via the Urgent Care Resource Hub(s) for GG&C would be to provide patients, carers, service users and professionals with the following:

- A single point of access for community settings to co-ordinated support from multiple services, based on need
- Triage / Signposting / Referrals to statutory / non-statutory services, based on need
- Focus on continuity of care and co-ordination of care for individuals with multiple conditions
- Co-ordinated assessment intervention and care at crisis / transition points for those most at risk with complex care needs or experiencing situations of significant risk
- Access to specialist advice by phone or in community settings if face to face assessments are required
- Rapid escalation of support / clinical care.

4.8 The development of an UCRH model would also add value to what is already provided by NHS24 and existing services working in the OOH period. These include:

- Electronic Records and Anticipatory Care Plans – secure, appropriate and confidential access to electronic records, including ACPs to support Health and Social Care professionals in their decision making during the OOHs period

- Asset Optimisation – managing demand and capacity across OOHs services by having up to date information about activity and available resources
- Civil Contingencies – supporting coordination of resources during major incidents
- Training and Development – providing a supportive and safe environment to provide training opportunities through rotational posts and Advanced or Extended roles. This will help to develop a flexible and skilled workforce across in-hours and OOHs services.

4.9 People with Specific Needs

It is essential that people with specific / complex needs should receive appropriate care and support access to resources which will help to prevent an escalation in their health problems. There are programmes of work underway across the NHS Board area which are developing and enhancing condition specific local care pathways and care provision. The implementation of an OOHs UCRH can support the co-ordination of resources and care, across statutory and non-statutory services, for specific areas of need which could include:

- Palliative Care – people with palliative care or end of life needs their carers should be able to access care and assistance efficiently and without organisational or system delays. The UCRH could manage and co-ordinate a local palliative helpline which would free up clinical time by reducing calls
- Mental Health – prioritising psychiatric urgent care is important. We need to increase the availability of community based places of safety to support our population with episodes of acute distress. This needs collaboration between partner agencies, statutory services, third and independent sectors
- Frail and Older People - OOH services should be configured and responsive to the growing numbers of frail and older people in the GG&C area, many with complex needs which includes older people with a mental health condition, predominantly dementia. The UCRH could support Care Homes to access a wider set of community supports to reduce hospital admissions. The response to and care of frail and older people who fall and are uninjured is variable and through the implementation of a robust system-wide agreement, a UCRH could support the co-ordination of an appropriate integrated response
- Children – children are a high volume group that access OOHs services. The UCRH could help to ensure that through local urgent care pathways, in accordance with the principles of *Getting it Right for Every Child* (GIRFEC), are efficiently actioned. For example, if a child is attending a PCEC and the GP / ANP determines Child Protection concerns, the UCRH could initiate the Emergency Social Work response to ensure the child is safe and protected.

4.10 Location and configuration of UCRH(s)

The UCRH will be aligned and connected with the NHS24 service and will operate with a detailed knowledge of the locality service operating in the OOH period within each HSCP area and to ensure a detailed understanding of who is working each day in the GP OOH service.

4.11 Further work is required to finalise the detail, but based on the modelling work undertaken to date, the service would be staffed by call handlers, supported by a Team Leader who have the knowledge and contact details of all services that are operating – both locality by locality and GG&C wide – to ensure the coordination of care is prioritised and managed effectively.

5. An Integrated, Coordinated, Patient Centred, Sustainable Health and Social Care OOHs Model for Greater Glasgow and Clyde: The Model

5.1 We used patient, service users, carer and staff scenarios, to develop the operating principles of the Urgent Care Resource Hub for Greater Glasgow and Clyde. This enabled us to explore the impact of an UCRH on other parts of the system and services, for example NHS 24 and daytime services.

5.2 The value adding function of the UCRH would be to mobilise and co-ordinate the most appropriate OOHs Health and Social Care response during times of crisis or escalation. The UCRH would support the increase of the number of multi-agency and multi-disciplinary responses which would match patient, service user and carer's needs, through a wide range of health and social care community based resources.

5.3 In addition, the UCRH would provide OOHs practitioners with the facility for professional to professional advice to support management decisions for patients and service users with increasing complexities. This should improve communication and coordination of services across; these functions are currently extremely challenging and resource intensive.

5.4 Various formats and configurations of the UCRH model were examined and tested prior to the development of preferred model. This model has been endorsed by the Programme Board, Chief Officers and LMC.

5.5 Proposed Model

The preferred model shows a clear patient, service user and carer pathways which would be actioned as required by NHS 24, District Nursing Services and Mental Health Services. In this option the service / UCRH interface has been developed to support onward referral for co-ordination of multiple services and complex needs of cases.

For this model to work effectively a number of critical service enablers for the UCRH have been agreed which include:

- Access to daytime contacts and services to support appropriate information sharing
- Access to ACPs
- Facility to directly transfer to other services

The use of the following patient and carer scenario assists in illustrating how this model would work.

<u>Health and Social Care Services and UCRH Interface: a possible scenario</u>
A 75 year old male and lives with his 76 year old wife. His wife was diagnosed with Dementia 2 years ago and she is frail, confused and requires her husband's assistance with all aspects of her personal care. He is his wife's only carer and although it is tiring he feels that they are both coping well and don't need any assistance at this time. Their children live abroad and they are not in contact with other members of the extended family. He has been feeling increasingly breathless, cold, clammy and generally unwell over the past 5 days. He attended his daytime GP 3 days ago and was commenced on a 7 day course of antibiotics and advised to take Paracetamol / Brufen as recommended for his temperature and any pain. It now 22:00 and he has been taking

his medication as prescribed but is feeling terrible and decides to contact NHS 24 for further help and advice.

The Nurse Advisor requests a Home Visit for further assessment. The GP attends, along with a trainee ANP approximately 3 hours later. The GP is concerned about his worsening condition and advises that he needs to go to hospital for further investigation. The patient explains to the GP and ANP that he knows that he isn't well and needs to go to hospital but doesn't want to leave his wife and would need to know that she would be looked after well before he could consider going to hospital.

The GP contacts the co-coordinator at the UCRH who records all the relevant information and confirms that this will be passed to Emergency Social Work colleagues who will undertake an urgent assessment and liaise directly with Home Care services to put in place a response to keep his wife safe and at home whilst he receives hospital care. The co-coordinator also confirms that the UCRH will provide update on progress to the patient and also to the GP when this has been completed. The GP and ANP are able to leave the patient, with advice should his symptoms worsen, and proceed to their next visit.

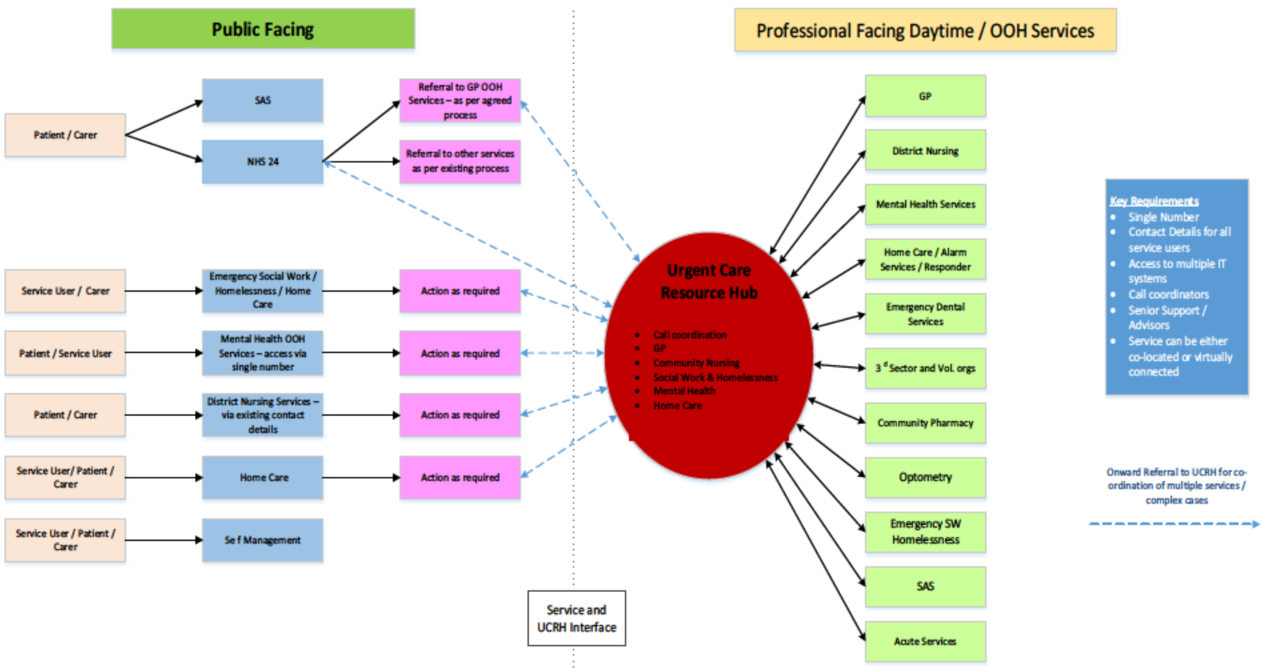
The outcome and enabler of the UCRH in this scenario is:

- *The patient will receive the care that is needed, when care package is in place, which will prevent further deterioration of his condition*
- *Increased effectiveness of our workforce resource*
- *An unnecessary social care admission for the patient's wife is prevented, even if the husband ends up having to be admitted to hospital*
- *The complexities of existing cross system access routes and arrangements is eradicated through the coordination of services via the UCRH*

Proposed Model - Outcomes of Implementation and Enablers to support implementation

Outcomes	Enablers to support implementation
• Supports Direct Access for professionals to other parts of the system as required, bypassing NHS 24 • Maintains existing contact arrangements and process for known patients, service users and carers • Describes NHS 24's relationship with the UCRH and wider Health and Social Care OOHs Services • Clarifies the added value benefits of the UCRH • Highlights the self management aspect of Health and Social Care OOHs Services • Supports integrated and cross system working during the OOHs period and co-ordination between in- hours and OOHs.	• Operational processes, systems and procedures not yet confirmed – this includes determining if services should be virtually or co-located • An UCRH options appraisal requires to be undertaken to determine the number and location(s) of the UCRH(s)

The Proposed Model – Health and Social Care Services and Urgent Care Resource Hub Interface



6. Confirming the Next Steps to finalise Greater Glasgow and Clyde's Review of Health and Social Care OOHs

6.1 The proposed key changes which will support the implementation of an Urgent Care Resource Hub across Greater Glasgow and Clyde have been agreed by members of the Review of Health and Social Care OOHs Programme Board who oversee this work on behalf of the 6 HSCP Chief Officers. It is acknowledged that further work is required prior to implementation which is described in 4 key phases.

6.2 The phased actions have been identified as:

Phase 1 – Immediate Actions (November 2018 – December 2018) – Now complete

- Chief Officers endorsed this model and approved next steps to support finalising the review phase of Health and Social Care OOHs

- The programme governance structures for the OOHs review have been updated and revised to support the planning and implementation phases. This has taken account of other relevant programmes of work e.g. Development work being undertaken by NHS 24 colleagues, Moving Forward Together, Primary Care Implementation Plans and considered areas of work that could be progressed collaboratively e.g. Workforce planning and E-Health /Technology requirements.

Phase 2 – Current Actions (January – March 2019)

- Undertake UCRH Options Appraisal across the Health and Social Care OOHs System. This will develop options which will consider the: number of UCRH(s) required and where they will be located; confirm service and agency access and pathways to the UCRH; determine if services should be co-located within the UCRH or virtual links established and how hosted services will be configured within the model. Further understanding to quantifying the volume of complex cases / people with specific needs will be required to inform the modelling. This will be linked into the work plans being progressed by the work streams underpinning the Review of Health and Social Care OOHs programme of work.

- Revise and update the Communication and Engagement Strategy which supports the recommendations of the UCRH Options Appraisal. It is important that this links with all other relevant programmes of work across the NHS Board, for example, Moving Forward Together, Primary Care Improvement Plans, Mental Health Re-design, UCC to ensure consistent key messages are being delivered regarding access and use of services. It is essential that we also consider how we engage and communicate with our more vulnerable and diverse communities as part of this work;

- Present all proposed models to the Expert Reference Group. Members of the Review of Health and Social Care OOHs Expert Reference Group have had an opportunity to review and comment on all options developed. Sharing the proposals with a more appropriate representative of the population is needed, e.g. younger adults and this is a crucial aspect of our public engagement work;

- Develop a risk management framework, which considers all possible consequences of the configuration of an UCRH and work in partnerships with services across the system to describe and establish appropriate mitigation actions;

- Recognising the potential impact of the proposed change of the change for members of the Board’s population, undertake a strategic EQIA to ensure that consequences and risks of the proposals are identified and control measures identified;

- Develop a Staff Engagement Plan, supported by members of our staff partnership, which will develop an understanding of the operational detail of the systems, processes and procedures required for an UCRH;

- Scope and map the pathway requirements of People with Specific Needs work for the UCRH and determine other work underway across the Board area and how it relates to this.

<u>Phase 3 – Next Steps to June 2019</u>

The impact of this work will result in a revision of configuration of Health and Social Care OOHs Services and therefore further development work is needed to:

- Develop an Integrated Workforce Plan. Maximising the contribution of our Health and Social Care workforce and challenging the existing boundaries is essential to develop and transform roles to meet the current and future needs of GG&C’s health and social care OOHs system. Recognising the intrinsic links between daytime and OOHs a workforce plan which supports the system will help to create and secure a sustainable MDT workforce to meet the immediate and future needs. Workforce planning, recruitment and retention is a high priority to ensure safety and sustainability. We help develop an enhanced understanding of the specific roles or tasks across the professions and services to determine where there is an opportunity, or a need, to do things differently. It will be essential that the future provision of OOHs services is not stilted by existing professional and service boundaries. Developing an integrated workforce planning approach will allow us to better meet and respond to the needs of local areas and communities;

- Revise and update the Communication Strategy which supports the recommendations of the UCRH Options Appraisal.

Phase 4 – Developing the Implementation Plan (July - September 2019)

- Members of the Review of Health and Social Care OOHs Programme Board agree the Implementation Plan which outlines the required steps for UCRH implementation;

- Develop a proposal for evaluating impact of the UCRH across the Health and Social Care system.

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 9

East Dunbartonshire HSCP Schedule of Topics / HSCP Board Development and Seminars Agenda Items HSCP Board meetings May 2019 to June 2020

Updated 20/05/2019

HALF DAY DEVELOPMENT SESSION
Thursday 3rd October 2019 - Review of Business Plan and future priorities
STANDING ITEMS (every meeting)
Expressions of Interest
Minutes of last meetings (SM)
Chief Officers Report (SM)
HSCP Board agenda items for - 28th May 2019
Topic Specific Seminar - Children's Services – start time 9am
ED HSCP Primary Care Improvement Plan – Implementation Position
Glasgow & Clyde Review of OOH Health & Social Care
MSG Self Evaluation
Transformation Board Business Plan 2019/20
Review of Winter Plan 2018/19
Future Chairing arrangements
HSCP Board agenda items for - 27th June 2019
Day Care Strategy – East Locality Implementation Update
Draft Annual Performance Report
Public Dental Service Review
Workforce Plan
Home Care Review
Strategic Inspection of Adult Services

East Dunbartonshire Health & Social Care Partnership

Alcohol and Drugs Partnership Work plan
Sexual Health Report
Clinical and Care Governance Annual report
Self Directed Support
LD Strategic Review
Financial Performance Budget 2018/19
Financial Planning 2019/20 Update
Public, Service User & Carer (PSUC) Representative Support Group report including PSUC Evaluation Report
Clinical & Care Governance Sub Group minutes of
East Dunbartonshire HSCP Staff Partnership Forum minutes of meeting of 18th March 2019
East Dunbartonshire Draft Performance, Audit & Risk Committee Minutes of
The Community Care (Personal Care and Nursing Care) (Scotland) Amendment (No. 2) Regulations 2018 (Frank's Law)
Community Care (Personal Care and Nursing Care) (Scotland) Amendment (No. 2) Regulations 2018 (Frank's Law)
Topics Planner
HSCP Board agenda items for - 5th September 2019
Climate Change report update
Quarterly Performance Report Q3 and Q4
Autism Strategy 2014 – 2024 Refresh
Strategic Review of Learning Disability Services
Strategic Review of Children & Families service
Oral Health Performance report
Chief Social Work Officer's Annual Report 2018 – 2019

HSCP Board Meeting - 14th November 2019
Quarterly Performance Report
Winter Plan
Home for Me and Caring Together
HSCP Board agenda items - 23rd January 2020
Topic Specific Seminar – Public Health Reform
Quarterly Performance report Q2 (JC)
HSCP Board agenda items - 26th March 2020
Topic Specific Seminar - To be agreed