For meeting on
**22 June 2017**

# Agenda 2017

# East Dunbartonshire Health & Social Care Partnership

NHS
Greater Glasgow and Clyde

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East Dunbartonshire Health & Social Care Partnership

A meeting of the East Dunbartonshire Health and Social Care Partnership Integration Joint Board will be held within the **Committee Room, 12 Strathkelvin Place, Kirkintilloch, G66 1XT** on **Thursday, 22ND June 2017** at **9.30 am** to consider the undernoted business.

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

12 Strathkelvin Place
KIRKINTILLOCH
Glasgow
G66 1XT

Tel: 0141 232 8237
Date: 15th June 2017

**A G E N D A**

Sederunt and apologies

Any other business Chair decides if urgent

Signature of minute of meeting HSCP Board held on **23 March 2017**

**Seminar: None**

| Item | Contact officer | Description | Page |
|---|---|---|---|
| | | **STANDING ITEMS** | |
| | Ian Fraser | Appoint Vice Chairperson | |
| 1. | Ian Fraser | Expressions of Interest | |
| 2. | Martin Cunningham | Minute of HSCP Board – 23 March 2017 (Copy herewith) | **1 - 8** |
| 3. | Susan Manion | Chief Officers Report | **9 - 18** |
| | | **GOVERNANCE ITEMS** | |
| 4. | Sandra Cairney | HSCP Freedom of Information Publication Scheme | **19 - 40** |
| 5. | Jean Campbell | Financial Out turn and Annual Accounts 2016/17 | **41 - 96** |
| 6. | Fiona McCulloch | Draft Annual Performance Report 2017 | **97 - 120** |

| | | | |
|---|---|---|---|
| 7. | Fiona McCulloch | Quarter 4 Performance Report | **121 - 134** |
| 8. | Frances McLinden | a. NHS GG&C Oral Health Report<br>b. East Dunbartonshire HSCP Oral Health Report | **135 - 182** |
| 9. | Lisa Williams | Clinical & Care Governance Minutes | **183 - 188** |
| 10. | Tom Quinn | Joint Staff Partnership Minutes | **189 - 192** |
| 11. | Sandra Cairney | Service User and Carer Representative Group Progress Report including a verbal update from the Group on any issues to report | **193 - 198** |
| 12. | Andy Martin | Update on Intermediate Care and Delayed Discharges | **199 - 204** |
| | | **STRATEGIC ITEMS** | |
| 13. | Jean Campbell | 2017/18 Revenue Budget Update and Directions to East Dunbartonshire Council and NHS Greater Glasgow & Clyde | **205 - 220** |
| 14. | Jean Campbell | Scottish Living Wage Update | **221 - 224** |
| 15. | Andy Martin | Unscheduled Care Commissioning Plan | **225 - 236** |
| 16. | Andy Martin | Strategic Review of Day Care Services for Older People | **237 - 244** |
| 17. | Andy Martin | Review of Out of Hours Services & Urgent Care | **245 - 268** |
| 18. | Sandra Cairney | Integrated Children's Plan (2017-20) | **269 - 288** |
| | | **ITEMS FOR NOTING** | |
| 19. | Susan Manion | Strategic Planning Group Action Minutes | **289 - 292** |
| 20. | Paolo Mazzoncini | Scotland Child Abuse Enquiry | **293 - 384** |
| 21. | Fiona McCulloch | Local Review of Winter 2016-17 | **385 - 400** |
| 22. | Susan Manion | HSCP Future Agenda Items | **401 – 402** |
| | | Date (s) of next meeting<br><br>**Thursday 31st August 2017 - 09.30am, Council Committee Room, Southbank Marina**<br><br>**9th November 2017**<br>**11th January 2018**<br>**15th March 2018**<br>**10th May 2018** | |

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| | | **28th June 2018**<br><br>**Seminar's will be held on <u>31/8/17, 12/1/18 and 10/5/18</u> all commencing at 9am** | |

Minute of meeting of the Health & Social Care Partnership Board held within the Committee Room, 12 Strathkelvin Place, Kirkintilloch on **Thursday, 23 March 2017.**

Voting Members Present: EDC Councillors **GEEKIE and MCNAIR**

NHSGGC Non-Executive Directors **LEGG & RITCHIE**

Non-Voting Members present:

| | |
|---|---|
| S. **Manion** | Chief Officer - East Dunbartonshire HSCP |
| M. **Brickley** | Service User Representative |
| W. **Hepburn** | Professional Nurse Adviser |
| P. **Mazzoncini** | Chief Social Work Officer |
| A. **McDaid** | Staff Partnership Forum - Secretary |
| C. **Shepherd** | Carers Representative |

Rhondda Geekie (Chair) presiding

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|---|---|---|
| Also Present: | G. **Cornes** | Chief Executive |
| | F. **Borland** | HSCP Communications |
| | S. **Cairney** | Head of Strategy, Planning & Health Improvement |
| | J. **Campbell** | Chief Finance and Resources Officer |
| | G. **Cameron** | Trades Union Representative |
| | A. **Martin** | Head of Adult & Primary Care Services |
| | L. **McKenzie** | Team Leader – Democratic Services |
| | G. **Notman** | Change & Re-design Manager |

**APOLOGIES FOR ABSENCE**

Apologies for absence were submitted on behalf of Councillor O'Donnell, Ian Fraser, Fiona McCulloch and Lisa Williams.

**CHAIR'S REMARKS**

The Chair advised that she had requested that there a separate item on the Agenda for Carers and Services Users to allow them the opportunity to raise any issues. On this occasion, it would be considered as part of Agenda Item 11 (Paragraph 11, below, refers).

**1. MINUTE OF MEETING – 26 JANUARY 2017**

There was submitted and noted minute of the meeting of the HSCP Board held on 26 January 2017.

## 2. CHIEF OFFICER'S REPORT

The Chief Officer submitted a Report HSCP 2016/17-02, copies of which had previously been circulated, which summarised the national and local developments in relation to the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 since the last meeting of the Partnership Board. Details from the Report included:-

- An update on the refurbishment of Kirkintilloch Health and Care Centre;
- Highlight our response to the National Health and Social Care Delivery Plan;
- HSCP Communications Plan;
- HSCP Strategic Planning Group;
- NHS Greater Glasgow and Clyde Chief Executive.

Following consideration, during the course of which the Chief Officer provided further detail in the content of the Report, the Board noted the Report.

## 3. UNSCHEDULED CARE COMMISSIONING PLAN

The Chief Officer submitted a Report HSCP 2016/17-03, copies of which had previously been circulated, which updated the Health & Social Care Partnership Board on Scottish Government expectations regarding unscheduled care and detailed HSCP and cross system work to develop a commissioning plan for unscheduled care for 2017/18 and beyond.

Following discussion, the Board agreed as follows:-

a) to approve the East Dunbartonshire Unscheduled Care Commissioning Plan for implementation 2017/18; and

b) to approve the HSCP's commitment to whole system planning across Greater Glasgow & Clyde to further develop and implement shifts in the balance of care.

## 4. PROCESS FOR DEVELOPING STRATEGIC PLAN 2018 - 2021

Report HSCP 2016/17-04 by the Chief Finance & Resources Officer, copies of which had previously been circulated, described the process and timeline for developing the East Dunbartonshire HSCP Strategic Plan 2018-21.

In accordance with the Public Bodies (Joint Working) (Scotland) Act 2014, the first East Dunbartonshire HSCP Strategic Plan covered the period 2015-18. Therefore, a replacement Plan was required for the three year period 2018-21.

The Act prescribed that the Strategic Planning Group (SPG) support the preparation of the Strategic Plan and subsequent reviews and monitoring arrangements. Rather than prescribing formal consultation on the Strategic Plan, the Act stated the content of the Plan and identified priorities which would be presented and consulted upon within the SPG. This paper described the process and timeline for developing the Strategic Plan 2018-21, in accordance with the requirements set out in the Act.

In response to a request from Councillor Geekie regarding feedback being back to the Partnership for discussion, the Head of Strategy, Planning & Health Improvement advised that this could be built in to the process.

Following further consideration, the Board noted the Report.

## 5. FINANCIAL PLANNING 2017/18

Report HSCP 2016/17-05 by the Chief Finance & Resources Officer, copies of which had previously been circulated, updated members on the financial allocations from partner agencies which would inform the level of funding available to the partnership to deliver on its strategic priorities for 2017/18.

The Chief Finance & Resources Officer provided members with further detail on the content of the Report. Councillor Geekie advised that, as an individual, she had written to Mr Robert Calderwood, Chief Executive of the NHS, advising that she did not accept the principles behind the proposed allocation from the NHS to the HSCP>e. There then followed full and detailed discussion with regard to the allocations from both the NHS and East Dunbartonshire Council. The Chief Officer was heard in response to members' questions. The Chief Finance Resources Officer advised that as work progressed she would bring back further reports to the Board. It was agreed that the recommendation be amended to reflect discussion.

Following further consideration, the Board agreed as follows:-

a) to note the detail of the allocation from GG&C NHS Board and the impact this would have on the partnership's ability to deliver on the strategic priorities set out for the HSCP and not accept at this stage the offer made by the NHS Board on the basis outlined in 4.21 of the Report;

b) to instruct the Chief Officer to formally write to the NHS Board Chief Executive to advise of the IJB decision and progress further discussions to reach an acceptable settlement for the partnership for the services delegated by NHS GG&C.

c) to note the detail of the allocation from East Dunbartonshire Council and the impact this would have on the partnership's ability to deliver on the strategic priorities set out for the HSCP and accept the offer made by East Dunbartonshire Council;

d) to note the Council's position that, as a last resort, the Council's reserves were available to underwrite any unmet demand pressures;

e) to approve the savings proposals outlined in 4.12 and 4.13 of the Report, subject to further detailed reports to the Board, in respect of Social Work services and 4.23 in respect of community health services;

f) to note the risks to the partnership in meeting the service demands for health & social care and progressing with the strategic priorities set out in the plan; and

g) to note that further Reports would be brought back to the Board and Council.

## 6. FINANCIAL PERFORMANCE – UPDTAE REPORT – MONTH 10

Report HSCP 2016/17-06, by the Chief Finance & Resources Officer, copies of which had previously been circulated, updated members on the projected outturn for the Health & Social Care partnership for 2016/17.

Following consideration, the Board noted the projected outturn position for the HSCP for 2016/17 and the risks to the projected out turn detailed in 4.15 of Report.

## 7. STRATEGIC REVIEW OF DAY CARE SERVICES FOR OLDER PEOPLE

The Head of Adult and Primary Care services submitted Report HSCP 2016/17-07, copies of which had previously been circulated, which described the findings and outcomes of a recent review of older peoples' day services conducted to establish an effective, quality assured and sustainable model of service that would contribute to the overall strategic aim of enabling older people with complex needs to live safely and independently at home or in a homely setting.

There followed full and detailed discussion on various aspects of the Report during the Head of Adult & Primary Care Services was heard in response to members' questions and outline the detail of the engagement process. The Chief Officer also responded to members questions in respect of the process, staff appointments and voluntary sector involvement. She advised that officers would report back with specific and detailed proposals. The Report before members sought approval for the broad principles and direction of travel.

Following further consideration, the Board agreed as follows:-

a) to note the content of the Report;

b) to approve both the broad principles and direction of travel set out within the Report;

c) to note that the Board was not in a position at this stage to approve the proposals to establish Local Area Coordinator posts and that a follow-on report be brought back to the Board; and

d) to move to a two centre locality model for formal day care as outlined within the Report.

## 8. PROPOSAL TO RELOCATE PODIATRY SERVICES FOR BISHOPBRIGGS

The Head of Adult & Primary Care presented Report HSCP 2016/17-8, copies of which had previously been circulated, which advised the Board of changes proposed by NHS Greater Glasgow & Clyde Podiatry to service arrangements for the Bishopbriggs area. Furthermore, it outlined the service user consultation that would be taken forward in respect of these changes.

During the course of discussion, Councillor McNair requested further information in respect of the outcome of the consultation. Councillor Geekie advised that officers report back.

Following further consideration, the Board noted the content of the Report.

## 9. INTERMEDIATE CARE PILOT - UPDATE

Report HSCP 2016/17-9 by the Head of Adult & Primary Care, copies of which had previously been circulated, advised the Board of the progress of the Intermediate Care Pilot Project established at Westerton Care Home first approved by the Board on 26th May 2016.

The Trades Union Representative advised that a number of figures contained within the Appendix to the Report had changes and an updated copy was tabled. With reference to the Questionnaire, it was noted that the detail could be reported as part of the next update. It was noted that it would also be useful if officers monitored how long clients remain at home thereafter. It was agreed that officers get a sense from the pilot clients on how valuable the service was.

During the course of further discussion, and having heard the Head of Adult & Primary Care in response to members' questions, the Board noted the Report.

## 10. PERFORMANCE REPORT – QUARTER 3

Report HSCP 2016/17-10 by the Chief Officer, copies of which had previously been circulated, presented a summary of the agreed HSCP targets and measures relating to the delivery of the strategic priorities for the period October - December 2016 (Quarter 3).

The Board were advised as follows:-

- Positive Performance (on target) improving (17 measures);
- Positive Performance (on target) declining (2 measures);
- Negative Performance (below target) improving (5 measures);
- Negative Performance (below target) declining (5 measures); and
- There are 9 measures for which data are not available.

A summary of the performance indicators for the reporting period was provided in Section 1 of the Report. The full list of measures and targets were also provided. Section 2 of the report listed the Adult Services data. Section 3 provided the Children's Services data and Section 4 provided the Community Justice data.

During the course of discussion, it was noted that supplementary information could be made available.

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Following further consideration, the Board noted that the Report.

## 11. PUBLIC, SERVICE USER & CARER REPRESENTATIVE SUPPORT GROUP

Report HSCP 2016/17-11 by the Head of Strategy, Planning and Health Improvement, copies of which had previously been circulated, described the processes and actions undertaken in the development of the Public, Service User & Carer Representatives Support Group (PSUCRG).

In total 4 meetings have taken place, the most recent on the 13th February 2017. The PSUCRSG has identified the key resources and mechanisms that members consider central to developing their capacity and understanding to effectively contribute, during the debates and discussions at the HSCP Board, Strategic Planning Group and the two locality Planning Groups. The PSUCRSG have agreed a process to monitor their progress at every meeting, through a RAG process (detailed in Appendix 1 of the report). At the most recent meeting members appointed a Chair to direct and facilitate their support meetings. Members have also received a comprehensive, draft, induction pack for their consideration and comment and completed a self-evaluation of the meeting, a process that will now be imbedded at all subsequent meetings.

Following discussion the Board noted the report.

## 12. HSCP EQUALITIES & DIVERSITY MAINSTREAM REPORT 2017 - 2021

Report HSCP 2016/17-12 by the Chief Officer, copies of which had previously been circulated, sought approval for the HSCP's Equalities and Diversity Mainstream Report 2017-2021, a copy of which was appended to the Report. Councillor Geekie recommended that the Report be referred to the Equalities Engagement Group and that they also be provided with a presentation.

Following further consideration the Board agreed to:

a) approve the HSCP's Equality and Diversity Mainstream Report 2017-2021 as attached to the Report; and

b) to refer the Report to the EDC Equalities Group for consideration and that they also be provided with a presentation.

## 13. BUSINESS CONTINUITY PLANNING

Report HSCP 2016/17-13 by the Chief Officer, copies of which had previously been circulated, sought to assure the HSCP Board that East Dunbartonshire HSCP had the required Business Continuity Planning (BCP) and processes in place. The HSCP BCP and Departmental BCPs were tested on 17th January 2107 through a table-top exercise. Actions and learning from the exercise were being taken forward. The Business Continuity Plan was provided as an attachment.

Following consideration, the Board accepted the assurance provided and noted the attached Business Continuity Plan

## 14. UPDATE OF THE ELIGIBILITY CRITERIA POLICY

Report HSCP 2016/17-14 by the Chief Officer, copies of which had previously been circulated, sought the Board's approval of an update of the Eligibility Criteria Policy which gatekeeps access to all adult and community care services. A copy of the updated Eligibility Criteria Policy was attached as Appendix 1 of the Report.

Following discussion, the Board note and approved the update of language and references to current legislation within the Eligibility Criteria Policy.

## 15. FUTURE HSCP BOARD AGENDA ITEMS

Report HSCP 2016/17-15 by the Chief Officer, copies of which had previously been circulated, presented the undernoted:-

**June HSCP Board**
Service User/Carer Progress Report
Annual Performance Report
Winter Plan Update
Register of Interests
OHD Performance Report

**Subsequent HSCP Board Meetings**
Finance: Approval of Budgets - August
Clinical Governance Annual Report - October
Performance Improvement Report - October
Winter Plan Update – October
Strategic Planning Group Progress Report - December
Chief Social Work Officer Report - December
GP Clusters Update - December
OHD Performance Report - December

Following consideration, during the course of which Councillor McNair requested more regular updates on the Strategic Plan, the Board noted the aforementioned information.

## 16. DATE OF NEXT MEETING – 22 JUNE 2017

The Board noted that the next meeting of the H&SCP would be held on Thursday, 22 June 2017 at 9.30 am within the Committee Room at the Council Headquarters, 12 Strathkelvin Place, Kirkintilloch.

## VALEDICTORY REMARKS

Councillor Geekie advised that Chris Shepherd, Carers Representative, was standing down as a member of the H&SCP and she thanked him for his contribution to the Board.

She also advised that Councillor McNair and O'Donnell were standing down at the Local Government Elections and she would be standing down as Chair. She wished the Board all the best in the future. She advised that Ian Fraser would now be the Chair of the H&SCP and advised that, following the Local Government Elections, an East Dunbartonshire Councillor would be appointed as Vice-Chair.

On behalf of officers, the Chief Officer thanked Councillor Geekie for steering the new partnership through challenging times and thanked her for the support she had given to herself, colleagues and Karen Murray, the previous Chief Officer. She welcomed the collaborative working a clear steer that Councillor Geekie had provided. John Legg thanked Councillor Geekie for welcoming new members on to the HSCP.

**Agenda Item Number: 3**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
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| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Chief Officers Report** |
| **Report By** | **Susan Manion, Chief Officer, East Dunbartonshire Health & Social Care Partnership** |
| **Contact Officer** | **Susan Manion, Chief Officer, East Dunbartonshire Health & Social Care Partnership**<br>**0141 232 8216**<br>**Susan.manion@ggc.scot.nhs.uk** |

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|---|---|
| **Purpose of Report** | To update Board Members on a number of local and national matters of interest |

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| **Recommendations** | To note content |

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| **Relevance to HSCP Board Strategic Plan** | Not relevant |

## Implications for Health & Social Care Partnership

Information relating to the operational arrangements of the Health and Social Care Partnership

| | |
|---|---|
| **Human Resources** | No specific implications |

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| **Equalities:** | No specific implications |

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| **Financial:** | No specific implications |

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| **Legal:** | There will be specific implications relating to item 1.1 The Duty of Candour which will be highlighted to the Board when it returns for approval later in 2017/18 |

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| **Economic Impact:** | No specific implications |

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| **Sustainability:** | No specific implications |

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| **Risk Implications:** | No specific implications |

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| **Implications for East Dunbartonshire Council:** | No specific implications |

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| **Implications for NHS Greater Glasgow & Clyde:** | No specific implications |

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|---|---|---|
| **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 Duty of Candour

From the 1st April 2018, the HSCP must ensure compliance with the duty of candour legislation. This requires us to be open, honest and supportive when there is an unexpected or unintended incident as defined in the Act.

As a Partnership we must act in accordance with the arrangements established for both East Dunbartonshire Council and Greater Glasgow and Clyde Health Board. It is our intention, therefore, to develop a protocol which clarifies arrangements for our staff and provides assurance that we are compliant with the legislation on behalf of both the Council and the NHS.

This protocol will come back to the HSCP Board for approval in November but before then, it will be included as a subject for discussion at a future Board development session.

The letter outlining our responsibilities from the Care Inspectorate, Health Improvement

Scotland and the Scottish Government is attached for information **(Appendix1)**

### 1.2 Prescribing Management plans

On the 26th April a Prescribing summit brought together the clinical and prescribing leads across the 6 Health and Social Care Partnerships within GGC Health Board. The intention was to collectively identify priority areas across the Board where we can ensure good practice in prescribing and create efficiencies. An action plan has been produced.

Prescribing budgets are a financial risk to the HSCPs so by working with the Health Board we can encourage the clinicians across primary care as well as the hospital services to prescribe effectively and efficiently. There is a Board wide Prescribing Management Group with responsibility for taking forward this work and I have recently joined as a representative of the HSCP Chief Officers.

This augments our local group within East Dunbartonshire where our prescribing advisor and Clinical Director work closely with local GP practices.

Progress will be reported back to the HSCP Board with a development session programmed during the year to consider the issues involved.

### 1.3 KHCC Accommodation Review

Members are aware the Kirkintilloch Health and Care Centre (KHCC) has undergone an extensive remodelling project. The building provides services from health and social work as well as visiting services/teams which include local voluntary o`rganisations and board wide health services. The project has helped to facilitate joint working and the collocation of integrated teams. It has also helped the move to smart working into all the floors. The work has resulted in a redesign of the reception area to make it more user friendly. Advice from our service users influenced the final design.

Teams that had to be decanted to the Marina and Southbank, along with some additional managers returned to KHCC on the 5th June. The Care at Home service move in the week beginning the 12th June. The plan is that the Community Rehabilitation team and the District Nurses will move together from the 1st to the 2nd Floor in the middle of July. This will allow the Joint Learning Disability team to move in to the 1st Floor from Enterprise House.

### 1.4 Business Continuity Planning

Following the terrorist event at Manchester Arena on the 22nd May, the UK Government determined the threat level within the UK from International Terrorism be raised to critical meaning an attack was considered to be imminent. This required the HSCP to work within the agreed Emergency Planning arrangements for both the Council and NHS.

Immediate measures were taken including reminding staff to display identification and check public areas. The importance of staff vigilance has been reiterated. The threat level was returned to severe on the 27th May and continues following the terrorist attack in

London on the 3rd June.

The HSCP Board at its meeting in March noted that an HSCP Business Continuity plan was established and will reviewed following recent events.

### 1.5 Review of Rehabilitation Services in North East Glasgow

A Review of the provision of Hospital-based Rehabilitation across NHS GG&C is in the final stages of consultation. A rationalisation of resources is proposed which impacts on Lightburn Hospital. This direction of travel reflects recent HSCP developments including the increased availability of intermediate care and other community based rehabilitation options. Whilst East Dunbartonshire has not been a major user of Lightburn Hospital in recent times, the shifts in the balance of care has seen more rehabilitation services based in the community to support more people. As part of the evaluation of our Intermediate Care pilot, we will analyse in detail the increase across the board, of demand upon our community rehabilitation resources. This analysis will be factored into our ongoing Unscheduled Care Commissioning Strategy.

### 1.6 The Care Inspectorate

The Care Inspectorate carried out inspections of a number of our care services recently. They visited our children's home, Ferndale, and the associated outreach service in February 2017. They then inspected our Community Support Team's care at home service provided to children and their families in March 2017. Finally in April 2017, our Home Care mainstream housing support service was inspected.

The results are positive as outlined in **Appendix 2** which sets out the grades, recommendations and requirements the Care Inspectorate awarded to the services. Where appropriate, our services completed improvement action plans to address the Care Inspectorate's concerns.

**8 February 2017**

**Duty of Candour implementation**

As you will be aware, the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 received Royal Assent on 1 April 2016 and introduced a new organisational duty of candour on health, care and social work services. This duty will apply to almost ten thousand organisations. Annex A gives a full list of the services to whom the duty applies. The implementation date for the duty of candour to come into effect is 1 April 2018.

The overall purpose of the new duty is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm, as defined in the Act. This duty requires organisations to follow a duty of candour procedure which will include notifying the person affected, apologising and offering a meeting to give an account of what happened. The procedure will also require the organisation to review each incident and offer support to those affected (people who deliver and receive care). The details of this procedure will be set out in Regulations which will be published prior to 1st April 2018. Organisations will have a new requirement to publish an annual report on when the duty has been applied. This will include the number of incidents, how the organisation has complied with the duty and what learning and improvements have been put in place.

An implementation structure has been set up to oversee this work, with representatives from a broad range of health and social care organisations. To assist you to meet these new requirements the Scottish Government, Healthcare Improvement Scotland (HIS), the Care Inspectorate (CI), Scottish Social Services Council (SSSC) and NHS Education for Scotland (NES) are working in partnership with a wide range of stakeholders to design and develop education and training resources and monitoring requirements to support organisations meet the new statutory duty of candour.

Annex B gives some questions and answers which you may wish to consider when planning local implementation of the duty. If you have any further questions, please do not hesitate to email dutyofcandour@gov.scot

A dedicated webpage with Frequently Asked Questions has been established. Regulations and guidance, examples of duty of candour templates and local policies will be added during 2017.

As Care Inspectorate and Healthcare Improvement Scotland already have existing eForms systems for regulated health and social care services, the intention is to align existing processes and systems as far as possible to minimise paperwork whilst still ensuring that the organisational duty is being applied through a culture of openness and learning.

Further information and updates will be issued as this work progresses.

Yours sincerely,

**Professor Craig White**
Divisional Clinical Lead, Planning & Quality Division
The Scottish Government

**Claire Sweeney,**
Interim Director of Quality Assurance
Healthcare Improvement Scotland

**Rami Okasha**
Executive Director of Strategy and Improvement
Care Inspectorate

**ANNEX A**

Duty of Candour: organisations covered by the Act

- NHS Boards
- Scottish Ambulance Service
- State Hospital
- Golden Jubilee
- GP services
- Dentistry
- Glasgow Dental Hospital
- Pharmacy
- Optometry
- Independent hospitals and hospices
- Private psychiatric hospitals
- Independent clinics
- Independent medical agencies
- Independent ambulance services
- Support services
- Care home services
- School care accommodation service
- Nurse agencies
- Child care agencies
- Secure accommodation services
- Offender accommodation services
- Adoption services
- Fostering services
- Adult placement services
- Day care of children
- Housing support services
- Social work services offered by or on behalf of local authorities

**ANNEX B**

Points to consider

1. How will your organisation identify the incidents that trigger the Duty of Candour procedure, as outlined in section 21? Have you satisfied yourself that you understand your responsibilities and have systems in place to respond effectively?
2. Who do you need to engage with to satisfy yourselves you can meet the responsibilities of the Duty and deliver the requirements outlined in the Act?
3. What systems do you have in place to support staff to provide an apology in a person-centred way and how do you support staff to enable them to do this?
4. Do your current systems and processes provide you with the information required to report on the Duty of Candour? How will you align this annual report with other reports you are required to provide such as feedback and complaints, significant events reviews, case reviews etc.?
5. What training and education do you have at present that will support the implementation of the Duty? This could be training that considers issues such as how to give an apology, being open, meetings with families, dealing with difficult situations. You should also consider national training that is available freely to your staff such as e-learning opportunities.
6. What support do you have available for people involved in invoking the procedure (staff) and those affected (staff and service users)?
7. How do you currently share lessons learned and best practice around incidents of harm? Could this be improved in any way?

Useful links

The links below include an example of a local duty of candour policy in England. Although the legislation differs (there is no requirement for an annual report, a written apology must be given, definitions of harm are based on national patient safety agency), the policy intention is the same: to be open and honest with service users, regulators and the general public.

Executive summary of the Mid-Staffordshire Inquiry:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

Case of Robbie Powell, whose father campaigned for a duty of candour
https://www.theguardian.com/society/2006/jan/04/health.healthandwellbeing

Sample policy from The Children'sTrust:
https://www.thechildrenstrust.org.uk/media/images/IncidentReportingInvestigationIncludingDutyofCandourPolicy_1183.pdf

## APPENDIX 2

**TABLE 1 – CARE INSPECTORATE GRADES, RECOMMENDATIONS AND REQUIREMENTS**

| Service | Inspection Areas | Grades | No of Recommendations and specific areas for improvement | No of Requirements and specific areas for improvement |
|---|---|---|---|---|
| Ferndale Children's Home | Quality of care and support<br><br>Quality of staffing | Good<br><br>Good | 3. Adherence to Social Services Council Codes of Practice; Clarity about the role of external manager and scrutiny; and child protection training for staff. | 1. To improve practice around notifications to Care Inspectorate |
| Ferndale Outreach Service | Quality of care and support<br><br>Quality of staffing<br><br>Quality of management and leadership | Good<br><br>Good<br><br>Good | 2. Clarity about the role of external manager and scrutiny; Conducting staff appraisal reviews in line with policy | 1. Preparation of a written plan which sets out how the service user's health, welfare and safety needs are to be met. To be completed within 28 days. |
| Community Support Team | Quality of care and support<br><br>Quality of staffing | Very Good<br><br>Very Good | 1. Ensuring all service users are involved in developing working agreements and personal plans. Written copies should be provided to people being supported. | Nil |
| Home Care Housing Support | Quality of care and support<br><br>Quality of management and leadership | Very Good<br><br>Very Good | Nil | Nil |

East Dunbartonshire Health & Social Care Partnership

**Chief Officer**
**Susan Manion**

**Agenda Item Number: 4**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **HSCP Freedom of Information Publication Scheme** |
| **Report By** | **Sandra Cairney, Head of Strategy, Planning & Health Improvement, East Dunbartonshire Health & Social Care Partnership** |
| **Contact Officer** | **Sandra Cairney , Head of Strategy, Planning & Health Improvement**<br>**0141 232 8233**<br>**Sandra.cairney@ggc.scot.nhs.uk** |

| | |
|---|---|
| **Purpose of Report** | To provide the HSCP Board with a draft Freedom of Information Guide to the Publication Scheme & Classes of Publications. |

| | |
|---|---|
| **Recommendations** | The HSCP Board is requested to approve and adopt the Freedom of Information Guide to the Publication Scheme & Classes of Publications. |

| | |
|---|---|
| **Relevance to HSCP Board Strategic Plan** | The attached document forms part of the HSCP Board's governance arrangements It ensures robust arrangements are in place to support strategic and operational oversight accountabilities and responsibilities. |

**Implications for Health & Social Care Partnership**

| | |
|---|---|
| **Human Resources** | All health and social care staff are required to comply with the HSCP Freedom of Information Guide to the Publication Scheme & Classes of Publications, as well as EDC and NHSGGC Freedom of Information Guide to the Publication Scheme & Classes of Publications. |

| | |
|---|---|
| **Equalities:** | Fair policies for employees |

| | |
|---|---|
| **Financial:** | Nil |

| | |
|---|---|
| **Legal:** | Compliance by employees with employing organisational policies |

| | |
|---|---|
| **Economic Impact:** | Nil |

| | |
|---|---|
| **Sustainability:** | Nil |

| | |
|---|---|
| **Risk Implications:** | Non compliance |

| | |
|---|---|
| **Implications for East Dunbartonshire Council:** | East Dunbartonshire Council Social Work employees will be expected to comply with this HSCP Freedom of Information Guide to the Publication Scheme & Classes of Publications with immediate effect. |

| | |
|---|---|
| **Implications for NHS Greater Glasgow & Clyde:** | Community Health employees will be expected to comply with this HSCP Freedom of Information Guide to the Publication Scheme & Classes of Publications with immediate effect. |

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

## 1.0 MAIN REPORT

**1.1** The Freedom of Information (Scotland) Act 2002 (the Act) requires Scottish public authorities to adopt and maintain a publication scheme.

**1.2** The HSCP is under a legal obligation to: (i) publish the classes of information that they make routinely available

**1.3** The East Dunbartonshire Health & Social Care Partnership Board **(Appendix 1)** has adopted the **Model Publication Scheme (2016)** produced and approved by the Scottish Information Commissioner.

**APPENDIX 1**

# EAST DUNBARTONSHIRE
# HEALTH & SOCIAL CARE PARTNERSHIP

# FREEDOM OF INFORMATION GUIDE
# TO THE PUBLICATION SCHEME
# & CLASSES OF PUBLICATIONS

**VERSION 3 - 15 March 2017**

# CONTENTS

# PART ONE

## SECTION 1: Introduction and Publication Scheme Guidance

1. The Freedom of Information (Scotland) Act 2002 (the Act) requires Scottish public authorities to adopt and maintain a publication scheme. Authorities are under a legal obligation to: (i) publish the classes of information that they make routinely available.
   (i) Publish the classes of information they make routinely available.
   (ii) tell the public how to access the information they publish and whether information is available free of charge or on payment.
2. The Act also allows for the development of model publication schemes which can be adopted by more than one authority. This Model Publication Scheme has been produced and approved by the Scottish Information Commissioner; it is approved until 31 May 2019.
3. The Commissioner has issued this guide to accompany this model scheme www.itspublicknowledge.info/MPS. This is essential reading for authorities adopting the model scheme: it explains the requirements of the scheme in detail and provides lists of types of information the Commissioner expects authorities will publish.

**Definition of "published" information**

4. For the purpose of this Publication Scheme, to be published", information must be;
   (i) Already produced and prepared and
   (ii) Available to anyone to access easily without having to make a request for it.
5. Research and information services which involve the commissioning of new information are not "publications".
6. Research and information services which involve the commissioning of new information are not "publications".

East Dunbartonshire Health & Social Care Partnership Board (HSCP Board) has adopted the **Model Publication Scheme (2016)** which has been produced and approved by the Scottish Information Commissioner. .

Information can be provided in differing formats. This FOI Publication Scheme can be viewed on the Health & Social Care Partnership (HSCP) website at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership . If a hard copy of the HSCP Publication Scheme is preferred, this can be requested in writing to the HSCP.

**The purpose of the Guide to information is to:**

- allow the public to see what information is available (and what is not available) for the HSCP Board in relation to each class in the HSCP Freedom of Information Publication Scheme (2016).
- state what charges may be applied.
- explain how to find the information easily
- provide contact details for enquiries and to get help with accessing the information
- explain how to request information that has not been published.

## SECTION 2: About East Dunbartonshire Health & Social Care Partnership Board

The East Dunbartonshire Integrated Joint Board, known as the Health &Social Care Partnership Board (HSCP Board), was established in September 2015 and was later revised in September 2016 to encompass NHS Children's Services, Children's Social Work Services; Criminal Justice Social Work Services.

As a corporate body under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014, it is one of 29 Integration Boards each coterminous with that of local authorities. The HSCP Board is responsible for the strategic planning and operational oversight of health and social care services described in full within the Scheme of Integration **[3A]** https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership . The HSCP works in co-operation with other HSCP Boards, the NHS Board, East Dunbartonshire Council and other agencies in planning and commissioning health and social care services. It is intended that these arrangement improve the outcome for patients, service users, carers and their families.

### The Health & Social Care Partnership Board

The HSCP Board has its principle offices at Kirkintilloch Health & Care Centre, 10 Saramago Street, Kirkintilloch, G66 3BF. Contact should be made through the Head of Administration who acts as the Freedom of Information Officer for the organisation.

Telephone: 0141 232 8237

Email: Louise.Martin2@ggc.scot.nhs.uk or website;

https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership

The Board is referred to as the East Dunbartonshire Health & Social Care Partnership Board (HSCP Board). The HSCP Board draws on staff from the Council and Health Board in order to support the Board in delivering it objectives.

### HSCP Board membership

The HSCP Board comprises of 16 members as follows:

- 3 Elected members (voting members)
- 3 NHS non executive members (voting members)
- 1 Voluntary Sector Representative
- 1 Service User Representative
- 1 Carers Representative
- 1 Professional Nurse Advisor
- provide contact details for enquiries and to get help with accessing the information
- 1 Chief Social Work Officer
- 1 Clinical Lead Representative
- 1 Acute Representative
- 2 Trade Union Representatives
- Chief Officer ED HSCP

## SECTION 3: Accessing Information under the Guide

### Availability and formats

Information published through the model scheme should, wherever possible, be made available on the HSCP website. Alternative arrangements are offered for people who do not want to, or cannot, access the information online or by inspection at our premises. The HSCP may for example, arrange to send out information in paper copy on request (although there may be a charge for doing so). If individuals have any difficulty identifying the information they want to access, they can contact the HSCP for assistance (see section 2 for contact details).

### Exempt information

If information described by the classes cannot be published and is exempt under Scotland's freedom of information laws (for example sensitive personal data or a trade secret), the HSCP may withhold the information or provide a redacted version for publication, but an explanation must be provided as to why it has done so.

## SECTION 4: Information the HSCP may withhold

All information covered by the HSCP Guide to Information can either be accessed through the website, or can be provided promptly following receipt of a request. The HSCP's aim in adopting the Commissioner's Model Publication Scheme 2016 and in maintaining this Guide to Information is to be as transparent as possible. However, there may be limited circumstances where information will be withheld from one of the classes of information. Information will only be withheld where the Act (or, in the case of environmental information, the EIRs) expressly permits it. Information may be withheld for example where its disclosure would break the law of confidentiality, harm organisations commercial interest or endanger the protection of the environment.

## SECTION 5: Charging policy

This section explains any charges which will comply with both NHS GG&C and East Dunbartonshire Local Authority Charging policies.

Requests will be considered under the Re-use of Public Sector Information Regulations 2005, which may provide the right to impose a charge. In the event that a charge is payable applicants will be advised what this is and how it is calculated

There is no charge to view information on the HSCP website, at the HSCP Headquarters (except where there is a statutory fee, for example to access registers), or where it can be sent electronically by email.

The HSCP may charge for providing information, for example photocopying and postage, but we will charge no more than it actually costs. The HSCP will always clarify what the cost will be prior to providing the information.

### NHS GGC Charging Costs

Photocopying charges per sheet of paper are shown in the table below.

| Size of paper/alternative format | Black & White<br>Pence per sheet | Colour<br>Pence per sheet |
|---|---|---|
| A4 | 10p | 20p |
| A3 | 20p | 40p |
| Postage | Charged at the cost to the HSCP of sending the information by first class | |

When providing copies of pre-printed publications, the HSCP will charge no more than the cost per copy of the total print run. The HSCP will not pass on any other costs in relation to the organisation's published information.

### East Dunbartonshire Council Charging Costs

| **Reproduction costs** | |
|---|---|
| Black and white copy | 10p per A4 sheet |
| Colour copies | 30p per sheet |
| **Alternative formats** | |
| **Postage** | |
| Charged at the cost to the Council of sending the information by first class | |

## SECTION 6: Copyright and re-use policy

East Dunbartonshire HSCP Board holds the copyright for much of the information in the Publication Scheme. All of this information can be copied or reproduced without our formal permission providing it is copied or reproduced accurately; is not used in a misleading context; is not used for profit; and the source of the material is acknowledged.

Providing access to information does not mean that copyright has been waived, nor does it give the recipient the right to re-use information for commercial purposes. If the intention is to re-use information obtained from the Publication Scheme, applicants must ensure they have the right to do so. Request to re-use the information should be directed to: **www.legislation.gov.uk**

**Head of Administration (Freedom of Information)**

East Dunbartonshire Health & Social Care Partnership

10 Saramago Street

Kirkintilloch

Glasgow G66 3BF

Telephone: 0141 232 8237

Email: Louise.Martin2@ggc.scot.nhs.uk

## SECTION 7: Records Management Policy

East Dunbartonshire HSCP Board regards its records as a major asset and one of the essential resources which support its governance, business and legal responsibilities. The HSCP Board will develop and continually review the Records Management and retention Plan **[5C]** which will be applied to the management of corporate information held by the HSCP. Records pertaining to employees and service users/patients will continue to be held and managed by the constituent bodies (EDC and NHSGGC).

## SECTION 8: Contact details for enquiries, feedback and complaints

The HSCP Board has adopted the Model Publication Scheme (2016) and this will be reviewed on an annual basis. The aim is to make the Publication Scheme as user-friendly as possible. The HSCP Board welcomes feedback on how the Publication Scheme can be further improved. Members of the public who would like to comment on the HSCP Board Publication Scheme, or comment or complain that information is not included then please contact:

**Head of Administration (Freedom of Information)**

East Dunbartonshire Health & Social Care Partnership

10 Saramago Street

Kirkintilloch

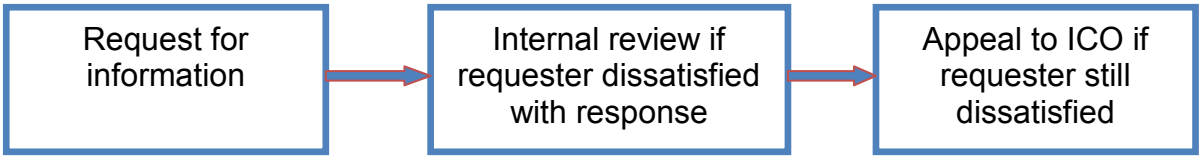
Glasgow G66 3BF

Telephone: 0141 232 8237

Email: Louise.Martin2@ggc.scot.nhs.uk

**Legal Rights to accessing information**

The public have legal rights to access information under the HSCP Board Publication Scheme (2016) and a right of appeal to the Scottish Information Commissioner if they are dissatisfied with the response. These rights apply only to information requests made in writing or another recordable format. The Commissioner's website has a guide to this three step process, and operates an enquiry service on Monday to Friday from 9:00am to 5:00pm.




The office can be contacted as follows:

**Scottish Information Commissioner**

Kinburn Castle

Doubledykes Road

St Andrews

Fife KY16 9DS

Tel: 01334 464610

Email: enquiries@itspublicknowledge.info

Website: www.itspublicknowledge.info/YourRights

## SECTION 9: How to access information which is not available in the Publication Scheme

The Act provides a right of access to the information the HSCP Board holds, subject to certain exemptions. Exemptions such as personal details of staff and Board members are exempt.

If the information being sought is not available through the ED HSCP Publication Scheme (2016), there is the option to request this directly from the HSCP and where appropriate requests will be redirected to either NHSGGC and/or East Dunbartonshire Council.

Requests should be directed to:

**Head of Administration (Freedom of Information)**

East Dunbartonshire Health & Social Care Partnership

10 Saramago Street

Kirkintilloch

Glasgow G66 3BF

Telephone: 0141 232 8237

Email: Louise.Martin2@ggc.scot.nhs.uk

# PART TWO

# FREEDOM OF INFORMATION PUBLICATION SCHEME CLASSES OF INFORMATION

**Document Control Sheet**

| | |
|---|---|
| Lead Manager | Louise Martin |
| Responsible Director | Susan Manion |
| Approved by | HSCP Board |
| Date Approved | 31st March 2017 |
| Date for Review | 31st March 2018 |
| Version | 1 |
| Replaces previous version (if applicable) | n/a |

| **Summary of changes / reviews to document** | | | |
|---|---|---|---|
| **Action by** | **Version updated** | **New version number** | **Brief description** |
| | *(e.g. v01.25-36**)** ***initials*** | *(e.g. v01.27, or 02.03)* | (*e.g. updated paras 1-8, updated on pages and updated, corrected typos, reformatted to new branding*) |
| | | | |
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# PART TWO

## SECTION 10 - Classes of Information

This section details all classes of information contained within the HSCP Publication Scheme.

**Summary of Classes**

| Class | Topic | Description |
|---|---|---|
| 1 | About the HSCP Board | Information about the HSCP Board, who the members are, how to contact the Board, how external relations are managed. |
| 2 | How the HSCP deliver functions and services | Information about the work, strategies and policies for delivering functions and services and information for service users. |
| 3 | How decisions are taken and what is decided | Information about the decisions the HSCP takes, how these decisions are made and how others are involved. |
| 4 | What and how the HSCP spends its budget | Information about the HSCP strategy for, and management of, financial resources (in sufficient detail to explain how the organisation plans to spend public money and what has actually been spent). |
| 5 | How the HSCP manages human, physical and information resources | Information about how the organisation manages the human, physical and information resources. |
| 6 | How the HSCP procures goods and services from external providers | Information about how the organisation procures goods and services and contracts with external providers. |
| 7 | How the HSCP is performing | Information about how the organisation is performing and how well functions and services are delivered. |
| 8 | Commercial publications | Information packaged and made available for sale on a commercial basis and sold at market value through a retail outlet e.g., bookshop, museum or research journal. |
| 9 | Open data | Open data made available by the HSCP as described by the Scottish Government's Open Data Strategy and resource pack, available under an open licence. |

**Summary of Available HSCP Documents**

All of the following documents can be provided on written request to the HSCP. A limited number of documents are available on the HSCP website (ticked below).

| Class | Ref | Document | Website |
|---|---|---|---|
| 1 | A. | Board papers | ✓ |
| | B. | Register of Interests | - |
| | C. | Code of Conduct | - |
| | D. | Scheme of Delegation to Officers | - |
| | E. | Standing Orders | - |
| | F. | Clinical & Care Governance meeting notes | ✓ |
| | G. | Chief Social Work Officer Protocol | ✓ |
| 2 | A. | Strategic Plan | ✓ |
| | B. | Integrated Children's Plan | ✓ |
| | C. | Joint health Improvement Plan | ✓ |
| | D. | Equality Plan | ✓ |
| | E. | Communications Plan (in development) | - |
| | F. | HSCP Risk Management Policy | ✓ |
| | G. | Service User & Carer Engagement Model | ✓ |
| | H. | HSCP FOI Policy (in development) | ✓ |
| | I. | Strategic Needs Assessment | ✓ |
| 3 | A. | Scheme of Integration | ✓ |
| | B. | Strategic Planning Group reports | ✓ |
| | C. | Locality Planning Group reports | ✓ |
| | D. | Service User and Carer Representative reports | ✓ |
| 4 | A. | Annual Accounts | ✓ |
| | B. | Audit Scotland's Reports | ✓ |
| | C. | Financial Monitoring Reports | ✓ |
| | D. | Audit Committee minutes | ✓ |
| 5 | A. | Joint Staff Partnership minutes | ✓ |
| | B. | Joint Health & Safety minutes | ✓ |
| | C. | Records Management Plan - required by Dec18 | ✓ |
| 6 | | No specific HSCP documents | |
| 7 | A. | Quarterly Performance reports | ✓ |
| | B. | Annual Performance Report | ✓ |
| | C. | Equality & Diversity Mainstream Report | ✓ |
| | D. | HSCP Complaints Policy (in development) | ✓ |
| 8 | | No specific HSCP documents | |

**Detailed Classes of Information**

| CLASS 1: ABOUT EAST DUNBARTONSHIRE HSCP BOARD | | |
|---|---|---|
| **Class description:**<br>Information about East Dunbartonshire HSCP Board, who we are, where to find us, how to contact us | | |
| **Information Type** | **Description** | **How to access** |
| About the HSCP | Contact details for the organisation including postal address, email and website | East Dunbartonshire Health & Social Care Partnership<br>Kirkintilloch Health & Care Centre<br>10 Saramago Street<br>Glasgow G66 3BF<br>Email: Louise.Martin2@ggc.scot.nhs.uk<br>Tel: 0141 232 8237 |
| | Board Composition | 16 members comprising of:<br>▪ 3 Elected members (voting members)<br>▪ 3 Non executive members (voting members)<br>▪ 1 Voluntary Sector Representative<br>▪ 1 Service User Representative<br>▪ 1 Carers Representative<br>▪ 1 Professional Nurse Advisor –NHS<br>▪ 2 Trade Union Representatives<br>▪ 1 Clinical Lead Representative<br>▪ 1 Acute Representative<br>▪ 1 Chief Social Work Officer<br>▪ Chief Officer |
| | Programme of Meeting and Papers for Board Meetings | The HSCP Board meets formally on a minimum of four times per year and is open to the public on receipt of request to attend to be sent to the Head of Administration at HQ address.<br>HSCP Board papers **[1A]** can be viewed following each meeting at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care- |

| | | |
|---|---|---|
| | | partnership |
| | Register of Interest by all voting Board members | **Register of Interests**<br>▪ For Elected Representatives Board members view at www.eastdunbarton.gov.uk<br>▪ For all other HSCP Board members **[1B]** register of Interests can be provided on written request to the Head of Administration at HQ address |
| | Code of Conduct for Board members | HSCP Code of Conduct **[1C]** can be provided on written request to the Head of Administration at HQ address |
| | Scheme of Administration including governance and committee arrangements | ▪ Scheme of Delegation to Officers **[1D]**<br>▪ Standing Orders **[1E]**<br>▪ Clinical & care Governance meeting notes **[1F]**<br>▪ Chief Social Work Officer Protocol **[1G]**<br>Documents can be provided via written request to the Head of Administration at HQ address |
| | Accountability and Audit Relationships provides details of bodies the HSCP is audited and/or regulated by, and the nature of the relationship with them. | ▪ Audit Scotland http://www.audit-scotland.gov.uk/<br>▪ Care Commission at http://www.careinspectorate.com/<br>▪ Health Improvement Scotland at http://www.healthcareimprovementscotland.org/<br>▪ Healthcare Environmental Inspection at http://healthcareimprovementscotland.org/our_work<br>▪ Mental Welfare Commission at http://www.mwcscot.org.uk/ |
| External Relations and working with others | Key partner organisations | ▪ East Dunbartonshire Council<br>▪ East Dunbartonshire Community Planning Partnership<br>▪ NHS Greater Glasgow & Clyde<br>▪ Primary Care Contractors<br>▪ East Dunbartonshire Voluntary Action<br>▪ Police Scotland and other emergency services |

| | | |
|---|---|---|
| | | ▪ Scottish Prison Service<br>▪ Scottish Children's Reporters Administration<br>▪ Third sector and independent contracted service providers of children's services<br>▪ Children's Hearing Scotland<br>▪ Local and national fostering and adoption agencies<br>▪ Social Work Scotland<br>▪ Community Justice Scotland and the Scottish Government<br>▪ A number of Scottish Universities |
| Information on rights, how to make a request | FOI/EIR<br>▪ With regard to service users and employees, the HSCP complies with NHS GG&C and EDC FOI Policies.<br>▪ The HSCP FOI Policy **[1l]** will relate to the HSCP Board's corporate business. This Policy is in development and a protocol/guide has been produced for health and Social Work employees. | ▪ FOI requests to NHS GGC should be directed to:<br>foi@ggc.scot.nhs.uk or<br>East Dunbartonshire Council<br>Stephen Armstrong<br>Freedom of Information/Data Protection Officer<br>0141 578 8057<br><br>▪ FOI requests to EDC should be directed to:<br>Communication/Media Team<br>0141 201 4751 or<br>foi@eastdunbarton.gov.uk<br><br>▪ HSCP FOI requests should be directed to:<br>Louise.Martin2@ggc.scot.nhs.uk or<br>Tel: 0141 232 8237 |

| CLASS 2: HOW WE DELIVER OUR FUNCTIONS AND SERVICES | | |
|---|---|---|
| **Class description:**<br>Information about our work, our strategy and policies for delivering functions and services and information for our service users | | |
| **Information Type** | **Description** | **How to access it/details of any charges** |
| Strategic Plans | The HSCP has produced a range of Strategic Plans that set out the organisational and partner strategic priorities | ▪ Strategic Plan **[2A]**<br>▪ Integrated Children's Plan **[2B]**<br>▪ Joint Health Improvement Plan **[2C]**<br>▪ Equality Plan **[2D]**<br>These plans can be viewed at:<br>https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership |
| Information about key Services | A description of the services delegated to the HSCP is provided on the HSCP website | https://www.eastdunbarton.gov.uk/health-and-social-care |
| Corporate policies and procedures. | The HSCP has developed a range of policies and procedures to support the delivery of delegated functions | ▪ Communications Plan **[2E]** (in development)<br>▪ HSCP Risk Management Policy **[2F]** and Service User & Carer Engagement Model **[2G]** can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership<br>▪ HSCP FOI Policy **[2H]** |
| Data and population Statistics | The HSCP shares and communications a range of information in relation to strategic population needs assessment information and aggregated service activity data | ▪ Strategic Needs Assessment **[2I]** can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership |

| CLASS 3: HOW WE TAKE DECISIONS AND WHAT WE HAVE DECIDED | | |
|---|---|---|
| **Class description:**<br>Information about the decisions we take how we make decisions and how we involve others. | | |
| **Information Type:** | **Description** | **How to access it/details of any charges** |
| HSCP Board meetings | Strategic decisions are taken at the HSCP Board. These decisions are recorded in Board minutes. The agendas, minutes and reports for the HSCP Board meeting are available. | ▪ Board Meeting Papers **[1A]** can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership |
| Board standing orders | Standing Orders for the conduct of business for the Board | ▪ Board Standing Orders **[1E]** can be provided on written request to the Head of Administration at the HSCP Headquarters |
| Scheme of Integration | Scheme of Integration outlines regulatory framework for the business of the Board | ▪ Scheme of Integration **[3A]** can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership |
| Strategic Planning engagement arrangements | Service Users, carer, the voluntary sector, in dependant sector and public service practitioners and managers are involved in the development and monitoring of the Strategic Plan through their participation on the Strategic Planning Group and Locality Planning Groups | ▪ Strategic Planning Group reports **[3B]** and Locality Planning Group reports **[3C]** form part of the HSCP Board papers and can be viewed at: https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership |
| Service User and Carer engagement | ▪ Service User and Carer engagement is secured primarily but nor exclusively through the Service User and Carers representatives on the HSCP Board, the Strategic Planning Group and Locality Planning Groups.<br>▪ A Service User and Carer Representative Support Group is in place and actions emerging from the Group are reported to the HSCP Board | ▪ Service User and Carer Representative reports **[3D]** form part of HSCP Board papers and can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership |

| CLASS 4: WHAT WE SPEND AND HOW WE SPEND IT | | |
|---|---|---|
| **Class description:**<br>Information about our strategy for, and management of, financial resources (in sufficient detail to explain how we plan to spend public money and what has actually been spent. | | |
| **Information Type** | **Description** | **How to access it/details of any charges** |
| Annual Accounts | ▪ The partnership publishes financial information through the production of Annual Audited Financial Accounts.<br><br>▪ The Governance statement is included within the Annual Accounts and subject to audit scrutiny and opinion. | ▪ Annual Accounts **[4A]** (Exchequer) can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership<br><br>▪ Audit Scotland's Reports **[4B]** can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership |
| Financial Plan | ▪ Details of arrangements for the governance and management of financial resources by East Dunbartonshire Health & Social Care Partnership Board.<br>▪ The partnership Boards strategy for the use of financial resources is integrated within the strategic plan.<br>▪ Regular financial reports are considered at meetings of the Partnership Board.<br>▪ The arrangements for and the minutes of the Partnership Board's Audit Committee. | ▪ Financial Monitoring Reports **[4C]** and Audit Committee minutes **[4D]** form part of the HSCP Board papers and can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership |

| CLASS 5: HOW WE MANAGE OUR HUMAN, PHYSICAL AND INFORMATION RESOURCES |
|---|
| **Class description:**<br>Information about how we manage the human, physical and information resources of the authority. |

| Information Type | Description | How to access it/details of any charges |
|---|---|---|
| Current Policies | ED HSCP Board does not directly employ staff. Staff are employees of either East Dunbartonshire Council or NHS Greater Glasgow and Clyde. For relevant Human Resource Policies refer NHS GGC & East Dunbartonshire Council | ▪ EDC policies can be viewed at www.eastdunbarton.gov.uk<br>▪ NHS GGC policies can be viewed at http://www.nhsggc.org.uk/working-with-us/hr-connect/policies-and-staff-governance/policies/ |
| Employee relations | Minutes of the Joint Staff Partnership Forum form part of HSCP Board papers | ▪ Joint Staff Partnership Forum **[5A]** form part of HSCP Board papers and can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership |
| Health & Safety | A local joint HSCP H&S Committee is currently being established. | ▪ H&S minutes **[5B]** will form part of HSCP Board papers and will be able to be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership |
| Records management and Information assurance | ▪ Service Users, Staff Records and property records is held by NHS GG&C or East Dunbartonshire Council including Information on using, protecting and the fair processing of another individual's personal information; information security; the information assurance strategy; information governance standards; and information asset registers<br>▪ The HSCP Records Management Plan which is required by December 2018 relates to the corporate business of the organisation. | ▪ GGC policies can be viewed at http://live.nhsggc.org.uk/about-us/nhs-board/finances-publications-reports/records-management-plan<br>▪ EDC policies can be viewed at https://www.eastdunbarton.gov.uk/council/information-and-records-preservation-archives-policy<br>▪ HSCP Records Management Plan **[5C]**, on completion will be viewed on the HSCP website |

| CLASS 6: HOW WE PROCURE GOODS AND SERVICES FROM EXTERNAL PROVIDERS |
|---|
| **Class description:** |

| Information about how we procure goods and services, and our contracts with external providers | | |
|---|---|---|
| **Information type** | **Description** | **How to access it/details of any charges** |
| Procurement policies<br>Invitations to tender<br>Contracts | ▪ NHS Greater Glasgow and Clyde Board and East Dunbartonshire Council procure the goods and services required. Information for this class is published through each organisation's respective FOI Publication Schemes | ▪ NHSGGC FOI Publication Scheme can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership<br>▪ EDC FOI Publication Scheme can be viewed at https://www.eastdunbarton.gov.uk/council/freedom-information |

| **CLASS 7: HOW WE ARE PERFORMING** | | |
|---|---|---|
| **Class description:**<br>Information about how we perform as an organisation, and how well we deliver our functions and services. | | |
| **Information Type** | **Description** | **How to access it/details of any charges** |
| Organisational Performance Reports | ▪ Performance against a comprehensive suite if indicators is reported on a quarterly basis to the HSCP Board<br>▪ Performance is reported retrospectively for the previous year within an Annual Performance<br>▪ The HSCP has produced its first Equality & Diversity Mainstream Report that provides evidence of how the organisation is meeting its duties under the Equality Act | ▪ Performance Reports **[7A]** form part of the HSCP Board papers and can be viewed at [https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership<br>▪ Annual Performance Report **[7B]** can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership<br>▪ Equality & Diversity Mainstream Report **[7C]** can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership |
| Service Users / Patient feedback | ▪ A range of methodologies are adopted to secure service user and carer experience and is presented to | ▪ Service User and Carer experience is reported in quarterly performance reports and forms part of HSCP |

| | | |
|---|---|---|
| | the Board through routine quarterly performance reports and the Annual Performance Report | Board papers **[1A]** and can be viewed at https://www.eastdunbarton.gov.uk/health-and-social-care/east-dunbartonshire-health-and-social-care-partnership |
| Complaints | ▪ The HSCP complies with NHS GG&C and EDC Complaints Policies with regard to service users and employees.<br>▪ The HSCP Complaints Policy is in development and a protocol/guide has been produced for health and Social Work employees. The Policy, relating to the corporate business of the HSCP Board, is in development. | ▪ NHSGGC Complaints Policy can be viewed at http://www.nhsggc.org.uk/get-in-touch-get-involved/complaints/<br>▪ EDC Complaints Policy can be viewed at https://www.eastdunbarton.gov.uk/customer-complaints<br>▪ HSCP Complaints Policy **[7D]**, on completion, will be published on the website |
| Reports of Regulatory Inspections | Reports of regulatory inspections, audits and investigations. | ▪ Relevant reports, when available, will be provided on written request to the Head of Administration at the HSCP Headquarters |

| **CLASS 8: COMMERCIAL PUBLICATIONS** | | |
|---|---|---|
| **Class description:**<br>Information packaged and made available for sale on a commercial basis and sold at market value through a retail outlet, for example bookshop, museum or research journal | | |
| **Information Type** | **Description** | **How to access it/details of any charges** |
| The partnership does not create commercial publications. | The HSCP does not create this type of information or products | Not applicable |

**Agenda Item Number: 5**

## EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Financial Out turn and Annual Accounts 2016/17** |
| **Report By** | **Jean Campbell, Chief Finance & Resources Officer**<br>**Tel: 0300 1234510 Ext 3221** |
| **Contact Officer** | **Jean Campbell, Chief Finance & Resources Officer**<br>**Tel: 0300 1234510 Ext 3221** |

| | |
|---|---|
| **Purpose of Report** | To update the Board on the financial out turn for 2016/17 and present the draft Annual Accounts. |

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| **Recommendations** | The Integration Joint Board is asked to:<br><br>a. Note the final Out turn position is reporting an under-spend of £4.1m for the period 1st April 2016 to 31st March 2017.<br><br>b. Approve the amended budget as at the 31st March 2017 including the apportionment of Children's SW & CJ Services relating to the period from 11th August 2016.<br><br>c. Approve the reserves position as at 2016/17 and the proposal on the application of reserves to provide some resilience for future year financial pressures and any slippage in savings targets and an element ear-marked for service re-design in furtherance of the priorities set out in the Strategic Plan.<br><br>d. Approve the local code of governance against which the IJB will measure itself in the Annual Governance Statement for 2016/17.<br><br>e. Note the unaudited Accounts for 2016/17. |
| | |

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

**Implications for Health & Social Care Partnership**

| | |
|---|---|
| **Human Resources** | None |

| | |
|---|---|
| **Equalities:** | None |

| | |
|---|---|
| **Financial:** | The performance during the year has generated a surplus on budget which can be allocated to reserves to provide some |

| | |
|---|---|
| | resilience for future year financial pressures and any slippage in savings targets. There will also be an element ear-marked for service re-design in furtherance of the priorities set out in the Strategic Plan. |

| | |
|---|---|
| **Legal:** | None. |

| | |
|---|---|
| **Economic Impact:** | None |

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

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

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

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

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

**b) MAIN REPORT**

**1.1** The financial position for the partnership for the year 1st April 2016 to 31 March 2017 has delivered an under spend of £4.1m. This is a slight improvement on the projection as at 23rd March of £400k. The table below shows the final position at the 31st March 2017:-

| Partnership Expenditure | Annual Budget £000 | YTD Budget £000 | YTD Actual £000 | Actual Out-turn Variance £000 |
|---|---|---|---|---|
| NHS Community Budgets | 21,330 | 21,330 | 20,090 | 1,240 |
| ED Social Care Fund (£250m) | 4,300 | 4,300 | 2,600 | 1,700 |
| Oral Health | 10,355 | 10,355 | 10,217 | 138 |
| FHS & Prescribing | 43,431 | 43,431 | 43,431 | 0 |
| Adult Social Care | 40,541 | 40,541 | 40,260 | 281 |
| Children & CJ Services | 7,360 | 7,360 | 6,901 | 459 |
| Care of | 78 | 78 | 85 | (7) |

| | | | | |
|---|---|---|---|---|
| Gardens | | | | |
| Adaptations (PSHG) | 450 | 450 | 259 | 191 |
| Care and Repair | 214 | 214 | 184 | 30 |
| Fleet | 452 | 452 | 431 | 21 |
| **SUB-TOTAL** | **128,511** | **128,511** | **124,458** | **4,053** |
| Acute Set Aside | 17,381 | 17,381 | 17,381 | 0 |
| **TOTAL** | **145,892** | **145,892** | **141,832** | **4,053** |

**1.2** Since the previous reported budget position as at period 10, there have been a number of budget adjustments revising the net expenditure budget to £145,892m. These relate predominantly to movements in the FHS budgets where there have been additional Board allocations in respect of prescribing and 'other' and an adjustment on GMS to account for an incorrect charging to East Dunbartonshire for a practice which sits as part of NW Glasgow.

**1.3** In addition, given responsibility for Children's SW & Criminal Justice services came to the IJB on the 11th August 2017, only the element that relates to the period for which this was the partnership's responsibility has been reflected in the Annual Accounts for 2016/17. The budget has therefore been adjusted to reflect this.

**1.4** The movement in the final out turn of £400k relates primarily to additional underspend in respect of Oral Health, Adaptations, Care and Repair and Fleets recharges from the Council. There was also some movement in Children's SW services where there was a delay in progressing the tendering process for a service development and the outcome of a service review which resulted in recovery of monies from the service provider, however this has been offset with a partial year reflection of the budget and actual position relating to the partnership.

**1.5** In line with the Reserves policy, the surplus on budget for 2016/17 will be taken to reserves to supplement the balance already available. As previously reported, partnership reserves totalled £1.2m; therefore this will provide a reserve for the partnership of £5.3m moving forward. This will provide some resilience for future year financial pressures and any slippage in savings targets and will also include an element ear-marked for service re-design in furtherance of the priorities set out in the Strategic Plan. A copy of the reserves statement is attached as **Appendix 1.**

## 2.0 2016/17 Annual Accounts

**2.1** The IJB is specified in legislation as a "section 106" body under the terms of the Local Government Scotland Act 1973 and as such is expected to prepare annual accounts in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

**2.2** LASAAC [The Local Authority (Scotland) Accounts Advisory Committee] has produced additional guidance on accounting for the integration of health and social care. The annual accounts for the IJB will be prepared in accordance with appropriate legislation and guidance.

**2.3** The regulations state that the unaudited accounts are submitted to the External Auditor no later than 30th June immediately following the financial year to which they relate. The IJB or committee whose remit includes audit and governance must meet to consider the unaudited annual accounts as submitted to the external auditor no later than the 31st August immediately following the financial year to which the annual accounts relate.

**2.4** The regulations require a number of key documents (within the annual accounts) to be signed by the Chair of the IJB, the Chief Officer and the Chief Financial Officer, namely:

| | |
|---|---|
| Management Commentary / Foreword | Chair of the IJB<br>Chief Officer |
| Statement of Responsibilities | Chair of the IJB<br>Chief Financial Officer |
| Annual Governance Statement | Chair of the IJB<br>Chief Officer |
| Remuneration Report | Chair of the IJB<br>Chief Officer |
| Balance Sheet | Chief Financial Officer |

**2.5** The IJB is responsible for ensuring that its business is conducted in accordance with the law appropriate to standing, safeguarding public funds and assets and making arrangements to ensure best value. In order to demonstrate this, an annual governance statement is produced each year and included with the Annual Accounts. The IJB is required to review the effectiveness of the control environment annually and these features in the annual governance statement.

**2.6** In April 2016, CIPFA / SOLACE published a report entitled 'Delivering Good Governance in Local Government: Framework'. The objective of this framework is to help local government in taking responsibility for developing and shaping an informed approach to governance, aiming at achieving the highest standards in a measured and proportionate way. This document is written in a local authority context, however most of the principles are applicable to the IJB, particularly as the legislation recognises the partnership (IJB) body as a local government body under Part V11 of the Local Government (Scotland) Act 1973.

**2.7** A review has been undertaken and is included as **Appendix 2**. Many of the assurances are reliant on documents which belong to NHS GG&C and East Dunbartonshire Council which is appropriate given decisions taken by the IJB require being actioned by the partner organisations.

**2.8** A copy of the Draft Annual Accounts, including the Annual Governance Statement is attached as **Appendix 3.**

# East Dunbartonshire Health& Social care Partnership

## Movement in Reserves Statement

This statement shows the movement in the year on the IJB's reserves. The movements which arise due to statutory adjustments which affect the General Fund balance are separately identified from the movements due to accounting practices.

| Movements in Reserves During 2016/17 | General Fund Balance | Ear-Marked Reserves | Total Reserves |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Opening Balance at 31 March 2016** | **(1,177)** | **(211)** | **(1,388)** |
| In Year drawdown of Reserves | 7 | 146 | 153 |
| Total Comprehensive Income and Expenditure | (1,550) | (2,505) | (4,055) |
| Increase or Decrease in 2016/17 | **(1,543)** | **(2,359)** | **(3,902)** |
| **Closing Balance at 31 March 2017** | **(2,720)** | **(2,570)** | **(5,290)** |

| Movements in Reserves During 2015/16 | General Fund Balance | Ear-Marked Reserves | Total Reserves |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Opening Balance at 31 March 2015** | **0** | **0** | **0** |
| Total Comprehensive Income and Expenditure | (1,177) | (211) | (1,388) |
| Increase or Decrease in 2015/16 | **(1,177)** | **(211)** | **(1,388)** |
| **Closing Balance at 31 March 2016** | **(1,177)** | **(211)** | **(1,388)** |

**2017/18 General Fund Reserve - Application**

| | 2016/17 Opening Balance | 2016/17 Drawdown | 2016/17 Additions | 2016/17 Closing Balance |
|---|---|---|---|---|
| Usable - General Reserve (LA) | 149,394 | | | 149,394 |
| Usable - General Reserve (Health) | 7,000 | | | 7,000 |
| Usable - Social Care Fund / DD / ICF | 1,020,825 | (7,422) | 23,374 | 1,036,777 |
| HSCP Surplus on Activities 16/17: | | | | |
| Community Health | | | 719,000 | 719,000 |
| Adults | | | 118,000 | 118,000 |
| Children | | | 454,000 | 454,000 |
| Other LA - Housing / Fleet | | | 235,000 | 235,000 |
| General Reserves | 1,177,219 | (7,422) | 1,549,374 | 2,719,171 |
| Ear-Marked | | | | |
| EDICT Aspergers Groupwork | 35,932 | | | 35,932 |
| SDS Training & Support | 85,700 | (85,700) | 105,570 | 105,570 |
| HSCP Communications Advisor | 60,000 | (60,000) | | - |
| Delayed Discharge - HAT Funding | 28,729 | | | 28,729 |
| Review of Learning Disability Services | | | | - |
| Social Care Fund - Service redesign | | | £1,704,225 | 1,704,225 |
| Keys to Life funding | | | £10,667 | 10,667 |
| Autism Innovation funding: | | | £18,729 | 18,729 |
| Police Scotland - Child Protection Committee Running Costs | | | £5,000 | 5,000 |
| Prescribing | | | | - |
| HSCP Surplus on Activities 16/17: | | | | - |
| Community Health - ICF / DD (Service Redesign) | | | 523,000 | 523,000 |

| | | | | |
|---|---|---|---|---|
| Oral HD | | | 138,000 | 138,000 |
| Earmarked reserves | 210,361 | (145,700) | 2,505,191 | 2,569,852 |
| **Total Reserves** | **1,387,580** | **(153,122)** | **4,054,565** | **5,289,023** |

**APPENDIX 2**

**East Dunbartonshire Health & Social Care Partnership Board**
**Local Code of Good Governance – Assurance Review & Assessment**
Owner: Chief Finance& Resources Officer Status: Draft Approval Date: Review Date:

| Governance Principle | Level of Compliance (Fully; Partial; or Not) |
|---|---|
| Behaving with integrity, demonstrating strong commitment to ethical values and representing the rule of the law. | Fully Compliant |

| Sources of Assurance | | |
|---|---|---|
| **Partnership Board** | **EDC** | **NHSGGC** |
| • Integration Scheme<br>• Governance Arrangements, Structures and Terms of Reference (Partnership Board and Audit Committee)<br>• Standing Orders<br>• Code of Conduct<br>• Local Code of Good Governance<br>• Declaration of Interests<br>• Minutes of meetings of Partnership Board and Audit Committee<br>• Strategic Plan<br>• Workforce & Organisational Development Strategy - Health & Social Care Partnership Board Development<br>• Participation & Engagement Strategy<br>• Strategic Partnership Agreements<br>• Financial Regulations<br>• Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet)<br>• Annual Audit Report 2015/16 by Audit Scotland as external (third party) auditors<br>• Audit Plans (Internal and Third Party)<br>• Information Governance (including | • Standing Orders<br>• Scheme of Delegation<br>• Governance Arrangements and Reporting (including Management Structures, Groups and Forums)<br>• Statutory Officers and Statutory Appointments<br>• Financial Regulations/Procedures<br>• Financial Reporting and Scrutiny across Management Structures (e.g., budget monitoring)<br>• Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting<br>• Chief Social Work Officer Annual Report<br>• Information Governance (including Freedom of Information, Records Management, Information Sharing and Information and Physical Security)<br>• Employee Code of Conduct<br>• HR Policies and Procedures (including Whistleblowing Policy)<br>• Declaration of Interests (required staff)<br>• Gifts and Hospitality Declaration | • Standing Orders<br>• Schedule of Reserved Decisions<br>• Scheme of Delegation and Standing Financial Instructions<br>• Governance Arrangements and Reporting (including Management Structures, Groups and Forums)<br>• Financial Procedures<br>• Financial Reporting and Scrutiny across Management Structures<br>• Clinical Governance and Integrated Clinical and Professional Governance Arrangements and Reporting<br>• Information Governance (Freedom of Information, Records Management, Information Sharing and Information Security)<br>• Staff Survey (iMatters)<br>• Employee Conduct Policy<br>• NHSGGC Board Members Code of Conduct<br>• eKSF Processes/Objective Setting<br>• HR Policies and Procedures (including Whistleblowing Policy) |

| Governance Principle | Level of Compliance (Fully; Partial; or Not) |
|---|---|
| Behaving with integrity, demonstrating strong commitment to ethical values and representing the rule of the law. | Fully Compliant |

| Sources of Assurance | | |
|---|---|---|
| **Partnership Board** | **EDC** | **NHSGGC** |
| Freedom of Information, Information Sharing and Publication Scheme)<br>• Complaints Handling Procedure<br>• Equalities Mainstream Report<br>• Integrated Clinical and Care Governance Arrangements and Reporting<br>• Internal Audit Report of the Partnership Board's Governance, Performance and Financial Management Arrangements | • Anti-Bribery/Fraud Policy<br>• Complaints Handling Procedure<br>• Equalities Arrangements (including EQIAs)<br>• Health and Safety Arrangements (including policies and procedures and audits)<br>• Workforce Plan (including Organisational Development Strategy)<br>• Supervision and Personal Development Plan Framework<br>• Staff Induction<br>• Staff Survey<br>• Communications Strategy<br>• Staff Engagement Opportunities | • Complaints Handling Procedure<br>• Equalities Arrangements (including EQIAs)<br>• Health and Safety Arrangements (including policies and procedures and audits)<br>• Workforce Plan (including Organisational Development Strategy)<br>• Supervision and Personal Development Plan Framework<br>• Staff Induction<br>• Staff Survey<br>• Communications Strategy<br>• Staff Engagement Opportunities |

| Governance Principle | Level of Compliance (Fully; Partial; or Not) |
|---|---|
| Ensuring openness and comprehensive stakeholder engagement. | |

| Sources of Assurance | | |
|---|---|---|
| **Partnership Board** | **EDC** | **NHSGGC** |
| • Governance Arrangements and Structure (Partnership Board and Audit Committee)<br>• Partnership Board Membership (incl. Stakeholder Members for patients/service users, carers, third sector and Trade Unions)<br>• Publication of Partnership Board and Audit Committee papers and minutes of public meetings<br>• Strategic Plan<br>• Annual and Quarterly Public Performance Report<br>• On-going Development of Other Strategies/Plans (e.g. Unscheduled Care Commissioning)<br>• Strategic Partnership Agreements<br>• Locality Group Work Plans<br>• Participation and Engagement Strategy<br>• Equalities Mainstreaming Report<br>• Locality Engagement Networks<br>• Information Governance (including Freedom of Information, Information Sharing and Publication Scheme)<br>• Complaints Handling Procedure<br>• HSCP website | • Governance Arrangements and Reporting (including Management Structures, Groups and Forums)<br>• Strategic Planning arrangements<br>• Performance Management Framework and Reporting (HGIOS)<br>• Information Governance (Freedom of Information, Records Management and Information Sharing)<br>• Publication of Committee papers<br>• Workforce Plan (including Organisational Development Strategy)<br>• Supervision Framework<br>• Staff Survey<br>• Practice Governance (social care) arrangements<br>• Communications Strategy<br>• Equalities Arrangements (including EQIAs)<br>• Trade Union liaison and engagement (JNG) | • NHSGGC Feedback Service<br>• NHSGGC Local Delivery Plan<br>• Governance Arrangements and Reporting (including Management Structures, Groups and Forums)<br>• Performance Management Framework and Reporting<br>• Information Governance (including Freedom of Information, Records Management, Information Sharing and Information Security)<br>• Publication of Board papers<br>• Workforce Plan (including Organisational Development Strategy)<br>• Supervision Framework<br>• Staff Governance Framework<br>• Staff Survey (iMatters)<br>• Communications Strategy<br>• Staff Engagement Opportunities<br>• Equalities Arrangements (including EQIAs)<br>• Trade Union liaison and engagement |

| Governance Principle | Level of Compliance (Fully; Partial; or Not) |
|---|---|
| Defining outcomes in terms of sustainable economic, social and environmental benefits. | |

| Sources of Assurance | | |
|---|---|---|
| **Partnership Board** | **EDC** | **NHSGGC** |
| • Strategic Plan<br>• Annual and Quarterly Performance Report<br>• On-going Development of Other Strategies/Plans (e.g. Unscheduled Care Commissioning)<br>• Locality Group Work Plans<br>• Participation and Engagement Strategy<br>• Equalities Mainstreaming Report<br>• Locality Engagement Networks<br>• Performance Management Framework and Reporting<br>• Annual and Quarterly Public Performance Report | • Strategic Planning arrangements<br>• Governance Arrangements and Reporting (including Management Structures, Groups and Forums)<br>• Performance Management Framework and Reporting<br>• Annual Performance Report | • NHSGGC Local Delivery Plan<br>• Governance Arrangements and Reporting (including Management Structures, Groups and Forums)<br>• Performance Management Framework and Reporting<br>• Annual Performance Report |

| Governance Principle | Level of Compliance (Fully; Partial; or Not) |
|---|---|
| Determining the interventions necessary to optimise the achievement of intended outcomes. | |

| Sources of Assurance | | |
|---|---|---|
| **Partnership Board** | **EDC** | **NHSGGC** |
| • Strategic Plan (including financial strategy)<br>• Risk Management Strategy and Procedure and Reporting<br>• Integrated Strategic Risk Register<br>• Business Continuity Plan<br>• Preparation of Budgets in accordance with Strategic Plan<br>• Budget Monitoring and Reporting<br>• Approved Savings and Recovery Plans<br>• Annual and Quarterly Public Performance Reports<br>• Management Framework and Reporting<br>• Audit Plans and Assurance (Internal and Third Party)<br>• On-going Development of Other Strategies/Plans (e.g. Unscheduled Care Commissioning)<br>• Clinical and Care Governance Arrangements and Reporting<br>• Information Governance (including Freedom of Information, Information Sharing and Publication Scheme) | • Strategic Planning arrangements<br>• Risk Management Strategy and Procedure and Reporting<br>• Resilience Plans and Arrangements (Business Continuity and Emergency Plans)<br>• Preparation of Budgets in accordance with organisational objectives, strategies and the medium term financial plan<br>• Budget Monitoring and Reporting<br>• Medium Term Financial Strategy<br>• Performance Management Framework and Reporting<br>• Audit Plans and Assurance (Internal and Third Party)<br>• Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting<br>• Information Governance Assurance (including Freedom of Information, Records Management, Information Sharing and Information and Physical Security)<br>• Health and Safety Arrangements (including policies and procedures and audits) | • NHSGGC Local Delivery Plan<br>• Risk Management Strategy and Procedure and Reporting<br>• Resilience Plans and Arrangements (Business Continuity and Emergency Plans)<br>• Budget Monitoring and Reporting<br>• Preparation of Budgets in accordance with organisational objectives and strategies<br>• Performance Management Framework and Reporting<br>• Audit Plans and Assurance (Internal and Third Party)<br>• Clinical Governance and Integrated Clinical and Professional Governance Arrangements and Reporting<br>• Information Governance Assurance (including Freedom of Information, Records Management, Information Sharing and Information Security)<br>• Health and Safety Arrangements (including policies and procedures and audits) |

| Governance Principle | Level of Compliance (Fully; Partial; or Not) |
|---|---|
| Developing the entity's capacity, including the capability of its leadership and individuals within it. | |

| Sources of Assurance | | |
|---|---|---|
| **Partnership Board** | **EDC** | **NHSGGC** |
| • Standing Orders<br>• Code of Conduct<br>• Scheme of Delegation<br>• Local Code of Good Governance<br>• Workforce & Organisational Development Strategy - Health & Social Care Partnership Board Development<br>• Complaints Handling Procedure<br>• Equalities Mainstream Report<br>• Integrated Clinical and Care Governance Arrangements and Reporting<br>• Joint Management Teams<br>• Internal Audit Report of the Partnership Board's Governance, Performance and Financial Management Arrangements | • Workforce Plan (including Organisational Development Strategy)<br>• Governance Arrangements and Reporting (including Management Structures, Groups and Forums)<br>• Scheme of Delegation<br>• Elected Member Induction<br>• Staff Induction<br>• Leadership and Staff Development and Training Opportunities<br>• Supervision and Personal Development Plan Framework<br>• Staff Groups for Equalities and Diversity<br>• Trade Union liaison and engagement (JNG) | • Workforce Plan (including Organisational Development Strategy)<br>• Governance Arrangements and Reporting (including Management Structures, Groups and Forums)<br>• Clinical and Care Governance Arrangements and Reporting<br>• Board Members Induction<br>• Staff Induction<br>• Leadership, First Line Management and Staff Development and Training Opportunities<br>• Supervision and Personal Development Plan Framework<br>• Staff Groups for Equalities and Diversity<br>• Trade Union liaison and engagement |

| Governance Principle | Level of Compliance (Fully; Partial; or Not) |
|---|---|
| Managing risk and performance through robust internal control and strong public financial management. | |

| Sources of Assurance | | |
|---|---|---|
| **Partnership Board** | **EDC** | **NHSGGC** |
| • Integration Scheme<br>• Financial Regulations<br>• Standing Orders<br>• Audit Committee – Terms of Reference<br>• Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet)<br>• Annual Audit Report<br>• Annual Governance Statement<br>• Strategic Plan (including financial strategy)<br>• Risk Management Strategy and Procedure and Reporting<br>• Integrated Strategic Risk Register<br>• Business Continuity Plan<br>• Preparation of budgets in accordance with Strategic Plan<br>• Budget Monitoring and Reporting<br>• Approved Savings and Recovery Plans<br>• Annual and Quarterly Public Performance Reports<br>• Management Framework and Reporting<br>• Audit Plans and Assurance (Internal and Third Party)<br>• Clinical and Care Governance Arrangements and Reporting<br>• Information Governance (including Freedom of Information, Information Sharing and Publication Scheme) | • Financial Regulations<br>• Standing Orders<br>• Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet)<br>• Audit Committee – Terms of Reference<br>• Risk Management Strategy and Procedures and Reporting<br>• Anti-Bribery/Fraud Policy<br>• Audit Plans and Assurance (Internal and Third Party)<br>• Annual Governance Statement<br>• Medium Term Financial Strategy<br>• Budget Monitoring and Reporting<br>• Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting<br>• Information Governance Assurance (including Freedom of Information, Records Management, Information Sharing and Information and Physical Security)<br>• Procurement regulations, training and development<br>• Contract Management Framework<br>• Project Management Framework (Transformation Board) | • Schedule of Reserved Decisions<br>• Scheme of Delegation and Standing Financial Instructions<br>• Governance Arrangements and Reporting (including Management Structures, Groups and Forums)<br>• Financial Procedures<br>• Annual Governance Statement<br>• Budget Monitoring and Reporting<br>• Financial Reporting and Scrutiny across Management Structures<br>• Risk Management Strategy and Procedures and Reporting<br>• Fraud Policy<br>• Audit Plans and Assurance (Internal and Third Party)<br>• Clinical and Care Governance Arrangements and Reporting<br>• Information Governance (including Freedom of Information, Records Management, Information Sharing and Information Security) |

| Governance Principle | Level of Compliance (Fully; Partial; or Not) |
|---|---|
| Implementing good practices in transparency, reporting and audit to deliver effective accountability. | |

| Sources of Assurance | | |
|---|---|---|
| **Partnership Board** | **EDC** | **NHSGGC** |
| • Integration Scheme<br>• Financial Regulations<br>• Governance Arrangements and Structure (Partnership Board and Audit Committee)<br>• Publication of Partnership Board and Audit Committee papers and minutes of public meetings<br>• Strategic Plan (including financial strategy)<br>• Annual and Quarterly Public Performance Report<br>• Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet)<br>• Annual Audit Report<br>• Risk Management Strategy and Procedure and Reporting<br>• Integrated Strategic Risk Register<br>• Business Continuity Plan<br>• Preparation of budgets in accordance with Strategic Plan<br>• Budget Monitoring and Reporting<br>• Approved Savings and Recovery Plans<br>• Annual and Quarterly Public Performance Reports<br>• Management Framework and Reporting | • Committee Reporting Framework and Schedule<br>• Publication of Committee papers<br>• Financial Regulations/Procedures<br>• Financial Reporting and Scrutiny across Management Structures (e.g., Budget Monitoring)<br>• Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet)<br>• Risk Management Strategy and Procedure and Reporting<br>• Performance Management Framework and Reporting<br>• Annual Performance Report<br>• Audit Plans and Assurance (Internal and Third Party)<br>• Social Work Professional Governance and Integrated Clinical and Professional Governance arrangements and reporting<br>• Information Governance (including Freedom of Information, Information Sharing and Publication Scheme)<br>• Council Website | • Committee Reporting Framework and Schedule<br>• Publication of Board papers<br>• Financial Regulations/Procedures<br>• Financial Reporting and Scrutiny across Management Structures (e.g., Budget Monitoring)<br>• Annual Accounts (including Governance Statement, Statement of Income and Expenditure and Balance Sheet)<br>• Risk Management Strategy and Procedure and Reporting<br>• Performance Management Framework and Reporting<br>• Audit Plans and Assurance (Internal and Third Party)<br>• Clinical and Care Governance Arrangements and Reporting<br>• Information Governance (including Freedom of Information, Information Sharing and Publication Scheme)<br>• Board Website |

| Governance Principle | Level of Compliance (Fully; Partial; or Not) |
|---|---|
| Implementing good practices in transparency, reporting and audit to deliver effective accountability. | |

| Sources of Assurance | | |
|---|---|---|
| **Partnership Board** | **EDC** | **NHSGGC** |
| • Audit Plans and Assurance (Internal and Third Party)<br>• Clinical and Care Governance Arrangements and Reporting<br>• Information Governance (including Freedom of Information, Information Sharing and Publication Scheme)<br>• HSCP website | | |



Signature
Name: Jean Campbell
Title: Chief Finance & Resources Officer – East Dunbartonshire Partnership (Integration Joint) Board

Signature
Name: tbc
Title: Chief Internal Auditor – for East Dunbartonshire Partnership (Integration Joint) Board

Signature
Name: Peter Lindsay
Title: - External Auditor (Audit Scotland) for East Dunbartonshire Partnership (Integration Joint) Board

East Dunbartonshire Health & Social Care Partnership

# EAST DUNBARTONSHIRE INTEGRATED JOINT BOARD

## Commonly known as the

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

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# ANNUAL ACCOUNTS

# 2016/17

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**CONTENTS**

# MANAGEMENT COMMENTARY

## Introduction

This document contains the financial statements for the 2016/17 operational year for East Dunbartonshire Health & Social Care Partnership (HSCP).

The management narrative outlines the key issues in relation to the HSCP financial planning and performance and how this has provided the foundation for the delivery of the priorities described within the Strategic Plan. The document also outlines future financial plans and the challenges and risks that the HSCP will face in meeting the continuing needs of the East Dunbartonshire population.

## The Health& Social Care Partnership

East Dunbartonshire Health and Social Care Partnership (HSCP) was formally established in September 2015 in accordance with the provisions of the Public Bodies (Joint Working) (Scotland) Act (2014) and corresponding Regulations in relation to a range of adult health and social care services. The Integration Scheme was revised and approved by the Scottish Government in August 2016 to extend delegated functions in relation to NHS Community Children's Services; Children's Social Work Services; and Criminal Justice Social Work Services.

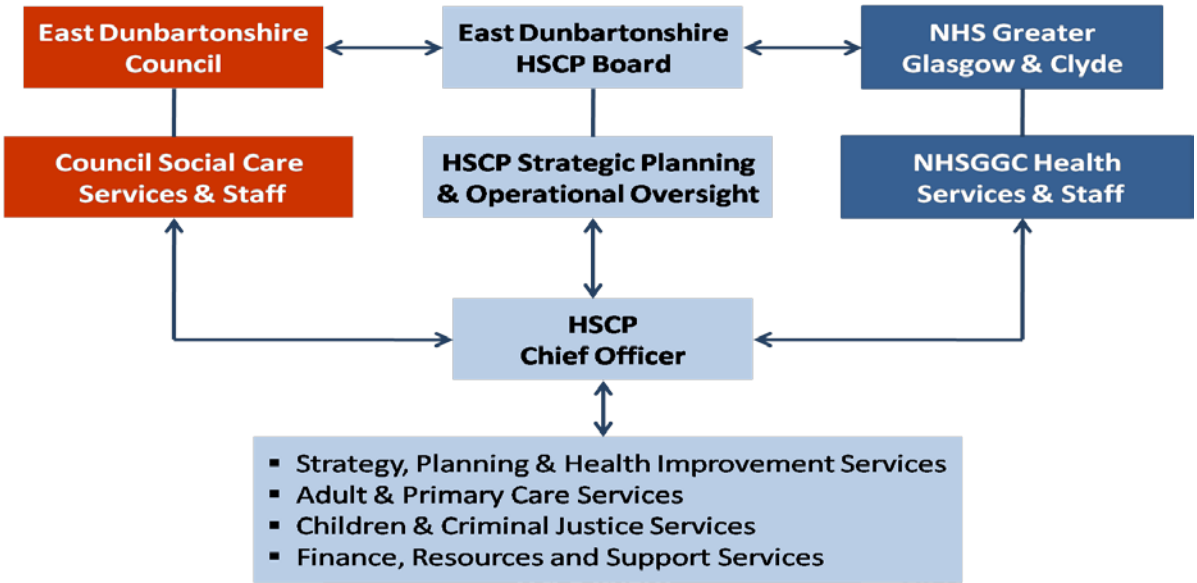
The HSCP Board, East Dunbartonshire Council and NHS Greater Glasgow & Clyde aim to work together to strategically plan for and provide high quality health and social care services that protect children and adults from harm, promote independence and deliver positive outcomes for East Dunbartonshire residents.

East Dunbartonshire HSCP Board has responsibility for the strategic planning and operational oversight of a range of health and social care services whilst East Dunbartonshire Council and NHSGGC Health Board retains responsibility for direct service delivery of social work and health services respectively, as well as remaining the employer of health and social care staff.

The HSCP Board's specific responsibility comprises of:

- Directions;
- Accounts
- Strategic Plans
- Strategic documents & governance papers

Exhibit 1 represents accountability arrangements for the planning and delivery of community health and social care services.



The Strategic Plan describes how the Health & Social Care Partnership, with partners across all sectors, service users and carers, work towards improving well- being and building strong communities across East Dunbartonshire. The aim is to provide seamless quality services that are person centred, effective and efficient.

The Strategic Plan outlines the vision and values (Exhibit 2) of the HSCP as well as strategic priorities to be achieved over a three year period. It is based on national policy which is designed to ensure people have a good quality of life, that they remain healthy and independent, and are able to stay in their own home or community for as long as possible, with the emphasis being on positive outcomes and preventative approaches.

**Exhibit 2**


The Strategic Plan was underpinned by a detailed Strategic Needs Assessment that informed decisions regarding the type and distribution of services required to achieve maximum population benefit and effective and efficient use of resources.

The Strategic Plan has been designed to meet the outcomes and performance measures for integration within the Scottish Government's National Performance Framework, focussed on achieving the nine national health and wellbeing outcomes.

The Strategic Plan is supported by a range of operational plans, work-streams and financial plans to support delivery.

The Strategic Plan also links to the Community Planning Partnership's Local Outcome Improvement Plan (previously SOA), whereby the HSCP has the lead for or plays a significant role in delivering against OUTCOME 3, 5 and 6.

Performance is monitored using a range of performance indicators outlined in a performance management framework and quarterly performance reports to the HSCP Board, Community Planning Board and other committees. Service uptake, waiting times and other pressures are closely reviewed and any negative variation from the planned strategic direction is reported to the HSCP Board through exception reporting arrangements which includes reasons for variation and planned remedial action to bring performance back on track.

## HSCP BOARD OPERATIONS FOR THE YEAR 2016/17

The HSCP achieved 68% of its performance indicator targets for 2016/17(based on Quarter 4 data), an improvement of 7% on 2015/16. This includes performance across all delegated functions to the partnership for Adults, Older People, Children and Criminal Justice Services.

In terms of Outcome 1, *people are able to look after and improve their own health and well-being and live in good health for longer*, there are a number of areas of positive performance for the Partnership that demonstrates effective delivery in this area.

For example, the number of successful smoke quits at 12 weeks in the 40% most deprived areas of East Dunbartonshire and the number of alcohol brief interventions per year exceeded targets pointing to a healthier population managing their own health outcomes.

In relation to Outcome 2, *people are able to live independently at home or in a homely setting in their community*, there are a range of good performance indications.

Of particular significance is the achievement of continued positive performance in the usage of acute bed days lost to delayed

discharges with the maintenance of zero delayed discharges for adults with incapacity. This is a key area which ensures people who are assessed as fit for discharge, from hospital, return home or to a homely setting as soon as possible.

There has been substantial investment in this area through delayed discharge funding, and in particular the development of an Intermediate care facility in Westerton Care Home which has had a positive impact on performance under this outcome. Further investment through the Change Fund and then the Integration Fund has delivered positive performance in relation the provision of homecare services for those with intensive needs, during the evenings, overnight and over the weekend.

There is also good performance in the area of Children's & Criminal Justice services in relation to timescales from referral to treatment for CAMH services, parenting support, child protection and LAAC review timescales and reports to the Court for Criminal Justice Social Work.

All of these indicators exceeding targets during 2016/17.

There are some areas where improvement is required, most notably around the rate of unplanned acute bed days for those aged 75+ and an un-scheduled care commissioning plan has been developed and approved by the IJB to take forward a range of initiatives to improve performance in this area as a key priority for the partnership. This will be linked to work underway across GG&C to ensure the set aside budget is more meaningful and linked to performance in reducing the usage of unplanned bed days within the Acute sector and the development of preventative, community based alternatives which keep people at home or in a homely setting.

The HSCP Board Performance Management Framework will be further developed to ensure we have a robust process for scrutinizing performance across the full range of objectives which are to be delivered through the HSCP.

Operational Highlights for 2016/17 include:-

- The development of an Intermediate Care Facility within a local nursing home providing 8 step down beds for patients ready to be discharged from hospital. This has provided a better co-ordinated, more effective rehabilitation opportunity enabling more (>30%) of patients to return home, with fewer moving into long term care.
- Continued development of community-led recovery-orientated resources to enable people with drug and alcohol difficulties or mental health issues to receive low intensity, often peer led support, and reduce reliance on formal services.
- Development of Pineview, a 3 person intensive residential facility for adults with complex learning disabilities and autism. This has enabled group living for hard to place individuals and repatriation from expensive distant commissioned resources.
- Progressed the final phase of a strategic review of Homecare, including the roll out of electronic time scheduling. This has created a more responsive, cost effective service delivering to a more complex service user group.

## HSCP BOARD'S POSITION AT 31 MARCH 2017

The activities of the Health and Social Care Partnership are funded through an arrangement whereby the Council and Health Board agree their respective contributions and it is for the partnership thereafter to deliver on the priorities set out in the Strategic Plan. The scope of budgets agreed for inclusion within the HSCP for 2016/17 from each of the partnership bodies were:-

HSCP Board Budgets 2016/17 (from the 1st April 2016 to the 31st March 2017)

| | |
|---|---|
| HSCP Board Health Budget | £79,416,000 |
| HSCP Board Social Work Budget Adult Services | £42,404,000 |
| HSCP Board Social Work Budget Children & Criminal Justice Services *(From 11th August 2016)* | £7,365,000 |
| HSCP Board Social Work Budget Other | £ 1,194,000 |
| Set Aside – Share of Prescribed Acute functions | £17,381,000 |
| **TOTAL** | **£147,760,000** |

The budget includes an element of funding provided by the Scottish Government to deliver on the key outcomes for the Partnership in the form of delayed discharge (£510k), integrated care funding (£1.2m) and Social Care funding (£4.3m).

The Health Budget includes an element relating to Oral Health Services (£10,355,000) which is a service hosted by East Dunbartonshire HSCP and delivered across Greater Glasgow & Clyde (GG&C).

The full extent of this budget is reflected in these accounts as prescribed within the Integration Scheme. There are services hosted within other GG&C partnerships which have similar arrangements and which support the population of East Dunbartonshire such as MSK Physio, Podiatry, and Continence Care etc.

The extent to which these services (incl Oral Health) are consumed by the population of East Dunbartonshire is reflected within the Income and Expenditure Statement to give a true cost of delivering services to support the population of East Dunbartonshire. The detail of these services is set out in note 10 to these Accounts.

The set aside budget relates to certain prescribed acute services including A&E, General Medicine, Respiratory care, Geriatric long stay etc. where the redesign and development of preventative, community based services may have an impact and reduce the overall unplanned admissions to the acute sector, offering better outcomes for patients and service users.

Further work will be progressed over the next year to develop a more accurate costing framework for unscheduled care services to make this allocation more real so that this more accurately reflects usage of these services and facilitates the resource shift required to deliver sustainable services within the community as opposed to a hospital setting. An allocation has been determined by the Greater Glasgow & Clyde Health Board for East Dunbartonshire of £17,380,000.

These notional budgets are based on direct costs per bed day for each relevant speciality within the IJB based on average activity for the 3 years 2011/12 – 2013/14 provided by NHSGGC Information Services department and cost for 2013/14 taken from the NHS Scotland Cost Book. Accident & Emergency outpatient attendances will be included at 3 year average activity and direct cost per attendance for 2013/14. This has been inflated by 1% for 2016/17 allocations.

During 2016/17, a due diligence exercise was carried out to consider the sufficiency of the budget provided to support the delivery of Children's Social Work and Criminal Justice Services which became part of the Partnership from the 11th August 2016. This identified significant financial pressure in relation to residential care packages which have been the subject of regular reports to the HSCP Board and will require on-going monitoring.

## KEY RISKS AND UNCERTAINTIES

The period of public sector austerity and reduction in the overall level of UK public sector expenditure is anticipated to extend over the medium term horizon.

Future Scottish Government grant settlements remain uncertain with further reductions in government funding predicted to 2019/20. The EU referendum result on the 23rd June 2016 created some further uncertainty and risk for the future for all public sector organisations.

The Partnership will prepare a financial plan aligned to its strategic priorities. The aim is to plan ahead to meet the challenges of demographic growth and policy pressures, taking appropriate action to maintain budgets within expected levels of funding and to maximise opportunities for delivery of the Strategic Plan.

Additional funding of £107m has been provided to Health and Social Care Partnerships for 2017/18 to support providers to pay the living wage to care workers and may provide some capacity to address social care pressures.

The most significant risks faced by the HSCP over the medium to longer term are:-

- The increased demand for services alongside reducing resources. In particular, the demographic increases predicted within East Dunbartonshire is significant with the numbers of older people aged 65+ is set to increase by 54% over the period 2012-2037 (an average increase of 9% every 5 years).

  In addition, more significantly older people aged 85+ is set to increase by 201.4% over the period 2012-2037 (an average increase of 25% every 5 years).

  East Dunbartonshire has a higher than national average proportion of older people, therefore any increases can have a significant impact on the need for services as people get older and frailer.

- The cost and demand volatility across the prescribing budget which is currently the subject of a risk sharing arrangement across GG&C, currently under review.

- The achievement of challenging savings targets from both partner agencies that face significant financial pressures and tight funding settlements, expected to continue in the medium to long term.

- The capacity of the private and independent care sector who are struggling to recruit adequate numbers of care staff to support service users which is being felt more acutely south of the border but remains a concern locally.

Financial governance arrangements have been developed to support the HSCP Board in the discharge of its business. This includes financial scoping, budget preparation, standing orders, financial regulations and the establishment of an Audit Committee to ensure the adequacy of the arrangements for risk management, governance and the control of the delegated resources.

## ANALYSIS OF THE FINANCIAL STATEMENTS (FINANCIAL PERFORMANCE)

The partnership's performance is presented in these Annual Accounts. The table on page 23 shows a net underspend of £4.1m on the partnership funding available for 2016/17.

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

In addition there were surpluses across Children's Social Work budgets (£460k) as a result of vacancies across the service which supported pressure on residential school expenditure and a small surplus on adult service budgets (£280k) across learning disability and mental health services supporting pressure in relation to older people services (care home and homecare

provision). There was some additional surplus in relation to other budgets delegated to the partnership in relation to the Private Sector Housing Grant (PSHG), care & repair and fleet recharges (£242k).

NHS Community budgets also delivered a surplus (£1.4m) in relation to delays in filling vacancies across community functions including Oral Health, District Nursing and Rehabilitation Services. There was also a surplus on the Integrated Care Fund which was not fully allocated in year and delayed discharge monies which were directed to fund an Intermediate Care Facility (part year costs only).

The surplus generated during 2016/17 will further the Partnership's reserves position and will provide some resilience for future year financial pressures and any slippage in savings targets. There will also be an element ear-marked for service re-design in furtherance of the priorities set out in the Strategic Plan. The level of partnership reserves is now £5.1m as set out in table on page 24.

The HSCP continues to face significant financial pressures from demographic growth particularly amongst the elderly population generating demand and increased costs across a range of adult care services.

Both partner organisations continue to face significant financial challenge.

The NHS Greater Glasgow & Clyde Health Board has savings of +£100m to secure during 2017/18 with a number of initiatives underway to deliver on this challenge. Of the circa. £95m savings target, £16.6m relates to Health & Social Care Partnerships of which £1.5m relates to East Dunbartonshire with potential for a further share of £3.6m (ED - £0.5m share) relating to un-achieved savings dating back to 2015/16 for CHP(s). This is currently the subject of ongoing discussion with NHSGGC Health Board and a solution hopeful during 2017/18 as to how these monies should be treated in future years.

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

In total the level of savings on Partnership savings to be delivered is £5.1m for 2017/18 and it is expected that this position will continue for future years given the challenging financial settlements expected to both the Local Authority and NHSGGC.

There is some recurring funding available to Health & Social Care Partnerships from the Scottish Government in 2017/18 in the form of Integration Funding (ED - £0.9m) and Delayed Discharge Funding (ED - £510k) and additional funding from a share of £107m (ED- £1.84m), This is aimed at increasing the living wage across the care home and care at home sectors, supporting implementation of the Cares Act and changes to local authority charging policies in respect of war veterans.

**Mr I Fraser** 26/9/17

HSCP Board Chair

**Mrs S Manion** 26/9/17

HSCP Chief Officer

26/9/17

**Ms J Campbell**

Chief Finance & Resources Officer

# STATEMENT OF RESPONSIBILITIES

## Responsibilities of the Integration Joint Board

The Integration Joint Board is required to:

- Make arrangements for the proper administration of its financial affairs and to secure that the proper officer of the board has responsibility for the administration of those affairs (section 95 of the Local Government (Scotland) Act 1973). In this authority, that officer is the chief financial officer.
- Manage its affairs to secure economic, efficient and effective use of resources and safeguard its assets.
- Ensure the Annual Accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland act 2003).
- Approve the Annual Accounts.

I confirm that these Annual Accounts were approved for signature at a meeting of the Audit Committee on 26th September 2017.

Signed on behalf of the East Dunbartonshire Integrated Joint Board.

**Mr I Fraser** **26/9/17**
IJB Chair

## Responsibilities of the Chief Financial Officer

The chief financial officer is responsible for the preparation of the IJB's Annual Accounts in accordance with proper practices as required by legislation and asset out in the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom (the Accounting Code).

In preparing the Annual Accounts, the chief financial officer has:

- selected suitable accounting policies and then applied them consistently
- made judgements and estimates that were reasonable and prudent
- complied with legislation
- complied with the local authority Code (in so far as it is compatible with legislation)

The chief financial officer has also:

- kept proper accounting records which were up to date
- taken reasonable steps for the prevention and detection of fraud and other irregularities

I certify that the financial statements give a true and fair view of the financial position of the East Dunbartonshire Integration Joint Board as at 31 March 2017 and the transactions for the year then ended.

**Ms J Campbell** **26/9/17**
Chief Finance &
Resources Officer

# REMUNERATION REPORT

## Introduction

This Remuneration Report is provided in accordance with the Local Authority Accounts (Scotland) Regulations 2014. It discloses information relating to the remuneration and pension benefits of specified IJB members and staff.

The information in the tables below is subject to external audit. The explanatory text in the Remuneration Report is reviewed by the external auditors to ensure it is consistent with the financial statements.

## Remuneration: IJB Chair and Vice Chair

The voting members of the IJB are appointed through nomination by East Dunbartonshire Council and NHS Greater Glasgow & Clyde in equal numbers being three nominations from each partner agency. Nomination of the IJB Chair and Vice Chair post holders alternates between a Councillor and a Health Board Non-Executive Director.

The remuneration of Senior Councillors is regulated by the Local Governance (Scotland) Act 2004 (Remuneration) Regulation 2007. A Senior Councillor is a Councillor who holds a significant position of responsibility in the Council's political management structure, such as the Chair or Vice Chair of a committee, sub-committee or board (such as the Integrated Joint Board).

The remuneration of Non-Executive Directors is regulated by the Remuneration Sub-committee which is a sub-committee of the Staff Governance Committee within the NHS Board. Its main role is to ensure the application and implementation of fair and equitable systems for pay and for performance management on behalf of the Board as determined by Scottish Ministers and the Scottish Government Health and Social Care Directorates.

The IJB does not provide any additional remuneration to the Chair, Vice Chair or any other board members relating to their role on the IJB. The IJB does not reimburse the relevant partner organisations for any voting board member costs borne by the partner. The details of the Chair and Vice Chair appointments and any taxable expenses paid by the IJB are shown below.

| Taxable Expenses 2015/16 £ | Name | Post(s) Held | Nominated by | Taxable Expenses 2016/17 £ |
|---|---|---|---|---|
| Nil | R. Geekie | Chair (IJB) and Leader of the Council April 2016 to March 2017 | East Dunbartonshire Council | Nil |
| Nil | I Fraser | Vice Chair (IJB) and Non- Executive DirectorApril2016 toMarch 2017 | NHS Greater Glasgow & Clyde | Nil |
| Nil | M. O'Donnell | Board Member (IJB) and Councillor | East Dunbartonshire Council | Nil |
| Nil | A. McNair | Board Member (IJB) and Councillor | East Dunbartonshire Council | Nil |
| Nil | I. Ritchie | Board Member (IJB from 01/09/16) and Non-Executive Director | NHS Greater Glasgow | Nil |
| Nil | J Legg | Board Member (IJB from 01/09/16) and Non-Executive Director | NHS Greater Glasgow | Nil |
| **Nil** | **Total** | | | **Nil** |

The IJB does not have responsibilities, either in the current year or in future years, for funding any pension entitlements of voting IJB members. Therefore no pension rights disclosures are provided for the Chair or Vice Chair.

**Remuneration: Officers of the IJB**

The IJB does not directly employ any staff in its own right; however specific post-holding officers are non-voting members of the Board.

Chief Officer

Under section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 a Chief Officer for the IJB has to be appointed and the employing partner has to formally second the officer to the IJB. The employment contract for the Chief Officer will adhere to the legislative and regulatory framework of the employing partner organisation. The remuneration terms of the Chief Officer's employment are approved by the IJB. The Chief Officer, Mrs Susan Manion, was appointed on the 12th December 2016 and is employed by NHS GG&C and seconded to the

Integration Joint Board. The previous Chief Officer, Mrs Karen Murray retired on the 30th September 2016. An Interim Chief Officer was appointed for the intervening period, Mr James Hobson, however the costs attaching to this secondment were met by NHS GG&C.

Other Officers

No other staff are appointed by the IJB under a similar legal regime. Other non-voting board members who meet the criteria for disclosure are included in the disclosures below.

The IJB Chief Financial Officer is employed by NHS GG&C. The Council and Health Board share the costs of all senior officer remunerations.

| Total 2015/16 £ | Senior Employees | Salary, Fees & Allowances £ | Compensation for Loss of Office £ | Total 2016/17 £ |
|---|---|---|---|---|
| 70,000 -75,000 (*Part year only from the 3rd September 2015)* | **K. Murray** Chief Officer 1 April 2016 to 30 September 2017 | 56,000 *(Part year until the 30th September 2016 - FYE 108,000)* | 0 | 56,000 |
| 0 | **S Manion** Chief Officer 12 December 2016 to 31 March 2017 | 28,000*(Part year from the 12 December 2016 - FYE 90,000)* | 0 | 28,000 |
| 0 | **J. Campbell** Chief Financial Officer 9 May 2016 to 31 March 2017 | 61,000*(Part year from the 9 May 2016 – FYE 68,000)* | 0 | 61,000 |
| **70,000 – 75,000** | **Total** | **145,000** | **0** | **145,000** |

*FYE = Full Year Equivalent*

In respect of officers' pension benefits the statutory liability for any future contributions to be made rests with the relevant employing partner organisation. On this basis there is no pensions liability reflected on the IJB balance sheet for the Chief Officer or any other officers.

The IJB however has responsibility for funding the employer contributions for the current year in respect of the officer time spent on fulfilling the responsibilities of their

role on the IJB. The following table shows the IJB's funding during the year to support officers' pension benefits. The table also shows the total value of accrued pension benefits which may include benefits earned in other employment positions and from each officer's own contributions.

| Senior Employee | In Year Pension Contributions | | Accrued Pension Benefits | | |
|---|---|---|---|---|---|
| | For Year to 31/03/16<br><br>£ | For Year to 31/03/17<br><br>£ | | Difference from 31/03/16<br><br>£000 | As at 31/03/17<br><br>£000 |
| K. Murray | 17,000 | 8,000 | Pension | -50 | 0 |
| Chief Officer April 2016 to September 2016 | | | Lump sum | -150 | 0 |
| S. Manion | 0 | 4,000 | Pension | 0 – 5 | 0 – 5 |
| Chief Officer December 2016 to March 2017 | | | Lump sum | | 0 |
| J. Campbell | 0 | 9,000 | Pension | 0 – 5 | 0 - 5 |
| Chief Financial Officer May 2016-March 2017 | | | Lump sum | | 0 |
| **Total** | **17,000** | **21,000** | **Pension** | **-40** | **0 - 10** |
| | | | **Lump Sum** | **-150** | **0** |

## Disclosure by Pay Bands

As required by the regulations, the following table shows the number of persons whose remuneration for the year was £50,000 or above, in bands of £5,000.

| Number of Employees in Band 2015/16 | Remuneration Band | Number of Employees in Band 2016/17 |
|---|---|---|
| | £50,000 - £54,999 | 3 |
| | £55,000 - £59,999 | 2 |
| | £60,000 - £64,999 | 2 |
| | £65,000 - £69,999 | |
| 1 | £70,000 - £74,999 | 3 |

**Mr I Fraser** 26/9/17
IJB Chair

**Mrs S Manion** 26/9/17
Chief Officer

# ANNUAL GOVERNANCE STATEMENT

## Scope of Responsibility

The Integration Joint Board is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, safeguarding public funds and assets and making arrangements to secure best value in their use.

In discharging this responsibility, the Chief Officer has put in place arrangements for governance which includes the system of internal control. The system is intended to manage risk to support the achievement of the IJB's policies, aims and objectives. Reliance is placed on the NHS GG&C and East Dunbartonshire Council systems of internal control that support compliance with both organisations' polices and promotes achievement of each organisation's aims and objectives, as well as those of the IJB.

This is designed to manage risk to a reasonable level, but cannot eliminate the risk to failure to achieve policies, aims and objectives and can therefore only provide reasonable but not absolute assurance of effectiveness.

## The Governance Framework and Internal Control System

The system of internal control is based on a framework designed to identify and prioritise the risks to the achievement of the Partnerships key outcomes, aims and objectives and comprises the structures, processes, cultures and values through which the partnership is directed and controlled.

The system of internal control is an ongoing process designed to identify and prioritise those risks that may impact the ability of the Partnership to deliver its aims and objectives. In doing so it evaluates the likelihood and impact of those risks and seeks to manage them efficiently, effectively and economically.

Governance arrangements have been in place throughout the year and up to the date of approval of the statement of accounts.

Key features of the governance framework during 2016/17 are:

- The Integrated Joint Board (IJB) is a formal full partner of the East Dunbartonshire Community Planning Partnership Board (CPPB) and will provide regular relevant update to the CPPB on the work of the Health & Social Care Partnership

- The Integrated Joint Board comprises six voting members – three non-executive Directors of the Health board and three local Councillors from the Local Authority. The Board are charged with responsibility for the planning of Integrated Services through directing the Council and the Health board to deliver on the strategic priorities set out in the Strategic Plan. In order to effectively discharge their responsibilities, board members are supported with a development programme aimed at providing opportunities to explore individual

member and Board collective responsibilities and values that facilitate decision making, develop understanding of service provision within the HSCP and engage with staff delivering these services and specific sessions on the conduct of the business of the IJB.

- IJBs are 'devolved public bodies' for the purposes of the Ethical Standards in Public Life (Scotland) Act 2000 which requires them to produce a code of conduct for members. The members of the IJB have adopted and signed up to the Code of Conduct for Members of Devolved Public Bodies and have committed to comply with the rules and regularly review their personal circumstances on an annual basis.

- The IJB has produced and adopted a Scheme of Administration that defines the powers, relationships and organisational aspects for the IJB. This includes the Integration Scheme (which was revised in June 2016), Standing Orders for meetings, Terms of reference and membership of IJB committees, the Scheme of Delegation to Officers and the Financial Regulations.

- The Strategic Plan for 2015-2018 was approved at the inaugural meeting of the HSCP Board on the 3rd September 2015. It sets out the identified strategic priorities for the HSCP under each of the nine national outcomes and describes for each priority what success will look like and the outcome measures to be used to monitor delivery. There is an established Strategic Planning Group (SPG) which oversees the delivery of the Strategic Plan comprising legislatively determined membership. This is supported by a range of planning groups to take forward particular priorities which reports through the SPG and to the IJB.

- Financial regulations have been developed for the Health & Social Care Partnership in accordance with the Integrated Resources Advisory Committee (IRAG) guidance and in consultation with the Director of Finance & Shared Services of East Dunbartonshire Council and the Assistant Director of Finance of NHS Greater Glasgow and Clyde. They set out the respective responsibilities of the Chief Officer and the Chief Finance Officer in the financial management of the monies delegated to the partnership.

- Establishment of an Audit Committee. The Audit Committee will advise the Partnership Board and its Chief Financial Officer on:
    - The strategic processes for risk, control and governance and the governance statement.
    - The financial governance and accounts of the Partnership Board, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors.
    - The planned activity and results of both internal and external audit as they relate to the activities of the Partnership Board.
    - The adequacy of management response to issues identified by audit activity, including external audit's management letter/report.
    - The effectiveness of the internal control environment.

- Assurances relating to the corporate governance requirements for the Partnership Board.
- Appointment of the internal audit service or for purchase of non-audit services from contractors who provide audit services.

**Roles and Responsibilities of the Audit Committee and Chief Internal Auditor**

Board members and officers of the IJB are committed to the concept of sound internal control and the effective delivery of IJB services. The IJB's Audit Committee operates in accordance with CIPFA's Audit Committee Principles in Local Authorities in Scotland and Audit Committees: Practical Guidance for Local Authorities.

The Audit Committee performs a scrutiny role in relation to the application of CIPFA's Public Sector Internal Audit Standards 2017 (PSIAS) and two or three times per year monitors the performance of the Partnership's internal audit service. The appointed Chief Internal Auditor has responsibility to review independently and report to the Audit Committee annually, to provide assurance on the adequacy and effectiveness of conformance with PSIAS.

The internal audit service undertakes an annual programme of work, approved by the Audit Committee, based on a strategic risk assessment. The appointed Chief Internal Auditor provides an independent opinion on the adequacy and effectiveness of internal control. The East Dunbartonshire Council's Head of Internal Audit is the *de facto* Chief Internal Auditor for the Partnership. In this role, their assurance is based on the EDC internal audit reports relating to the Partnership for which they have direct responsibility. Assurance is always from a variety of sources, and one of those sources is the reports of the internal auditors (PwC) of NHS Greater Glasgow and Clyde that relate to the partnership as reported by the Chief Finance & Resources Officer.

The Chief Internal Auditor has conducted a review of all EDC produced Internal Audit reports issued in the financial year and Certificates of Assurance from the EDC and partnership Senior Management Team. In conclusion, although no system of internal control can provide absolute assurance nor can Internal Audit give that assurance, on the basis of audit work undertaken during the reporting period, there have been no significant issues reported by Internal Audit.

Furthermore, on the basis of the audit work undertaken during the reporting period, the Chief Internal Auditor is able to conclude that a reasonable level of assurance can be given that the system of internal control is operating effectively within the organisation.

- Performance Reporting – Regular performance reports are presented to the IJB to monitor progress on an agreed suite of measures and targets against the priorities set out in the strategic plan. This includes the provision of exception

reports for targets not being achieved identifying corrective action and steps to be taken to address performance not on target.

- Clinical and Care Governance arrangements have been developed and led locally by the Associate Clinical Director for the HSCP and involving the Chief Social Work Officer for East Dunbartonshire Council.

- A Risk Management Register has been developed which covers the partnership's risk policy, procedure, process, systems, risk management roles and responsibilities.

- Internal / External Review of Governance Arrangements – there has been specific work undertaken by each partners audit functions on the integrity of financial governance, financial assurance and risk assessment arrangements as they relate to the integration of adult health and social care services.

- Information Governance – the Public Records (Scotland) Act 2011 (Section1 (1)) requires the HSCP Board to prepare a Records Management Plan setting out the proper arrangements for the authority's public records. In addition, under the Freedom of Information (Scotland) Act, the HSCP Board is required to develop a Freedom of Information Publication Scheme – this was published in March 2017.

With regard to the entries taken from the Health Board and Council Accounts, the IJB is not aware of any weaknesses within their internal control systems and has placed reliance on the individual Statements of Internal Financial Control where appropriate.

**Review of Effectiveness**

East Dunbartonshire IJB has responsibility for reviewing the effectiveness of the governance arrangements including the system of internal control. This review is informed by the work of the Chief Officer and the Senior Management Team who have responsibility for the development and maintenance of the governance environment, the Annual Governance Report, the work of internal audit functions for the respective partner organisations and also by comments made by external auditors and other review agencies and inspectorates.

The partnership has put in place appropriate management and reporting arrangements to enable it to be satisfied that its approach to corporate governance is both appropriate and effective in practice.

On the basis of internal audit work, a range of audit assignments have been completed that are relevant to the operation of internal controls of relevance to the IJB. These were generally found to operate as intended with reasonable assurance provided on the integrity of control. A number of recommendations have been made for areas for further improvement and action plans developed to address the risks identified.

There has been specific work undertaken by each partners audit functions on the integrity of financial governance, financial assurance and risk assessment arrangements as they relate to the Council's contribution toward the integration of adult health and social care services and the robustness of the process for setting NHS budgets to be allocated to IJB's. The Council's internal auditors were able to provide reasonable assurance over the areas reviewed and the auditors acting for NHS Greater Glasgow and Clyde found no significant issues or findings from their review. There were a number of areas identified with actions to be progressed and these are being taking forward within the partnership.

Internal audit reviews of NHS Greater Glasgow and Clyde as a whole reported the following issues that they considered should be reported in the health board's annual governance statement:

- Waiting times management and reporting (only limited assurance that action plans are completed and being used);
- IT Resilience (improvements to disaster recovery programme were required);
- Business continuity management (a lack of Board-wide and strategic direction to business continuity); and
- Reporting and monitoring arrangements of efficiency savings (further action is required in respect of unallocated savings plans at directorate level).

There have been regular Integrated Joint Board meetings since the partnership came into being which have received a wide range of reports to enable effective scrutiny of the partnerships' performance including regular Chief Officer Updates, Financial reports, quarterly performance reports and service development reports which contribute to the delivery of the Strategic Plan. There been a number of development sessions for members as well as induction visits to some of the operational hubs of service delivery. These have been very positive and have resulted in a programme of development activities being agreed for 2017/18 including a re-visiting of some areas as a result of the newly appointed Councillors to the IJB following the local elections in May 2017..

The Accounts Commission published a report on Health and Social Care Integration in December 2015 providing a national overview of the emerging arrangements for setting up, managing and scrutinizing Integration Authorities as they become established. East Dunbartonshire undertook a process of Self Evaluation against the recommendations and developed an action plan to progress areas for improvement to ensure effective implementation.

**Governance Improvement Plans**

There are a number of areas of improvement identified which will be progressed during 2017/18 which will seek to enhance governance arrangements within the partnership:

- External Reports – there are a number of areas of scrutiny as partnerships develop and the HSCP will take cognisance of these and develop action plans which seek to improve governance arrangements in line with best practice.

- EDC Internal Audit Reports – There have been a number of areas subject to scrutiny through organisation internal audit processes including homecare, Clients budgetary accounts and direct payments which are of interest to the HSCP. These highlighted areas requiring further improvement and formal action plans have been developed to mitigate the risks identified – these will continue to be monitored for compliance during 2017/18, as are earlier reports.

- NHS GG&C internal audit reports that related to HSCP - There have been a number of areas subject to scrutiny, including delayed discharge (use of additional funding), HSCP governance arrangements, risk management and clinical governance. These will be subject to PwC processes for risk mitigation.

- Information Governance – The Public Records (Scotland Act) 2011 (Section 1(1)) requires the HSCP Board to prepare a Records Management Plan setting out the partnership's proper arrangements for its public records. Under the Freedom of Information (Scotland) Act, the HSCP Board is required to develop a freedom of information publication scheme to be approved by the Scottish Commissioner – this was published in March 2017. This will include the development and approval of a Complaints handling process for the partnership.

- Risk Management – the development of a HSCP risk register will be further enhanced by the development of a HSCP Risk Management Policy & Strategy.

- In April 2016 CIPFA/SOLACE published a report titled 'Delivering Good Governance in Local Government: Framework. A report will be presented to the IJB in June 2017 which will adopt the principles set out within this document and will establish a local code of corporate governance for the partnership which will be subject to annual review with any improvement actions detailed and progressed to ensure performance against these principles.

- It was noted by Audit Scotland that there was no formal mechanism in place for the internal audit service provider for NHS Greater Glasgow & Clyde to consult with the Audit Committee regarding the audit work they planned to carry out in relation to the Partnership, nor was there a protocol for PwC reports to be presented to the Audit Committee. An improved process is being discussed at the Audit & Risk Committee and will be progressed with the appointment of the new Chief Internal Auditor support the partnership with appropriate linkages established with the wider NHS Board audit work..

## Assurance

The system of governance (including the system of internal control) operating during 2016/7 provides reasonable assurance that transactions are authorised and properly recorded; that material errors or irregularities are either prevented or detected within a timely period; and that significant risks impacting on the achievement of our strategic priorities and outcomes have been mitigated.

Systems are in place to continually review and improve the governance and internal control environment and action plans are in place to address identified areas for improvement.

## Certification

It is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the East Dunbartonshire Integration Joint Board's systems of governance.

**Mr I Fraser** 26/9/17

IJB Chair

**Mrs S Manion** 26/9/17

Chief Officer

## COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT

This statement shows the cost of providing services for the year according to accepted accounting practices.

| 2015/16 Gross Expenditure £000 | 2015/16 Gross Income £000 | 2015/16 Net Expenditure £000 | | 2016/17 Gross Expenditure £000 | 2016/17 Gross Income £000 | 2016/17 Net Expenditure £000 |
|---|---|---|---|---|---|---|
| | | | Local Authority Services: | | | |
| | | | Adults Services | 57,220 | (1,722) | 55,498 |
| | | | Children & Criminal Justice Services | 7,598 | (692) | 6,906 |
| | | | Other Council Services | 959 | 0 | 959 |
| | | 24,661 | Total Local Authority Services | 65,777 | (2,414) | 63,363 |
| | | | Health Services: | | | |
| | | | Community Health Services | 9,965 | (842) | 9,123 |
| | | | Family Health Services | 44,715 | (1,283) | 43,431 |
| | | | Hosted – Oral Dental Health Services | 10,999 | (782) | 10,217 |
| | | | Set Aside for Delegated Services provided in Acute Services | 17,381 | | 17,381 |
| | | 48,060 | Total Health Services | 83,060 | (2,908) | 80,152 |
| | | 17 | IJB Operational Costs*(note 4)* | 190 | | 190 |
| | | **72,738** | **Cost of Services Directly Managed by ED HSCP** | **149,027** | **(5,322)** | **143,706** |
| | | | Services Hosted by other NHS GG&C IJBs *(note 10)* | 13,835 | (1,403) | 12,432 |
| | | | Services hosted by East Dunbartonshire IJB for other IJB's *(note 10)* | (10,220) | 718 | (9,502) |
| | | | **Total Cost of Services to East Dunbartonshire IJB** | 152,642 | (6,007) | 146,636 |
| | | (74,126) | Taxation and Non-Specific Grant Income *(note 6)* | | (150,690) | (150,690) |
| | | **(1,388)** | **(Surplus) or Deficit on Provision of Services** | **152,424** | **(156,697)** | **(4,055)** |
| | | **(1,388)** | **Total Comprehensive Income and Expenditure** | | | **(4,055)** |

The IJB was established on the 27th July 2015. Integrated delivery of health and care services did not commence until the 3rd September 2016 for all Adult health and

Social Care services. There was as amendment to the Scheme of Establishment in August 2016 which brought all Children's Health, Social Work and Criminal Justice services within the responsibility of the IJB. Consequently the 2016/17 financial year is the first fully operational financial year for the IJB in the delivery of Adult health and Social Care Services and a part year for Children's Health, Social Work & Criminal Justice services. The figures above reflect this position.

## Movement in Reserves Statement

This statement shows the movement in the year on the IJB's reserves. The movements which arise due to statutory adjustments which affect the General Fund balance are separately identified from the movements due to accounting practices.

| Movements in Reserves During 2016/17 | General Fund Balance | Ear-Marked Reserves | Total Reserves |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Opening Balance at 31 March 2016** | **(1,177)** | **(211)** | **(1,388)** |
| In Year drawdown of Reserves | 7 | 146 | 153 |
| Total Comprehensive Income and Expenditure | (1,550) | (2,505) | (4,055) |
| Increase or Decrease in 2016/17 | **(1,543)** | **(2,359)** | **(3,902)** |
| **Closing Balance at 31 March 2017** | **(2,720)** | **(2,570)** | **(5,290)** |

| Movements in Reserves During 2015/16 | General Fund Balance | Ear-Marked Reserves | Total Reserves |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Opening Balance at 31 March 2015** | **0** | **0** | **0** |
| Total Comprehensive Income and Expenditure | (1,177) | (211) | (1,388) |
| Increase or Decrease in 2015/16 | **(1,177)** | **(211)** | **(1,388)** |
| **Closing Balance at 31 March 2016** | **(1,177)** | **(211)** | **(1,388)** |

## BALANCE SHEET

The Balance Sheet shows the value as at the 31st March 2017 of the IJB's assets and liabilities. The net assets of the IJB (assets less liabilities) are matched by the reserves held by the IJB.

| 31 March 2016 £000 | | Notes | 31 March 2017 £000 |
|---|---|---|---|
| 1,405 | Short term Debtors | 7 | 5,290 |
| | **Current Assets** | | |
| (17) | Short-term Creditors | 8 | |
| | **Current Liabilities** | | |
| | Provisions | | |
| | **Long-term Liabilities** | | |
| **1,388** | **Net Assets** | | **5,290** |
| 1,388 | Usable Reserve: General Fund | 9 | (2,719) |
| | Unusable Reserve: Earmarked | 9 | (2,571) |
| **1,388** | **Total Reserves** | | **5,290** |

The unaudited accounts were issued on 22 June 2017 and the audited accounts were authorised for issue on 26 September 2017.

**Ms J Campbell** 26/9/17
Chief Financial
Officer

# NOTES TO THE FINANCIAL STATEMENTS

## 1. Significant Accounting Policies

General Principles

The Financial Statements summarises the authority's transactions for the 2016/17 financial year and its position at the year-end of 31 March 2017.

The IJB was established under the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 and is a Section 106 body as defined in the Local Government (Scotland) Act 1973.

The Financial Statements are therefore prepared in compliance with the Code of Practice on Local Authority Accounting in the United Kingdom 2016/17, supported by International Financial Reporting Standards (IFRS), unless legislation or statutory guidance requires different treatment.

The accounts are prepared on a going concern basis, which assumes that the IJB will continue in operational existence for the foreseeable future. The historical cost convention has been adopted.

Accruals of Income and Expenditure

Activity is accounted for in the year that it takes place, not simply when settlement in cash occurs. In particular:

- Expenditure is recognised when goods or services are received and their benefits are used by the IJB.
- Income is recognised when the IJB has a right to the income, for instance by meeting any terms and conditions required to earn the income, and receipt of the income is probable.
- Where income and expenditure have been recognised but settlement in cash has not taken place, a debtor or creditor is recorded in the Balance Sheet.
- Where debts may not be received, the balance of debtors is written down

Funding

The IJB is primarily funded through funding contributions from the statutory funding partners, East Dunbartonshire Council and NHS Greater Glasgow & Clyde (NHS GG&C). Expenditure is incurred as the IJB commissions specified health and social care services from the funding partners for the benefit of service recipients in East Dunbartonshire.

Cash and Cash Equivalents

The IJB does not operate a bank account or hold cash. Transactions are settled on behalf of the IJB by the funding partners. Consequently the IJB does not present a 'Cash and Cash Equivalent' figure on the balance sheet. The funding balance due to or from each funding partner as at 31 March is represented as a debtor or creditor on the IJB's Balance Sheet.

Employee Benefits

The IJB does not directly employ staff. Staff are formally employed by the funding partners who retain the liability for pension benefits payable in the future. The IJB therefore does not present a Pensions Liability on its Balance Sheet.

The IJB has a legal responsibility to appoint a Chief Officer. More details on the arrangements are provided in the Remuneration Report. The charges from the employing partner are treated as employee costs. Where material the Chief Officer's absence entitlement as at 31 March is accrued, for example in relation to annual leave earned but not yet taken.

Charges from funding partners for other staff are treated as administration costs.

Provisions, Contingent Liabilities and Contingent Assets

Provisions are liabilities of uncertain timing or amount. A provision is recognised as a liability on the balance sheet when there is an obligation as at 31 March due to a past event; settlement of the obligation is probable; and a reliable estimate of the amount can be made. Recognition of a provision will result in expenditure being charged to the Comprehensive Income and Expenditure Statement and will normally be a charge to the General Fund.

A contingent liability is a possible liability arising from events on or before 31 March, whose existence will only be confirmed by later events. A provision that cannot be reasonably estimated, or where settlement is not probable, is treated as a contingent liability. A contingent liability is not recognised in the IJB's Balance Sheet, but is disclosed in a note where it is material.

A contingent asset is a possible asset arising from events on or before 31 March, whose existence will only be confirmed by later events. A contingent asset is not recognised in the IJB's Balance Sheet, but is disclosed in a note only if it is probable to arise and can be reliably measured.

Reserves

The IJB's reserves are classified as either Usable or Ear-marked Reserves.

The IJB's only Usable Reserve is the General Fund. The balance of the General Fund as at 31 March 2017 shows the extent of resources which the IJB can use in later years to support service provision and complies with the Reserves Strategy for the partnership.

The ear marked reserve shows the extent of resource available to support service re-design in achievement of the priorities set out in the Strategic Plan including monies which have been allocated for specific purposes but not spent in year.

Indemnity Insurance

The IJB has indemnity insurance for costs relating primarily to potential claim liabilities regarding Board member and officer responsibilities. The NHS GG&C and East Dunbartonshire Council have responsibility for claims in respect of the services that they are statutorily responsible for and that they provide.

Unlike NHS Boards, the IJB does not have any 'shared risk' exposure from participation in CNORIS. The IJB participation in the CNORIS scheme is therefore analogous to normal insurance arrangements.

Known claims are assessed as to the value and probability of settlement. Where it is material the overall expected value of known claims taking probability of settlement into consideration is provided for in the IJB's Balance Sheet.

The likelihood of receipt of an insurance settlement to cover any claims is separately assessed and, where material, presented as either a debtor or disclosed as a contingent asset.

## 2. Events After the Reporting Period

The Annual Accounts were authorised for issue by the Chief Finance & Resources Officer on 26th September 2017. Events taking place after this date are not reflected in the financial statements or notes. Where events taking place before this date provided information about conditions existing at 31 March 2017, the figures in the financial statements and notes have been adjusted in all material respects to reflect the impact of this information.

## 3. Expenditure and Income Analysis by Nature

| 2015/16 £000 | | 2016/17 £000 |
|---|---|---|
| | **Health Services** | |
| | Employee Costs | |
| | Property Costs | |
| | Supplies and Services | |
| | Payments to Other Bodies | |
| | Purchase of Healthcare | |
| | Family Health Service | |
| | Prescribing | |
| | Transport | |
| | Set Aside | |
| | Income | |
| | **Social Work Services** | |
| | Employee Costs | 17,010 |
| | Property Costs | 166 |
| | Supplies and Services | 914 |
| | Contractors | 46,661 |
| | Transport | 900 |
| | Administrative Costs | 225 |
| | Operational Costs | 98 |
| | Income | (2,413) |
| | Partners Funding Contributions and Non-Specific | (150,690) |
| | **Surplus or Deficit on the Provision of Services** | **(4,055)** |

## 4. IJB Operational Costs

| 2015/16 £000 | | 2016/17 £000 |
|---|---|---|
| | Staff Costs | 184 |
| 17 | Audit Fees | 6 |
| **17** | **Total Operational Costs** | **190** |

**External Audit Costs**
The appointed Auditors to ED HSCP were Audit Scotland. Fees payable to Audit Scotland in respect of external audit service undertaken in accordance with the Code of Audit Practice in financial year 2016/17 were £17.4k, of which £5.8k was actually paid in year. Given the IJB cannot physically pay for invoices, this will be paid through the Council or the Health Board and charged as a cost in the IJB Accounts.

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## 5. Support Services

Support services were not delegated to the Integration Joint Board through the Integration Scheme and are instead provided by the Health Board and Council free of charge as a 'service in kind'. The support services provided is mainly comprised of: provision of the Interim Chief Officer (*for the period September 2016 – December 2016*), financial management and accountancy support, human resources, legal, committee administration services, ICT, payroll, internal audit and the provision of the Chief Internal Auditor.

All support services provided to the IJB were considered not material to these accounts.

## 6. Taxation and Non-Specific Grant Income

| £000 | | 2016/17 £000 |
|---|---|---|
| 26,059 | Funding Contribution from East Dunbartonshire Council | 50,963 |
| 48,067 | Funding Contribution from NHS Greater Glasgow & Clyde | 99,727 |
| **74,126** | **Taxation and Non-specific Grant Income** | **150,690** |

The funding contribution from the NHS Board shown above includes £17.4m in respect of 'set aside' resources relating to acute hospital and other resources. These are provided by the NHS which retains responsibility for managing the costs of providing the services. The IJB however has responsibility for the consumption of, and level of demand placed on, these resources. The NHS Contribution also includes an element relating to the usage of services hosted by other IJB's on behalf of East Dunbartonshire (net contribution £2.9m).

The funding contributions from the partners shown above exclude any funding which is ring-fenced for the provision of specific services. Such ring-fenced funding is presented as income in the Cost of Services in the Comprehensive Income and Expenditure Statement.

## 7. Debtors

| 31 March 2016 £000 | | 31 March 2017 £000 |
|---|---|---|
| 7 | NHS Greater Glasgow & Clyde | 1,380 |
| 1398 | East Dunbartonshire Council | 3,910 |
| | Non-public sector | |
| **1,405** | **Debtors** | **5,290** |

The short term debtor relates to the reported surplus on the respective health and social care expenditure and is money held by the parent bodies as reserves available to the partnership.

## 8. Creditors

| 31 March 2016 £000 | | 31 March 2017 £000 |
|---|---|---|
| | NHS Greater Glasgow & Clyde | |
| 17 | East Dunbartonshire Council | |
| **17** | **Creditors** | |

There are no short term creditors for 2016/17.

## 9. Usable Reserve: General Fund

The IJB holds a balance on the General Fund for two main purposes:

- To earmark, or build up, funds which are to be used for specific purposes in the future, such as known or predicted future expenditure needs. This supports strategic financial management.

- To provide a contingency fund to cushion the impact of unexpected events or emergencies. This is regarded as a key part of the IJB's risk management framework.

The table below shows the movements on the General Fund balance, analysed between those elements earmarked for specific planned future expenditure, and the amount held as a general contingency.

| | | | 2015/16 | | | | 2016/17 |
|---|---|---|---|---|---|---|---|
| Balance at 1 April 2015 £000 | Transfers Out 2015/16 £000 | Transfers In 2015/16 £000 | Balance at 31 March 2016 £000 | | Transfers Out 2016/17 £000 | Transfers In 2016/17 £000 | Balance at 31 March 2017 £000 |
| 0 | 0 | (86) | (86) | Scottish Govt. Funding - SDS | 86 | (106) | (106) |
| | | (36) | (36) | Mental Health project | 0 | | (36) |
| | | (29) | (29) | Delayed Discharge | | | (29) |
| | | (60) | (60) | Communications Post | 60 | | 0 |
| | | | | Social Care Fund | | (1,704) | (1,704) |
| 0 | 0 | 0 | 0 | Keys to Life Funding | | (11) | (11) |
| 0 | 0 | 0 | 0 | Autism Funding | | (19) | (19) |
| | | | | Police Scotland – CPC Funding | | (5) | (5) |
| | | | | Integrated Care / Delayed Discharge Funding | | (523) | (523) |
| 0 | | | | Oral Health Funding | | (138) | (138) |
| | 0 | (211) | (211) | Total Earmarked | 146 | (2,506) | (2,571) |
| 0 | 0 | (1,177) | (1,177) | Contingency | 7 | (1,549) | (2,719) |
| **0** | **0** | **(1,388)** | **(1,388)** | **General Fund** | **153** | **(4,055)** | **(5,290)** |

## 10. Agency Income and Expenditure

On behalf of all IJBs within the NHS Greater Glasgow & Clyde area, the IJB acts as the lead manager for Oral Dental Health services It commissions services on behalf of the other IJBs and reclaims the costs involved. The payments that are made on behalf of the other IJBs, and the consequential reimbursement, are not included in the Comprehensive Income and Expenditure Statement (CIES) since the IJB is not acting as principal in these transactions.

The amount of expenditure and income relating to the agency arrangement is shown below.

| 2015/16 £000 | | 2016/17 £000 |
|---|---|---|
| | Expenditure on Agency Services – Oral Health | 9,502 |
| | Reimbursement for Agency Services | (9,502) |
| **0** | **Net Agency Expenditure excluded from the CIES** | **0** |

Similarly, other IJBs within the NHS Greater Glasgow and Clyde area act as the lead manager for a number of delegated services on behalf of East Dunbartonshire IJB. The payments that are made by the other IJBs on behalf of East Dunbartonshire IJB, and the consequential reimbursement, are included in the Comprehensive Income and Expenditure Statement, since this expenditure is incurred for the residents of East Dunbartonshire.

The net amount of expenditure and income relating to those agency arrangements is shown below.

| 2015/16 £000 | | 2016/17 £000 |
|---|---|---|
| | MSK Physio | 524 |
| | Retinal Screening | 61 |
| | Podiatry | 506 |
| | Primary Care Support | 408 |
| | Continence | 379 |
| | Sexual Health | 656 |
| | Earning Disability | 91 |
| | Mental Health Services | 1,546 |
| | Addiction | 948 |
| | Prison Healthcare | 153 |
| | Healthcare in Police Custody | 176 |
| | General Psychiatry | 2,374 |
| | Old Age Psychiatry | 4,610 |
| | Reimbursement for Agency Services | (12,432) |
| **0** | **Net Agency Expenditure excluded from the CIES** | **0** |

## 11. Related Party Transactions

The IJB has related party relationships with the NHS Greater Glasgow & Clyde Health Board and the East Dunbartonshire Council In particular the nature of the partnership means that the IJB may influence, and be influenced by, its partners. The following transactions and balances included in the IJB's accounts are presented to provide additional information on the relationships.

Transactions with NHS Greater Glasgow & Clyde

| 2015/16 £000 | | 2016/17 £000 |
|---|---|---|
| (48,067) | Funding Contributions received from the NHS Board | (99,727) |
| 48,060 | Expenditure on Services Provided by the NHS Board | 83,082 |
| | Key Management Personnel: Non-Voting Board Members | 92 |
| | Support Services | 0 |
| **(7)** | **Net Transactions with the NHS Board** | **(16,553)** |

Key Management Personnel: The non-voting Board members employed by the NHS Board and recharged to the IJB include the Chief Officer and the Chief Financial Officer. These costs are met in equal share by the NHS GG&C and East Dunbartonshire Council. The details of the remuneration for some specific post-holders are provided in the Remuneration Report.

Balances with NHS Greater Glasgow & Clyde

| 31 March 2016 £000 | | 31 March 2017 £000 |
|---|---|---|
| 7 | Debtor balances: Amounts due from the NHS Board | 1,380 |
| | Creditor balances: Amounts due to the NHS Board | 0 |
| **7** | **Net Balance with the NHS Board** | **1,380** |

Transactions with East Dunbartonshire Council

| 2015/16 £000 | | 2016/17 £000 |
|---|---|---|
| (26,059) | Funding Contributions received from the Council | (50,963) |
| 24,661 | Expenditure on Services Provided by the Council | 63,363 |
| | Key Management Personnel: Non-Voting Board Members | 98 |
| | Support Services | 0 |
| **1,398** | **Net Transactions with the Council** | **12,498** |

Key Management Personnel: The non-voting Board members employed by the NHS Board and recharged to the IJB include the Chief Officer and the Chief Financial Officer. These costs are met in equal share by the NHS GG&C and East Dunbartonshire Council. The details of the remuneration for some specific post-holders are provided in the Remuneration Report.

Balances with East Dunbartonshire Council

| 31 March 2016 £000 | | 31 March 2017 £000 |
|---|---|---|
| 1,398 | Debtor balances: Amounts due from the Council | 3,910 |
| | Creditor balances: Amounts due to the Council | 0 |
| **1,398** | **Net Balance with the Council** | **3,910** |

## 12. Contingent Assets &Liabilities

A contingent asset or liability arises where an event has taken place that gives the IJB a possible obligation or benefit whose existence will only be confirmed by the occurrence or otherwise of uncertain future events not wholly within the control of the IJB. Contingent liabilities or assets also arise in circumstances where a provision would otherwise be made but, either it is not probable that an outflow of resources will be required or the amount of the obligation cannot be measured reliably.

Contingent assets and liabilities are not recognised in the Balance Sheet but disclosed in a note to the Accounts where they are deemed material.

There are no contingent assets or liabilities.

## 13. VAT

VAT payable is included as an expense only to the extent that it is not recoverable from Her Majesty's Revenue and Customs. VAT receivable is excluded from income.

**Agenda Item Number: 6**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Draft Annual Performance Report 2017** |
| **Report By** | **Sandra Cairney Head of Strategy, Planning & Health Improvement, East Dunbartonshire Health & Social Care Partnership** |
| **Contact Officer** | **Fiona McCulloch, Planning, Performance & Quality Manager 0141 355 2395 Fiona.mcculloch@ggc.scot.nhs.uk** |

| | |
|---|---|
| **Purpose of Report** | The purpose of this report is to update the Board on the progress of the strategic review and reform of Out of Hours services across NHS Greater Glasgow & Clyde |

| | |
|---|---|
| **Recommendations** | The Partnership Board is asked to:<br>a) note the content of the Draft Annual Performance Report and the data not yet available<br>b) Approve the content of the draft report as presented |

| | |
|---|---|
| **Relevance to HSCP Board Strategic Plan** | The Strategic Plan 2015-18 details the HSCP priorities and improvements to be delivered to our adult population. These priorities are set out and measured against the 9 National Health and Wellbeing outcomes and related Indicators. The purpose of the Annual Performance Report is to provide an assessment of the HSCP's performance in relation to the delivery of the National Outcomes and indicators, and related local outcome measures. |

**Implications for Health & Social Care Partnership**

| | |
|---|---|
| **Human Resources** | None |

| | |
|---|---|
| **Equalities:** | None |

| | |
|---|---|
| **Financial:** | The Annual Report is required to report on finance and Best Value against the National Outcomes. |

| | |
|---|---|
| **Legal:** | It is prescribed in the Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 that integration authorities are required to prepare an Annual Performance Report. The report must be published by the end of July each year. |

| | |
|---|---|
| **Economic Impact:** | None. |

| | |
|---|---|
| **Sustainability:** | None. |

| | |
|---|---|
| **Risk Implications:** | None |

| | |
|---|---|
| **Implications for East Dunbartonshire Council:** | None. |

| | |
|---|---|
| **Implications for NHS Greater Glasgow & Clyde:** | None. |

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

| | |
|---|---|
| **1.0** | **MAIN REPORT**<br>**PDF Attached** |

East Dunbartonshire Health & Social Care Partnership

# HEALTH & SOCIAL CARE PARTNERSHIP BOARD

# ANNUAL PERFORMANCE REPORT 2016- 2017

## DRAFT JUNE 2017

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

NHS
Greater Glasgow and Clyde

# CONTENTS

# PART 1. INTRODUCTION

The Public Bodies (Joint Working) (Scotland) Act (2014) requires Integrated Joint Boards to produce and publish an Annual Performance Report which reports performance in relation to each of the 9 National Health & Wellbeing Outcomes and the associated Core Suite of Indicators.

This document represents the second Annual Performance Report produced by East Dunbartonshire Health and Social Care Partnership Board (HSCP Board). This Annual Performance Report relates to the key priorities for adult health and social care set out in the Strategic plan (2015-2018).

NHS Community Children's Services, Children's Social Work Service and Criminal Justice Social Work Services were not delegated functions until August 2016. As a consequence these services were not reflected in the Strategic Plan and associated Annual Performance Reports for the period of 2015-2017.

The document is set out under the nine National Outcomes to reflect the format of the Strategic Plan. Performance reporting relates to the period 2016-2017. A range of methods are used to report progress and includes statistical information, case studies and service user/carer feedback.

**Table 1. National Outcomes**

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

# PART 2. DELIVERING THE NATIONAL OUTCOMES

**Outcome 1**

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

| Local Performance Measures | 2016 | 2017 | Target |
|---|---|---|---|
| Number of alcohol brief interventions delivered | 625 | 717 | 487 |
| Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral | 98.4% | 92.5% | 85% |
| Percentage of clients will wait no longer than 3 weeks from referral to alcohol and drug treatment | 58% | 84.7% (Dec 2016) | 91.5% |

The Health & Social Care Partnership (HSCP) leads the delivery of the Community Planning Partnership's mainstreaming aspiration through the delivery of priorities outlined in the Joint Health Improvement Plan (JHIP). The JHIP recognises the scope to improve local universal health and wellbeing activity which is described through a matrix of shared objectives and actions across partner organisations. The Plan seeks to promote equality of access to services and opportunities that support individuals, families and communities to be involved in improving their own health and wellbeing. Diagram 1 reflects some examples of health improvement interventions and activity.

**Diagram 1. Health Improvement Interventions & Activity**

| | |
|---|---|
| **100** | **3rd sector well-being reviews** |
| **33%** | **increase in uptake of Community cookery programmes** |
| **£470k** | **income secure for 121 older people's through the financial Inclusion Service** |
| **2,400** | **residents participated in 219 walks** |
| **624** | **referrals to Live Active Gym** |

Psychological therapies 18 week target has remained above target for 2016/17. Evening appointments and localised clinics have been introduced to further improve access to early intervention and support for those with mental health issues.

The number of Alcohol Brief Interventions (ABIs) completed for 2016/17 was 147% above target. The uptake of ABIs within the wider community setting was very positive, but there is a general low uptake within Primary Care setting. The annual performance plan for ABI's will reflect actions to encourage and support uptake within primary care.

The integrated East Dunbartonshire Drugs & Alcohol Service (EDADS) are working to improve on the waiting times from referral to alcohol and drug treatment. The team have begun to redesign the referral process, integrate health and social work administration

processes, and ensure senior staff within the team are overseeing the recording processes for waiting times.

## Outcome 2

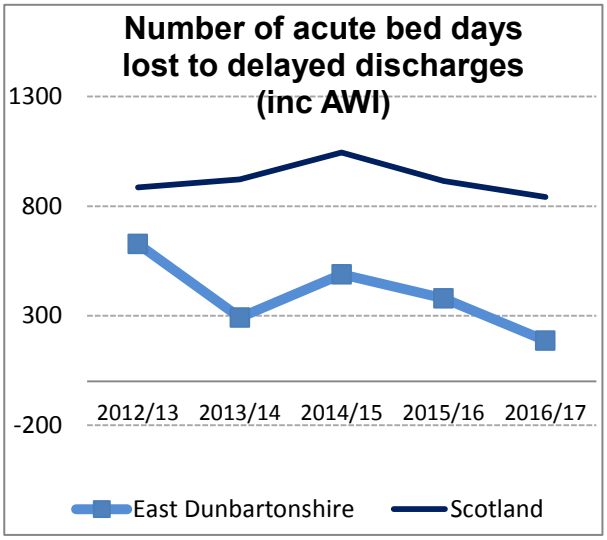
**People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.**

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

| Local Performance Measures | 2015/16 | 2016/17 | Target |
|---|---|---|---|
| Number of people aged 65+ in permanent care home placement | 674 | 681 | 640 |
| Percentage of people 65 or over with intensive needs receiving care at home | 38.1% | 38.4% | 32% |
| Percentage of people 65+ receiving a homecare service during evenings or overnight | 50.9% | 52.9% | 50 |
| Percentage of people 65+ receiving a homecare service at weekends | 90.2% | 93.3% | 84% |

Reduction in delayed discharges has been achieved over a sustained period. A range of activities have contributed to this success including:

- weekly delayed discharge meetings enable early identification of people admitted to hospital who potentially require complex discharge planning. This includes consideration of those suitable for intermediate care;
- eight intermediate care beds have been commissioned within a local Care Home and have been operational since November 2016. The inter agency approach is undergoing a formal evaluation, but early indicators suggest



that **over 30%** of those transferred to this facility are able to return to their own homes after a short period of rehabilitation; and

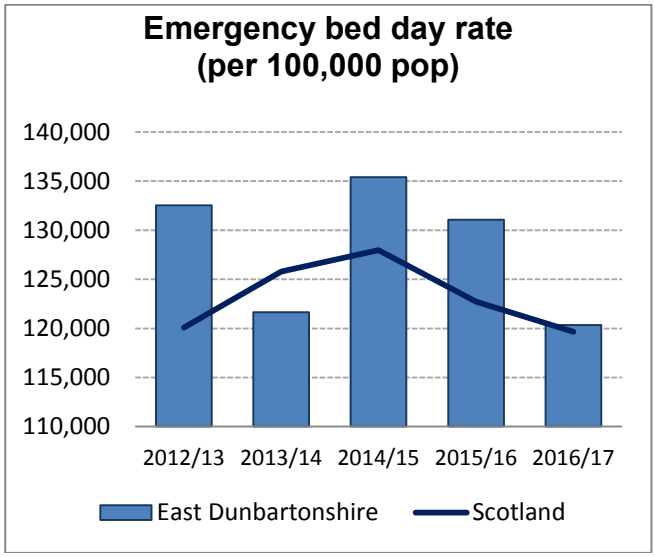
- access to services has been improved including self referral to the Community Rehabilitation Team(CRT). A single point of access for all weekend calls from acute services to nursing and CRT is now being coordinated through the Homecare Team to enable people to be discharged from hospital at the weekends.

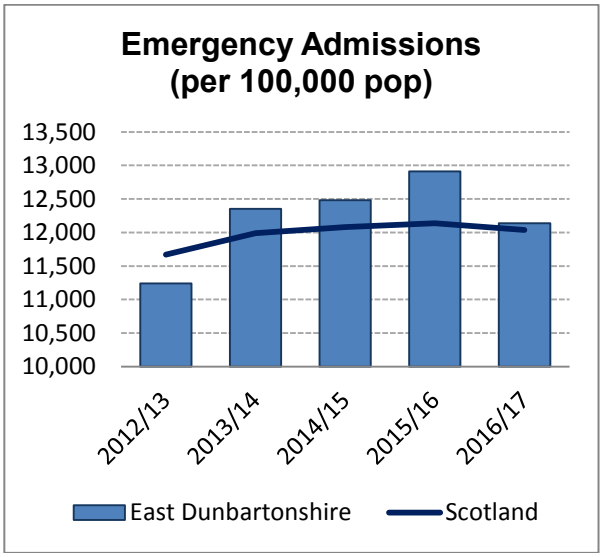
***Case Study***

***Mr A was very frail, and was discharged from hospital to the Intermediate Care Unit with a view to finding a suitable long term care placement, although he wanted to return to his own home.***

***While in the unit, the multidisciplinary rehabilitation team worked with the care staff to maximise his mobility. Mr A thrived in the Unit, gaining confidence and function. As a result, he was able to be safely and effectively discharged back to his own home and has managed to remain in his home, with support, rather than going into long term care.***

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




Some examples of work being undertaken to prevent avoidable admissions include:

- The Rapid Assessment Link team provides GPs with a rapid response service for people who are at potential risk of hospital admission. During 2016/17, the team received 264 referrals of which 202 **(76.5%)** people avoided the requirement for a hospital admission by receiving appropriate care in their own home.
- The Red Cross, funded, through the Integrated Care Fund, provide transport home for older people who are discharged from A&E. This involves taking the patient home and helping settle them back into their homes. During 2016, **118** East Dunbartonshire residents benefitted from this service and avoided unnecessary hospital admission.

- The Community Mental Health Team meets weekly with Secondary Care and Crisis Team colleagues to review hospital admissions and repeat A&E attendees, and discuss if they could have been avoided. Each person's individual care and treatment plan is reviewed to ensure they receive the correct treatment and support in the community to prevent hospital attendance.

Partnership working with our local independent Care Homes is being strengthened through the provision of liaison nurses, including Mental Health Liaison nurses, and pharmacist support. Enhanced level '*Stress and Distress in Dementia'* training was delivered to both HSCP and Care Home senior staff. There are some early indications of the success of this joint work with a **77.8%** reduction in Crisis duty calls from Care Homes. The Post Diagnostic Support Model will continue to be delivered as well as introducing the recording of *Stress & Distress* information in service user Personal Support Plans in preparation for their increased complexity and level of need. This work is being recognised nationally and a poster presentation has been accepted at the NHS Scotland Event in June 2017 to showcase this model.


There is a range of assistive technology equipment available to support people to remain independent in their own homes including personal alarms, falls monitors, activity monitors and property exit sensors. The HSCP has created a dedicated post to promote assistive technology solutions (Data Pending).

## Outcome 3

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

| Local Performance Measures | 2015/16 | 2016/17 | Target |
|---|---|---|---|
| Percentage of people 65+ indicating satisfaction with their social interaction opportunities | 93% | 100% | 95% |
| Percentage of service users satisfied with their involvement in the design of their care packages | 95% | 100% | 95% |
| Percentage of service users satisfied with the quality of social care provided | 99% | 100% | 99% |

The national Health & Social Care Experience survey **(Table 2)** is undertaken ever two years focussed on the importance of a personal outcomes approach. The HSCP improved performance against all these outcomes in 2015/16. A working group has been established to develop a tool which will collate service user data on a more regular basis to ensure personalised care is at the centre of service delivery. This will build on the service user Reflective Questionnaire developed by the Community Rehabilitation Team, and the 'How Are We Doing' methodology introduced by Community Nursing.

| Table 2. National User Feedback Outcomes | 2013/14 | 2015/16 |
|---|---|---|
| Percentage of adults able to look after their health very well or quite well | 95.1% | 95.1% |
| Percentage of adults supported at home who agree that they are supported to live as independently as possible | 82% | 88.3% |
| Percentage of adults supported at home who agree that they had a say in how their held, care or support was provided | 76% | 86% |
| Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated | 75% | 75% |
| Total % of adults receiving any care or support who rated it as excellent or good | 82% | 84% |
| Percentage of people with positive experience of the care provided by their GP practice | 91% | 91% |
| Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life | 83% | 86% |
| Total combined % carers who feel supported to continue in their caring role | 39% | 45% |
| Percentage of adults supported at home who agreed they felt safe | 83% | 86% |

Service users and carers were supported to undertake a survey regarding the reception at the Kirkintilloch Health & Care Centre. The findings of their survey highlighted areas for improvement including possible redesign of the reception desk and waiting areas to address issues of confidentiality, stigma and accessibility. As a direct consequence of these findings a range of work is underway to improve the structural layout, furnishings and reception processes to better meet the needs of people accessing the facility.

**Photograph of the KHCC Reception Area**

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The HSCP Board produced its first Equality & Diversity Mainstream Report and Outcomes (2017–21) which support the organisation to meet the general equality duty (Equality Act 2010). This outlines the planned activities and measures towards achieving our equality and diversity outcomes. Equalities leads have been identified within each of the HSCP's services and are responsible for ensuring their team follows the equalities development framework when developing new, or significantly updating, any plans, programmes or strategies related to the services they manage.

Self Directed Support (SDS) is implemented across all service user groups in East Dunbartonshire, providing service users with the flexibility, control and choice over the provision of their social care and support. There are four options offered: Option 1(direct payment); Option 2 (individual service fund); Option 3 (local authority arranged services), and Option 4 (mixture of options). During 2017/18, the current SDS Strategy will be reviewed to inform an update of the SDS Communication Strategy and Action Plan.

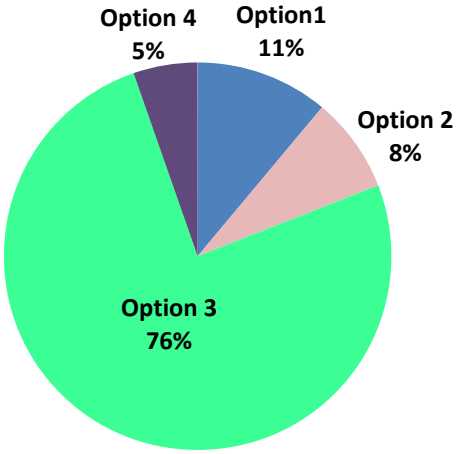


**Diagram 2 SDS Uptake 2016/17**

An Alcohol & Drugs Partnership pathway has been implemented across recovery services and this will be supported by the introduction of a single referral process across all services during 2017, ensuring the delivery of integrated and co-ordinated, person-centred services for service users.

HSCP Mental Health staff and East Dunbartonshire Alcohol & Drug Services (EDADS) undertook trauma awareness training, and have worked with service users who have experienced trauma. This model is encouraging service users to attend the clinic sessions which have been designed to provide a more positive experience and positive environment for those attending.

## Outcome 4

**Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**

| Local Performance Measures | 2015/16 | 2016/17 | Target |
|---|---|---|---|
| Number of newly diagnosed people with Dementia in receipt of one year's post diagnostic support (PDS) | 100% | 18% | 100% |

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

- Dementia website now live: **www.eddn.org.uk**
- Intergenerational café supported by 48 secondary 6 school pupils

- People with dementia are contributing to the quality of their life through introduction of PRESENT Charter and local Dementia Voices group
- Dementia friendly sites established in supermarkets and golf clubs.
- 4 weekly supported walks
- Music Network

The HSCP has worked in partnership with a third sector organisation to develop a pathway for the provision of Post Diagnostic Support. Following initial success in working towards the target, the programme stalled due to unexpected staff vacancies and subsequent recruitment difficulties. This has had a detrimental impact on the delivery of the service in the short term. The vacancies have now been filled and it performance will improve significantly during 2017/18.

The East Dunbartonshire Information Line (OPAL) is funded through the Integrated Care Fund. The service connects people with a wide variety of local services, information, and social activities. During 2016/17, **405** contacts were made to the service and **890** onward referrals were made, in particular for income maximisation advice and links to social activities.

To develop self-management approaches for those living with one or more long term conditions (LTCs), the HSCP is supporting 4 GP practices to participate in the House of Care pilot. This holistic approach supports a process of joint decision making, goal setting and action planning that enables people to articulate their own needs and decide on their own priorities.

The HSCP coordinates the joint endeavours of four different cancer programmes. Some examples of partnership work include

- Detect Cancer Early campaigns, in partnership with local Housing Associations in PLACE Communities, have delivered key messages through community newsletters and social media.
- Third sector volunteers, who have previously been diagnosed with cancer, have provided 13 community meetings and campaigns during 2016/17 to share experiences and raise awareness.
- 7 local GP practices offer a post diagnostic holistic needs assessment to support their patients with a diagnosis of cancer.

Diagram 2 provides a visual representation of a good practice model that has been developed and implemented by the mental health and health improvement teams, in collaboration with our third sector partners to help improve the physical health and wellbeing of our mental health service users in East Dunbartonshire.

**Diagram 2. Self Management Model**


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The Joint Learning Disability Team (JLDT) provides specialist assessment, advice, treatment and support services for adults with a learning disability and their carers and help people to live as independently as possible with whatever support they need. A local, person intensive, residential facility has been developed for three adults with complex learning disabilities and autism to enable group living for hard to place individuals previously placed a distance from East Dunbartonshire.

***Case Study***

***Mr B is a 21 years old with a severe learning disability, autism and history of challenging behaviour. He lives at home with his mum, supported by a specialist service. He has no verbal communication and is unable to attend GP/hospital appointments for routine screening due to the complexity of his condition.***

***He started showing signs of increased aggression, poor colour, decreased appetite, lethargy and an onset of seizures. Through liaison with his GP, family, care providers and the Learning Disability team, the LD Nurse Specialist was able to take bloods for investigation. It was found that he was very unwell with a severe Vitamin B12 deficiency.***

***After commencing on medication, his behaviour improved and he is now much***

## Outcome 5

**Health and social care services contribute to reducing health inequalities.**

| National Core Indicators | 2015/16 |
|---|---|
| Premature mortality rate per 100,000 persons (Latest available data) | 307 |

The European age-standardised mortality per 100,000 for people aged under 75yrs, the national core indicator for premature mortality, is also considered as a proxy for deprivation.

East Dunbartonshire has the second lowest deprivation rate in Scotland. However, five datazones are in the 20% most deprived datazones and 28 are in the lowest 40% most deprived datazones. Together with Community Planning partners, the HSCP targets services within these areas to address the inequalities gap.

The Smoking Cessation Incentive Scheme, in partnership with Strathkelvin Credit Union, has been nationally recognised as a model of good practice. Over the last two years, 50 people accessing stop smoking support have participated in this scheme by also joining the Credit Union, resulting in an average **£650** being deposited into accounts of individuals.

Access to smoking cessation services has been enhanced by providing open access sessions across East Dunbartonshire, and weekly sessions in local pharmacies from a Smokefree community advisor. Service users have reported that they found it beneficial to have access to the face-to-face support for as long as they need it.

The Primary Care Mental Health Team has improved access to Psychological therapies for local communities, including Lennoxtown, and Auchinairn, to increase the availability of evening sessions, and EDADS has established a local drop-in service in the Lennoxtown Hub.

> ***"I found it easier to access services which I have had to travel further to in the past"***
>
> ***Service user feedback***

## Outcome 6

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

| Local Performance Measures | 2015/16 | 2016/17 | Target |
|---|---|---|---|
| Number of carers who feel supported and capable of continuing in a caring role | 100% | 97% | 94% |

The social care service user feedback demonstrates high level performance which exceeds the local target in relation to supporting Carers to continue in their caring role.

Carer's Link is the local third sector carer organisation which is commissioned to provide support, information and advocacy to carers. Carers Link has had direct, or telephone contact with **1153** carers during 2016/17, of which 393 were new contacts.

The Carer Information Strategy fund provides the opportunity to support the provision of the '*Caring with Confidence'* programme aimed to increase the resilience of carers. This programme, developed and provided by Carer's Link, supported 187 carers through one or more of training sessions offered during 2016-17. Carer feedback reported that **98%** agreed or strongly agreed that the session they attended made them feel more confident, less stressed and better informed in their caring role.

> ***"I found the course extremely beneficial and have adopted some of the techniques which I use daily"***
>
> ***Carer Feedback***

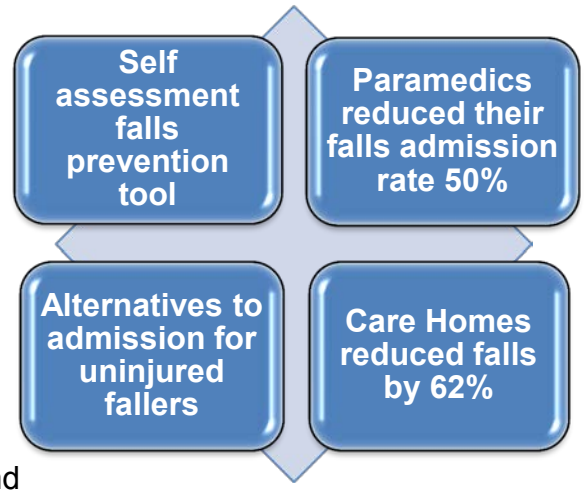
Work is underway to prepare for the implementation of the Carers (Scotland) Act 2016 which is due to comes into force in March 2018. The East Dunbartonshire Carers Strategy is in the early stages of preparation and will be developed following the publication of the awaited Regulations and Guidance. The Carers Strategy will set out key priorities that will focus on the identification, assessment and support for carers.

## Outcome 7

**People who use health and social care services are safe from harm.**

| National Core Indicators | 2015/16 | 2016/17 |
|---|---|---|
| Falls rate per 1,000 population aged 65+ | 21 | 21 |
| Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections | 83% | Updated data pending |

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




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

A Scottish Patient Safety Programme pilot has been commenced in 5 care homes within East Dunbartonshire. The programme was particularly focused on reducing pressure ulcers and the introduction of insulin management plans for appropriate individuals. The peer grading of pressure ulcers and review of record keeping was introduced and pressure ulcer data collection commenced in November 2016, with the 5 Homes submitting results monthly. A local learning set took place in March 2017 and focussed on ensuring accurate data collection and the PDSA cycle will be utilised to analyse the effect of the implemented change.

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

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

The Care Commission undertakes scheduled and unscheduled inspections across a range of services. Services are graded 0-6 (6 being the best) under the headings of: Support; Environment; Staffing, and Management. The inspections of the following services were graded only on Support and Staffing.

In East Dunbartonshire, 5 services were inspected in the last year and the findings were extremely positive (Table 3) and provide an indication of the quality of services delivered. Plans are in development to progress areas for improvement. The full inspection reports can be found on the Care Inspectorate web page: http://www.careinspectorate.com/index.php/type-of-care

**Table 3 Summary of Inspection findings**

| Base<br>Care Inspectorate No. | Insp. Date | Quality Theme Care Grades | | No. Of Recommendations |
|---|---|---|---|---|
| **Milan Support Service**<br>CS2006125849 | 04/08/16 | Support | **5** | **3** |
| | | Staffing | **5** | |
| **John Street House**<br>CS2003000797 | 24/08/16 | Support | **5** | **3** |
| | | Staffing | **5** | |
| **Meiklehill Service**<br>CS2004077753 | 24/10/16 | Support | **5** | **2** |
| | | Staffing | **5** | |
| **Ferndale**<br>CS2006124929 | 16/02/17 | Support | **4** | **3** |
| | | Staffing | **4** | |
| **Kelvinbank Resource Centre**<br>CS2004057808 | 27/02/17 | Support | **5** | **4** |
| | | Staffing | **5** | |

**Outcome 8**

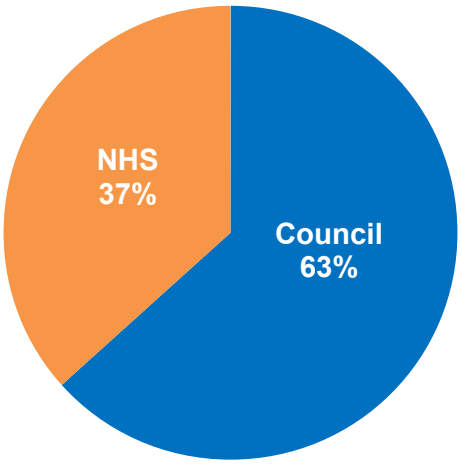
**People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**

The Kirkintilloch Health & Care Centre (KHCC) has become the new headquarters for the HSCP, with the Senior Management Team and support functions transferring from Stobhill in December 2016. The KHCC re-modelling project has also provided opportunities for health and social care staff to relocate from a range disparate building across the Authority into the KHCC further enhancing integrated working between service teams.

Electronic systems, such as EMIS and Carefirst, are now being accessed by health and social care staff to improve communication and interface working to assist in the sharing of information to support integrated service provision.

Workforce planning for the Health & Social Care Partnership is at an early stage of development, working through many of the current characteristics and demographics of the current workforce before starting the process of looking at the future workforce.

**Diagram 3 Staff by Employing Authority**




The HSCP Chief Officer has responsibility for the management of a directly deployed workforce of 721 staff, (594.45 wte). The workforce is employed by either NHSGGC or East Dunbartonshire Council and provides a wide range of social care and health care to the population of East Dunbartonshire.

The workforce is being reviewed to further strengthen integrated services to ensure that our evolving integrated structures are able to achieve the ambitions set out in our Strategic plan. This is being supported by a learning and education plan which assists staff to change and improve service delivery models.

An Organisational Development programme for staff involvement is in being further developed to take forward the 20:20 Vision priorities: Leadership, Service Improvement, Culture, and Team Development. The Organisational Development Action Plan, linked to the Workforce Development Plan, sets out the process by which to address these four priorities with staff during 2017/18.

**Outcome 9** **Resources are used effectively and efficiently in the provision of health and social care services**

| National Core Indicators | 2015/16 | 2016/17 |
|---|---|---|
| Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency | 23% | 22% |

The indicator, 'percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency' provides an overall indication of the financial resource spent on emergency hospital care where appropriate care in a community setting would be more beneficial for the person, and ensure resources were spent more effectively. The HSCP has successfully reduced this percentage to below the Scottish average during 2016/17

It is important that resources are used effectively and efficiently, in partnership with key partners and commissioned services.

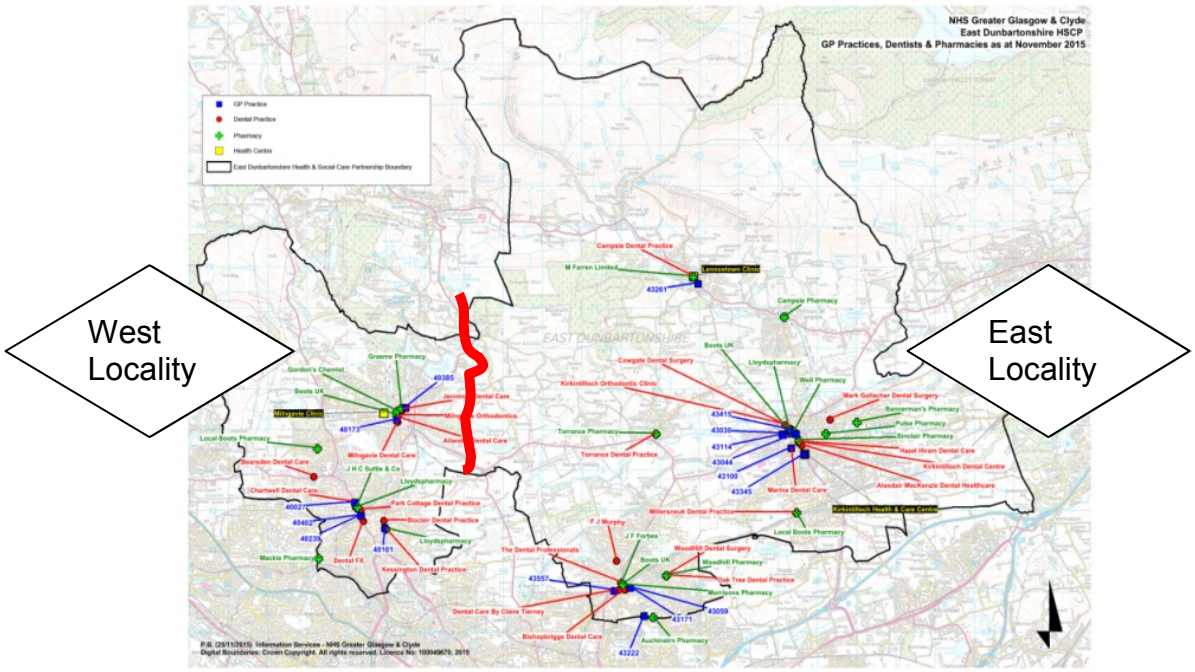
A number of strategic service reviews are being identified and scoped to determine potential redesign to ensure service provision is effective, flexible and responsive to local needs, as well as being financially sustainable in the longer term. Key areas include:

- Older People Day Care;
- Learning Disability; and
- Mental Health

Learning from these reviews, along with data from the Joint Strategic Needs Assessment, will help to shape and structure current and future of service provision and inform the Market Facilitation process.

# PART 3. LOCALITIES

The HSCP has two localities: an East Locality and a West Locality. The Locality Planning Groups, have been established and are meeting regularly, and the Chairs of the Locality Groups attend the Strategic Planning Group meeting to inform the SPG on progress against their priorities.




Each locality has agreed their priorities, as set out below. During 2017, the Locality Groups will be provided with their locality dataset to assist in future planning and service provision:

**West Locality Priorities**

- Supporting people with dementia and mild cognitive impairment, improving access to day care services.
- Emulating the memory joggers groups into the community setting.
- Developing dialogue with Acute services on intermediate and continuing care

**East Locality Priorities**

- Focus on Care After Cancer treatment with emphases on social prescribing
- Awareness raising of prevention and early screening for cancer
- Development of a walking group for people with long term conditions
- Supporting people who are housebound in the community

# PART 4. PUBLIC ENGAGEMENT

The HSCP ensures a comprehensive approach to public, service user and carer engagement to support the review and revision of local service delivery. Service user and carer representatives attend the statutory Strategic Planning Group and Locality Planning Groups, and they are supported by the Public, Service User and Carer group to make effective contributions to these strategic planning groups. A range of engagement activities have taken place over the last year. Examples of the discussions to which public, service user and carer representatives contributed are provided in Diagram 4.

**Diagram 4. Public, Service User and Carer Contribution**

**Strategic Planning Group**

- Provided views and comments on 3 Strategic: Supporting People with Mental Health in their Community; Self Management / Long Term Conditions; and Preventing Unnecessary Hospital Admission .

**East Locality Planning Group**

- Provided views and comments on:health inequalities; cancer prevention and recovery; implementation of new GP based physical activity programme; and issues relating to those who are housebound..

**West Locality Planning Group**

- Provided views and comments on:current pathway for people with dementia; Day Care review; Long term conditions and self care management; and, the new Intermediate Care Model.

**Public Service User & Carer Network**

- Agreed and confirmed representatives for the HSCP Board, Strategic Planning Group and Locality Planning Group; agreed to establish a support mechanism for service user and carer representatives on statutory groups; and, discussed current consultations.

A range of methods are used to widely engage service users and carers regarding their experience of the services they receive and contributing to HSCP service development, for example:

- Engaging with communities in using the PLACE standard tool to review current and future community service provision across sectors.
- Using a Mental Health Peer Support Worker approach to act as a ‘critical friend’ to inform the development of service information; and evaluation.
- Exploring the ‘Triangle of Care’ model in Mental Health Services to improve joint care planning between the clinical staff, service users and carers.
- Involving members of the public in the development and implementation of the ‘Canal Festival Smoke Free Areas’, through developing public notices and participating in a public survey pre and post the event to inform how this initiative may be further developed.
- Launching the HSCP Website which provides a mechanism for wider public engagement and information sharing www.eastdunbarton.gov.uk/health-and-social-care

# PART 5. FINANCE

## HSCP BOARD'S POSITION AT 31 MARCH 2017

The activities of the Health and Social Care Partnership are funded through an arrangement whereby the Council and Health Board agree their respective contributions and it is for the partnership thereafter to deliver on the priorities set out in the Strategic Plan. The scope of budgets agreed for inclusion within the HSCP for 2016/17 from each of the partnership bodies were:-

**Table 4. HSCP Board Budgets 2016/17 (from 1st April 2016 to 31st March 2017)**

| | |
|---|---|
| HSCP Board Health Budget | £79,416,000 |
| HSCP Board Social Work Budget Adult Services | £42,404,000 |
| HSCP Board Social Work Budget Children & Criminal Justice Services *(From 11th August 2016)* | £7,365,000 |
| HSCP Board Social Work Budget Other | £ 1,194,000 |
| Set Aside – Share of Prescribed Acute functions | £17,381,000 |
| **TOTAL** | **£147,760,000** |

The budget includes an element of funding provided by the Scottish Government to deliver on the key outcomes for the Partnership in the form of delayed discharge (£510k), integrated care funding (£1.2m) and Social Care funding (£4.3m).

The Health Budget includes an element relating to Oral Health Services (£10,355,000) which is a service hosted by East Dunbartonshire HSCP and delivered across Greater Glasgow & Clyde (GG&C).

The full extent of this budget is reflected in these accounts as prescribed within the Integration Scheme. There are services hosted within other GG&C partnerships which have similar arrangements and which support the population of East Dunbartonshire such as MSK Physio, Podiatry, and Continence Care etc.

The extent to which these services (incl Oral Health) are consumed by the population of East Dunbartonshire is reflected within the Income and Expenditure Statement to give a true cost of delivering services to support the population of East Dunbartonshire. The detail of these services is set out in note 10 to these Accounts.

The set aside budget relates to certain prescribed acute services including A&E, General Medicine, Respiratory care, Geriatric long stay etc. where the redesign and development of preventative, community based services may have an impact and reduce the overall unplanned admissions to the acute sector, offering better outcomes for patients and service users.

Further work will be progressed over the next year to develop a more accurate costing framework for unscheduled care services to make this allocation more real so that this more accurately reflects usage of these services and facilitates the resource shift required to deliver sustainable services within the community as opposed to a hospital setting. An allocation has been determined by the Greater Glasgow & Clyde Health Board for East Dunbartonshire of £17,380,000.

These notional budgets are based on direct costs per bed day for each relevant speciality within the IJB based on average activity for the 3 years 2011/12 – 2013/14 provided by NHSGGC Information Services department and cost for 2013/14 taken from the NHS Scotland Cost Book. Accident & Emergency outpatient attendances will be included at 3 year average activity and direct cost per attendance for 2013/14. This has been inflated by 1% for 2016/17 allocations.

During 2016/17, a due diligence exercise was carried out to consider the sufficiency of the budget provided to support the delivery of Children's Social Work and Criminal Justice Services which became part of the Partnership from the 11th August 2016. This identified significant financial pressure in relation to residential care packages which have been the subject of regular reports to the HSCP Board and will require on-going monitoring.

## KEY RISKS AND UNCERTAINTIES

The period of public sector austerity and reduction in the overall level of UK public sector expenditure is anticipated to extend over the medium term horizon.

Future Scottish Government grant settlements remain uncertain with further reductions in government funding predicted to 2019/20. The EU referendum result on the 23rd June 2016 created some further uncertainty and risk for the future for all public sector organisations.

The Partnership will prepare a financial plan aligned to its strategic priorities. The aim is to plan ahead to meet the challenges of demographic growth and policy pressures, taking appropriate action to maintain budgets within expected levels of funding and to maximise opportunities for delivery of the Strategic Plan.

Additional funding of £107m has been provided to Health and Social Care Partnerships for 2017/18 to support providers to pay the living wage to care workers and may provide some capacity to address social care pressures.

The most significant risks faced by the HSCP over the medium to longer term are:-

- The increased demand for services alongside reducing resources. In particular, the demographic increases predicted within East Dunbartonshire is significant with the numbers of older people aged 65+ is set to increase by 54% over the period 2012-2037 (an average increase of 9% every 5 years).

  In addition, more significantly older people aged 85+ is set to increase by 201.4% over the period 2012-2037 (an average increase of 25% every 5 years).

  East Dunbartonshire has a higher than national average proportion of older people, therefore any increases can have a significant impact on the need for services as people get older and frailer.

- The cost and demand volatility across the prescribing budget which is currently the subject of a risk sharing arrangement across GG&C, currently under review.

- The achievement of challenging savings targets from both partner agencies that face significant financial pressures and tight funding settlements, expected to continue in the medium to long term.
- The capacity of the private and independent care sector who are struggling to recruit adequate numbers of care staff to support service users which is being felt more acutely south of the border but remains a concern locally.

Financial governance arrangements have been developed to support the HSCP Board in the discharge of its business. This includes financial scoping, budget preparation, standing orders, financial regulations and the establishment of an Audit Committee to ensure the adequacy of the arrangements for risk management, governance and the control of the delegated resources.

**ANALYSIS OF THE FINANCIAL STATEMENTS (FINANCIAL PERFORMANCE)**

The partnership's performance is presented in these Annual Accounts. Table 4 on page 17 shows a net underspend of £4.1m on the partnership funding available for 2016/17.

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

In addition there were surpluses across Children's Social Work budgets (£460k) as a result of vacancies across the service which supported pressure on residential school expenditure and a small surplus on adult service budgets (£280k) across learning disability and mental health services supporting pressure in relation to older people services (care home and homecare provision). There was some additional surplus in relation to other budgets delegated to the partnership in relation to the Private Sector Housing Grant (PSHG), care & repair and fleet recharges (£242k).

NHS Community budgets also delivered a surplus (£1.4m) in relation to delays in filling vacancies across community functions including Oral Health, District Nursing and Rehabilitation Services. There was also a surplus on the Integrated Care Fund which was not fully allocated in year and delayed discharge monies which were directed to fund an Intermediate Care Facility (part year costs only).

The surplus generated during 2016/17 will further the Partnership's reserves position and will provide some resilience for future year financial pressures and any slippage in savings targets. There will also be an element ear-marked for service re-design in furtherance of the priorities set out in the Strategic Plan. The level of partnership reserves is now £5.1m as set out in table on page 24.

The HSCP continues to face significant financial pressures from demographic growth particularly amongst the elderly population generating demand and increased costs across a range of adult care services.

Both partner organisations continue to face significant financial challenge.

The NHS Greater Glasgow & Clyde Health Board has savings of +£100m to secure during 2017/18 with a number of initiatives underway to deliver on this challenge. Of the circa.£95m savings target, £16.6m relates to Health & Social Care Partnerships of which £1.5m relates to East Dunbartonshire with potential for a further share of £3.6m (ED -

£0.5m share) relating to un-achieved savings dating back to 2015/16 for CHP(s). This is currently the subject of ongoing discussion with NHSGGC Health Board and a solution hopeful during 2017/18 as to how these monies should be treated in future years.

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

In total the level of savings on Partnership savings to be delivered is £5.1m for 2017/18 and it is expected that this position will continue for future years given the challenging financial settlements expected to both the Local Authority and NHSGGC.

There is some recurring funding available to Health & Social Care Partnerships from the Scottish Government in 2017/18 in the form of Integration Funding (ED - £0.9m) and Delayed Discharge Funding (ED - £510k) and additional funding from a share of £107m (ED- £1.84m), This is aimed at increasing the living wage across the care home and care at home sectors, supporting implementation of the Cares Act and changes to local authority charging policies in respect of war veterans.

**Agenda Item Number: 7**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Quarter 4 Performance Report** |
| **Report By** | **Sandra Cairney, Head of Planning, Strategy & Health Improvement, East Dunbartonshire Health & Social Care Partnership** |
| **Contact Officer** | **Fiona McCulloch, Planning, Performance & Quality Manager**<br>**0141 355 2395**<br>**Fiona.mcculloch@ggc.scot.nhs.uk** |

| | |
|---|---|
| **Purpose of Report** | The purpose of this report is to present a summary of the agreed HSCP targets and measures, relating to the delivery of the strategic priorities, for the period January – March 2017 (Quarter 4). |

| | |
|---|---|
| **Recommendations** | It is recommended that the Health & Social Care Partnership Board:<br><br>Notes the content of the Quarter 4 Performance Report |

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

**Implications for Health & Social Care Partnership**

| | |
|---|---|
| **Human Resources** | None |

| | |
|---|---|
| **Equalities:** | None |

| | |
|---|---|
| **Financial:** | None |

| | |
|---|---|
| **Legal:** | None |

| | |
|---|---|
| **Economic Impact:** | None |

| | |
|---|---|
| **Sustainability:** | None |

| | |
|---|---|
| **Risk Implications:** | None |

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

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

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

## 1.0 MAIN REPORT

### SECTION 1 Performance Summary

| Key | |
|---|---|
| Positive Performance (on target) improving / declining |  |
| Negative Performance (below target) improving / declining |  |

 **Positive Performance (on target & improving) is reported in: (20)**

| Ref | | |
|---|---|---|
| **2.1.1** | Sustain and embed smoking quits, at 12 weeks post quit, in the 40% SIMD areas (Cumulative quarterly) |  |
| **2.1.2** | Sustain and embed alcohol brief interventions in three priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings. (Cumulative quarterly) |  |
| **2.2.2** | Number of emergency admissions 75+ (per 1,000 pop) (rate at quarter end) |  |
| **2.2.3** | Number of delayed discharges for Adults with Incapacity (Acute Beds) |  |
| **2.2.4** | Number of acute bed days lost to delayed discharges for patients 65+ (inc AWI) |  |
| **2.2.5** | Number of acute beds days lost to delayed discharges for Adults with Incapacity (65+) |  |
| **2.2.14** | Percentage of people 65 or over with intensive needs receiving care at home (% at quarter end) |  |
| **2.2.15** | Percentage of EDC homecare customers 65+ receiving a service during evenings or overnight |  |
| **2.2.16** | Percentage of EDC homecare customers 65+ receiving a service during at weekends |  |
| **2.4.1** | Percentage of people 65+ indicating satisfaction with their social interaction opportunities (Social Care only) |  |
| **2.4.2** | Percentage of service users satisfied with their involvement in the design of their care packages (Social Care only) |  |
| **3.1** | 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services |  |
| **3.4** | Percentage of parents receiving 1:1 parenting support within the first 6 weeks following birth |  |
| **3.6** | Number of parents receiving planned 1:1 parenting support |  |

| | | |
|---|---|---|
| **3.7** | Percentage of child care Integrated Assessments (ICA) for SCRA completed within target timescales (20 days) | |
| **3.9** | Percentage of first Chid Protection review conferences taking place within 3 months of registration | |
| **3.11** | Percentage of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated | |
| **3.12** | Percentage of Social Work reports submitted to Child Protection Case Conference | |
| **4.1** | Percentage of Court report requests allocated to a Social Worker within 2 working days of receipt | |
| **4.3** | Percentage of CJSW reports submitted to Court by due date | |

**Positive Performance (on target but declining) is reported in: (1)**

| Ref | | |
|---|---|---|
| **2.6.1** | Percentage of carers who feel supported and capable of continuing in a caring role (Social Care only) | |

**Negative Performance (below target but maintaining/improving) is reported in: (5)**

| Ref | | |
|---|---|---|
| **2.2.7** | Percentage of people newly diagnosed with dementia accessing a minimum of one year's post-diagnostic support | |
| **2.2.9** | Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral | |
| **2.2.12** | Number of people aged 65+ in permanent care home placements (at quarter end) | |
| **3.8** | Percentage of Initial Child Protection Case Conferences taking place within 21 days from receipt of referral | |
| **3.10** | Balance of care for Looked After Children: Percentage of children being looked after in the community | |

**Negative Performance (below target and declining) is reported in: (5)**

| Ref | | |
|---|---|---|
| **2.2.1** | Rate of unplanned acute bed days 75+ (per 1,000 pop) (rate at quarter end) | |
| **2.2.8** | Number of people aged 65 years+ with an anticipatory care plan in place (DNs only) | |

| | | |
|---|---|---|
| **2.3.1** | Percentage of service users/clients satisfied with the quality of care provided (Social Care only) |  |
| **3.5** | As a proportion of parents who attend a Triple P group – the percentage of parents completing the Triple P programme |  |
| **4.2** | Percentage of Individuals beginning a work placement within 7 days of receiving a Community Payback Order |  |

**Indicators with no current data available: (7)**

| Ref. | | Notes |
|---|---|---|
| **2.1.3** | Percentage of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery | Not yet available from GG&C |
| **2.2.6** | Delayed Discharge >14 days | This indicator is no longer measured |
| **2.2.10** | Waiting Times for PCMHT - % of patients referred to 1st appointment offered <4 weeks | NHSGG&C Performance Team are currently developing reporting system. |
| **2.2.11** | Waiting Times for PCMHT - % of patients referred to 1st appointment offered <9 weeks | NHSGG&C Performance Team are currently developing reporting system. |
| **2.2.13** | Number of people 75+ with a telecare package (at quarter end) | Measurement and Reporting processes under Review. Accurate up-to-date baseline information will be available 2017 |
| **3.2** | Uptake of MMR: 24 Months | Not yet available from GG&C |
| **3.3** | Uptake of MMR: 5 Years | Not yet available from GG&C |

**SECTION 2 Adult Performance Quarterly Measures 2016-17**

| | Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | Quarter | | | | |
| **Ref.** | **Measure** | **Status** | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2017/18** | **2017/18** |
| | | | **Value** | **Value** | **Value** | | **Target** |
| **2.1.1** | Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas (estimated local data) | ✔ | **3** | **5** | **5** | **8** | **6** |
| **2.1.2** | Sustain and embed alcohol brief interventions in three priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings. (Cumulative quarterly) | ✔ | **207** | **390** | **416** | **717** | **487** |
| **2.1.3** | Percentage of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery | - | **96.8%** | **90.5%** | **87.4%** | **Not Available** | **91.5%** |

**SECTION 2 Adult Performance Quarterly Measures 2016-17**

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

| | | | Quarter | | | | |
|---|---|---|---|---|---|---|---|
| **Ref.** | **Measure** | **Status** | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2017/18** | **2017/18** |
| | | | **Value** | **Value** | **Value** | **Value** | **Target** |
| **2.2.1** | Rate of unplanned acute bed days 75+ (per 1,000 pop) (rate at quarter end) |  | **343** | **364** | **346** | **364** | **345** |
| **2.2.2** | Number of emergency admissions 75+ rate (per 1,000 pop) (rate at quarter end) |  | **28** | **28** | **31** | **28** | **29** |
| **2.2.3** | Number of delayed discharges for Adults with Incapacity (Acute Beds) |  | **0** | **0** | **0** | **0** | **0** |
| **2.2.4** | Number of acute bed days lost to delayed discharges for patients 65+ (inc AWI) |  | **527** | **513** | **633** | **474** | **622** |
| **2.2.5** | Number of acute bed days lost to delayed discharges for Adults with Incapacity (65+) |  | **0** | **0** | **0** | **0** | **0** |
| **2.2.6** | Delayed Discharge >14 days | **-** | **0** | **Not Available** | **Not Available** | **Not Available** | **0** |

## 2 Adult Performance Quarterly Measures 2016-17

| Ref. | Measure | Status | Quarter | | | | |
|---|---|---|---|---|---|---|---|
| | | | Q1 2016/17 | Q2 2016/17 | Q3 2016/17 | Q4 2017/18 | 2017/18 |
| | | | Value | Value | Value | | Target |
| 2.2.7 | Percentage of people newly diagnosed with dementia accessing a minimum of one year's post-diagnostic support. |  | 95% | 2% | 5.2% | 18% | 100% |
| 2.2.8 | Number of people aged 65 years+ with an anticipatory care plan in place (DNs only) |  | 65 | 70 | 68 | 67 | 70 |
| 2.2.9 | Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral |  | 100% | 100% | 0% | 80% | 85% |
| | Waiting Times PCMHT | | | | | | |
| 2.2.10 | % of patients referred to 1st appointment offered <4 wks | - | 99.6% | Not Available | Not Available | Not Available | 100% |
| 2.2.11 | % of patients referred to 1st treatment appt offered <9wks | - | 88% | Not Available | Not Available | Not Available | 100% |
| 2.2.12 | Number of people aged 65+ in permanent care home placements (at quarter end) |  | 669 | 700 | 685 | 681 | 640 |
| 2.2.13 | Number of people 75+ with a telecare package (at quarter end) | - | 491 | Not Available | Not Available | Not Available | 188 |
| 2.2.14 | Percentage of people 65 or over with intensive needs receiving care at home (% at quarter end) |  | 37.33% | 38.32% | 37.8% | 38.4% | 32% |
| 2.2.15 | Percentage of EDC homecare customers 65+ receiving a service during evenings or overnight |  | 49.9% | 51.6% | 51.9% | 52.9% | 50% |
| 2.2.16 | Percentage of EDC homecare customers 65+ receiving a service at weekends |  | 90.4% | 92.7% | 91.3% | 93.3% | 84% |

| Outcome 3 People who use health and social care services have positive experiences of those services, and have their dignity respected | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | Quarter | | | | |
| Ref. | Measure | Status | Q1 2016/17 | Q2 2016/17 | Q3 2016/17 | Q4 2017/18 | 2017/18 |
| | | | Value | Value | Value | | Target |
| 2.3.1 | Percentage of service users/clients satisfied with the quality of care provided (Social Care only) | | 91% | 93% | 100% | 93% | 99% |

| Outcome 4 Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services. | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | Quarter | | | | |
| Ref. | Measure | Status | Q1 2016/17 | Q2 2016/17 | Q3 2016/17 | Q4 2017/18 | 2017/18 |
| | | | Value | Value | Value | | Target |
| 2.4.1 | Percentage of people 65+ indicating satisfaction with their social interaction opportunities (Social Care only) | | 83% | 95% | 97% | 98% | 95% |
| 2.4.2 | Percentage of service users satisfied with their involvement in the design of their care packages (Social Care only) | | 91% | 92% | 100% | 100% | 95% |

## SECTION 2 Adult Performance Quarterly Measures 2016-17

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

| | | | Quarter | | | | |
|---|---|---|---|---|---|---|---|
| **Ref.** | **Measure** | **Status** | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2017/18** | **2017/18** |
| | | | **Value** | **Value** | **Value** | | **Target** |
| **2.6.1** | Percentage of carers who feel supported and capable of continuing in a caring role (Social Care only) |  | **100%** | **93%** | **100%** | **97%** | **94%** |

## SECTION 2 Exception Reports - Adult Performance Quarterly Measures 2016-17 (descending order of variance from target)

| Ref. | Performance below Target | Exception Report | Action(s) to improve | Variance from target |
|---|---|---|---|---|
| **2.2.1** | Rate of unplanned acute bed days 75+ (per 1,000 pop) (rate at quarter end) | Slight decrease in admission, overall trend continues down ward | Continue to monitor at Weekly Operational Discharge Meetings | **5.5%** |
| **2.2.8** | Number of people aged 65 years+ with an anticipatory care plan in place (DNs only) | Target group lessened due to pervious ACPs completed so less identified by GPs and DNs. | Continue to develop anticipatory care and collaborative approaches across community services to include long term conditions, Community Rehab and Mental Health<br><br>. | **4.3% (No. 3)** |

| | | | | |
|---|---|---|---|---|
| **2.3.1** | Percentage of service users/clients satisfied with the quality of care provided (Social Care only) | Q4 figure of 93% based on a total of 46 reviews with the remaining 30 reviews which took place omitted from the figures as they were either n/a or left blank. | The number of reviews recorded has increased since the introduction of recording on CareAssess. Will continue to monitor. | **6%** |

**SECTION 3 Children's Performance Quarterly Measures 2016-17**

| | | | Quarter | | | | |
|---|---|---|---|---|---|---|---|
| **Ref.** | **Measure** | **Status** | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2017/18** | **2017/18** |
| | | | **Value** | **Value** | **Value** | | **Target** |
| **3.1** | 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services | ✓ | **100%** | **100%** | **100%** | **100%** | **100%** |
| | Uptake of MMR | | | | | | |
| **3.2** | 24 months | - | **96.8%** | **96.3%** | **96.9%** | **Not Available** | **95%** |
| **3.3** | 5 years | - | **97.8%** | **98.6%** | **97.1%** | **Not Available** | **95%** |
| **3.4** | Percentage of parents receiving 1:1 parenting support within the first 6 weeks following birth | ✓ | **100%** | **100%** | **100%** | **100%** | **100%** |
| **3.5** | As a proportion of parents who attend a Triple P group - the percentage of parents completing the Triple P programme | ✗ | **74%** | **68%** | **73%** | **58%** | **70%** |
| **3.6** | Number of parents receiving planned 1:1 parenting support | ✓ | **33** | **115** | **560** | **821** | **40** |
| **3.7** | Percentage of child care Integrated Assessments (ICA) for SCRA completed within target timescales (20 days) | ✓ | **100%** | **85%** | **93%** | **100%** | **75%** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **3.8** | Percentage of Initial Child Protection Case Conferences taking place within 21 days from receipt of referral |  | **89%** | **75%** | **57%** | **78%** | **90%** |
| **3.9** | Percentage of first Child Protection review conferences taking place within 3 months of registration |  | **100%** | **100%** | **100%** | **100%** | **95%** |
| **3.10** | Balance of care for Looked After Children: Percentage of children being looked after in the community |  | **88%** | **84%** | **85%** | **87%** | **89%** |
| **3.11** | Percentage of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated |  | **88%** | **100%** | **100%** | **100%** | **100%** |
| **3.12** | Percentage of Social Work reports submitted to Child Protection Case Conference |  | **100%** | **100%** | **100%** | **100%** | **100%** |

**SECTION 3 Exception Reports - Children's Performance Quarterly Measures 2016-17 (descending order of variance from target)**

| Ref. | Performance below Target | Exception Report | Action(s) to improve | Variance from target |
|---|---|---|---|---|
| **3.5** | As a proportion of parents who attend a Triple P group – the percentage of parents completing the Triple P programme | The variance from target is due to:<br>1. Cancelation of one group due to no uptake – only two groups were delivered in Q4<br>2. Low numbers of participants attending the 2 groups<br>3. The times of day which the groups take place was problematic in terms of childcare | 1. Plans are in place to schedule Triple P groups for the year ahead; this will facilitate flexibility for parents around the dates, venues and times of day groups run<br>2. Plans are in place to deliver Triple P training to Social work Staff to support the delivery of additional groups | **12%** |

**SECTION 4 Community Justice Performance Quarterly Measures 2016-17**

| Ref. | Measure | Status | Quarter | | | | |
|---|---|---|---|---|---|---|---|
| | | | Q1 2016/17 | Q2 2016/17 | Q3 2016/17 | Q4 2017/18 | 2016/17 |
| | | | Value | Value | Value | Value | Target |
| 4.1 | Percentage of Court report requests allocated to a Social Worker within 2 working days of receipt |  | 100% | 97.26% | 94.12% | 100% | 100% |
| 4.2 | Percentage of individuals beginning a work placement within 7 days of receiving a Community Payback Order |  | 72% | 66% | 79% | 69% | 80% |
| 4.3 | Percentage of CJSW reports submitted to Court by due date |  | 100% | 100% | 100% | 100% | 95% |

**SECTION 4 Exception Reports – Community Justice Performance Quarterly Measures 2016-17 (descending order of variance from target)**

| Ref. | Performance below Target | Exception Report | Action(s) to improve | Variance from target |
|---|---|---|---|---|
| 4.2 | Percentage of individuals beginning a work placement within 7 days of receiving a Community Payback Order | Performance in quarter 4 is below target. 27 out of 39 individuals started an unpaid work placement within the agreed timescale. Reasons as to why work placement did not begin within 7 working days for the other 12 individuals were as follows; 1 currently on Order / Supervision; 4 had late notification from Court; 1 in custody; 3 failed to attend; 1 was ill; 1 other client reason (not specified); 1 being supervised on behalf of another authority. | Continue to monitor | 11% |

**Agenda Item Number: 8a**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Oral Health Report – NHS Greater Glasgow & Clyde** |
| **Report By** | **Frances McLinden, General Manager, Oral Health Directorate** |
| **Contact Officer** | **Frances McLinden, General Manager, Oral Health Directorate**<br>**0141 201 4271**<br>**Frances.McLinden@ggc.scot.nhs.uk** |

| | |
|---|---|
| **Purpose of Report** | To provide an overview of the activities carried out by the Oral Health Directorate within East Dunbartonshire HSCP and across NHS GG&C. |

| | |
|---|---|
| **Recommendations** | To note the content. |

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

**Implications for Health & Social Care Partnership**

| | |
|---|---|
| **Human Resources** | None |

| | |
|---|---|
| **Equalities:** | None |

| | |
|---|---|
| **Financial:** | None |

| | |
|---|---|
| **Legal:** | None |

| | |
|---|---|
| **Economic Impact:** | None |

| | |
|---|---|
| **Sustainability:** | None |

| | |
|---|---|
| **Risk Implications:** | None |

| | |
|---|---|
| **Implications for East Dunbartonshire Council:** | None |

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

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

| **1.0 MAIN REPORT** |
|---|
| **1.1** This report provides an overview of Oral Health Services provided throughout NHS Greater Glasgow and Clyde. |

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

# Foreword

This report outlines the activities carried out by the Oral Health Directorate within Greater Glasgow and Clyde.

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

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

Registration of adults and children is at the highest level we have ever seen in Greater Glasgow and Clyde and better than the average for Scotland.

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

Registration of 0-2 year old children is higher than the Scottish average but still remains low at 50.9%.

The National Dental Inspection Programme (NDIP)shows that our Primary 1 and Primary 7 children have dental decay outcomes lower than the Scottish average. It is with this in mind that increasing the registration of young children will assist to improve oral health and the decay outcomes for the children in Greater Glasgow and Clyde.

To meet these and other oral health targets will require continued partnership working and community development with our colleagues in each HSCP in Greater Glasgow and Clyde.

We will strive to work collaboratively, innovatively and effectively to improve the oral health of the population of Greater Glasgow and Clyde. We will continue to deliver a safe, person-centered, effective and efficient oral health service across each HSCP.

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

**Table of Contents**

# GENERAL DENTAL SERVICES

There are 827 dentists working in 270 independent contractor practices providing NHS dentistry in NHS GG&C. These practices provide General Dental Services (GDS) and in addition 76 practices provide sedation services. NHS GG&C has 10 practices that provide only orthodontic services meaning no patients are registered with them for GDS.

| HSCP | No. Dentists | No. Practices | No. Ortho Practices | No. Sedation Practices |
|---|---|---|---|---|
| West Dunbartonshire | 53 | 16 | 0 | 5 |
| Renfrewshire | 105 | 33 | 1 | 11 |
| Inverclyde | 39 | 12 | 1 | 5 |
| Glasgow South | 180 | 59 | 1 | 19 |
| Glasgow North West | 179 | 64 | 2 | 15 |
| Glasgow North East | 126 | 38 | 1 | 15 |
| East Renfrewshire | 66 | 22 | 2 | 3 |
| East Dunbartonshire | 79 | 26 | 2 | 3 |

### Registration with NHS Dental Services

Data available from Information Services Division (ISD) (September 2016) shows the proportion of patients registered in NHS GG&C are:

- 95.0% Children (compared to 94.1% Scotland)
- 94.8% Adults (compared to 91.1% Scotland)

The registration data for children in GG&C are higher than the data for Scotland. There are possible explanations for the data, relating to activities in addressing inequalities. A number of patients (particularly adults) may be registered with non-NHS dentists, or may travel outside of their HSCP area for dental treatment. As data is not collected for non-NHS dental practices, it is not possible to determine numbers of patients seeking treatment outside of the NHS. This explanation may not hold as robustly for children, as dentists may hold list numbers with NHS GG&C to provide NHS dental registration and treatment for children, whilst providing non-NHS treatment for parents.

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

More detailed data on dental registrations from ISD[1] highlights an issue relating to the registration of very young children (aged 0-2 years). In NHS GG&C the proportion of children aged 0-2 years who are registered with a dentist is 50.9%. This compares to 48.1% for Scotland.

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

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

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

## Key Findings and Recommendations

- **Registration and participation rates in GG&C are lower than would be desired**
- **The proportion of very young children registered with a NHS dentist in GG&Cis low and needs to be increased**
- **Childsmile Practice activity is low with several practices not registering sufficient activity**
- **The Oral Health Directorate would be keen to work in partnership with our colleagues in HSCP's to improve the oral health outcomes for their population, with a focus in the following areas:**
- **The Oral Health Improvement Team should seek to improve targeting more vulnerable, or deprived children**
- **There needs to be a focus on increasing the number of children registered and participating in oral health service, particularly very young children aged 0-2 years**
- **The Oral Health Improvement Team need to engage with NHS dental practices to improve the uptake and delivery of Childsmile Practice**

# PUBLIC DENTAL SERVICE

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

## Location and services delivered by the PDS

| Locations/Services | Paediatric Dentistry | Special Care Dentistry | Adult Special Care – General Anaesthetic Assessment | Adult Special Care – General Anaesthetic | Adult Special Care – Sedation Services | General Dental Services | Oral Hygiene Services | Domiciliary Care |
|---|---|---|---|---|---|---|---|---|
| **East Dunbartonshire** | | | | | | | | |
| Kirkintilloch Health Centre | √ | | | | | | √ | √ |
| Low Moss Prison | | | | | | √ | | |
| **Inverclyde** | | | | | | | | |
| Greenock Health Centre | √ | √ | √ | | √ | | √ | √ |
| Inverclyde Royal Hospital | | | | | | | √ | |
| Greenock Prison | | | | | | √ | √ | |
| **Renfrewshire** | | | | | | | | |
| Royal Alexandra Hospital | √ | √ | √ | √ | √ | √ | √ | √ |
| **East Renfrewshire** | | | | | | | | |
| Victoria ACH | | √ | | | √ | | | √ |
| QEUH | | | | | | | | √ |
| **West Dunbartonshire** | | | | | | | | |
| Vale Centre for Health & Care | √ | √ | | | √ | | √ | √ |
| Golden Jubilee National Hospital * (*Secondary Care Facility) | | √ | | | | √ | | √ |

| Locations/Services | Paediatric Dentistry | Special Care Dentistry | Adult Special Care – General Anaesthetic Assessment | Adult Special Care – General Anaesthetic | Adult Special Care – Sedation Services | General Dental Services | Oral Hygiene Services | Domiciliary Care |
|---|---|---|---|---|---|---|---|---|
| **Glasgow City** | | | | | | | | |
| Stobhill ACH | | √ | √ | √ | √ | | √ | √ |
| Springburn Health Centre* | √ | √ | | | | | | √ |
| Maryhill Health Centre | √ | √ | | | | | | √ |
| Parkhead Health Centre | √ | √ | | | | | √ | √ |
| Drumchapel Health Centre | √ | | | | | | | |
| Possilpark Health Centre | √ | | | | | | | |
| Gartnavel General Hospital | | √ | | | | | | |
| Community Centre for Health | √ | | | | | | | |
| Easterhouse Health Centre | | √ | | | | | √ | √ |
| Townhead Health Centre | √ | √ | | | | | √ | |
| Bridgeton Health Centre* | √ | | | | | | | |
| Barlinnie Prison | | | | | | √ | | |
| Gorbals Health Centre | √ | | | | | | | |
| Pollock Health Centre* | √ | √ | | | √ | | | |
| Govan Health Centre | √ | | | | | | | |
| Victoria ACH | | √ | | | √ | | | √ |
| Castlemilk Health Centre* | √ | | | | | | | |
| QUEH | | | | | | | | √ |
| Govanhill Health Centre | √ | | | | | | | |

*Including outreach

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

# DENTAL PUBLIC HEALTH

The oral health of children in NHS GG&C has improved significantly over the last 20 years. A major contributing factor in this has been the implementation of the Childsmile Programme. Children in GG&C are now demonstrating child oral health levels comparable to the average for Scotland, supported by data from the National Dental Inspection Programme (NDIP). However, there remain wide variations within GG&C

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

| % of Primary 1, with no obvious decay experience | | |
|---|---|---|
| | 2014 | 2016 |
| Scotland | 68.20% | 69.4% |
| NHSGGC | 65.30% | 68.2% |

| Pr 1 Mean dmft for Children With dmft>0 | | |
|---|---|---|
| | 2014 | 2016 |
| Scotland | 3.97 | 3.93 |
| NHSGGC | 4.10 | 4.07 |

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

| % of Primary 7, with no obvious decay experience | | |
|---|---|---|
| | 2013 | 2015 |
| Scotland | 72.8% | 75.3% |
| NHSGGC | 67.8% | 72.5% |

| Pr 7 Mean dmft for Children With dmft>0 | | |
|---|---|---|
| | 2013 | 2015 |
| Scotland | 2.24 | 2.16 |
| NHSGGC | 2.33 | 2.27 |

The proportion of children who do not have obvious dental decay is now comparable (albeit slightly worse) between GG&C and Scotland for both P1 and P7 children. Where children have decay experience, the DMFT (number of decayed, missing or filled teeth) is slightly higher in GG&C than the average for Scotland.

Comparison of data between 2013 and 2015 suggests a steady improvement in oral health at a local and national level.

The NDIP programme also reports on all children attending state schools in P1 and P7 at a more basic level. This provides an overall assessment of oral health. Data are reported as three categories:

- Category A- (High Risk) – severe decay and should seek immediate dental care; or
- Category B- (Medium Risk) – some decay experience and should seek dental care in the near future; or
- Category C- (Low Risk) – no obvious decay but should continue to see the family dentist on a regular basis

Data for P1 and P7 Basic NDIP for Scotland (2015/16) is illustrated below.

**Summary of Basic P1 NDIP Programme 2015/16**

| NHS Board | Estimated Total no. of P1 children in Local Authority schools | Total no. of P1 children inspected | Percentage (%) of P1 children inspected | Percentage (%) of A letters issued | Percentage (%) of B letters issued | Percentage (%) of C letters issued |
|---|---|---|---|---|---|---|
| Ayrshire & Arran | 4,029 | 3,571 | 88.6 | 4.1 | 23.4 | 72.6 |
| Borders | 1,196 | 1,070 | 89.5 | 2.2 | 21.2 | 76.5 |
| Dumfries & Galloway | 1,527 | 1,370 | 89.7 | 7.9 | 22.7 | 69.4 |
| Fife | 4,282 | 3,749 | 87.6 | 6.2 | 24.2 | 69.6 |
| Forth Valley | 3,417 | 2,932 | 85.8 | 8.2 | 21.2 | 70.6 |
| Grampian | 6,684 | 5,404 | 80.8 | 7.2 | 21.5 | 71.3 |
| Greater Glasgow & Clyde | 12,284 | 11,396 | 92.8 | 9.7 | 24.3 | 66.0 |
| Highland | 3,498 | 2,586 | 73.9 | 6.7 | 20.6 | 72.7 |
| Lanarkshire | 7,714 | 6,873 | 89.1 | 8.3 | 22.4 | 69.3 |
| Lothian | 10,005 | 8,136 | 81.3 | 6.1 | 21.7 | 72.2 |
| Orkney | 237 | 214 | 90.3 | 1.9 | 19.6 | 78.5 |
| Shetland | 277 | 237 | 85.6 | 3.0 | 20.3 | 76.8 |
| Tayside | 4,375 | 3,923 | 89.7 | 9.8 | 22.5 | 67.7 |
| Western Isles | 271 | 248 | 91.5 | 2.8 | 18.1 | 79.0 |
| **Scotland** | **59,796** | **51,709** | **86.5** | **7.5** | **22.6** | **69.9** |

Source: ISD NDIP Database

## Summary of Basic P7 NDIP Programme 2015/16

| NHS Board | Total no. of P7 children in Local Authority schools | Total no. of P7 children inspected | Percentage (%) of P7 children inspected | Percentage (%) of A letters issued | Percentage (%) of B letters issued | Percentage (%) of C letters issued |
|---|---|---|---|---|---|---|
| Ayrshire & Arran | 3,783 | 3,350 | 88.6 | 1.3 | 24.2 | 74.4 |
| Borders | 1,199 | 1,043 | 87.0 | 0.6 | 16.7 | 82.7 |
| Dumfries & Galloway | 1,397 | 1,389 | 99.4 | 3.2 | 34.1 | 62.8 |
| Fife | 3,645 | 3,471 | 95.2 | 1.7 | 32.0 | 66.3 |
| Forth Valley | 3,129 | 2,837 | 90.7 | 7.5 | 26.6 | 65.8 |
| Grampian | 5,575 | 4,713 | 84.5 | 0.9 | 46.3 | 52.8 |
| Greater Glasgow & Clyde | 10,785 | 10,193 | 94.5 | 2.4 | 30.4 | 67.2 |
| Highland | 3,323 | 2,939 | 88.4 | 1.5 | 23.5 | 75.1 |
| Lanarkshire | 7,038 | 6,637 | 94.3 | 2.4 | 30.9 | 66.7 |
| Lothian | 8,134 | 6,576 | 80.8 | 1.5 | 24.7 | 73.9 |
| Orkney | 221 | 185 | 83.7 | 0.0 | 16.8 | 83.2 |
| Shetland | 261 | 233 | 89.3 | 1.7 | 17.6 | 80.7 |
| Tayside | 4,032 | 3,509 | 87.0 | 1.6 | 31.1 | 67.3 |
| Western Isles | 262 | 228 | 87.0 | 0.9 | 16.7 | 82.5 |
| **Scotland** | **52,784** | **47,303** | **89.6** | **2.1** | **30.0** | **67.9** |

Source: ISD NDIP Database

The data for Basic NDIP is supportive of the Detailed NDIP findings – the oral health of children in GG&C is steadily improving and approaching the average for Scotland.

## Dental Extraction under General Anaesthetic

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

| Postcode | 2013 | 2014 | 2015 | 2016 | Total | Pop$^{n}$ Rate (per 1000) in 2015 |
|---|---|---|---|---|---|---|
| **Total GG&C** | 2339 | 2340 | 2413 | 2007 | 9099 | 15 |

**Referrals for dental extractions under general anaesthetic for children in GG&C (rates calculated from mid 2014 population estimates ages 3-16)**

As with data for dental caries the numbers of referrals for extractions under general anaesthetic are high in GG&C. However, the data illustrates there has been a marked decrease in the number of children referred in GG&C between 2015 and 2016. This data will be monitored along with associated oral health data to explore trends and inform practice.

Overall, the oral health of children in GG&C is approaching the average for Scotland. However, it is not without its challenges. There remain pockets of significant dental decay in some localities. A major challenge in GG&C will be to sustain improvements in oral health. The Childsmile programme has contributed to rapid improvements in oral health since 2006.

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

## Key Findings and Recommendations

- **The oral health of children in GG&C is generally poorer than the rest of NHS Scotland, but is improving**

- **The Oral Health Directorate would be keen to work in partnership with our colleagues in HSCP's to improve the oral health outcomes for their population, with a focus in the following areas:**

- **The Dental Public Health team should continue to monitor national and local data intelligence on oral health outcomes and engage with partners in HSCP and Education in priority setting and strategic planning**

- **To identify areas and/or populations where increased focus is needed to tackle inequalities and poorer oral health**

# ORAL HEALTH IMPROVEMENT

## Childsmile

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

## Childsmile Practice

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

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

| SIMD | Children with (at least one) kept DHSW appointment | Children whose families refused Childsmile | 'Family could not be contacted' | Families with outcome 'FTA / Not at home' (Further contact required) |
|---|---|---|---|---|
| 1 | 3662 | 73 | 16 | 668 |
| 2 | 1199 | 41 | 5 | 160 |
| 3 | 879 | 22 | 2 | 94 |
| 4 | 736 | 39 | 1 | 68 |
| 5 | 726 | 25 | 0 | 68 |
| Total | 7358 | 204 | 24 | 1079 |
| Unknown | 156 | 4 | 0 | 21 |

Figures as at 23rd May 2017

Figures recorded under unknown are as a result of being unable to establish the child's postcode.

## Childsmile Core

There are currently 275/297 mainstream schools and 18 Additional Support Needs schools taking part in the programme. Oral Health Educator's (OHE's) have established effective partnership working with HSCP colleagues to support this work.

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

## NHS GG&C Establishments Participating in Tooth-brushing 2016/2017

| SIMD | NURSERIES | PRIMARY SCHOOLS | ADDITIONAL SUPPORT NEEDS | TOTAL BRUSHING |
|---|---|---|---|---|
| 1 | 106 | 61 | 4 | 171 |
| 2 | 108 | 86 | 8 | 202 |
| 3 | 96 | 58 | 3 | 157 |
| 4 | 73 | 37 | 1 | 111 |
| 5 | 66 | 33 | 2 | 101 |
| Unknown | 1 | 0 | 0 | 1 |
| Total | 450 | 275/297 | 18 | 743 |

Figures as at 23rd May 2017

100% of nurseries and Additional Support Needs schools are participating in toothbrushing.

### Children with Tooth-brushing Consents 2016/2017

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

### Childsmile Fluoride Varnish Programme

The Oral Health Improvement Team work with HSCP partners to deliver the Childsmile Fluoride Varnish programme in nurseries and schools within NHS GG&C.

### Childsmile Nursery and School: Fluoride Varnish activity 2016/17

Please note the information below was extracted from Childsmile HIC site on 23rd May – additional activity may be added until end of June 2017

| CLASS TYPE | Targeted Children | Children with validated consents | | Children receiving at least one FVA | | | Children receiving two or more FVAs | | |
|---|---|---|---|---|---|---|---|---|---|
| | T | V | % of T | n | % of T | % of V | n | % of T | % of V |
| nursery | 13944 | 7577 | 54.3% | 5835 | 41.8% | 77.0% | 2784 | 20.0% | 36.7% |
| p1 | 6296 | 4932 | 78.3% | 4601 | 73.1% | 93.3% | 3277 | 52.0% | 66.4% |
| p2 | 5774 | 5128 | 88.8% | 4739 | 82.1% | 92.4% | 3687 | 63.9% | 71.9% |
| p3 | 5536 | 4987 | 90.1% | 4625 | 83.5% | 92.7% | 3449 | 62.3% | 69.2% |
| p4 | 5291 | 4803 | 90.8% | 4349 | 82.2% | 90.5% | 2858 | 54.0% | 59.5% |
| p5 | 381 | 33 | 8.7% | 10 | 2.6% | 30.3% | 6 | 1.6% | 18.2% |

Oral Health Educators (OHEs) have established effective partnership working with HSCP colleagues within NHS GG&C.

**Summary of OHE Activity**

This year the Oral Health Educators(OHE's) have been involved in the universal Oral Health Improvement Programmes for children and vulnerable adults. Programmes activities includetoothbrushing, oral health training, oral health promotion sessions, monitoring visits, and health events both local and national.

In addition OHE's are involved in targeted programme including; Fluoride Varnish sessions, providing support to families who have received an A NDIP letter, providing support to families who have contacted NHS24, providing oral health promotion to parents/carers at Glasgow Dental Hospital General Aesthetic sessions. This support offered includes 1-1 advice to parents to address their individual needs and encourage registration with a dentist. Support is also offered to children who have a fear around going to the dentist by offering acclimatisation sessions before their dental appointment.

The OHE's have providedmentoring and supervision to 10 Modern Apprentice Dental Health Support Worker.

OHEs offer all school staff training to re-enforces the national toothbushing standards. OHEs also assist Oral Health Training Officers to provide training and support to care homes staff.

In order to increase networking and support to General Dental Practitioners the OHEs have offered all GDP's update sessions on Childsmile and Caring for Smile.

National Smile Month

The Oral Health Directorate invite all schools to participate in an oral health promotion competition. This years competition was to produce a two minute toothbrushing song which was judged by Frances McLinden, OHD General Manager. The Winning school was Gavinburn, West Dunbartonshire and runner up was St Thomas's East Renfrewshire. The song will be performed at the Big Band Big Smile event on 9th June.

Targeted OHE Sessions

Parents' workshops and one to one oral health advice have been delivered to parents on different occasions e.g. parent's evenings, induction days, providing dentists list to encourage dental registration. Summer community lead activities took place and oral health resources were distributed in communities with high oral health needs.

Social media

In order to reach as many people as possible the OHE's have engaged the community via twitter by advertising events, showcasing oral health promotion activities, and promoting key oral health messages throughout the community.

## Caring for Smiles

Caring for Smiles is Scotland's national oral health promotion, training and support programme, which aims to improve the oral health of older people, particularly those living in care homes. The Caring for Smiles Programme contains information, which is adaptable to all adults, particularly those who are dependent or vulnerable.

The table below provides data on the number of Care Homes involved in the programme within GG&C.

| HSCP | Number of Care Homes | Number participating in CFS Training | Number participating in CFS Monitoring | Total number of Residents | Number registered & seen by a dentist within last 12 months | % of residents seen & registered with a dentist within last 12 months |
|---|---|---|---|---|---|---|
| East Dunbartonshire | 13 | 13 | 12 | 496 | 384 | 77% |
| East Renfrewshire | 16 | 16 | 16 | 660 | 481 | 73% |
| Renfrewshire | 21 | 21 | 20 | 1227 | 736 | 60% |
| Inverclyde | 15 | 15 | 15 | 591 | 440 | 74% |
| West Dunbartonshire | 13 | 13 | 13 | 527 | 349 | 66% |
| North East Glasgow | 24 | 24 | 24 | 1056 | 684 | 65% |
| North West Glasgow | 19 | 19 | 19 | 1151 | 776 | 67% |
| South | 31 | 31 | 31 | 1201 | 814 | 68% |

NHS GGC standard for training asks that 30% of care home staff have been trained in the caring for smiles dental programme. Between 1st April 2016 and 31st March 2017,152 staff have been trained.

All establishments are visited by an OHE on a monthly basis to check the baseline audit and update the dental registration figures which are reported back to the Oral Health Directorate.

## Key Findings and Recommendations

- **There needs to be an increase in activity reported for Childsmile Practice**
- **There is a need to continue the monitoring and support for Childsmile Core**
- **Continued support and training are required for Caring for Smiles and other priority groups**
- **The Oral Health Directorate would be keen to work in partnership with our colleagues in HSCP's to improve the oral health outcomes for their population, with a focus in the following areas:**
- **The Oral Health Improvement team will aim to improve links between dental practices and HSCP's to promote and ensure the links between oral health and general health are highlighted within workstreams**
- **The Oral Health Directorate will continue to provide support & training for Childsmile and Caring for Smiles**
- **The Oral Health Improvement Team will continue to work with partners in HSCP and education to improve the uptake and delivery of Childsmile Core and the Fluoride Varnish programme**

**Agenda Item Number: 8b**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Oral Health Report – East Dunbartonshire HSCP** |
| **Report By** | **Frances McLinden, General Manager, Oral Health Directorate** |
| **Contact Officer** | **Frances McLinden, General Manager, Oral Health Directorate**<br>**0141 201 4271**<br>**Frances.McLinden@ggc.scot.nhs.uk** |

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

| | |
|---|---|
| **Recommendations** | To note the content. |

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

**Implications for Health & Social Care Partnership**

| | |
|---|---|
| **Human Resources** | None |

| | |
|---|---|
| **Equalities:** | None |

| | |
|---|---|
| **Financial:** | None |

| | |
|---|---|
| **Legal:** | None |

| | |
|---|---|
| **Economic Impact:** | None |

| | |
|---|---|
| **Sustainability:** | None |

| | |
|---|---|
| **Risk Implications:** | None |

| | |
|---|---|
| **Implications for East Dunbartonshire Council:** | None |

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

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

## 1.0 MAIN REPORT

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

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

# East Dunbartonshire HSCP

# Foreword

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

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

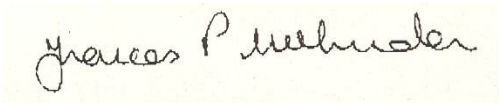
East Dunbartonshire can be proud of the progress made in improving oral health, particularly in addressing inequalities linked with deprivation, but there are still improvements to be made.

Child Oral Health in East Dunbartonshire has failed to demonstrate sustained improvements found elsewhere in NHS Greater Glasgow & Clyde (NHS GG&C). Registration of very young children with an NHS dentist remains low and needs to be addressed.

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

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

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



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

## Table of Contents

# GENERAL DENTAL SERVICES

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

### Registration with NHS Dental Services

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

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

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

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

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

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

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

However, it is probable the proportion of patients with routine or regular dental attendance is lower than the proportion of patients registered with an NHS dentist.

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

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

East Dunbartonshire Health & Social Care Partnership

NHS Greater Glasgow and Clyde

# Details for NHS Dental Practices

| Practice name | Address | Postcode | Date of Combined PI | Date of Sedation PI | Orthodontic Practice | Sedation Practice | Childsmile activity (Y/N) | Number of patients registered | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Age 0-2 | Age 3-5 | Age 6-12 | Age 13-17 | Age 18-64 | Age 65+ | Total registrations |
| CHARTWELL DENTAL CARE | 148-150 DRYMEN ROAD, BEARSDEN, GLASGOW | G61 3RE | 03/07/14 | | | | Y | 31 | 79 | 291 | 278 | 930 | 50 | **1,659** |
| PARK COTTAGE DENTAL PRACTICE | 8A ROMAN ROAD, BEARSDEN, GLASGOW | G61 2SW | 31/10/14 | | | | Y | 70 | 133 | 348 | 262 | 1,621 | 367 | **2,801** |
| MILNGAVIE DENTAL CARE | SUITE 6, DOUGLAS HOUSE, 42 MAIN ST, GLASGOW | G62 6BU | 02/07/14 | | | | N | 7 | 16 | 76 | 52 | 295 | 167 | **613** |
| JENNINGS DENTAL CARE | 4 STATION ROAD, MILNGAVIE, GLASGOW | G62 8AB | 10/12/14 | | | | N | 59 | 130 | 357 | 253 | 2,744 | 1,366 | **4,909** |
| BISHOPBRIGGS DENTAL CARE | 17 ARNOLD AVENUE, BISHOPBRIGGS, GLASGOW | G64 1PE | 07/05/15 | | | | Y | 99 | 171 | 431 | 266 | 3,313 | 1,113 | **5,393** |
| DENTAL PROFESSIONALS BISHOPBRIGGS | 171 KIRKINTILLOCH ROAD, BISHOPBRIGGS | G64 2LS | 29/10/14 | | | | Y | 61 | 127 | 333 | 302 | 3,754 | 1,181 | **5,758** |
| F J MURPHY | 4 MORAR CRESCENT, BISHOPBRIGGS, GLASGOW | G64 3DQ | 06/08/14 | | | | Y | 33 | 93 | 213 | 145 | 1,586 | 678 | **2,748** |
| TORRANCE DENTAL PRACTICE | 22-24A MAIN STREET, TORRANCE, GLASGOW | G64 4EL | 21/08/14 | | | | Y | 22 | 54 | 158 | 129 | 1,172 | 310 | **1,845** |
| CAMPSIE DENTAL PRACTICE | 127 MAIN STREET, LENNOXTOWN, GLASGOW | G66 7DB | 31/08/16 | | | | Y | 67 | 99 | 259 | 163 | 1,970 | 549 | **3,107** |
| ALASDAIR MACKENZIE DENTAL HEALTHCARE | 69 TOWNHEAD, KIRKINTILLOCH | G66 1NN | 02/09/14 | 07/05/15 | | Y | Y | 52 | 120 | 394 | 328 | 3,725 | 1,138 | **5,757** |
| RICHARD SKILLEN DENTAL CARE | 95 HILLHEAD ROAD, KIRKINTILLOCH | G66 2JD | 23/09/14 | | | | Y | 24 | 42 | 169 | 138 | 910 | 412 | **1,695** |
| MILLERSNEUK DENTAL PRACTICE | 112 KIRKINTILLOCH ROAD, LENZIE | G66 4LQ | 26/02/14 | 13/11/15 | | Y | Y | 109 | 169 | 473 | 316 | 1,238 | 193 | **2,498** |
| ALLANDER DENTAL CARE | 7 STEWART STREET, MILNGAVIE, GLASGOW | G62 6BW | 16/12/14 | | | | Y | 87 | 252 | 646 | 572 | 6,445 | 2,564 | **10,566** |
| WOODHILL DENTAL SURGERY | 176 WOODHILL ROAD, BISHOPBRIGGS, GLASGOW | G64 1DH | 04/07/14 | | | | Y | 56 | 88 | 300 | 276 | 1,305 | 202 | **2,227** |
| BEARSDEN DENTAL CARE | 8-12 LEDI DRIVE, BEARSDEN, GLASGOW | G61 4JJ | 28/05/14 | 23/05/14 | | Y | Y | 165 | 274 | 722 | 460 | 4,366 | 1,689 | **7,676** |
| MILNGAVIE ORTHODONTICS | SUITE 1, 13 MAIN STREET, MILNGAVIE, GLASGOW | G62 6BJ | 10/02/16 | | Y | | N | - | - | - | - | 1 | - | **1** |
| KIRKINTILLOCH ORTHODONTIC CLINIC | 22 WEST HIGH STREET, KIRKINTILLOCH | G66 1AA | 11/08/14 | | Y | | N | - | - | - | - | 1 | - | **1** |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| KESSINGTON DENTAL PRACTICE | 53 MILNGAVIE ROAD, BEARSDEN, GLASGOW | G61 2DW | 02/10/14 | | | | Y | 72 | 178 | 511 | 376 | 3,452 | 1,004 | **5,593** |
| DENTAL FX | 84 DRYMEN ROAD, BEARSDEN, GLASGOW | G61 2RH | 14/12/16 | | | | Y | 14 | 45 | 144 | 101 | 1,083 | 211 | **1,598** |
| OAK TREE DENTAL KIRKINTILLOCH | 14-16 TOWNHEAD, KIRKINTILLOCH | G66 1NL | 04/02/16 | | | | Y | 91 | 157 | 361 | 227 | 2,687 | 667 | **4,190** |
| OAK TREE DENTAL BISHOPBRIGGS | 180 WOODHILL ROAD, BISHOPBRIGGS, GLASGOW | G64 1DH | 18/08/15 | | | | Y | 54 | 88 | 309 | 189 | 2,116 | 428 | **3,184** |
| COWGATE DENTAL SURGERY | 11 COWGATE, KIRKINTILLOCH, GLASGOW | G66 1HW | 16/02/15 | | | | Y | 68 | 127 | 339 | 212 | 2,830 | 1,040 | **4,616** |
| MARINA DENTAL CARE | SOUTHBANK MARINA, 8 STRATHKELVIN PLACE, KIRKINTILLOCH | G66 1XQ | 27/10/15 | | | | Y | 143 | 276 | 669 | 419 | 5,331 | 1,828 | **8,666** |
| BOCLAIR DENTAL CARE | 91 MILNGAVIE RD, BEARSDEN, GLASGOW | G61 2EN | 13/12/13 | | | | Y | 70 | 130 | 284 | 123 | 1,558 | 589 | **2,754** |
| HAZEL HIRAM DENTAL CARE | 26 TOWNHEAD, KIRKINTILLOCH | G66 1NL | 11/02/14 | | | | Y | 52 | 54 | 163 | 119 | 1,388 | 349 | **2,125** |
| DENTAL CARE BY CLAIRE TIERNEY | UNIT 1, 122 KIRKINTILLOCH RD, BISHOPBRIGGS | G64 2AB | 24/02/15 | | | | Y | 37 | 73 | 223 | 147 | 1,366 | 309 | **2,155** |
| | | | | | | | **Total** | 1,543 | 2,975 | 8,173 | 5,853 | 57,187 | 18,404 | |

**Key Findings and Recommendations**

- **Registration and participation rates continue to be lower in East Dunbartonshire than would be desired**
- **The proportion of very young children registered with a NHS dentist in East Dunbartonshire continues to be low and needs to be increased**
- **Childsmile Practice activity is low with several practices not registering sufficient activity**
- **The Oral Health Directorate would be keen to work in partnership with our colleagues in the HSCP to improve the oral health outcomes for their population, with a focus in the following areas:**
- **The Oral Health Improvement Team should seek to improve targeting more vulnerable, or deprived children**
- **There needs to be a continued focus on increasing the number of children registered and participating in oral health service, particularly very young children aged 0-2 years**
- **The Oral Health Improvement Team need to continue engagement with NHS dental practices to improve the uptake and delivery of Childsmile Practice**

East Dunbartonshire Health & Social Care Partnership

NHS Greater Glasgow and Clyde

# PUBLIC DENTAL SERVICE

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

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



**Location and services delivered by the PDS**

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

# DENTAL PUBLIC HEALTH

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

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

| % of Primary 1, with no obvious decay experience | | |
|---|---|---|
| | 2014 | 2016 |
| Scotland | 68.20% | 69.4% |
| NHSGGC | 65.30% | 68.2% |
| East Dunbartonshire | 75.60% | 81.3% |

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

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

| % of Primary 7, with no obvious decay experience | | |
|---|---|---|
| | 2013 | 2015 |
| Scotland | 72.8% | 75.3% |
| NHSGGC | 67.8% | 72.5% |
| East Dunbartonshire | 77.0% | 81.4% |

| Pr 7 Mean dmft for Children With dmft>0 | | |
|---|---|---|
| | 2013 | 2015 |
| Scotland | 2.24 | 2.16 |
| NHSGGC | 2.33 | 2.27 |
| East Dunbartonshire | 2.2 | 1.9 |

The proportion of children who do not have obvious dental decay is higher in East Dunbartonshire than in GG&C and Scotland for both P1 and P7 children and this has improved from the previous NDIP data. Where children have decay experience, the DMFT (number of decayed, missing or filled teeth) is lower in East Dunbartonshire than the average for GG&C and Scotland, but the dmft in East Dunbartonshire has not improved since the last NDIP data.

Comparison of data between 2013 and 2016 suggests a steady improvement in oral health at a local and national level, with the exception of P1 detailed inspection data in East Dunbartonshire, where there has been no improvement on the data from 2014.

Analysis of detailed inspection data at HSCP level may have less precision than data at a NHS Board or national level (as it is from a sampled population). However, the detailed data still supports the position that the oral health of children in East Dunbartonshire is better than the average for GG&C and Scotland as a whole and is generally supportive of continued improvement.

The NDIP programme also reports on all children attending state schools in P1 and P7 at a more basic level. This provides an overall assessment of oral health. Data are reported as three categories:

- Category A- (High Risk) – severe decay and should seek immediate dental care; or
- Category B- (Medium Risk) – some decay experience and should seek dental care in the near future; or
- Category C- (Low Risk) – no obvious decay but should continue to see the family dentist on a regular basis

School level data for P1 and P7 Basic NDIP for East Dunbartonshire (2015/16) is illustrated overleaf. A summary of the totals (and proportions) of each category letter is also displayed, together with corresponding summaries for the years 2013-2015 for comparison.

## Summary of Basic P1 NDIP Programme 2015/16

**Letter A** : child should seek immediate dental care on account of severe decay or abscess
**Letter B** : child should seek dental care in the near future due to one or more of the following: presence of decay, a broken or damaged front tooth, poor oral hygiene or may require orthodontics
**Letter C** : no obvious decay experience but child should continue to see the family dentist on a regular basis

| School | Class | Letter A (n) | Letter B (n) | Letter C (n) | Not Inspected (n) |
|---|---|---|---|---|---|
| Auchinairn | P1 | 0 | 9 | 22 | 4 |
| Baldernock | P1 | 0 | 0 | 5 | 0 |
| Baljaffray | P1 | 0 | 8 | 28 | 6 |
| Balmuildy | P1 | 1 | 5 | 38 | 5 |
| Bearsden | P1 | 2 | 3 | 46 | 1 |
| Castlehill | P1 | 0 | 3 | 17 | 2 |
| Clober | P1 | 5 | 3 | 35 | 5 |
| Colquhoun Park | P1 | 1 | 12 | 28 | 4 |
| Craigdhu | P1 | 2 | 1 | 36 | 1 |
| Craighead | P1 | 1 | 7 | 32 | 4 |
| Gartconner | P1 | 0 | 6 | 18 | 3 |
| Harestanes | P1 | 1 | 6 | 13 | 2 |
| Hillhead (Kirkintilloch) | P1 | 7 | 7 | 10 | 3 |
| Holy Family | P1 | 1 | 14 | 30 | 5 |
| Killermont | P1 | 3 | 4 | 41 | 2 |
| Lairdsland | P1 | 0 | 10 | 43 | 2 |
| Lennoxtown | P1 | 0 | 4 | 13 | 4 |
| Lenzie | P1 | 0 | 0 | 24 | 1 |
| Lenzie Moss | P1 | 1 | 6 | 28 | 0 |
| Meadowburn | P1 | 1 | 6 | 46 | 3 |
| Millersneuk | P1 | 0 | 3 | 35 | 0 |
| Milngavie | P1 | 0 | 6 | 31 | 4 |
| Mosshead | P1 | 0 | 6 | 34 | 0 |
| Oxgang | P1 | 2 | 3 | 30 | 3 |
| St Agatha's | P1 | 1 | 7 | 10 | 1 |
| St Andrew's (Bearsden) | P1 | 3 | 3 | 31 | 2 |
| St Flannan's | P1 | 0 | 12 | 16 | 1 |
| St Helen's | P1 | 9 | 7 | 45 | 2 |
| St Joseph's (Milngavie) | P1 | 1 | 2 | 7 | 0 |
| St Machan's | P1 | 3 | 3 | 13 | 1 |
| St Matthew's | P1 | 0 | 7 | 35 | 6 |
| Torrance | P1 | 0 | 6 | 13 | 1 |
| Twechar | P1 | 1 | 8 | 3 | 1 |
| Wester Cleddens | P1 | 5 | 8 | 32 | 0 |
| Westerton | P1 | 0 | 8 | 34 | 4 |
| Woodhill | P1 | 3 | 9 | 37 | 2 |

| | | |
|---|---|---|
| Number of NDIP Schools | 36 | |
| Total number of P1's on Roll | 1310 | |
| Total number of P1's not receiving NDIP | 85 | |
| Number (%) Children Inspected: Letter A | 54 | 4.4% |
| Number (%) Children Inspected: Letter B | 212 | 17.3% |
| Number (%) Children Inspected: Letter C | 959 | 78.3% |

## Basic NDIP P1 Schools 2013-2015

| | 2013 | | 2014 | | 2015 | |
|---|---|---|---|---|---|---|
| Number of NDIP Schools | 36 | | 36 | | 36 | |
| Total number of P1's on Roll | 1191 | | 1268 | | 1238 | |
| Total number of P1's not receiving NDIP | 53 | | 40 | | 47 | |
| Number (%) Children Inspected: Letter A | 67 | 5.9% | 80 | 6.5% | 52 | 4.4% |
| Number (%) Children Inspected: Letter B | 203 | 17.8% | 241 | 19.6% | 219 | 18.4% |
| Number (%) Children Inspected: Letter C | 868 | 76.3% | 907 | 73.9% | 920 | 77.2% |
| Number (%) with Poor Oral Hygiene | 6 | 0.5% | 9 | 0.7% | 4 | 0.3% |

East Dunbartonshire Health & Social Care Partnership

NHS Greater Glasgow and Clyde

## Summary of Basic P7 NDIP Programme 2015/16

**Letter A** : child should seek immediate dental care on account of severe decay or abscess
**Letter B** : child should seek dental care in the near future due to one or more of the following: presence of decay, a broken or damaged front tooth, poor oral hygiene or may require orthodontics
**Letter C** : no obvious decay experience but child should continue to see the family dentist on a regular basis

| School | Class | Letter A (n) | Letter B (n) | Letter C (n) | Not Inspected (n) |
|---|---|---|---|---|---|
| Auchinairn | P7 | 1 | 10 | 7 | 3 |
| Baldernock | P7 | 0 | 0 | 3 | 0 |
| Baljaffray | P7 | 0 | 8 | 27 | 6 |
| Balmuildy | P7 | 0 | 10 | 22 | 2 |
| Bearsden | P7 | 2 | 5 | 53 | 3 |
| Castlehill | P7 | 0 | 4 | 8 | 0 |
| Clober | P7 | 0 | 9 | 17 | 3 |
| Colquhoun Park | P7 | 1 | 9 | 19 | 4 |
| Craigdhu | P7 | 0 | 7 | 44 | 0 |
| Craighead | P7 | 1 | 12 | 18 | 2 |
| Gartconner | P7 | 0 | 5 | 5 | 0 |
| Harestanes | P7 | 0 | 8 | 13 | 3 |
| Hillhead (Kirkintilloch) | P7 | 0 | 7 | 14 | 1 |
| Holy Family | P7 | 0 | 7 | 27 | 3 |
| Killermont | P7 | 0 | 8 | 35 | 4 |
| Lairdsland | P7 | 1 | 7 | 26 | 1 |
| Lennoxtown | P7 | 2 | 7 | 9 | 3 |
| Lenzie | P7 | 0 | 2 | 24 | 0 |
| Lenzie Moss | P7 | 0 | 5 | 38 | 0 |
| Meadowburn | P7 | 0 | 4 | 20 | 0 |
| Millersneuk | P7 | 1 | 6 | 41 | 2 |
| Milngavie | P7 | 0 | 12 | 41 | 1 |
| Mosshead | P7 | 0 | 3 | 44 | 2 |
| Oxgang | P7 | 0 | 11 | 13 | 1 |
| St Agatha's | P7 | 0 | 6 | 10 | 2 |
| St Andrew's (Bearsden) | P7 | 0 | 11 | 29 | 2 |
| St Flannan's | P7 | 1 | 11 | 21 | 1 |
| St Helen's | P7 | 0 | 17 | 38 | 4 |
| St Joseph's (Milngavie) | P7 | 0 | 3 | 15 | 1 |
| St Machan's | P7 | 0 | 3 | 15 | 1 |
| St Matthew's | P7 | 1 | 12 | 36 | 3 |
| Torrance | P7 | 0 | 6 | 23 | 3 |
| Twechar | P7 | 0 | 3 | 4 | 1 |
| Wester Cleddens | P7 | 0 | 4 | 24 | 1 |
| Westerton | P7 | 0 | 6 | 33 | 3 |
| Woodhill | P7 | 0 | 8 | 38 | 4 |

| | | |
|---|---|---|
| Number of NDIP Schools | 36 | |
| Total number of P7's on Roll | 1191 | |
| Total number of P7's not receiving NDIP | 70 | |
| Number (%) Children Inspected: Letter A | 11 | 1.0% |
| Number (%) Children Inspected: Letter B | 256 | 22.8% |
| Number (%) Children Inspected: Letter C | 854 | 76.2% |

## Basic NDIP Data P7 Schools 2013-2015

| | 2013 | | 2014 | | 2015 | |
|---|---|---|---|---|---|---|
| Number of NDIP Schools | 36 | | 36 | | 36 | |
| Total number of P7's on Roll | 1179 | | 1107 | | 1231 | |
| Total number of P7's not receiving NDIP | 76 | | 72 | | 78 | |
| Number (%) Children Inspected: Letter A | 16 | 1.5% | 13 | 1.3% | 9 | 0.8% |
| Number (%) Children Inspected: Letter B | 537 | 48.7% | 438 | 42.3% | 458 | 39.7% |
| Number (%) Children Inspected: Letter C | 550 | 49.9% | 584 | 56.4% | 686 | 59.5% |
| Number (%) with Poor Oral Hygiene | 171 | 15.5% | 98 | 9.5% | 106 | 9.2% |
| Number (%) Letter B - Ortho Only | 61 | 5.5% | 72 | 7.0% | 83 | 7.2% |

The data for Basic NDIP is supportive of the Detailed NDIP findings – the oral health of children in East Dunbartonshire is steadily improving. The Basic NDIP data for P1 supports the detailed P1 NDIP data suggesting no additional improvement in oral health for this age group. However, the P7 data suggests a marked reduction in the number of children receiving B letters and an increase in children receiving C letters. Closer examination of the data at a school level suggests whilst the overall picture of oral health in East Dunbartonshire is good, there are areas where oral health is poor. There are a number of schools in localities where higher numbers of category A and B letters were issued. This is reflected in both the P1 and the P7 data. Caution should be used when interpreting this data as the sample sizes are low and comparisons between schools may not be robust. However, the data are suggestive there are areas of East Dunbartonshire where closer scrutiny of population oral health may be needed. Deprivation can be linked to an increased risk of dental decay, but there are schools located in more affluent areas where the prevalence and severity of dental decay is higher than expected.

## Dental Extraction under General Anaesthetic

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

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

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

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

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

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

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

**Key Findings and Recommendations**

- **The oral health of children in East Dunbartonshire is generally better than the rest of NHS GG&C and Scotland**
- **There have not been significant or continued improvements in child oral health in East Dunbartonshire for P1 children**
- **The Oral Health Directorate would be keen to work in partnership with our colleagues in the HSCP to improve the oral health outcomes for their population, with a focus in the following areas:**
- **The Dental Public Health team should continue to monitor national and local data intelligence on oral health outcomes and engage with partners in HSCP and Education in priority setting and strategic planning**
- **To identify areas and/or populations where increased focus is needed to tackle inequalities and poorer oral health**

# ORAL HEALTH IMPROVEMENT

## Childsmile

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

## Childsmile Practice

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

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

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

Figures as at 23rd May 2017

The number of children with (at least one) kept DHSW appointment has fallen this year. One DHSW post is currently vacant in East Dunbartonshire and recruitment is currently in progress.

## Childsmile Core

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

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

## East Dunbartonshire Establishments Participating in Tooth-brushing 2016/2017

| SIMD | Nurseries | Primary Schools | % Brushing | Additional support needs | Overall total brushing |
|---|---|---|---|---|---|
| 1 | 1 | 0/1 | 0% | 0 | 1 |
| 2 | 5 | 5/6 | 83% | 1 | 10 |
| 3 | 8 | 7/7 | 100% | 0 | 15 |
| 4 | 9 | 4/4 | 100% | 1 | 13 |
| 5 | 25 | 17/17 | 100% | 0 | 42 |
| Total | 48 | 33/35 | 94% | 2 | 81 |

Figures as at as at 23rd May 2017

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

### East Dunbartonshire Children with Tooth-brushing Consents 2016/2017

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

### OHE Activity

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

The OHE offers Toothbrushing training to all establishments, this training re-enforces the national toothbrushing standards. The OHE monitor all toothbrushing establishments every term and record data onto HIC (Health Informatics Centre) system hosted by Dundee University. Several parents workshops and one to one oral health advice have been delivered to parents on different occasions e.g. parents evenings, induction days, providing dentists list to encourage dental registration. OHE's along with 2 Modern Apprentices (DHSW) assisted East Dunbartonshire Health Improvement Team with Childsmile Nursery Core Toothbrushing programme to achieve the completion of Toothbrushing standards for Nursery Toothbrushing.

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

## Summary of OHE Activity

| Area | Health Days | OH Session | Induction Days | ED HSCP Events | School Nurse Referral/ School | NSM Talk/Event | Training |
|---|---|---|---|---|---|---|---|
| **East Dunbartonshire** | 10 | 88 | 08 (1 still to attend this month) | 1 | 1 | 7 | 13 (1 still to attend this month) |

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

## Caring for Smiles

Caring for Smiles is Scotland's national oral health promotion, training and support programme, which aims to improve the oral health of older people, particularly those living in care homes. The Caring for Smiles Programme contains information, which is adaptable to all adults, particularly those who are dependent or vulnerable.

The table below provides data on the number of Care Home involved in the programme in East Dunbartonshire. The number of care homes participating in training and monitoring has stayed stable. The total number of residents seen and registered by a dentist has increased from 59% to 68%.

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

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

10 staff had attended for SCQF (Foundation) training - 6 completed and 4 dropped out. Date set for SCQF Intermediate training, offered to those who passed Foundation.

| Care Home | Total Number of staff | Number of WTE | Number of WTE trained | % of WTE trained | Number of staff trained |
|---|---|---|---|---|---|
| Canniesburn Care Home | 101 | 69.0 | 26.9 | 39% | 30 |
| Abbotsford House | 20 | 15.0 | 7.5 | 50% | 10 |
| Buchanan House | 80 | 70.0 | 15.2 | 22% | 13 |
| Buchanan Lodge | 30 | 26.6 | 22.2 | 83% | 36 |
| Mavis Bank | 45 | 35.2 | 26.6 | 76% | 32 |
| Campsie View | 125 | 90.0 | 31.8 | 35% | 47 |
| Campsie House | 17 | 14.0 | 13.6 | 97% | 17 |
| Whitefield Lodge | 41 | 36.0 | 17.1 | 48% | 19 |
| Lillyburn | 80 | 42.3 | 17.7 | 42% | 21 |
| Westerton Care Home | 77 | 66.0 | 28.79 | 44% | 33 |
| Antonine Care Home | 70 | 65.0 | 42.3 | 65% | 51 |
| Whitehill Court Care Home (respite) | 8 | 6.0 | 5.4 | 91% | 11 |
| Mugdock House | 54 | 44.0 | 24.3 | 55% | 28 |

12 out of the 13 Care Homes in East Dunbartonshire have trained between (35 - 97%) of staff in the Caring for Smiles Programme. Buchanan House is below recommended training of 30% WTE. Onsite training for the care home was organised, however, the care home staff failed to engage. Additional opportunities are being sought with the Care Home manager. The OHD will continue to support all care homes to increase and maintain the number of trained staff.

All 13 care homes are visited on a monthly basis. Two care homes performing particularly well will now be reduced to quarterly monitoring visits.

**Key Findings and Recommendations**

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

**Clinical & Care Governance Sub Group**
**25th January 2017, 2.30pm**
**F33A, Kirkintilloch Health & Care Centre**

**Members Present**

| Name | Designation |
|---|---|
| Lisa Williams | Clinical Director |
| Andy Martin | Head of Adult & Primary Care Services |
| Claire Carthy | Fieldwork Manager |
| Fraser Ross | Senior Nurse, Adults |
| Lorna Hood | Senior Nurse, Children & Families |
| Fiona Munro | Manager, Rehab & Older Peoples Services |
| Lorraine Currie | Nurse Team Leader, PCMHT / CMHT |

**In Attendance**

| Name | Designation |
|---|---|
| Jackie King | Team Lead, Woodlands Resource Centre |
| Eleni Morifi | Clinical Psychologist, Older Peoples Mental Health |
| Dianne Rice | Clinical Governance Support Officer |

**Apologies**

| Name | Designation |
|---|---|
| Philip O'Hare | Clinical Risk Co-ordinator |
| Andrew Millar | Clinical Effectiveness Co-ordinator |
| Carolyn Fitzpatrick | Lead for Clinical Pharmacy and Prescribing |
| Wilma Hepburn | Professional Nurse Advisor |

| No. | Topic | Action |
|---|---|---|
| **1.** | **Apologies and attendance** | |
| | Apologies and attendance are detailed on page 1<br><br>Lisa Williams welcomed all attendees to the group and advised them that she had been successful in gaining the post of Clinical Director for East Dunbartonshire HSCP. Lisa will continue to be responsible for Clinical & Care Governance until an Associate Clinical Director is appointed. | |
| **2.** | **Presentation – Stress & Distress** | |
| | Dr Eleni Morifi and Jacqueline King, Team Lead Woodlands Resource Centre attending the meeting today to present the outcomes from the Stress & Distress model which has been rolled out to 4 care homes within East Dunbartonshire.<br><br>The model currently running has 1 0.6wte Care Home Liaison Nurse. This ensures continuity of care.<br><br><u>The aims of this service is to offer;</u><br>• Assessment and formulation-driven care plans<br>• Promote evidence-based, person-centred care<br>• Reduce preventable admissions and prevent re-admission to hospital<br>• Promote compliance with clinical guidelines for the use of anti-psychotic Medication<br>• Support care home staff training and education<br><br><u>Quality Improvement Outcomes</u><br>• Robust physical health screening. Early identification and treatment of physical health factors (50% of cases)<br>• Development of personalised formulation and treatment plans<br>• Increase in percentage of residents who were offered reviews / monitoring of anti-psychotic and other psychotropic medication.<br><br>Dr Morifi explained that as a result of the above, the audit has shown that there has been a potential reduction of urgent referrals due to an improved ability of the care home staff able to deal with distress and that there has also been a reduction off 77.8% in the use of the Woodlands Duty Service.<br><br>Throughout the 9 months the model has been active, Dr Morifi expressed those relationships between Woodlands and Care Home Staff have improved. There have also been notable reductions in care home staff stress, incidents & complaints. Care home staff have also voiced an eagerness to engage in further learning.<br><br>Lisa Williams thanked both Dr Morifi and Jacqueline for presenting to the group. Both attendees requested that Senior Managers attending the group champion the model at future forums. | |
| **3.** | **Minutes of previous meeting – 23rd November 2016** | |
| | The minutes of the meeting on 23rd November 2016 were agreed as an accurate reflection. | |

| | | |
|---|---|---|
| **4.** | **Matters arising** | |
| | Terms of Reference / Governance Structure<br>The group reviewed the membership of the Terms of Reference and requested that it be updated due to the structures being confirmed. Dianne Rice and Lisa Williams will update the Terms of Reference.<br><br>Lengthy discussion took place around Service User/ Care Representative at the meeting. Dianne Rice will speak to David Radford regarding this. | **DR/LW**<br><br>**DR** |
| | Governance Structure<br>The group reviewed the structure. This structure will be updated using Leads from management structure. | **DR/LW** |
| | SCI – Sign Off<br>Philip O'Hare was unfortunately unavailable to attend the meeting, however, had emailed to advise that there East Dunbartonshire HSCP currently had 2 SCI's outstanding, one Mental Health and one EDADS. Lorraine Currie will investigate the Mental Health SCI and Dianne Rice will highlight the EDADS SCI to EDADS Team Lead. | **LC/DR** |
| | Complaints Review & Learning Outcomes Session<br>Lisa Williams reminded members that the meeting in March 2017 will be used to review actions / outcomes from previous complaints and incidents. This will be for both Health and Social Work complaints. | |
| **5.** | **Governance Leads Update / Reports** | |
| **(a)** | Core Audit Reports<br>Both the District Nursing and Woodlands core audit reports were included within the agenda for discussion as they did not achieve 100%. Fraser Ross, Senior Nurse Adults and Fiona Munro, Team Manager Older Peoples Mental Health & CRT both advised the group that they had no concerns in relation to these reports. | |
| **(b)** | Safety Cross Report<br>Fraser Ross advised that there were no concerns in relation to this report. Fraser also informed the group that another reports available from Tissue Viability will now be included with this paper at future meetings. | |
| **(c)** | LD Governance<br>Andy Martin advised that David Aitken has been appointed Joint Adult Services Manager and is responsible for LD. | |
| **(d)** | Mental Health Governance<br>Lorraine Currie attends the overall Mental Health Governance meeting and will be the link to the local Clinical & Care Governance group. | |
| **(e)** | CG Partnership Minutes – 13th October 2016<br>These minutes were circulated previously with the agenda for noting. | |
| **(f)** | Board Clinical Governance Forum<br>These minutes were circulated previously with the agenda for noting. | |

| | | |
|---|---|---|
| **6.** | **Risk Management** | |
| **(a)** | Care Home Update<br>Andy Martin informed the group that the Care Home Governance group has been established and will feedback any issues highlighted to this group.<br><br>Andy also advised that group that the intermediate care pilot, running at Westerton Care Home has been successful and they now have 7 beds in use. The funding for the pilot is due to end in November 2017. An audit will be carried out to show successes and learning from the pilot. | |
| **(b)** | Clinical Risk Update<br>Philip O'Hare provided the above report which was circulated previously with the agenda for information. No issues or concerns were noted. | |
| **(c)** | Incident Report – 10/11/16-18/01/17<br>The group reviewed the incident report.<br><br>**439690** – This incident was due to a recording error and as a result, the patient received a double dose of flu vaccine. Lisa Williams also acknowledged that there had been a significant reduction in flu vaccine incidents from previous year.<br><br>**439476** – Reduction in patient insulin dose. The description of this incident did not explain why the patients' dose was reduced. Fraser Ross will investigate and have the incident updated.<br><br>**440975** – Suicide. Fiona Munro advised that a Rapid Alert had been completed for this incident and that it will progress to a full SCI. | **FR**<br><br>**FM** |
| **(d)** | Datix Meeting- 2nd December 2016<br>The group agreed that the minutes should be removed from the agenda. Louise Martin, Head of Administration is the lead for Datix and should advise if any relevant actions / learning come from this group. | |
| **(e)** | HSE Inspection<br>The templates were circulated previously for action. All teams to complete and send to Dianne Rice prior to inspection.<br><br>Dianne to check if all teams were sent this template. | **All**<br><br>**DR** |
| **7.** | **Public Health Reports / Prescribing Updates** | |
| | There were no reports or issues to note.<br><br>Fraser Ross advised the group that Carolyn Fitzpatrick and he are discussing waste medications with repeat prescriptions within Care Homes and will keep the group updated. | |

| | | |
|---|---|---|
| **8.** | **Quality Improvement Work plan** | |
| | The workplan was circulated prior to the meeting. The group had noted concerns around timescales for updating the workplan prior to the meeting. Dianne will contact Andrew Millar to discuss this.<br><br>Lisa Williams announced to the members that all teams should be sharing information through Team Brief. Lisa also noted that the NHS Annual Conference will take place in June 2017 and that all teams should submit a poster / presentation showing patient centered care embedded within practice. | |
| **9.** | **Clinical & Care Governance Workplan - Update** | |
| | The workplan was circulated prior to the meeting for comments. It was decided that Lisa, Andy, Claire Carthy and Paolo Mazzoncini would meet to start preliminary discussions around the process of developing a Datix recording process for use within Social Care. LW to contact AM, CC and PM with proposed dates for an initial meeting. | **LW** |
| **10.** | **Scottish Patient Safety Programme** | |
| **(a)** | Scottish Patient Safety Programme (SPSP)<br>This November update was circulated previously with the agenda for information. | |
| **(b)** | Clinical Governance Related Guidance Newsletter<br>The newsletter was not available for the meeting | |
| **(d)** | SPSO Update – December 2016<br>The December update was circulated previously with the agenda for information. | |
| **(e)** | Patient Feedback Options Paper<br>Fraser Ross advised that the short life working group were in the process of drafting an options paper. The group agreed that the options paper should be finalised and submitted and taken to the SMT for approval by the Head of Strategy, Planning & Health Improvement. Once a definitive option has been agreed by the SMT the Clinical & Care Governance group will discuss support required for the role out of the preferred option. | **FR** |
| **11.** | **Enabled to Deliver Person Centered Care** | |
| **(a)** | Complaints report – 10/11/16 – 18/01/17<br>The group reviewed the complaints report. One complaint was categorised as outstanding. Lorraine Currie advised that this complaint was complete. Dianne will check the status on Datix. | |
| **(b)** | GP Complaints Report<br>The report was not available for the meeting, however, Lisa Williams advised that the report had been submitted with no concerns to note. | |
| **(c)** | Pharmacy Report<br>The report was not available for the meeting. | |
| **(d)** | Optometry Report<br>The report was not available for the meeting. | |

| | | |
|---|---|---|
| **12.** | **Vulnerable Children & Adults** | |
| **(a)** | Case Conference Attendance Report<br>The report was circulated previously with the agenda for information. Dianne Rice advised that the process of the SPOA for case conference invites was ongoing. Dianne and Claire Carthy will meet to discuss processes for case conference reporting. | **DR/CC** |
| **(b)** | Child Protection Operational (Partnership) Group minutes – 13th October 2016<br>The minutes were circulated previously with the agenda for information. | |
| **(c)** | Adult Protection<br>Andy Martin advised that there will be an event held at Woodhill Evangelical Church regarding Capacity & Relationships on Wednesday 1st February 2017 at 9.30am. | |
| **14.** | **Infection Control Minutes** | |
| | The minutes were circulated previously with the agenda for information. | |
| **15.** | **AOCB** | |
| | Lisa Williams explained that the agenda for the Clinical & Care Governance meeting needs to reflect integration and include more input from the "care" element and asked Social Work colleagues for suggestions to add to the agenda.<br><br>The following suggestions were made;<br>• Child Protection<br>• Looked After & Accommodated Children<br>• Social Work complaints<br>These areas will appear under Standing Items on the agenda.<br><br>Dianne will update the agenda to reflect the additions. | **DR** |
| **16.** | **Date and time of next meeting**<br>**Wednesday 22nd March 2017, 2.30pm, Room F33A, KHCC** | |

East Dunbartonshire Health & Social Care Partnership

**Chief Officer**
**Mrs Susan Manion**

**Minutes of East Dunbartonshire Staff Forum Meeting**
**Monday 27 March 2017 in the F33A KHCC**

**PRESENT**

| | |
|---|---|
| Susan Manion (SM) | Chief Officer |
| Andrew McCready (AMcC) | Unite Senior Representative (Co Chair) |
| Andy Martin (AM) | Head of Adult & Social Care |
| Tom Quinn (TQ) | Head of People & Change |
| David Aitken (DA) | Joint Adult Services Manager |
| Paolo Mazzonicini (PM) | Chief Social Worker / Head of Children's Services |
| Jean Campbell (JC) | Chief Finance & Resources Officer |
| Stephen McDonald (SMcD) | Joint Service Manager |
| Lorraine Currie (LC) | Operations Manager, Mental Health |
| Frances McLinden (FMc) | General Manager –Oral Health |
| Gillian Notman (GN) | Change & Redesign Manager |
| Margaret Hopkirk (MH) | People & Change Manager |
| David Radford (DR) | Health Improvement Manager |
| Linda Tindall (LT) | Senior Organisational Development Advisor |
| Rosemary Workman (RW) | EDC HR Strategy Lead |
| Robert McIlreavy (RMc) | Senior Learning and Education Advisor |
| Anne McDaid (AMcD) | RCN Representative |
| Margaret McCarthy (MMc) | Unison Representative |
| Simon McFarlane (SMc) | Unison Official (Visiting) |
| Thomas Robertson (TR) | Unison Representative |
| George Frew (GF) | Unite Representative |
| Gillian Cameron (GC) | Unite Representative |
| Kirsty Gilliland (KAG) | HSCP Administrator (Minute Taker) |

| ITEM | SUBJECT | ACTION |
|---|---|---|
| 1. | **Welcome & Apologies**<br><br>Apologies were submitted on behalf of Jamie Carrick and Michael Crainie.<br><br>Round table introductions were given for the benefit of those attending the SPF for the first time. | |
| 2. | **Partnership Agreement**<br><br>*Membership* – The group agreed that the Union should be listed by name. The number of seats was not required.<br><br>*Frequency of meetings, notice and papers* – The notes should be circulated 10 working days in advance. | |

| | | |
|---|---|---|
| | *Quorum* – AMcC clarified that four staff side representatives should at a minimum comprise two different staff side organisations with at least two being from the Council and two from the Health Board. | |
| **3.** | **HSCP Update**<br><br>MMc requested that the IJB papers be circulated 10 working days in advance. SM will pass this request to the chair of the IJB. She requested that the Staff forum paper also be circulated 10 working days in advance to allow the reps to prepare in advance. It was agreed that papers outlining the verbal updates would be provided where possible and any links would be circulated in advance. | **SM**<br><br>**TQ** |
| **4.** | **Finance Update**<br><br>JC gave a verbal overview on the papers that were submitted to the IJB last week. They have approved the recommendations.<br>JC advised that there is 3.6m under spend which will be carried forward into reserves and provide some budget stability for 2017/2018.<br>MMc requested that the finance papers be circulated prior to the meeting. JC advised that this may need to be done in retrospect due to timing but would ensure that these are circulated when possible. | **JC** |
| **5.** | **Healthy Working Lives**<br><br>DR gave an update on Healthy Working Lives (HWL). There are 3 levels, which include Bronze, Silver and Gold. The HSCP currently have the Gold Award. This is a long term commitment and is reviewed on an annual basis. The latest plan (2014-2018) was awarded in June 2016 and agreement was sought to transfer this to the HSCP. We are currently in year 3 of the plan, therefore, this will have to be reviewed and resubmitted. The 3 aspects of HWL include Strategy & requirements; Campaigns and Evaluation & Benchmark.<br><br>There are a number of activities that are currently being offered to staff, which include: walking group; coffee mornings; yoga classes; pedometer walking challenge; energy sessions etc. A singing group is currently being developed. Information regarding activities can be found in the HSCP newsletter. | |

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| **6.** | **Home Care: 4 visits / CM200 / Reviews**<br><br>TR asked for an update on the finance and any planned cuts as there is concern that any work outsourced by third parties will have a detrimental effect on our staff.<br>SMcD advised that there is currently no change and he has not been asked to provide an update. There is a 60/40 provision and we are currently sitting at 39.2% of the target.<br>JC highlighted that a joint review will be arranged by Pauline Halligan to effectively monitor this and look at a combination of staff and third party organisations to deliver this.<br><br>TR asked what process we have in place to monitor if third party organisations miss visits. SMcD advised that there are individual monitoring systems in place, however, this is something that will be scoped out further with Pauline Halligan as part of the review and staff side will be involved in this. | |
| **7** | **Workforce Planning Update**<br><br>TQ gave an overview of the Workforce Planning event which took place on 8th February<br>He outlined a number of areas for action, which include; establishing a co-ordinating group; start process of populating 6 step framework; complete Head of Service reporting structure; establish within care group/service areas, proposed service change; develop initial draft of 2017/18 workforce plan; collate responses to the Scottish Government discussion on National Workforce Plan; ensure that compliance with any Nationally Agreed processes or requirements as we continue to monitor 2017/18 plan; develop recruitment protocol for Joint posts and develop local recruitment protocol which is mindful of overall workforce plan and supports succession plan. This will be brought to the Staff forum in May 2017.<br>TQ asked for staff side representation to participate in the co-ordinating group.<br><br>GF highlighted an issue around qualifications as we are not attracting younger people.<br>TQ advised that this is being considered and the organisation have a commitment to work with Careers Development Scotland as well as student placements etc. in order to bring people back. In addition, there has been more apprenticeships offered | **Staff side** |
| **8.** | **iMatter Update**<br><br>LT informed the group that the questionnaires had been issued. The statistics show a 29% return (including SW), however, staff still have 2 weeks to complete the questionnaires. | |

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| **9.** | **Service Redesign – Integrated Admin Proposal**<br><br>TR asked for an update on the administration review as this was highlighted in the finance report.<br>JC advised that there was no proposal to integrate. There is however plans to look at synergies with shared services for elements in order to support the partnership. Health administration will remain within the services. | |
| **10.** | **H&S Minutes**<br><br>AM referred to the notes of the Health & Safety Sub Group and asked if there were any questions. He advised that EDC have a similar structure whereby they feed into the Tier 2 meeting which is convened at the Marina. Informal discussions have begun in order to harmonise Health & Safety.<br>SM highlighted that any issues should be directed to AM in the meantime. | |
| **11.** | **HR representation at Case meetings**<br><br>Discussion took place regarding HR representation from 2 organisations at a joint investigatory meeting. Clarification sought regarding the different policies.<br>SM advised that this discussion should continue out with the staff forum. | |
| **12.** | **HR Reports**<br><br>MH referred to the circulated HR reports and advised that sickness absence for the HSCP is reportedly 5.5% for February 2017 which is an increase from 5.36%. The Oral Health Directorate is reportedly 3.85% which is a decrease from 4.09% the previous month. | |
| **13.** | **Unison Ethical Care Chapter**<br><br>TR / SMc advised that the IJB asked us to sign up to ethical care charter, which is underwritten by the Government to ensure homecare workers are paid the Scottish living wage for care at home. This would bring us in line with other areas.<br><br>JC highlighted that the IJB were not the employer and suggested that it might be helpful to look at the wording from other IJB's.<br>Diane McCrone will look into this. | **DMc** |
| **14.** | **Staff Forum Development**<br><br>LT proposed taking some time to pull together an action plan and look at how we ensure we promote joined up working across the HSCP. | |
| **15.** | **Date and Time of Next Meeting**<br><br>Monday 22nd May 2017, 2.00pm, Venue tbc | |

**Agenda Item Number: 11**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Public, Service User & Carer Representative Support Group** |
| **Report By** | **Sandra Cairney**<br>**Head of Strategy, Planning and Health Improvement** |
| **Contact Officer** | **David Radford**<br>**Health Improvement & Inequalities Manager**<br>**David.radford@ggc.scot.nhs.uk**<br>**0141 355 2391** |

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| **Purpose of Report** | The report describes the processes and actions undertaken in the development of the Public, Service User & Carer Representatives Support Group (PSUCRSG) |

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

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

**Implications for Health & Social Care Partnership**

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|---|---|
| **Human Resources** | None |

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|---|---|
| **Equalities:** | None |

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|---|---|
| **Financial:** | None |

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|---|---|
| **Legal:** | None |

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|---|---|
| **Economic Impact:** | None |

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|---|---|
| **Sustainability:** | None |

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|---|---|
| **Risk Implications:** | None |

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|---|---|
| **Implications for East Dunbartonshire Council:** | None |

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|---|---|
| **Implications for NHS Greater Glasgow & Clyde:** | None |

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

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|---|---|
| **1.0** | **PURPOSE OF REPORT** |
| 1.1 | The attached report describes the processes and actions undertaken in the development of the Public, Service User & Carer Representatives Support Group (PSUCRSG). To monitor their progress a RAG process is detailed in **Appendix 1**. |
| **2.0** | **SUMMARY** |
| **2.1** | In total 6 meetings have taken place, the most recent was on the 5th June 2017. |
| **2.2** | At the March meeting the PSUCRSG received a detailed overview to the planning and performance responsibilities for the HSCP. |
| **2.3** | Members received and considered a draft PSUCRSG Induction Pack which aims to support new members in their orientation, as a volunteer representative. |
| **2.4** | Each member agreed to join the 'Knowledge Hub' - a virtual communication tool where both formal and informal information can be shared. |
| **2.5** | At the June meeting the PSUCRSG identified a number of volunteer representative vacancies within HSCP Board, Strategic Planning and the West Locality Groups |
| **2.6** | Members received and commented on a presentation that sets out to explain their role within the HSCP. The PSUCRSG Chair will deliver this presentation to the Carers Link Service Users meeting in June |
| **2.7** | Members received, reviewed and amended a Service User / Carers information letter. The Letter will be forwarded to 3rd sector organisations to increase awareness to the role of a as a volunteer representative within the HSCP. |
| **2.8** | Members agreed to be involved within a wider community engagement process to raise awareness of the HSCP and to encourage feedback on proposed HSCP |

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|---|
| strategies and plans. |

East Dunbartonshire Health & Social Care Partnership

**Appendix 1**

# PUBLIC, SERVICE USER & CARER REPRESETITVE SUPPORT GROUP

## CONTEXT

The Public Bodies (Joint Working) (Scotland) Act 2014 and associated regulations and guidance requires the Health & Social Care Partnership (HSCP) to establish mechanisms to take account of the particular needs of communities, service-users and carers in different parts of the authority and to engage them in shaping health & social care services.

1.1 The HSCP Board's consultative/engagement obligations stipulated in the Act relate to the Scheme of Integration and the Strategic Plan and are achieved primarily but not exclusively supported through public, service user and carer representatives on the; HSCP Board, the Strategic Planning Group and two locality planning groups.

## 2.0 BACKGROUND

2.1 In order to ensure public, service user and carer representatives are supported to undertake their role on the statutory groups, a representative Support Group has been established.

2.2 The first meeting was held in September 2016.

2.3 Members include the representatives and their proxies on the HSCP Board, the Strategic Planning Group and the Locality Planning Groups.

2.4 The Support Group agreed to meet no less than four times per year, where possible align with HSCP Board meetings.

2.5 The members of the group undertook a process to appoint a chair who will facilitate their meetings for a period of 12 months.

## 3.0 RECORDING ACTIONS & PROGRESS

3.1 Agreed individual and collective action(s) are recorded at each meeting using a RAG tool. This process enables the Support Group to track their progress and document their contribution to the HSCP Board, Strategic Planning Group and the Locality Planning Groups.

3.2 At the June meeting members contributed and reviewed the following; a final draft of their induction pack, a generic letter and a presentation to increase awareness of the role and remit of Service User and Carer representatives. Both resources are aimed at increasing the number and spread of volunteer representatives within the HSCP strategic and planning structures

3.3 At the March meeting the induction pack, the communication strategy and the group's terms of reference was reviewed by all group members.

## 4.0 ACTION NOTES FROM MEETINGS

4.1 Action note from June 2017

4.2 Action note from March 2017

East Dunbartonshire Health & Social Care Partnership

Public Service User and Carer Support Group

5th June 2017 – Room G34, KHCC.

**Attending**:

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

Apologies: David Bain, Sandra Docherty,

HSCP Officers In attendance; Susan Manion, David Radford,

Action points agreed at meeting;

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

East Dunbartonshire Health & Social Care Partnership

Public Service User and Carer Support Group

27th March 2016 – Room G34, KHCC.

Attending:

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

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

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

Action points agreed at meeting;

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

**Agenda Item Number:12**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Update on Intermediate Care and Delayed Discharges** |
| **Report By** | **Andy Martin, Head of Adult & Primary Care Services, East Dunbartonshire Health & Social Care Partnership** |
| **Contact Officer** | **Andy Martin, Head of Adult & Primary Care Services**<br>**0141 777 3000**<br>**Andy.martin@ggc.scot.nhs.uk** |

| | |
|---|---|
| **Purpose of Report** | To advise the Board of recent developments and performance with respect to hospital discharge |

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|---|---|
| **Recommendations** | To Note the content of the Report |

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|---|---|
| **Relevance to HSCP Board Strategic Plan** | Reduction of Delayed Discharges, , of AWI patients delayed, and of Unscheduled Care are prioritized within the Strategic Plan 2017-18 |

**Implications for Health & Social Care Partnership**

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|---|---|
| **Human Resources** | None |

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|---|---|
| **Equalities:** | None |

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|---|---|
| **Financial:** | There are potential implications for East Dunbartonshire's 'set-aside' budget for Acute Services usage |

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|---|---|
| **Legal:** | None |

| | |
|---|---|
| **Economic Impact:** | None |

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|---|---|
| **Sustainability:** | None at this point. Emerging risks will be managed via the Older Peoples Planning Group, and the Delayed Discharges workstream |

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|---|---|
| **Risk Implications:** | None |

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|---|---|
| **Implications for East Dunbartonshire Council:** | As noted |

| | |
|---|---|
| **Implications for NHS Greater Glasgow & Clyde:** | As noted |

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

## 1.0 MAIN REPORT

**1.1** This report summarises recent developments and issues relevant to the effective, proactive and timeous discharge of East Dunbartonshire patients from hospital.

**1.2** East Dunbartonshire Health & Social Care Partnership has a positive record in this area, improving performance year on year and standing favourable comparison with other partnerships, both across NHS Greater Glasgow and Clyde and nationally.

**1.3** The requirement for Health & Social Care Partnerships is to take on the planning and commissioning responsibility for unscheduled care reinforces the necessity to consolidate and improve delayed discharge performance, but also should provide clarity of purpose and approach, especially in the more difficult areas of reducing emergency admissions and average lengths of stay.

**1.4** Our approach needs to encapsulate a revised and strengthened relationship with Acute services, and a more focussed analysis of activity and performance widely across Primary Care. These areas are among the prioritised spheres of activity being identified within our Unscheduled Care Plan.

**1.5** Similarly a different kind of relationship with care homes needs to emerge. This is on where care homes can contribute to a wider refreshed opportunity for rehabilitation, so that more patients can return home. Care homes also require to be more accountable and proactive with regard to their patterns of admission. This is also highlighted in the Unscheduled Care Plan.

## 2.0 INTERMEDIATE CARE

**2.1** The intermediate care facility at Westerton Care Home in Bearsden was set up as a one year pilot in December 2016. It has now been in operation for 6 months. All the indications are that it is operating successfully and is making a major contribution to positive performance not only in discharging patients but in increasing the numbers of patients able to return home after enhanced care.

## PERFORMANCE INFORMATION FROM INTERMEDIATE CARE

**Activity from November 2016 to April 2017**

45 clients have been admitted to the unit.

- 30 referrals to Rapid Assessment Link Service
- 27 were placed in to care
- 10 have gone home

The breakdown of postcodes for this cohort is:-

- Kirkintilloch ( G66) – 12
- Bearsden (G61) – 11
- Milngavie (G62) – 11
- Bishopbriggs (G64) – 11
- Tweecher (G65) – 0

**Voids related to bed capacity**

| | Beds | Beds used | Voids | Capacity |
|---|---|---|---|---|
| Nov | 102 | 32 | 59 | 42% |
| Dec | 186 | 149 | 37 | 80% |
| Jan | 198 | 149 | 49 | 75% |
| Feb | 224 | 218 | 6 | 98% |
| Mar | 248 | 236 | 12 | 95% |
| Apr | 240 | 213 | 27 | 89% |

**Delayed discharges from the past two years – recorded on Edison**

| Month | 2015/2016 | 2016/2017 |
|---|---|---|
| Nov | 29 | 24 |
| Dec | 26 | 20 |
| Jan | 27 | 20 |
| Feb | 25 | 18 |
| Mar | 17 | 15 |
| Apr | 18 | 17 |

**2.2** Following on from the NHS GG&C Review of Complex and Continuing Care, some further commissioned resources have been freed up which are now available to East Dunbartonshire to use as an intermediate option for patients who are fit for discharge but unable to return home. These resources include a ration of beds in Fourhills and Greenfield Park, care homes which previously provided beds for patients identified as needing hospital based complex and continuing care within the eligibility of the previous Guidance.

**2.3** We are already prioritising the use of these beds, under the guidance of relevant geriatric consultants, for East Dunbartonshire patients who may be on a palliative pathway, where a return home is not considered appropriate. As well as being the best option for such patients, this facility provides another option to reduced patients delayed in acute beds. Its impact on overall delayed discharge performance will be closely monitored by the Delayed Discharge workstream.

## 3.0 PLANNING

**3.1** From 1st May 2017 new arrangements have been agreed between Acute Care Divison of NHS Greater Glasgow and Clyde and the Chief Officers of the 6 HSCPs. This change is based upon the premise that at the point at which a patient is declared "fit for discharge", financial and planning responsibility for that patient will pass from Acute to HSCP.

**3.2** The context for this decision is that the Acute Division needs to reduce beds which have been non recurrently funded in 2016/2017 as well as implemting further bed reductions in the early part of 2017/2018 to reduce costs to the level of available resources. This will also form part of the measures being put in place to improve unscheduled care performance and the flow of patients through acute sites. A significant issue at hospital front doors across NHS GG&C is lack of beds to enable admission.

**3.3** In light of this change of arrangements and proposed shift responsibility, a weekly conference call has been established between all of the Discharge Leads for the 6 Partnerships and leads from the Acute Care Division. This will enable immediate and focussed discussion to ensure all patients ready for discharge are identified on a daily basis and that appropriate moves are coordinated. Oversight of all aspects of East Dunbartonshire's Hospital Discharge, including Intermediate Care, will be excercised

via the Delayed Discharge workstream which reports to the Older Peoples Planning Group.

**3.4** Further financial discussion is anticipated with regard to these arrangements and the "set-aside" budgets established for HSCPs as a reflection of recent and projected draw upon Acute Care division resources.

## 4.0 PERFORMANCE

**4.1** Performance in reducing Delayed Discharges has continued to improve. This is in spite of an overall rise in unscheduled events for patients from East Dunbartonshire.

**4.2** The 2016-17 performance report for older people is attached as **Appendix 1**. It shows a total of acute bed days lost to delay (inc. AWI) of **2147**. This is down from **3636** in year 2015-16. This reflects an annual reduction of **35%**.

**4.3** The positive performance trend with respect to AWI patients delayed is consolidated with **0** acute beds lost reported in year 2016-17. A small number of days were consumed by AWI patients in beds on other sites, principally commissioned care homes (intermediate). This total was **52** bed days for the year.

**4.4** The trend in overall Unplanned Bed Days continues upward, rising from a total of **56,333** in 2015-16 to **59,362** in 2016-17. This reflects an annual increase of **5%.** The %rate of Emergency Admissions for both patients aged 65+ and those aged 75+ has continued to rise.

**4.5** The Health & Social Care Partnership Board is invited to scrutinise and comment on the detail contained within **Appendix 1.**

# APPENDIX 1

**EAST DUNBARTONSHIRE HSCP**

| Ref No | Performance Measures | 2009/10 Baseline | 2010/11 Actual | 2011/12 Actual | 2012/13 Actual | 2013/14 Actual | 2014/15 Actual | 2015/16 Actual | 2012/13 April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | 2013/14 April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | 2014/15 Apr | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Mar 50% | Mar 75% | 2015/16 Apr | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | June | July |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Number of acute bed days lost to delayed discharges (inc Adults With Incapacity) Age 65 years & over | 7,359 | 6,883 | 6,370 | 5,534 | 2,686 | 4,916 | 3,636 | 326 | 225 | 393 | 382 | 468 | 325 | 569 | 569 | 595 | 567 | 579 | 536 | 408 | 360 | 270 | 90 | 163 | 205 | 260 | 169 | 178 | 149 | 271 | 163 | 424 | 475 | 283 | 243 | 477 | 393 | 408 | 366 | 326 | 573 | 413 | 533 | 307 | 153 | 462 | 458 | 287 | 308 | 216 | 146 | 283 | 254 | 379 | 347 | 276 | 220 | 187 | 102 | 238 | 163 |
| 2 | Number of acute bed days lost to delayed discharges for Adults With Incapacity, age 65 years & over | 3,200 | 2,075 | 1,351 | 63 | 15 | 1,185 | 596 | 23 | 1 | 30 | 9 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 15 | 30 | 110 | 53 | 63 | 93 | 101 | 127 | 100 | 114 | 123 | 86 | 185 | 133 | 67 | 210 | 154 | 63 | 62 | 36 | 30 | 31 | 0 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 3 | Number of acute delayed discharges (within period) Age 65 years & over | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 22 | 22 | 22 | 31 | 29 | 26 | 34 | 40 | 35 | 37 | 41 | 42 | 35 | 31 | 23 | 11 | 11 | 21 | 22 | 19 | 17 | 19 | 20 | 22 | 36 | 36 | 25 | 23 | 36 | 34 | 31 | 26 | 21 | 42 | 38 | 49 | | | 35 | 35 | 39 | 28 | 22 | 13 | 24 | 35 | 41 | 34 | 31 | 24 | 23 | 16 | 24 | 25 |
| 4 | Delayed Discharges (at census) | n/a | n/a | n/a | n/a | n/a | n/a | n/a | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 |
| | Delayed Discharge < = 3 days | n/a | n/a | n/a | n/a | n/a | n/a | n/a | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 |
| | Delayed Discharge = > 4 days | n/a | n/a | n/a | n/a | n/a | n/a | n/a | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 |
| 5 | Unplanned acute bed days (age 65+) | 59,883 | 59,192 | 54,865 | 63,051 | 52,633 | 58,944 | 56,333 | 4,976 | 5,216 | 4,672 | 4,730 | 4,975 | 4,791 | 5,165 | 5,356 | 5,728 | 6,233 | 5,251 | 5,958 | 5,320 | 4,827 | 4,106 | 4,122 | 3,982 | 3,845 | 4,088 | 4,295 | 4,533 | 4,878 | 3,895 | 4,742 | 4,771 | 5,260 | 4,744 | 4,654 | 4,870 | 4,794 | 4,934 | 4,667 | 5,108 | 5,756 | 4,755 | 4,631 | | | 4,379 | 4,877 | 4,305 | 4,677 | 4,412 | 3,949 | 4,733 | 4,623 | 5,034 | 5,566 | 4,641 | 5,137 | 4,865 | 5,149 | 4,585 | 4,832 |
| | Unplanned acute bed days (age 65+) rate per 1,000 population | 3,039 | 2,936 | 2,661 | 2,938 | 2,392 | 2,679 | 2,490 | 232 | 243 | 218 | 220 | 232 | 223 | 241 | 250 | 267 | 290 | 245 | 278 | 242 | 219 | 187 | 187 | 181 | 175 | 186 | 195 | 206 | 222 | 177 | 216 | 217 | 239 | 216 | 212 | 221 | 218 | 224 | 212 | 232 | 262 | 216 | 210 | | | 194 | 216 | 190 | 207 | 195 | 175 | 209 | 204 | 223 | 246 | 205 | 227 | 211 | 224 | 199 | 210 |
| 6 | Unplanned acute bed days (age 75+) | 46,369 | 46,382 | 43,358 | 48,377 | 41,715 | 47,106 | 44,380 | 3,831 | 4,104 | 3,632 | 3,105 | 3,671 | 3,652 | 4,041 | 4,063 | 4,540 | 5,003 | 3,980 | 4,755 | 4,276 | 3,878 | 3,267 | 3,148 | 3,011 | 3,017 | 3,160 | 3,426 | 3,570 | 4,045 | 3,202 | 3,715 | 3,879 | 4,402 | 3,898 | 3,710 | 3,761 | 3,798 | 3,985 | 3,447 | 4,207 | 4,625 | 3,739 | 3,655 | | | 3,353 | 3,557 | 3,295 | 3,675 | 3,482 | 3,225 | 3,676 | 3,664 | 4,290 | 4,475 | 3,688 | 3,980 | 3,788 | 4,080 | 3,730 | 3,828 |
| | Unplanned acute bed days (age 75+) rate per 1,000 population | 5,198 | 5,021 | 4,544 | 4,843 | 4,043 | 4,566 | 4,148 | 384 | 411 | 364 | 311 | 368 | 366 | 405 | 407 | 454 | 501 | 398 | 476 | 414 | 376 | 317 | 305 | 292 | 292 | 306 | 332 | 346 | 392 | 310 | 360 | 376 | 427 | 376 | 360 | 365 | 368 | 386 | 334 | 408 | 448 | 362 | 354 | | | 314 | 333 | 308 | 344 | 326 | 302 | 344 | 343 | 401 | 418 | 345 | 372 | 349 | 375 | 343 | 352 |
| 7 | Number of emergency admissions (age 65+) | 4,547 | 4,910 | 4,736 | 5,105 | 4,901 | 5,463 | 5,533 | 411 | 430 | 368 | 418 | 426 | 416 | 437 | 418 | 478 | 439 | 409 | 455 | 440 | 369 | 407 | 372 | 384 | 417 | 403 | 403 | 451 | 435 | 373 | 447 | 463 | 478 | 444 | 417 | 476 | 454 | 427 | 417 | 497 | 486 | 430 | 474 | | | 435 | 443 | 423 | 445 | 474 | 448 | 453 | 406 | 504 | 495 | 460 | 547 | 493 | 504 | 421 | 528 |
| | Number of emergency admissions (age 65+) rate per 1,000 population | 231 | 244 | 230 | 238 | 223 | 248 | 245 | 19 | 20 | 17 | 19 | 20 | 19 | 20 | 19 | 22 | 20 | 19 | 21 | 20 | 17 | 18 | 17 | 17 | 19 | 18 | 18 | 20 | 20 | 17 | 20 | 21 | 22 | 20 | 19 | 22 | 21 | 19 | 19 | 23 | 22 | 20 | 22 | | | 19 | 20 | 19 | 20 | 21 | 20 | 20 | 18 | 22 | 22 | 20 | 24 | 21 | 22 | 18 | 23 |
| | Number of emergency admissions (age 75+) | | | | | 3,288 | 3,823 | 3,737 | | | | | | | | 274 | 325 | 295 | 274 | 310 | 301 | 258 | 283 | 225 | 250 | 274 | 277 | 270 | 307 | 301 | 249 | 293 | 331 | 340 | 311 | 274 | 335 | 325 | 277 | 289 | 360 | 349 | 297 | 335 | | | 292 | 289 | 287 | 302 | 322 | 308 | 292 | 272 | 369 | 346 | 307 | 351 | 331 | 345 | 300 | 345 |
| | Emergency admissions (age 75+) rate per 1,000 population | | | | | 319 | 371 | 349 | | | | | | | | 27 | 33 | 30 | 27 | 31 | 29 | 25 | 27 | 22 | 24 | 27 | 27 | 26 | 30 | 29 | 24 | 28 | 32 | 33 | 30 | 27 | 32 | 32 | 27 | 28 | 35 | 34 | 29 | 32 | | | 27 | 27 | 27 | 28 | 30 | 29 | 27 | 25 | 35 | 32 | 29 | 33 | 30 | 32 | 28 | 32 |
| 8 | Number of unplanned admissions by SIMD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | SIMD Quintile 1 | 58 | 61 | 0 | 0 | 17 | 67 | 84 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 3 | 4 | 2 | 4 | 5 | 2 | 8 | 5 | 2 | 3 | 6 | 10 | 9 | 7 | 6 | | | 6 | 8 | 6 | 5 | 5 | 4 | 12 | 1 | 7 | 12 | 9 | 9 | 9 | 6 | 8 | 9 |
| | SIMD Quintile 2 | 258 | 241 | 133 | 128 | 156 | 194 | 198 | 12 | 11 | 12 | 14 | 13 | 13 | 12 | 4 | 8 | 15 | 3 | 11 | 7 | 8 | 11 | 12 | 13 | 8 | 13 | 11 | 18 | 23 | 14 | 18 | 14 | 14 | 14 | 12 | 17 | 19 | 19 | 16 | 18 | 16 | 16 | 19 | | | 15 | 14 | 20 | 10 | 16 | 18 | 20 | 20 | 18 | 24 | 7 | 16 | 19 | 16 | 17 | 19 |
| | SIMD Quintile 3 | 1126 | 1,078 | 912 | 935 | 1,054 | 1,263 | 1,200 | 84 | 90 | 79 | 68 | 85 | 59 | 79 | 87 | 77 | 72 | 75 | 80 | 89 | 79 | 87 | 90 | 79 | 76 | 75 | 72 | 109 | 105 | 87 | 104 | 111 | 129 | 104 | 106 | 96 | 98 | 99 | 98 | 102 | 111 | 111 | 98 | | | 89 | 95 | 78 | 104 | 107 | 101 | 105 | 75 | 114 | 94 | 114 | 124 | 95 | 130 | 93 | 117 |
| | SIMD Quintile 4 | 778 | 902 | 875 | 965 | 974 | 1,128 | 1,159 | 75 | 81 | 63 | 88 | 83 | 82 | 79 | 77 | 82 | 93 | 79 | 83 | 79 | 57 | 85 | 63 | 87 | 77 | 73 | 96 | 91 | 96 | 62 | 108 | 99 | 103 | 102 | 87 | 103 | 93 | 82 | 88 | 99 | 98 | 87 | 87 | | | 99 | 92 | 77 | 88 | 106 | 101 | 79 | 85 | 96 | 105 | 97 | 134 | 99 | 105 | 95 | 104 |
| | SIMD Quintile 5 | 2327 | 2,620 | 2,782 | 3,033 | 2,668 | 2,811 | 2,892 | 239 | 245 | 211 | 247 | 242 | 261 | 264 | 247 | 304 | 256 | 243 | 274 | 262 | 219 | 220 | 202 | 203 | 252 | 235 | 221 | 225 | 208 | 206 | 215 | 235 | 227 | 222 | 204 | 255 | 242 | 224 | 209 | 268 | 252 | 209 | 264 | | | 226 | 234 | 242 | 238 | 240 | 224 | 237 | 225 | 269 | 260 | 233 | 264 | 271 | 247 | 208 | 279 |
| 9 | Number of delayed discharges for Adults with Incapacity (Acute Beds) | 47 | 33 | 51 | 5 | 1 | 50 | 25 | 2 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 4 | 3 | 3 | 5 | 5 | 4 | 4 | 5 | 7 | 6 | | | 8 | 7 | 3 | 2 | 2 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 10 | Reduced ALOS for over 75s in mental health beds | 176 | 144 | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | | | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |

East Dunbartonshire Health & Social Care Partnership

**Chief Officer**
**Susan Manion**

**Agenda Item Number: 13**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **2017/18 Revenue Budget Update and Directions to East Dunbartonshire Council and NHS Greater Glasgow & Clyde** |
| **Report By** | **Jean Campbell, Chief Finance & Resources Officer**<br>**Tel: 0300 1234510 Ext 3221** |
| **Contact Officer** | **Jean Campbell, Chief Finance & Resources Officer**<br>**Tel: 0300 1234510 Ext 3221** |

| | |
|---|---|
| **Purpose of Report** | To update the Board on the revenue budget position for 2017/18 and to seek approval to issue directions to East Dunbartonshire Council and Greater Glasgow & Clyde NHS Board in respect of the delivery of the functions delegated to the IJB under the Public Bodies (Joint Working)(Scotland) Act 2014. |

| | |
|---|---|
| **Recommendations** | The Integration Joint Board is asked to:<br><br>a) Note and agree the budget allocations for 2017/18.<br><br>b) Note the updated position in relation to the 2017/18 budget and in particular the continued work around prescribing budget pressures.<br><br>c) Approve the Directions to East Dunbartonshire Council and NHS Greater Glasgow & Clyde in respect of the delivery of the functions delegated to the East Dunbartonshire Integration Joint Board as set out in Appendix 1 f this report;<br><br>d) Delegate authority to the Chief Officer to issue the Directions to the Chief Executives of east Dunbartonshire Council and NHS GG&C;<br><br>e) Agree that both sets of Directions are reviewed by the IJB as and when updates are required and at a minimum on an annual basis in respect of the following financial year. |

| | |
|---|---|
| **Relevance to HSCP Board Strategic Plan** | The delivery of the Strategic Plan is dependent on the allocation of sufficient resource to support service delivery and proper systems in place to direct partner agencies in its delivery. |

**Implications for Health & Social Care Partnership**

| | |
|---|---|
| **Human Resources** | None at this stage, albeit review of current service delivery models and service re-design to meet future demand forecasts may have implications moving forward. |

| | |
|---|---|
| **Equalities:** | None |

| | |
|---|---|
| **Financial:** | The allocations from each partner agency inform the financial planning for partnership service delivery and the changes required to current models to work within the overall financial framework and deliver on the strategic priorities. The Directions include the budget allocations made available to both partner agencies to deliver the relevant functions as agreed by the IJB. |

| | |
|---|---|
| **Legal:** | The IJB, under Sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014 is required to direct East Dunbartonshire Council and Greater Glasgow & Clyde NHS Board to deliver services to support the delivery of the Strategic Plan. |

| | |
|---|---|
| **Economic Impact:** | None |

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

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

| | |
|---|---|
| **Implications for East Dunbartonshire Council:** | The Council is directed to deliver services in line with the strategic plan in line with the financial framework agreed by the IJB. |

| | |
|---|---|
| **Implications for NHS Greater Glasgow & Clyde:** | The NHS Board is directed to deliver services in line with the strategic plan in line with the financial framework agreed by the IJB. |

| | | |
|---|---|---|
| **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** |

## 2.0 MAIN REPORT

**2.1** The previous reports to the IJB on the 26th January 2017 and the 23rd March 2017 provided an update on the financial allocations from both East Dunbartonshire Council and NHS GG&C. This was based on the outcome of discussions with the relevant partner agencies and guidance issued by the Scottish Government as part of the financial settlement and budget announcements of the 15th December 2016 to Local Authorities and Health Boards.

**2.2** This provided that NHS contributions to Integration Authorities for delegated health functions will be maintained at least at 2016/17 cash levels and for Local Authorities, an adjustment can be made to allocations to IJBs up to their share of £80m below the level of budget agreed for 2016/17.

**2.3** There remains an outstanding issue with the health allocation in respect of a share of £3.6m (revised from £7.8m following a decision taken by NHS GG&C Board on the 21st February 2017) being un-achieved savings dating back to 2015/16 relating to then CHPs. Further discussions are on-going with the Director of Finance and the Chief Executive of NHS GG&C with the hope of reaching a satisfactory conclusion for all parties. The Health Board is required to set its final budget by the end June 2017 for 2017/18.

**2.4** In respect of both allocations, there was no provision made for any demographic or cost pressures which resulted in a gap in resources to meet the costs of services in 2017/18 of £5.1m. This culminated in a savings programme being agreed totalling £4.6m which leaves a shortfall of approx. £500k of further savings to be identified. The partnership has reserves of £5.3m which can be used to provide some in year capacity to address savings gaps and delays, however measures to address this gap will have to be identified on a recurring basis.

**2.5** The respective anticipated budget allocations for 2017/18 are:

| Partner Agency | Budget Allocation 17/18 | Savings Target | Savings Identified |
|---|---|---|---|
| East Dunbartonshire Council – SW | £50.5m | £3.6m | £3.1m |
| East Dunbartonshire Council – Other | £1.2m | £0m | £0 |
| NHS GG&C | £79.6m | £1.5m | £1.5m |
| Set Aside | £17.4m | £0m | £0m |
| TOTAL | £148.7m | £5.1m | £4.6m |

**Budget Update - NHS Greater Glasgow and Clyde**

**2.6** Following the last Board meeting on the 23rd March 2017, a further letter was received from the NHS GG&C Board Chief Executive re-enforcing the Board decision on the 21st February to incorporate a deduction of £3.6m to HSCP's 2017/18 budgets relating to savings dating back to 2015/16 in respect of CH(C)P's. A copy of the letter is attached as **Appendix 1(a).**

**2.7** The Chief Officer formally wrote to the Chief Executive of NHS GG&C to notify of the IJB decision not to accept the offer made by the NHS Board, a copy of the letter is attached as **Appendix 1(b)**.

**2.8** There remains an expectation that partnerships will meet this cost and until such times as the matter is concluded ED HSCP will consider this a cost pressure for this financial year and will report this through the regular monitoring reports to the IJB.

**2.9** An update on additional prescribing pressures was presented to the IJB on the 23rd March estimated at £8.5m for 2017/18. A Prescribing Efficiency Group has been established which met on the 26th April 2017 to look at what additional measures can be applied in 2017/18 to mitigate the demand and cost pressures from prescribing. Key areas identified for further scoping centre around Scriptswitch, Polypharmacy, Serial dispensing, repeat prescribing and care home reviews aimed at driving down volumes and costs and influencing current prescribing practice across both Acute and Community health services.

**2.10** A follow up meeting of this group on the 8th June provided for further tariff savings expected on prescribing of £4m, the removal of sexual health prescribing budgets (managed separately) of £0.6m and some additional measures of £1m leaving a revised gap of £2.8m. Work is ongoing to scope other possible measures and a range of work programmes are progressing around drug wastage, communications and serial dispensing which may generate further efficiency.

**2.11** The share of prescribing pressures to be met by East Dunbartonshire HSCP was originally estimated at £640k and savings have been identified which include an element relating to this pressure so any further savings on prescribing will contribute to the overall ED HSCP position and will bring some flexibility in the management of this budget going forward. There remains significant risk around the prescribing budget in relation to drug shortages and significant price increases which may alter the outlook for the prescribing budget which will require close monitoring as the year progresses

**2.12** There is currently a review of the risk sharing arrangement amongst the six HSCPs and the Board as to how this arrangement should continue beyond 2017/18. An interim risk sharing arrangement remains during 2017/18 with the Board maintaining the risk for any additional pressures over and above the £2.85m predicted. Until the out turn position for 2016/17 prescribing is finalised, budget allocations will not be known with certainty for 2017/18.

**Directions**

**2.13** The Public Bodies (Joint Working)(Scotland) Act 2014 places a duty on the IJB to develop and publish a Strategic Plan for integrated functions and budgets under its control. The IJB approved its Strategic Plan on the 3rd September 2015 for the period

2015 – 2018 when responsibility for services and functions were then fully delegated from East Dunbartonshire Council and NHS Greater Glasgow & Clyde.

**2.14** The Act also places a duty on the IJB to set out its mechanism for implementing the Strategic Plan and this to take the form of Directions from the IJB to East Dunbartonshire Council and NHS GG&C. This mechanism takes the form of binding written directions from the IJB to one or both of East Dunbartonshire Council or NHS GG&C. A direction must be issued in respect of every function which has been delegated to the IJB and must set out how each function is to be delivered and the budget associated with that. One direction can cover more than one function.

**2.15** Directions should set out a clear framework for operational delivery of the functions that have been delegated to the IJB. A function can be described in terms of delivery of services, achievement of outcomes, and/or by reference to the Strategic Plan. The direction may also specify what the Health Board or Council is to do in relation to carrying out a particular function and so there is scope to include detailed operational instructions in relation to particular functions (and associated services).

**2.16** Directions must include detailed information on the financial resources that are available for carrying out the functions that are the subject of the Directions, including the allocated budget and how that budget (whether it is a payment, or an amount made available) is to be used.

**2.17** No standard template or format for Directions has been prescribed. The Scottish Government has produced only a good practice note – which is not statutory guidance – for IJBs in relation to Directions. The format of Directions is therefore a matter for each IJB, taking into account the legislative requirements of Sections 26 to 28 of the Act. The draft Directions attached at **Appendix 2** are therefore framed within the context of the IJB's Strategic Plan and existing operational arrangements.

**2.18** A Direction does not have a fixed timescale and will remain in place until it is varied, revoked or superseded by a later Direction issued by the IJB in respect of the same function.

**2.19** It would be good practice to review the Directions on a regular basis and particularly when there are any developments – such as changes to strategic and/or operational plans or when action is needed to balance budgets.

**2.20** The mechanism of Directions has flexibility to ensure that delivery of integrated health and social care functions is consistent with the Strategic Plan, and takes account of any changes in local circumstances.

**Greater Glasgow and Clyde NHS Board**

JB Russell House
Gartnavel Royal Hospital
1055 Great Western Road
GLASGOW
G12 0XH
Tel. 0141-201-4444
Fax. 0141-201-4601
Textphone: 0141-201-4479
www.nhsggc.org.uk

NHS
Greater Glasgow and Clyde

Susan Manion
Chief Officer
East Dunbartonshire Health and Social Care Partnership
CHP Offices
Stobhill Hospital
300 Balgrayhill Road
Glasgow, G21 3UR

Date: 29th March 2017
Our Ref: RC/LL

Enquiries to: Robert Calderwood
Direct Line: 0141-201-4614
E-mail: robert.calderwood@ggc.scot.nhs.uk

received
06/04/17

Dear Susan

**Budget Allocations to Health and Social Care Partnerships for 2017/18**

I refer to previous correspondence and the Board's subsequent decision on 21st February 2017 to allocate the £7.8m across the Board (Corporate and Acute Services) and the 6 Health and Social Care Partnership's (HSCPs) in 2017/18 on a pro rata basis to the Budget. The Board's Standing Orders do not allow a motion which contradicts a previous decision to be competent within a six month period. The Board's allocations to HSCPs from 1st April 2017 will therefore incorporate a deduction of £3.6m in accordance with the decision taken by the Board on 21st February 2017. I appreciate that HSCPs have not accepted this position and there will be ongoing discussions over the next few weeks which may ultimately require arbitration.

However, as the Accountable Officer for NHS Greater Glasgow and Clyde it is my expectation that as the Accountable Officer for your partnership you will operate within the budget offer from NHS Greater Glasgow and Clyde until such time the above matter is finally resolved.

Yours sincerely

**Robert Calderwood**
**Chief Executive**
**NHS Greater Glasgow and Clyde**

East Dunbartonshire Health & Social Care Partnership

**Chief Officer**
**Susan Manion**

Mr Robert Calderwood
Chief Executive
NHS Greater Glasgow & Clyde
JB Russell House
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1055 Great Western Road
Glasgow
G12 0XH

East Dunbartonshire HSCP
HSCP HQ Office
Kirkintilloch Health & Care Centre
10 Saramago Street
Kirkintilloch
G66 3BF
Telephone: 0141 232 8216
Our Ref: SM/GM

31st March 2017

Dear Robert,

Thank you very much for your letter of the 29th March. The East Dunbartonshire Health and Social Care Partnership Board met on the 23rd March and discussed the proposed allocations from both Greater Glasgow and Clyde Health Board and East Dunbartonshire Council.

I have attached a copy of the paper outlining the position and the recommendations from the Chief Finance Officer supported by myself. The recommendations were agreed by the HSCP Board with the exception of the first recommendation agreed in principle but the wording amended to read as follows:-

"Consider the detail of the allocation from GG&C NHS Board and the impact this will have on the Partnerships ability to deliver on the strategic priorities set out for the HSCP and not accept **at this stage** the offer made by the NHS Board on the basis outlined in 4.2.1"

It reinforces the view of the HSCP Board that while they could not accept the position as it stands, there was an eagerness to resolve the issue as soon possible and they asked the Chief Finance Officer and myself to work with the NHS Board to find an acceptable settlement.

I also acknowledge your final point about ensuring plans are in place to meet all eventualities and I will have a plan in place on the basis of the Board position as it stands until final position is agreed. This would of course have to go back to the HSCP Board for approval.

Yours sincerely,

Mrs Susan Manion
**Chief Officer**
**East Dunbartonshire Health & Social Care Partnership**

**EAST DUNBARTONSHIRE INTEGRATION JOINT BOARD**
**DIRECTION**
ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

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**THE EAST DUNBARTONHSIRE COUNCIL** is hereby directed to deliver for the East Dunbartonshire Integration Joint Board (the IJB), the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the IJB's Strategic Plan and existing operational arrangements pending future directions from the IJB.

| | |
|---|---|
| Services: | All services listed in Annex 2, Part 2 of the East Dunbartonshire Health and Social Care Partnership Integration Scheme. |
| Functions: | All functions listed in Annex 2, Part 1 of the East Dunbartonshire Health and Social Care Partnership Integration Scheme. |

**Associated Budget:**

(see attached spreadsheet)

This direction is effective from 1 April 2017.

**Health and Social Care Partnership**

**Full Year Budget 2017/18 - Delegated Social Work Services by Subjective**

| Social Work Services | Full Year Budget |
|---|---|
| Non-Teaching Employee Costs | 19,261,823 |
| Property Costs | 169,446 |
| Supplies & Services | 1,032,849 |
| Agencies & Other Bodies | 47,924,541 |
| Transport & Plant | 499,231 |
| Transfer Payments | 116,821 |
| Administrative Costs | 167,385 |
| Financing Costs | 0 |
| Income from Government Grants | -622,000 |
| Budget Savings | -502,000 |
| Sales | -8,785 |
| Fees & Charges | -810,971 |
| Recharges to Other Departments | -81,037 |
| Income from Rents | 0 |
| Other Income | -16,676,151 |
| **OVERALL TOTAL** | **50,471,152** |

| Adults and Older People | Full Year Budget |
|---|---|
| Non-Teaching Employee Costs | 13,679,946 |
| Property Costs | 107,573 |
| Supplies & Services | 941,836 |
| Agencies & Other Bodies | 41,814,306 |
| Transport & Plant | 415,623 |
| Transfer Payments | 33,256 |
| Administrative Costs | 117,339 |
| Financing Costs | 0 |
| Income from Government Grants | 0 |
| Budget Savings | -502,000 |
| Sales | -8,785 |
| Fees & Charges | -810,971 |
| Recharges to Other Departments | -81,037 |
| Income from Rents | 0 |
| Other Income | -16,359,039 |
| **Adults and Older People - Total** | **39,348,047** |

| Children and Families | Full Year Budget |
|---|---|
| Non-Teaching Employee Costs | 5,581,877 |
| Property Costs | 61,873 |
| Supplies & Services | 91,013 |
| Agencies & Other Bodies | 6,110,235 |
| Transport & Plant | 83,608 |
| Transfer Payments | 83,565 |
| Administrative Costs | 50,046 |
| Financing Costs | 0 |
| Income from Government Grants | -622,000 |
| Budget Savings | 0 |
| Sales | 0 |
| Fees & Charges | 0 |
| Recharges to Other Departments | 0 |
| Income from Rents | 0 |
| Other Income | -317,112 |
| **Children and Families - Total** | **11,123,105** |

**Health and Social Care Partnership**

**Full Year Budget 2017/18 - Delegated Social Work Services by Care Group**

| Adults and Older People | Full Year Budget |
|---|---|
| Older People | ` |
| Learning Disability | 12,965,213 |
| Physical Disability | 4,019,300 |
| Mental Health | 1,986,975 |
| Addiction Services | 570,401 |
| Homecare | 6,186,674 |
| Resources Day Services | 2,235,370 |
| Sheltered Housing | 50,501 |
| Other | 2,146,844 |
| Womens Aid | 75,114 |
| Resource Transfer Income | -15,165,477 |
| **TOTAL** | **39,348,047** |

| Children and Families | Full Year Budget |
|---|---|
| Children & Young People | 3,240,736 |
| Criminal Justice | -16,805 |
| Childcare Resources | 7,698,080 |
| Other | 201,094 |
| **TOTAL** | **11,123,105** |

| | |
|---|---|
| **Overall Total** | **50,471,152** |

**Health and Social Care Partnership**

**Full Year Budget 2017/18 - Other Delegated Council Services**

| Council - Other Budgets | Full Year Budget |
|---|---|
| Care of Gardens | 78,000 |
| Adaptations (PSHG) | 450,000 |
| Care & Repair | 214,000 |
| Fleet | 452,000 |
| **TOTAL** | **1,194,000** |

**EAST DUNBARTONSHIRE INTEGRATION JOINT BOARD**
**DIRECTION**
ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

---

**GREATER GLASGOW & CLYDE NHS BOARD** is hereby directed to deliver for the East Dunbartonshire Integration Joint Board (the IJB), the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the IJB's Strategic Plan and existing operational arrangements pending future directions from the IJB.

| | |
|---|---|
| Services: | All services listed in Annex 1, Part 2 of the East Dunbartonshire Health and Social Care Partnership Integration Scheme. |
| Functions: | All functions listed in Annex 1, Part 1 of the East Dunbartonshire Health and Social Care Partnership Integration Scheme. |

Associated Budget:

(see attached spreadsheet)

This direction is effective from 1 April 2017.

**Health and Social Care Partnership**

**Full Year Budget 2017/18 - Delegated Health Services by Subjective**

| Health Services | Full Year Budget |
|---|---|
| Payroll | 19,075 |
| Non Payroll | 5,201 |
| Purchase of Healthcare | 13,712 |
| Family Health Services | 44,345 |
| Income | -2,723 |
| **OVERALL TOTAL** | **79,610** |

**Health and Social Care Partnership**

**Full Year Budget 2017/18 - Delegated Health Services by Care Group**

| Health Services | Full Year Budget |
|---|---|
| Alcohol & Drugs | 703 |
| Adult Community Services | 4,426 |
| Integrated care Fund | 833 |
| Child Services Community | 1,296 |
| FHS - Prescribing | 18,961 |
| FHS - GMS | 12,452 |
| FHS - Other | 11,649 |
| Learning Disability - Community | 639 |
| Mental Health - Adult Community | 1,260 |
| Mental Health - Elderly Services | 623 |
| Oral Health | 10,293 |
| Other Services | 2,610 |
| Planning & Health Improvement | 668 |
| Resource transfer - Local Authority | 13,199 |
| **TOTAL** | **79,610** |

**Health and Social Care Partnership**
**Full Year Budget 2017/18**

| Council - Other Budgets | Full Year Budget |
|---|---|
| Care of Gardens | 78,000 |
| Adaptations (PSHG) | 450,000 |
| Care & Repair | 214,000 |
| Fleet | 452,000 |
| **TOTAL** | **1,194,000** |

**Agenda Item Number: 14**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Scottish Living Wage Update** |
| **Report By** | **Jean Campbell, Chief Finance and Resource Manager**<br>**East Dunbartonshire Health & Social Care Partnership** |
| **Contact Officer** | **Gillian Healey, Team Leader, Planning & Service Development**<br>**East Dunbartonshire Council**<br>**0141 777 3000**<br>**Gillian.healey@eastdunbarton.gov.uk** |

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| **Purpose of Report** | The purpose of this report is to update members on the Scottish Living Wage (SLW) commitment for 2017/18 |

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| **Recommendations** | Members are asked to note the contents of this paper |

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| **Relevance to HSCP Board Strategic Plan** | The aim of the SLW is to build a highly valued, committed and productive workforce - thus increasing capacity and service quality, a key requirement embedded across the Strategic Plan |

**Implications for Health & Social Care Partnership**

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| **Human Resources** | • None |

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| **Equalities:** | • The provision of the SLW addresses low and inequitable pay across the care and support markets |

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| **Financial:** | • The settlement is insufficient to meet the true and full costs of implementing the SLW - this burden is currently reverting to providers who are already struggling financially. Providers may seek financial support from the HSCP in order to protect and maintain on-going viability/service delivery. |

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| **Legal:** | • EDC Legal colleagues will be required to implement a Minute of Variation (MOV) across current contracts which obligates providers to pay care and support staff the SLW |

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| **Economic Impact:** | • Since the introduction of the SLW is still in its infancy, it is difficult to quantify any real economic impact. However, early reports suggest that there is no real tangible improvement across the marketplace particularly in relation to:<br>- recruitment and retention<br>- zero hour contracts - which many staff prefer<br>• Providers also report that care workers, particularly those who work in care homes, have been reluctant to accept the SLW as it directly impacts on their benefits. Subsequently staff have requested shorter working hours to offset any financial differences |

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| **Sustainability:** | • To protect the integrity and on-going sustainability of the SLW, future settlements must take account of the full cost implications - as noted in section 1.8 |

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| **Risk Implications:** | • Providers may struggle to absorb cost differentials - thus increasing potential risk to provider /service viability and financial reliance on the HSCP |

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| **Implications for East Dunbartonshire Council:** | • EDC's Shared Services team will be required to implement uplifts |

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| **Implications for NHS Greater Glasgow & Clyde:** | • None at this point |

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| **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** On the 1st May 2017, the Scottish Living Wage (SLW) increased from £8.25 to £8.45 per hour

**1.2** The SLW is applicable to all staff who provide direct care and support across the Adult/Older People Care at Home, Housing Support and Care Home markets. This includes Direct Payments and more latterly Day Care services.

**1.3** In line with its on-going commitment to deliver the SLW - along with other key agendas, the Scottish Government allocated £107 million as a part of its 2017/18 settlement. The HSCP's share (1.72%) equates to £1.845 million of which £1.260 million is available to Implement to SLW.

**1.4** In 2016, and following the circulation of national implementation guidance, the HSCP entered into individual negotiations with all providers with a view to mutually concluding revised rates. In reality, this route proved to be extremely challenging - both in terms of resources and timescales and managing provider expectations.

**1.5** Subsequently, alternative routes were explored resulting in the HSCP adopting a more pragmatic approach to the 2017/18 implementation: the total amount of funding available split equally across all providers. The net result is a 2.5% uplift award.

**1.6** Notwithstanding the above, care home providers who are aligned to the National Care Home Contract received 2.8% uplift - as per national negotiations**.**

**1.7** Sleepovers are included within the settlement but are paid at £7.50 per hour in line with current HMRC Regulations.

**1.8** The settlement seeks to support any sustainability issues particularly around cost differentials (increase in basic pay across service structure). However, the level of funding available is not sufficient to meet these pressures which inexorably reverts to provider's to absorb via reserve levels and/or restructuring of organisations costs.

**1.9** Full year implementation costs are estimated at £1.260 million. The actual cost calculated over 11 months (May - March) is £1.163 million - leaving a surplus of £97k.

**1.10** The HSCP proposes to use the £97k surplus to help support providers who can evidence on-going sustainability issues.

**1.11** As implementation of the SLW progresses, further updates to the Board will be Submitted.

**Agenda Item Number: 15**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

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|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Unscheduled Care Commissioning Plan** |
| **Report By** | **Andy Martin, Head of Adult & Primary Care Services, East Dunbartonshire Health & Social Care Partnership** |
| **Contact Officer** | **Andy Martin, Head of Adult & Primary Care Services**<br>**0141 777 3000**<br>**Andy.martin@ggc.scot.nhs.uk** |

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| **Purpose of Report** | To update the Board on progress in taking forward the actions set out in the Unscheduled Care Plan. |

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| **Recommendations** | To note the content of the Report. |

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| **Relevance to HSCP Board Strategic Plan** | Reducing Unscheduled Care is a key commitment within the Strategic Plan 2017/18. |

**Implications for Health & Social Care Partnership**
Significant shift of activity from Acute Division into HSCP.

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| **Human Resources** | There is the potential for workforce change in relation to service redesign. |

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| **Equalities:** | An Equalities Impact Assessment will be carried out ahead of any final proposals being presented to the Partnership Board. |

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| **Financial:** | Financial implications re. set-aside budget for the use of Acute Division resources. Still to be explored. |

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| **Legal:** | None |

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| **Economic Impact:** | None |

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| **Sustainability:** | None |

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| **Risk Implications:** | None at this point. Emerging risks will be managed via the Older People's Planning Group and relevant workstreams as appropriate. |

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| **Implications for East Dunbartonshire Council:** | |

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| **Implications for NHS Greater Glasgow & Clyde:** | Acute services are a significant stakeholder across many of the activities and priorities outlined |

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

**1.0 MAIN REPORT**

**1.1** This report sets out the framework and detail of the actions being put in place to take forward the commitments and priorities set out in the Unscheduled Care Commissioning statement recently agreed by the Health & Social Care Partnership Board and submitted to the Scottish Government.

**1.2** Whilst much of the activity planned and prioritised is local in focus, there is a significant NHS Board-wide context which is also reflected in the Action Plan.

**2.0 BACKGROUND**

**2.1** A report entitled *Unscheduled Care Commissioning Plan* (2016/17_3) was considered and approved at the Health & Social Care Partnership Board meeting of 23rd March 2017. This report set out the context for East Dunbartonshire HSCP's intentions for the commissioning of unscheduled care. It was an interim statement. It had been agreed that the 6 Health & Social Care Partnerships within NHS Greater Glasgow & Clyde, which share a common Acute sector, would develop a coordinated joint statement of commissioning intentions.

**2.2** An initial suite of actions were framed and agreed by the six HSCPs within NHS GG&C on the basis that there is a shared acknowledgement of the joint responsibilities across

Acute Services, Primary Care and HSCP's to effect change. These actions were focused in the following 7 areas:

- Communication - acute and community services
- Unplanned admissions
- Occupied bed days for unscheduled care
- A&E performance
- Delayed discharges
- End of life care
- Balance of Spend - for both HSCP and Acute

**3.0 SUMMARY**

**3.1** A key focus of East Dunbartonshire Health and Social Care Partnership is to develop models of care that support the redirection of avoidable admissions in order to reduce acute bed usage and delayed discharges. This is being realised through the development of models, in partnership with Primary Care and Acute services, which provide alternatives to admission, including assistive technology, homecare, carers support plans, day care and intermediate care provision. All of this activity is now being coordinated through an Unscheduled Care Action Plan (**Appendix 1**).

**3.2** The Unscheduled Care Action Plan identifies discrete and measurable actions with responsible leads, outline resources and timescales which will enable the Health & Social Care Partnership's commitments and priorities for Unscheduled Care Commissioning to be taken forward in a framework of clear governance and accountability.

**3.3** The delivery of the Unscheduled Care Action Plan will be overseen by the Older Peoples Planning Group. Certain key actions set out will be delivered in the context of a number of sub-workstreams identified within the Older People's Planning Framework.

**3.4** A number of key commitments require a framework of discussion and governance which overlays the whole system. One of the key early priorities identified within the Unscheduled Care Action Plan is to establish a Board-wide HSCP / Acute / Primary Care group with decision-making authority.

**APPENDIX 1**

# Unscheduled Care Action Plan

| PRIORITY | ACTIONS | LEAD | TIMESCALE | SUB-ACTIONS | MEASURES |
|---|---|---|---|---|---|
| Communication – (acute and community services) | Review mechanisms whereby GPs can access advice from senior acute medical staff pre-admission relating to the need for admission and/or options other than admission (e.g. potential hot clinics). | Fiona McCulloch/ Gillian Notman/ Barry Sillars | | • Establish HSCP / Acute / Primary Care group with decision-making authority (Board-wide?)<br>• Further discussion at GP Forum<br>• Local discussion with M. McIlroy and L. Simpson | • To be developed |
| | Establish a consistent system whereby HSCPs are alerted by acute services, at the point of admission, of all patients already identified as at risk of unnecessary admission. | Barry Sillars | | • Establish local (board wide?) methodology to identify patients at risk of admission in the community. What is the status of SPARRA?<br>• Develop access to / use of Trakcare<br>• Support development of Primary Care 'House of Care' | • To be developed |

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| | | | | approach<br>• Strengthen Anticipatory Care Planning | |
| Unplanned admissions | HSCPs and acute services will identify a joint scoring matrix for identifying patients at risk of unnecessary admission. | Barry Sillars | | As above | |
| | Establish GP access to a range of options for patients at the point of pre-admission, for example urgent next day outpatient appointment by speciality and direct access to diagnostics | Gillian Notman/ Barry Sillars | | As above<br>• Discuss with M. McIlroy and L. Simpson<br>• Establish Single Point of Access with relevant alternative resource options | |
| | Review and optimise admissions pathways across acute sites with a view to reduce inappropriate variation. | Barry Sillars | | • Scope Locality profile in this area.<br>• Discuss in GP Clusters | • To be developed |
| | Identify patterns and causes of Care Home admissions to hospital and target support to nursing homes with a focus on reducing demand on primary care, reduce admissions to acute care, deaths in hospital, reduce demand for GP and other | Fraser Ross/ Janice Cameron | | • Analyse Care Home data supplied by Pamela Ralphs<br>• Develop local information / dataset within Care Home Steeri | • To be developed |

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| | OOH services. | | | ng Group | |
| | Review the models of working between GP practices and care homes to share lessons on best practice. | Gillian Notman/ Janice Cameron | | As above.<br>• Develop work within Care Home Steering Group<br>• Specific information development work re. individual GP practices and Care Homes | |
| | Consolidate and strengthen Care Home Liaison Nursing and Older People Mental Health Team support to homes. | Fraser Ross/ Janice Cameron/ Fiona Munro | | • Care Home Steering Group to review current operation and deployment of CHL nurses<br>• Develop Business Case to secure Funding for further Care Home Liaison Nursing resources (inc. CPN) | • To be developed |
| Occupied bed days for unscheduled care | Acute Services have undertaken to demonstrate progress in working towards compliance with agreed national benchmark length of stay | Barry Sillars | | | |

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| | across all sites and specialities. | | | | |
| | Optimise discharge processes across all sites and specialities to create an earlier in the day discharge profile and increase weekend discharges | Barry Sillars/ Stephen McDonald | | • Liaise between M. McCracken / L. Miller / P. McGinlay to review current status and scope impact of change on pathways and resources<br>• Clarify Homecare arrangements re. Triage for DN and Rehab functions<br>• Review and if necessary strengthen Social Work resources in HAT | • To be developed |
| A&E performance | Acute services to work with HSCP and primary care to create and implement redirection pathway back to minor injury units and primary care. | Barry Sillars/ Stephen McDonald/ Gillian Notman | | • Develop Single Point of Entry model – establish short-life working group | • To be developed |
| | Review the balance of staffing in A&E departments to ensure that frail older patients have speedy access to appropriate clinical support and imaging and investigations | Barry Sillars | | | |

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| | Establish a process whereby GPs are able to access imaging investigations to support diagnosis and decision-making. | | | | |
| Delayed discharge | Utilise the evaluation our intermediate care pilot to inform the potential increase in provision | Gillian Notman/ Stephen McDonald/Jean Campbell/ Gillian Healey | | | |
| | Establish a system whereby community staff, SAS and acute clinicians routinely use anticipatory care plans and the summary recorded on eKISS as part of assessment process to avoid admission and to expedite discharge. | Barry Sillars Frazer Ross | | • Fraser to scope and report on current range and availability of ACP's | • To be developed |
| | Roll out a model of community based rehabilitation where those no longer requiring inpatient care but still require rehabilitation, would be transferred to local community facilities for their on-going care. There will be a strong focus on re-ablement. | Stephen McDonald/ Fiona Munro | | • Evaluate, consolidate and extend intermediate care model<br>• Particular emphasis on evaluation of impact of model on rehab team resources | • To be developed |
| | Explore the potential for further step- | Stephen | | • Closely monitor | • To be developed |

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| | down intermediate resources and test the model on a locality basis. Develop a step-up model, utilising learning from the step-down pilot. This model will potentially operate both in spot-purchased or specifically commissioned care home beds, and within the patient's home. | McDonald/ Gillian Healey/ Gillian Notman | | uptake / allocation of intermediate beds at Fourhills and Greenfield Park<br>• Explore models of 'virtual' step-up provision via SPOA Group | |
| | Strengthen discharge planning between Acute discharge planning and our Hospital Assessment Team. | Stephen McDonald/ Lisa Miller/ Patricia McGinlay | | | |
| | Continue to improve the early referral of patients who are unable to return home from hospital. | Lisa Miller | | • Set challenging target re. early referral – monitor by hospital site / ward? | • To be developed |
| | Establish formal process to review NHS continuing care beds in light of revised complex care guidance | Stephen McDonald / Jean Campbell/ Gillian Healey | | Ongoing<br>• Closely monitor uptake / allocation of intermediate beds at Fourhills and Greenfield Park<br>• Explore necessity for specially commissioned | |

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| | | | | robust care home provision | |
| End of life care | Establish a consistent system whereby HSCPs are given early notice by Acute Services of patients who require end of life care. | Fraser Ross<br>Barry Sillars | | • Develop palliative planning methodology inc. link to acute system within HSCP Palliative Strategy Group | • |
| | Explore with Acute Services the impact of our service redesign and the impact on clinical support, specifically considering how best to ensure the right input from currently acute based geriatricians | Adam Bowman / Morven McIlroy | | • Establish HSCP / Acute / Primary Care group with decision-making authority (Board-wide?) | • To be developed |
| Balance of spend | Acute Services to review and ensure effective medicines management at point of admission and discharge. | Barry Sillars<br>Carolyn Ftzpatrick | | | |
| | Agree a way of working between Acute sites and the 6 HSCPs in Greater Glasgow and Clyde services through which a proportion of set aside budgets is used to support development of interface services out-with acute sites. | Barry Sillars | | • Establish HSCP / Acute / Primary Care group with decision-making authority (Board-wide?) | • To be developed |

**Key Local Groups:**

1. **Care Home Steering Group**

*Develop local information / dataset within Care Home Steering Group*
*Specific information development work re. individual GP practices and Care Homes*
*Analyse Care Home data supplied by Pamela Ralphs*
*Care Home Steering Group to review current operation and deployment of CHL nurses*
*Develop Business Case to secure Funding for further Care Home Liaison Nursing resources (inc. CPN)*

**2. Palliative Care Strategy Group**

*Develop palliative planning methodology inc. link to acute system*

**3. Locality Planning Groups / GP Clusters**

*Examine admissions pathways per Locality*
*Analyse and compare patterns of care home behaviour*
*Iniaite discussions with GP's re. alternative options to admission*

**4. SPOA Short Life Group**

*Develop Single Point of Entry model – establish short-life working group*
*Explore necessity for specially commissioned robust care home provision*
*Explore models of 'virtual' step-up provision via SPOA Group*
*Fraser to scope and report on current range and availability of ACP's*
*Clarify Homecare arrangements re. Triage for DN and Rehab functions*

**5. Delayed Discharge Group**

*Set challenging target re.early referral – monitor by hospital site / ward?*
*Closely monitor uptake / allocation of intermediate beds at Fourhills and Greenfield Park*
*Explore necessity for specially commissioned robust care home provision*
*Liaise between M. McCracken / L. Miller / P. McGinlay to review current status and scope impact of change on pathways and resources*
*Review and if necessary strengthen Social Work resources in HAT*

**Board-Wide Group:**

*1. Review mechanisms whereby GPs can access advice from senior acute medical staff pre-admission relating to the need for admission and/or options other than admission (e.g. potential hot clinics).*
*2. Develop a consistent system, including a joint scoring matrix, whereby HSCPs are alerted by acute services, at the point of admission, of all patients already identified as at risk of unnecessary admission.*

*3. Develop a consistent system whereby HSCPs are given early notice by Acute Services of patients who require end of life care*
*4. Explore the impact of service redesign on clinical support, specifically considering how best to ensure the right input from currently acute based geriatricians*

**Agenda Item Number: 16**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

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|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Strategic Review of Day Care Services for Older People Update** |
| **Report By** | **Andy Martin, Head of Adult & Primary Care Services, East Dunbartonshire Health & Social Care Partnership** |
| **Contact Officer** | **Andy Martin, Head of Adult & Primary Care Services**<br>**0141 777 3000**<br>**Andy.martin@ggc.scot.nhs.uk** |

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|---|---|
| **Purpose of Report** | To update the Board on progress in taking forward the Strategic Review of Older People's Day Care approved by the Board on 23rd March 2017. |

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| **Recommendations** | To note the content of the Report. |

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| **Relevance to HSCP Board Strategic Plan** | The Partnership has committed to implementing a strategic review of older people's day care in the Strategic Plan 2016-17. |

**Implications for Health & Social Care Partnership**

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| **Human Resources** | Proposed creation of new posts of Local Area Coordinator (Older People) will be taken forward in the wider planned restructure of Older People teams. |

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| **Equalities:** | The provision of an appropriate range of day services for older people is in line with statutory responsibilities towards this protected characteristic. |

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| **Financial:** | There is potential for financial savings to be realized within the overall restructuring of Older Peoples services. Although the intention is to re-invest monies freed up from de-commissioned day services into new services in line with the proposed model. There may be a requirement to make use of partnership reserves to support the capital costs associated with re-provisioning day care in the East Locality. |

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| **Legal:** | None. |

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| **Economic Impact:** | The co-production approach aspires to lever in other types of external funding, e.g. Grants, Big Lottery, voluntary and independent investment, etc. |

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| **Sustainability:** | The model proposed makes maximum use of already existing community assets, e.g. community halls and church premises, increasing their sustainability. |

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| **Risk Implications:** | None at this point. Emerging risks will be managed via the Older Peoples Planning Group, and the Cay Care workstream. |

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| **Implications for East Dunbartonshire Council:** | Proposal to establish 2 x posts of Local Area coordinator within the revised Social Work (Adults) structure. |

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| **Implications for NHS Greater Glasgow & Clyde:** | The accessibility and effectiveness if Day Care for Older People can have significant impact upon reducing Unscheduled Care. |

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

**1.0 MAIN REPORT**

**1.1** This report updates the position as reported to the Health & Social Care Partnership Board at its meeting of 23rd March 2017.

**1.2** At that meeting a report Strategic Review of Day Services for Older People (2016/17_7) advised the Committee of the findings and outcomes of a recent review of older peoples' day care services.

**1.3** It particularly highlighted the proposed strategic realignment of formal day services into two main day care centres; one in each locality, and the development of a model of lower intensity community-led preventative provision, including the proposed establishment of two posts of Local Area Coordinators.

**1.4** At that time, whilst approving the broad direction of travel set out in the report. The Board was not persuaded that the business case proposing the establishment of the two posts of Local Area Coordinator had been adequately made.

**1.5** The Board requested that further work be done to elucidate and explain the functioning of the Local Area Coordinators within the model being proposed.

## 2.0 BACKGROUND

**2.1** A Day Care Review Group was established in early 2016 to scope current provision, examine patterns of current and projected demand and uptake, and identify a strategic commissioning route for day care in light of the priorities set out with the HSCP's Strategic Plan. The Review group comprised the Head of Adults & Primary Care Services, managers from Older People Social Work and Health teams, Commissioning and Finance staff.

**2.2** At the point of the Review Group's establishment, there were concerns about the number of voids within current provision. Also the commissioning cycle meant that middle-to-long term decisions to continue funding certain services were imminent. It was felt that certain existing provision did not fit the Partnership's strategic priorities because of persistent under-attendance, poor physical environment, or potentially unsustainable costs moving into the future.

**2.3** Alongside these concerns, recent positive experience had been evidenced of different and innovative ways to meet need based on principles of co-production and maximizing personal and community assets. Particularly important in this respect have been the *Present* initiative developed by the Dementia Network and the *Assets in Action* mapping initiative developed in Adult Mental Health. Also of interest was *OPAL*, the helpline service set up by the local voluntary sector to facilitate access by older people to the range of opportunities available within that sector.

**2.4** Self Directed Support (SDS) has proved to be popular with older people and their carers in East Dunbartonshire since its introduction in 2014.The flexibility and control available to families via SDS options makes it an ideal vehicle for accessing the type of model which is proposed.

**2.5** The report of the Review Group sets out the range of current commissioned day care provision and the financial framework that resources it. Beyond that it describes the emerging network of less formal co-productive activity currently supported by the Partnership- voluntary older people groups, lunch clubs etc. A wider landscape of community-led activity across the localities of East Dunbartonshire concludes the report. This system of voluntary activity is the field which Local Area Coordinators would seek to coordinate, develop, expand and facilitate access to, both individually and on a locality-wide basis.

## 3.0 LOCAL AREA COORDINATORS

**3.1** It is proposed by the Review Group to establish the post of Local Area Coordinator (Older People) in both of the established localities – Bearsden & Milngavie and Strathkelvin. It is proposed that the majority of older people requiring day support will receive a service reflecting this model – accessing much more mainstream and community-linked activity than is currently the case.

**3.2** The function of Local Area Coordinators, sometimes called Community Connectors, first emerged in Learning Disability services, and has now been developed very successfully in Older People services across Scotland in a number of localities, including neighbouring partnership areas.

**3.3** These postholders can act as catalysts and facilitators of community-led service development, helping local initiatives to set up, for example, lunch clubs and community

activities - linking people with premises, connecting groups with funding sources, supporting groups to negotiate obstacles and barriers, providing a dedicated link into the decision-making centres of formal agencies, leading co-production.

**3.4** A key area of potential improvement on current practice is in relation to transport. Significant resources are currently spent on supplying transport to traditional day services. Community-led initiatives often struggle to access even limited assistance with transport. The success of the Woodhill Evangelical Centre Lunch Club in Bishopbriggs is testament to the co-production model whereby Partnership provision of transport supplements entirely voluntary and community-led activity to create a vibrant and sustainable day provision for up to 80 older people three times weekly – a service which would cost the formal agencies many thousands of pounds to replicate.

**3.5** As well as community development and service generation, Local Area Coordinators have a case management role, taking referrals of individual older people who may have been identified at other points in the system by other professionals, e.g. after hospital discharge by a social worker, or following on from a fall by a rehab team member, and then connecting these individual older people with activities and opportunities available and accessible in their communities that may be appropriate to their needs and wishes. They can also be active in supporting first contact and early attendance until older people settle into services.

**3.6** Often what older people are assessed as needing, and what they often express themselves as their choice for service and support are low level, socially-oriented opportunities that allow them to meet with friends and peers and facilitate their access, on the basis of common citizenship, to good mainstream activities and services such as shopping, going for lunch, church attendance. Local Area Coordinators can provide individual and group support to bring these often overlooked staples of community life into play where they have become no-go areas for isolated older people.

**3.7** Funding to support a Local Area Coordinating model will be made available by the rationalization of the existing traditional commissioned day care provision. It is anticipated that the service changes proposed will be cost-neutral within current allocations. There may be some potential for savings to be generated.

## 4.0 SERVICE DEVELOPMENT AND DECOMMISSIONING

**4.1** The vision is to have only 2 traditional day care services, one in each locality, housed in specialist premises, available 7 days a week, targeted on the most needy and vulnerable older people. It is envisaged that these centres will provide a locus for wider services including rehab for older people recently discharged from hospital, and intensive multi-disciplinary support for those requiring step-up approaches to prevent admission. These functions may link to current and developing Intermediate Care provision.

**4.2** The specialist Day Care Centre at Oakburn Park in Milngavie already provides the locus for this type of service for the Bearsden & Milngavie locality. This will be consolidated and further enhanced. For Strathkelvin, it is planned to develop a purpose-built Day Care Centre in Kirkintilloch in partnership with Bield Housing and Care to be available and on-stream by 2019. Monies currently tied into currently commissioned day services will form the basis of ongoing revenue funding for this new provision.

**4.3** A specific Day Care workstream has been established, overseen within the Older People's Planning Framework. This will take forward service developments and de-

commissioning in line with the recommendations of the Strategic Review. The Older Peoples Planning Framework is attached as Appendix 1.

**4.4** Discussions are ongoing with East Dunbartonshire Capital Asset Planning and Housing leads to establish the final route to provide the capital contribution to the wider joint development with Bield Housing & Care which will encompass the purpose built Day Care Centre for Kirkintilloch. This may require a contribution from partnership reserves to support this development.

**4.5** A consultation and engagement exercise will be undertaken with all service users and carers whose service is expected to undergo change, and more widely with older people and key stakeholders. This will exercise reflect HSCP standards for patient and service user engagement.

| PRIORITY/OUTCOME | SUB-ACTIONS | LEAD | OTHER RESOURCES | TIMESCALE |
|---|---|---|---|---|
| 1. Daycare Service Model focused on 2 purpose-built centres + Co-production resources | 1. Develop Local Area Coordination posts | S.McDonald | Day Care Short Life Working Group* | December 2017 |
| | 2. Progress Capital Bid for Cleddens Field Day Care Centre | J. Campbell | | December 2017 |
| | 3. Consult Service users / Carers re. strategy | S. Cairney | | August 2017 |
| | 4. De-Commission outdated models | J. Campbell | | December 2017 |
| 2.Homecare Improvement Programme – increasing efficiency and targeting of resources | 1. Implement CM2000 across all in-house Homecare provision | M. McCracken | | December 2017 |
| | 2. Develop Revised Telecare / Telehealth Strategy | M. Wills / K. Gainty | | March 2018 |
| | 3.Commission Revised external provision Framework which is CM2000 compliant | G.Healey | | August 2017 |
| | 4. Implement Carefirst Finance upgrade programme | J. Campbell | Transformational Change Programme Board*[1] | December 2017 |
| 3.Care Homes – Strengthen accountability and provide targeted support | 1. Expand Care Home Liaison Nursing resource (CPN's?) | F. Ross /F. Munro | Care Home Steering Group* | December 2017 |
| | 2. Consolidate Pharmacy support programme. Each Home to have a pharmacy management plan driving efficiency and safety | C. Fitzpatrick | | Immediate |
| | 3. Develop Strategic approach to Care Home developments, eg. Planning Objections, LES etc | G. Notman | | Immediate |
| | 4. Work with Care Homes to agree Hospital Admission and | F. Ross/J. Cameron | | December 2017 |

[1] Existing Group

| | | | | |
|---|---|---|---|---|
| | Palliative approaches and protocols | | | |
| 4. Single Point of Access for GP and Acute referral | 1. Establish Band 6 post of Triage Nurse in Homecare<br>2. Further develop Referral Hub within Homecare / DN interface<br>3. Develop Carefirst / EMIS interface protocol and train key managers | S.McDonald<br><br>F. Munro / M.McCracken<br>A. Martin / J. Campbell | SPOA Short Life Working Group #[2]<br><br><br><br>HSCP Information Integration Group | December 2017<br><br>March 2018<br><br>March 2018 |
| 5. Strategic Approach to Older Peoples Mental Health Service Provision | 1. Implement Local Dementia Strategy<br>2. Integrate Glenkirk and Woodlands Management Teams / Approaches | S. McDonald<br><br>F. Munro/J. King/ A.M. Benes | Dementia Strategy Steering Group* | Immediate<br><br>March 2018 |
| 6. Improved Hospital Discharge | 1. Complete and evaluate Intermediate Care Pilot<br>2. Develop local implementation plan for Complex & Continuing Care Review | L. Miller / G. Notman<br><br><br>S. McDonald | Delayed Discharge Group* | December 2017<br><br><br>August 2017 |
| 7. Joint Rehab Strategy | 1. Develop Joint Aids & Equipment Strategy across SW / Community Nursing<br>2. Implement Joint Palliative Care Strategy linking Homecare and Community Nursing functions . | T. Gahagan/G. Notman<br><br><br>F. Ross / M.McCracken | <br><br><br>Palliative Care Strategy Group* | December 2017<br><br><br>December 2017 |



[2] To be established

**Agenda Item Number: 17**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Review of Out of Hours Services & Urgent Care** |
| **Report By** | **Andy Martin, Head of Adult & Primary Care Services, East Dunbartonshire Health & Social Care Partnership** |
| **Contact Officer** | **Andy Martin, Head of Adult & Primary Care Services**<br>**0141 777 3000**<br>**Andy.martin@ggc.scot.nhs.uk** |

| | |
|---|---|
| **Purpose of Report** | The purpose of this report is to update the Board on the progress of the strategic review and reform of Out of Hours services across NHS Greater Glasgow & Clyde |

| | |
|---|---|
| **Recommendations** | The Partnership Board is asked to:<br><br>a) note the content of the Report |

| | |
|---|---|
| **Relevance to HSCP Board Strategic Plan** | Strategic Plan commits to ensuring that Out of Hours services are accessible, effective and sustainable |

**Implications for Health & Social Care Partnership**

| | |
|---|---|
| **Human Resources** | There is the potential for workforce change in relation to service redesign. |

| | |
|---|---|
| **Equalities:** | An Equalities Impact Assessment will be carried out ahead of final proposals being presented to Partnership Boards and NHSGG& C Board. |

| | |
|---|---|
| **Financial:** | There is potential for financial savings to be realized through rationalization of service delivery models and locations, however there may also be a need for investment to support implementation of proposed new models of service. Financial impacts will be outlined to Partnership Boards and to NHSGG&C Board when final proposals are presented. |

| | |
|---|---|
| **Legal:** | Partnership Boards are responsible for the planning and commissioning of safe and effective Out of Hours services. |

| | |
|---|---|
| **Economic Impact:** | None. |

| | |
|---|---|
| **Sustainability:** | None. |

| | |
|---|---|
| **Risk Implications:** | None at this point. Emerging risks will be managed via the Steering Group, Executive Operational Group and work streams as appropriate. |

| | |
|---|---|
| **Implications for East Dunbartonshire Council:** | None at this point. |

| | |
|---|---|
| **Implications for NHS Greater Glasgow & Clyde:** | Acute services are a significant stakeholder in the review of GP Out of Hours services. |

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

**1.0 MAIN REPORT**

**1.1** The National Review of Primary Care Out of Hours Services led by Sir Lewis Ritchie was asked by the Scottish Government to evaluate the effectiveness of the delivery of primary care Out of Hours services in Scotland.

**1.2** The review published its findings in December 2015, concluding that the present situation for delivery of Out of Hours services at a national level is both “fragile” and “not sustainable”.

**1.3** A key recommendation of the review was that Health & Social Care Partnerships and Integrated Joint Boards be required to look for “opportunities for integrated Out of Hours provision by local authorities and the NHS, including (where possible) co-locating opportunities”.

**1.4** A programme has been established jointly among the 6 Health & Social Care Partnerships that cover the NHS Greater Glasgow & Clyde area to review and reform Out of Hours provision. This programme reflects and builds upon the recommendations of National Review.

**1.5** The Chief Officers of the six Health & Social Care Partnerships within NHS Greater Glasgow and Clyde have agreed that the Chief Officer. Planning, Strategy and Commissioning for Glasgow City Health and Social Care Partnership should lead this

project on behalf of all Greater Glasgow & Clyde HSCPs.

## 2.0 Background

**2.1** The 6 Partnerships and the Scottish Government recognize that the breadth, complexity and timeframes for the Out of Hours Review (estimated at 18 months – 2 years) require a project of some scale to ensure coordination, consistency and an overall approach which allows for existing work streams to proceed, whilst creating space for fresh thinking in critical areas, for example the natural alignment of the existing GP Out of Hours action plan being reflected within the broader Out of Hours review.

**2.2** A Steering Group of Senior Officers, Clinicians and other key stakeholders across the NHSGGC area has been established to provide strategic governance and oversight to the programme. The Steering Group is chaired by the Chief Officer: Planning, Strategy and Commissioning for Glasgow City HSCP. Initial meetings of the Steering Group have considered terms of reference, wider project governance, and shared objectives and priorities. The Head of Adult & Primary Care Services represents East Dunbartonshire on this group.

**2.3** The Steering Group has also agreed to establish an Executive Operational Group. It is envisaged that the Executive Operational Group will act as the primary vehicle for taking forward tasks in relation to the Out of Hours Review, directing and monitoring progress of work streams as necessary. The Executive Operational Group itself will operate under direction from the Steering Group.

**2.4** A number of work streams have been established or proposed to take forward specific tasks. These are:

- **Scoping, Mapping and Future** Models – this work stream will map out current out of hours services across the health and social care system, following which it will begin to identify potential options for future service delivery models.
- **Transformation of GP Out of Hours** – this work stream will consider current and potential future service delivery models for the GP Out of Hours service (see section 5 of this report)
- **Transformation of Health and Social Care Out of Hours** – this work stream will build on the outputs of the 'Scoping, Mapping and Future Models' work stream to develop firm proposals and implementation plans for redesigned out of hours health and social care services in Glasgow.

**2.5** It is noted that there is a range of other related activities underway across the system, in particular in relation to Unscheduled Care. Appropriate links will be established between such pieces of work and the Steering Group, Executive Operational Group and the work streams outlined above.

## 3.0 Transitional Funding

**3.1** To support implementation of the recommendations of the national review of Out of Hours services, the Scottish Government has made additional funds available to Partnerships to support local actions.

**3.2** A bid was made on behalf of all six HSCPs in the Greater Glasgow and Clyde area, covering two specific areas:

1) **Project management capacity to support the review and redesign of Out of Hours services across Greater Glasgow & Clyde** – given the scale of this project, there is requirement for a specific resource to support project management activity, as spare capacity is not readily available within Partnerships at present.

2) **Funding to recruit additional Mental Health Nurses to ensure 24/7 Mental Health service coverage to all A&E departments within NHSGGC** - Currently Glasgow Royal Infirmary and Queen Elizabeth University Hospital A&Es do not receive an outreach Community Psychiatric Nurse (CPN) / Liaison service Mon - Friday from 5pm until 8pm - Out of Hours CPN service starts at 8pm and they will respond from that time. Both A&Es also do not have a direct CPN/Liaison service on Saturdays, Sundays and Public Holidays from 9am - 5pm. The additional funding will close these gaps and eliminate the requirement for A&Es to rely on duty psychiatric medical cover based at Mental Health Hospitals for Mental Health advice and assessment. This will improve service response times and patient experience for individuals who present at A&E during these service 'gap' times.

**3.3** The Greater Glasgow & Clyde bid was approved by the Scottish Government, to the sum of £523,000 per year for two years, and work is ongoing to recruit to both the Project Management roles and the additional Mental Health nursing posts.

**3.4** Greater Glasgow was eligible to make a further funding bid, as the amount secured for proposals outlined at **3.2** above did not utilise the full level of funds (£1,615,812 over two years) available to Greater Glasgow. A further bid was submitted to address some of the pressures on Out of Hours GP services, through recruitment of additional capacity to expand the current Advanced Nurse Practitioner role within Out of Hours services.

**3.5** This additional bid has also been approved by Scottish Government and will increase the number of Advanced Nurse Practitioners within the service by 4 Whole Time Equivalent Band 7 nurses. Their role will be to provide an enhanced service on specific sites to enable the site to remain open when a full cohort of GPs is not available.

**4.0 GP Out of Hours Service**

**4.1** Strategic planning of the GP Out of Hours service is hosted by Renfrewshire Health & Social Care Partnership on behalf of the six partnerships in the NHSGGC area. Operational delivery of the service is hosted by Acute Services.

**4.2** A review of the current GP service model is underway to ensure that it can continue to provide an efficient, responsive service that is sustainable going forward. Delivering safe, accessible services to patients and staff during the Out of Hours period is a key factor in ensuring high quality services to the population of NHS Greater Glasgow & Clyde.

**4.3** A discussion paper outlining current issues and pressures within GP Out of Hours services is attached as **Appendix 1** to this report. The paper notes cost pressures within the service, and that the current service is under consistent operational pressure due to an increasing lack of availability of GPs willing to participate in the GP Out of Hours service. This is further exacerbated at holiday periods when there are higher levels of demand and call upon the same GPs to work extremely long hours.

**4.4** A number of factors are identified as contributing to the lack of GP willingness to participate in the Out of Hours service, such as:

- Workload pressures (both in the out of hours service, and during normal daytime service) and volumes of home visits
- Changing age demographic of the GP workforce – evidence informs that that younger doctors do fewer out of hours sessions than their older colleagues
- Rates of pay on offer in Glasgow are lower than other neighbouring NHS Boards. In addition, locum GP rates are higher than out of hours rates, resulting therefore in a more attractive option for GPs to cover 'in' rather than 'out' of hours.

**4.5** The review of the GP Out of Hours service will look at the number of Primary Care Centres from which the service is currently operational and consider the potential to reduce these, with consequent reductions in the number of "walk-in" patients. In addition, the potential benefits of introducing an appointment system, which is not currently in place, will be explored.

**4.6** Rationalising the number of Primary Care sites provides a number of potential benefits:

- Consolidating services in a fewer locations
- Increasing the sustainability of the service overall
- Reduction in the number of "walk-in" patients
- Financial savings through a reduction in support service and premises costs

**4.7** Each potential benefit will be further explored in the process of the review and outlined in a business case to be presented to each of the partnerships and to NHSGGC Board at a future date.

**4.8** The discussion paper attached as **Appendix 1** to this report also outlines three potential models for future service delivery:

- **Option 1** - co-located with main Emergency Department / Receiving Units i.e. Glasgow Royal Infirmary / Queen Elizabeth University Hospital / Royal Alexandra Hospital
- **Option 2** - mixture of acute and community sites linked to population centres
- **Option 3** - solely community centres

**4.9** The advantages and disadvantages of each service model are outlined in the discussion paper, with a recommendation that option 2 is most suited to the Greater Glasgow and Clyde area. The Partnership Board is asked to provide comments on this recommendation.

**5.0 Next Steps**

**5.1** Sir Lewis Ritchie and members of his review team visited Glasgow on 19 April 2017 to understand current Out of Hours provision across the NHS Board area. The itinerary for the visit comprised :

- Meeting in Commonwealth House Board Room, presentation from Sir Lewis/team on vision nationally and presentation from Chief Officer: Strategy, Planning and Commissioning and members of Out of Hours Steering group on work to date
- Visit to Victoria Infirmary to GP Out of Hours and District Nursing Out of Hours
- Visit to Hamish Allen Centre to Social Work Out of Hours, [Glasgow City] Home

Care Out of Hours and Homelessness Out of Hours

**5.3** The mapping exercise has now been concluded and the Executive Operational Group formed. The Joint Services Manager (Adults) represents East Dunbartonshire on this group. Work streams will now progress work to develop firm proposals and implementation plans for redesigned Out of Hours health and social care services across Greater Glasgow. Updates and, where appropriate, requests for approval of specific proposals, will be presented to the six Partnership Boards across the NHS Greater Glasgow and Clyde area as required.

**Appendix 1 – DISCUSSION PAPER ON NHS GREATER GLASGOW & CLYDE - GP OUT OF HOURS SERVICE**

## 1. Background

1.1 NHS Greater Glasgow & Clyde have been carrying out a review of Primary Care Out of Hours services in the context of the recently published National Review by Sir Lewis Ritchie and the Board's service and financial planning for 2016/17.

1.2 In 2004, the General Medical Services (GMS) contract came into force. This gave General Practitioners (GPs) the opportunity to opt out of providing out of hours care for their patients. The GMS contract means that NHS Greater Glasgow & Clyde is responsible for ensuring all patients can access out of hours care. Access to the GPOOH service was initially intended to be through NHS24, however, over time, a significant number of patients now walk in into the service.

Strategically the new IJBs are responsible for the planning and commissioning of safe and effective OOH services.

1.3 Up until 2015, OOH GPs in the Greater Glasgow Health Board service were independent contractors. In 2015, following a nationwide investigation into the way individual Boards paid out of hours GPs, HMRC implemented a ruling that GPs working in out of hours services required to be on the Board payroll, rather than treated as independent contractors. The result of the changes to the tax treatment of GPs working in out of hours services for GGC has incurred an additional cost of £2.5m per annum. This funding requires to be found on a recurrent basis as to date it has been covered non-recurring.

Rates of pay are increased at times of peak activity in OOH – namely Public Holidays and the Festive fortnight and this has also resulted in an unfunded cost pressure of c500k.

The service has constantly reviewed its costs and service delivery model and has made cost reducing efficiencies of £300k over the last 5 years.

However with the budget for the entire Board service being £16m, predominately in staff costs, it is not possible for the service to cover these increased staffing costs from within the service.

Currently other WOS boards pay GPs higher rates than GGC and this is causing high levels of unfilled shifts. The service are using agency staff consistently for the first time since its inception.

1.4 We are undertaking a review of the current GP service model to ensure that we can continue to provide an efficient, responsive service that is sustainable going forward. Ensuring safe, accessible services to patients and staff during the Out of Hours period is a key factor in ensuring high quality services to the population of NHS Greater Glasgow & Clyde.

1.5 In the recently published National Out of Hours Review, out of hours care is defined as care to a patient which cannot wait until the GP surgery is open again.

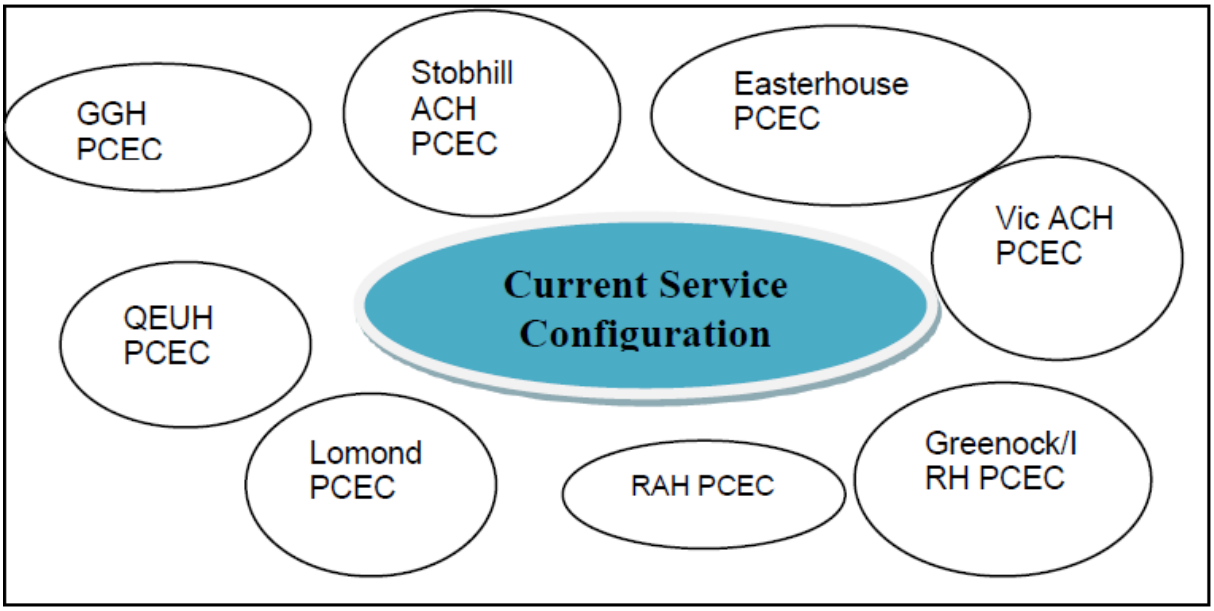
## 2. Current Service Configuration

**2.1** A Home Visiting Service – this extends into Lanarkshire to cover Camglen and to Highland to cover Helensburgh and the Lochside.

2.2 A telephone advice service – this is provided from the Hub at Cardonald by the GP advisor who has a wide role in co-ordinating the service.

2.3 A pre-prioritised call service to support NHS24 – this is provided from the Hub at Cardonald utilising GG&C clinical workforce and funded by NHS 24

2.4 8 Primary Care Centres - these are located geographically around the city to support access locally for patients – these centres see patients who are directed by NHS24, or self present and those adjacent to A/E departments will see those redirected by A/E.




The service offers a patient transport service to and from these centres for patients who cannot afford public transport and do not have their own transport. This to minimise the need for home visits.

The service does not operate an appointment system and patients are directed by NHS24 to their nearest PCEC.

- The service is currently adjacent to Emergency Departments at Queen Elizabeth University Hospital, and Royal Alexandra Hospital and overnight at Inverclyde Royal Hospital
- The service is co-located with Minor Injury Units at Stobhill ACH; Victoria ACH and Vale of Leven.
- There are 3 other centres at Gartnavel General Hospital for West Glasgow, Easterhouse Health Centre – North/East Glasgow and Greenock Health Centre – Inverclyde
- There are only three main centres open overnight at RAH, Victoria ACH and Stobhill ACH. An overnight service is provided by the Home Visiting doctor at IRH and at Vale of Leven.

## 3. Summary of Work in 2016/17

3.1 Closure of Western Infirmary and Drumchapel Primary Care Centre and centralisation of West sector service at Gartnavel General Hospital.

3.2 Introduction of nurses into centres to reduce demand for medical staff.

3.3 Trial of nurses undertaking home visits to test viability of alternative models.

3.4 Other work which is also progressing in reviewing pathways into/out of the out of hours service include :

- **Alternative care pathways:** we are working with NHS 24 to implement changes to care pathways which will reduce pressure on the service e.g.
- 12 hour disposition – improving use of this which will feed back to in hours GP services
- Introduction of a self care guide for patients
- Reinforcing SIGN guidelines on use of antibiotics for self limiting conditions – joint letter from LMC and GPOOH has been distributed to all GPs across GGC
- Pilot of "speak to doctor" being developed within NHS24
- Introduction of Prescribing pharmacists within NHS24 – this will support reducing demand on GPs for repeat prescriptions.
- Prescribing guidelines for Pharmacies – these are being developed nationally for specific pathways e.g. uncomplicated UTI.

- **Nursing homes:** to reduce the numbers of home visits to nursing homes with the purpose of Pronouncing Life Extinct which put pressure in the service we are changing the interface with nursing homes to reduce demand;

- **Patient Transport Service –** initial review of this has been undertaken to improve efficiency of service.

## 4 Activity

4.1 The following provides a description of GPOOH activity which is taken from the published ISD datamart. This reports on all GPOOH services across Scotland with the most recent report scheduled to be published at the end of February 2017.
***Note*** *– the location within ADASTRA in which GGC activity is recorded is slightly different to the way other Boards record this information. Whilst the service have been working with ISD to try to get as accurate a picture as possible, the reported figures are slightly different to those which the service themselves produce although the trend data is consistent.*

4.2 **Consultations** - ISD 2015/16 reports 246,617 Consultations which was 3.3% higher than the previous year.

In 2016/2017 the figures have shown a reduction – the latest monthly activity for 2016/17 is to October 2016

| | April to October | Variance |
|---|---|---|
| 2014/15 | 134,782 | |
| 2015/16 | 139,367 | 3.4 % |
| 2016/7 | 131,830 | -5.4% |

4.3 **Primary Care Centres/Home Visiting** The following table shows a 2.9% increase in 2015/16 but a 3.7% drop in 2016/17 to Primary Care Centres and a 0.9% drop in 2015/16 and 6% drop in 2016/17 to the Home Visiting service.

| *Data Source : ISD* | April to October Activity | | | |
|---|---|---|---|---|
| | Primary Care Centres | | Home Visiting Service | |
| | Activity | %age diff | Activity | %age diff |
| 2014/15 | 87701 | | 21360 | |
| 2015/16 | 90238 | 2.90% | 21163 | -0.90% |
| 2016/17 | 86875 | -3.70% | 19892 | -6.00% |

4.4 **Recent Experience : West Glasgow**

In July 2016 Drumchapel PCEC closed and was merged with the Western site (which had closed and relocated in November 2015) at Gartnavel. It was anticipated that the numbers of patients attending the Gartnavel site would be less than the numbers previously attending the separate sites and this has in fact been the experience

| | 13/14 | 14/15 | 15/16 | 16/17 |
|---|---|---|---|---|
| West Glasgow | 19040 | 20514 | 19673 | 16240 |
| %diff in year | | 7.7% | -4.1% | -17.5% |

These initial figures suggest that the initial move to Gartnavel resulted in a significant reduction in OOH attendances. Of note when Western site moved, the walk in rate reduced from almost 30% to 15%. This can be explained by;

- lack of accessibility to student and visiting population
- move away from adjacency to an A/E department.

The West population may not be typical and this experience might not be mirrored should other services move. The following table provides a description of the mode of arrival of patients to other Primary Care Centres across GGC as a percentage of the total attendances.

| | as %age of attendances at PCEC | | | |
|---|---|---|---|---|
| | NHS24 | Walk-in | Refer MIU/E | Other |
| Easterhouse | 75% | 23% | 0% | 2% |
| Greenock | 87% | 12% | 0% | 1% |
| Inverclyde | 97% | 0% | 0% | 3% |
| Lomond | 32% | 51% | 7% | 10% |
| Renfrewshire | 84% | 9% | 2% | 5% |
| QEUH | 71% | 21% | 6% | 2% |
| Stobhill | 63% | 29% | 1% | 7% |
| Victoria | 67% | 27% | 1% | 5% |

4.5 The following table describes the current daily average attendances to the PCEC's :

| Current Daily average activity | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Vic ACH | QEUH | GGH | Stobhill A | Easterhou | RAH | IRH | Vale |
| Monday | 66 | 18 | 30 | 48 | 26 | 29 | 11 | 26 |
| Tuesday | 64 | 19 | 31 | 49 | 26 | 27 | 12 | 24 |
| Wednesday | 61 | 19 | 29 | 46 | 24 | 28 | 10 | 24 |
| Thursday | 61 | 19 | 29 | 43 | 23 | 27 | 10 | 23 |
| Friday | 65 | 20 | 33 | 47 | 26 | 28 | 11 | 25 |
| Saturday | 202 | 76 | 133 | 133 | 98 | 103 | 47 | 85 |
| Sunday | 197 | 77 | 132 | 133 | 97 | 103 | 43 | 84 |

4.6 **Postcode analysis of attendances**

Of the total attendances, the Greater Glasgow area accounts for 70.4% of attendances, Clyde sector 27.3% and out of board area 2.3%.

- In the out of board area, attendances from the ML (Motherwell) catchment area are highest at 18.5% followed by KA (Kilmarnock) at 18.4%, EH (Lothian) at 9.6% and G74 (East Kilbride) at 8.7%.
- In the Greater Glasgow area – G33 (Blackhill, Riddrie…) account for 6.2% of Greater Glasgow attendances, following by G81 (Dalmuir…) at 4.9%, G32 (Springboig….) at 4.4% and G53 (Pollok…) at 4%
- In the Clyde area – G83 (Balloch) is the highest at 15%, followed by G82 (Dumbarton) at 12.2%, PA2 (Foxbar….) at 9.8% and PA3 (Ferguslie….) at 7%.

| GPOOH POSTCODE DISTRIBUTION OF ATTENDANCES (based on year 2014/15) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Out of Board Area | | | Greater Glasgow Area | | | Clyde | | |
| Postcode | Area | %age | Postcode | Area | %age | Postcode | Area | %AGE |
| overall | | 2.3% | overall | | 70.4% | overall | | 27.3% |
| *following describes highest users of out of board area* | | | *of the Greater Glasgow areas - following is highest postcode areas* | | | *of the Clyde areas - following is highest postcode areas* | | |
| ML | ML Motherwell | 18.5% | G33 | Blackhill, Riddrie, Ruchazie, Garthamlock, Stepps | 6.2% | G83 | Balloch, Luss | 15.0% |
| KA | KA Kilmarnock | 18.4% | G81 | Dalmuir, Faifley, Duntocher | 4.9% | G82 | Dumbarton | 12.2% |
| EH | EH Lothian | 9.6% | G32 | Springboig, Shettleston, Carmyle, Carntyne | 4.4% | PA2 | Foxbar, Glenburn, Hu nterhill | 9.8% |
| G74 | G74 East Kilbride | 8.7% | G53 | Pollok, Nitshill, Darnley | 4.0% | PA3 | Ferguslie, Linwood | 7.0% |
| AB | AB Aberdeen | 6.9% | G21 | Cowlairs, Gargad, Barmulloch, Barlornock, Robroyston | 3.9% | PA16 | Greenock | 6.5% |
| FK | FK Falkirk | 6.3% | G42 | Polmadie, Battlefield, Crosshill, Govanhill | 3.9% | PA4 | Renfrew, Inchinnan | 6.3% |
| DD | DD Dundee | 4.0% | G13 | Jordanhill, knightswood, yoker | 3.8% | G84 | Helensburgh | 6.3% |
| KY | KY Kirkcaldy | 3.4% | G66 | Lenzie, Lennoxtown | 3.7% | PA5 | Johnston, Elderslie | 5.7% |
| | | | G69 | Gartcosh, Chryston | 3.7% | PA1 | Paisley central, Ralston | 5.3% |
| | | | G15 | Drumchapel | 3.6% | PA15 | Greenock | 5.5% |
| | | | G52 | Mosspark, Cardonald, Penilee | 3.6% | G78 | Barrhead, Neilston, Uplawmoor | 5.0% |
| | | | G41 | Shawlands, Pollokshields, Strathbung | 3.5% | PA14 | Port Glasgow | 3.9% |
| | | | G73 | Rutherglen | 3.4% | | | |
| | | | G44 | Cathcart, Kingspark, Croftfoot | 3.1% | | | |
| | | | G64 | Bishopbriggs, Torrance | 3.1% | | | |
| | | | G72 | Cambuslang | 2.9% | | | |
| | | | G20 | Ruchill, N Kelvinside, Woodside | 2.9% | | | |
| | | | G51 | Kinningpark, Ibrox, Govan | 2.7% | | | |

## 5 Challenges for the service

5.1 The current service is under consistent pressure due to the increasing lack of availability of GPs willing to participate in the GP Out of Hours service. This is further exacerbated at holiday periods when there is higher levels of demand and call upon the same GPs to work extremely long hours.

5.2 The reasons for this are multi-factorial but it cannot be ignored that the workload at PCE and home visiting sessions is a disincentive for GPs who would traditionally have done C sessions. It is also evidenced that doctors towards the end of their careers, who tradition would have done a significant number of sessions, are being replaced by younger docto who may do a few sessions but nowhere near the number of sessions previously done b their departing colleagues. There are many other contributing factors including:

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## 6 Next Stage

6.1 The next stage of the review is to look at the number of Primary Care Centres from which the service is operational and consider the potential to reduce these and the number of walk in patients.

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back up doctor who is on call from home (these doctors are paid a retainer to be immediately available from home if required). Currently these back up shifts are rarely filled.

6.5 Rationalising the number of Primary Care sites provides an opportunity to consolidate services, perhaps to increase the sustainability of the service, potential to reduce walk-in numbers and may contribute towards the savings plan. This will come predominantly through a reduction in support service costs.

6.6 There are a number of key strategic decisions to be made that would then inform a service model

- Option 1 - should sites be co-located with main ED/Receiving Units i.e. GRI / QUEH / RAH
- Option 2 - mixture of acute and community sites linked to population centres
- Option 3 solely community centres

6.7 **Description of Options :**

- **Option 1 – Co-location with main ED/Receiving Units**

o **Advantages**
- ❖ high walk in rate may reduce ;
- ❖ consolidates clinical staff on one site in each area which allows potential to redesign shift patterns and skill mix;
- ❖ makes service less vulnerable if a clinician calls off at short notice
- ❖ Potential to improve training environment for GP registrars

o **Disadvantages**
- ❖ Removes centres from areas with high levels of deprivation and this will reduce ease of access for these vulnerable groups of patients
- ❖ These will be high volume sites, particularly at weekends, which may make it even more difficult to attract GPs to work in such an environment
- ❖ busy transport moves – would reduce any further opportunities to reduce Patient Transport service
- ❖ Potential impact on increased attendances to Emergency Departments
- ❖ Challenges to accommodate such a large service on one site
- ❖ Suitable area within GRI would require to be found as service not currently located on this site and at QEUH Children's Hospital as current area not suitable for expansion

- **Option2 - mixture of acute and community based on demand**

o **Advantages**
- ❖ Could develop a pattern with fewer sites midweek
- ❖ Potential to improve training environment for GP registrars mid week
- ❖ Opportunity to redesign shift patterns and skill mix mid week
- ❖ Moving from an acute site has shown to potentially reduce walk- ins (a/e redirects are counted as walk ins) and overall attendances.

- **Disadvantages**
  - ❖ Potential impact on increased attendances to Emergency Departments
  - ❖ Removal from acute site and proximity to acute receiving and resuscitation if not on ED/Receiving site
  - ❖ Reduces ease of access for people who stay in either rural areas or areas of high deprivation
  - ❖ Potential increased patient transport requirement

- **Option 3 - entirely in community settings**

- **Advantages**
  - ❖ Frees up space on acute sites
  - ❖ Clearly differentiates GP and hospital services
  - ❖ Subject to sites selected potential reduction in walk-ins
  - ❖ consolidates clinical staff on one site in each area which allows potential to redesign shift patterns and skill mix;
  - ❖ makes service less vulnerable if a clinician calls off at short notice

- **Disadvantages**
  - ❖ Will require new locations to be found – Easterhouse only community site currently
  - ❖ Significant costs of moving IT etc
  - ❖ Significant workforce challenges depending on location and number of sites
  - ❖ Depending on sites chosen could lead to people attending local ED instead
  - ❖ Removes ability for ED to redirect

## 7 Conclusion

7.1 In GG&C, the service are of the opinion that three overnight sites are required –one in the North, one in the South and one in Clyde.

7.2 It was recognised too that the requirements midweek evening and overnight offer opportunities for change and efficiency, whereas weekends are extremely busy with PCECs fully occupied and at times significant waiting times developing. The service feels that investments in weekend services is required and are preparing a paper on this.

7.3 With the above in mind the service suggests a configuration of Option 2 - mixture of community and acute sites. The service would propose that the number of weekend sites remain the same but midweek reducing the number of sites to five (Stobhill ACH; Victoria ACH; RAH – all overnight and GGH and Easterhouse to midnight). It is the view that this is both likely to provide efficiency savings, offer stabilisation of the service, and continues to provide accessible high quality care.

7.4 These options now need to be discussed with a wider group of stakeholders.

**Appendix 1 – DISCUSSION PAPER ON NHS GREATER GLASGOW & CLYDE - GP OUT OF HOURS SERVICE**

## 1 Background

1.1 NHS Greater Glasgow & Clyde have been carrying out a review of Primary Care Out of Hours services in the context of the recently published National Review by Sir Lewis Ritchie and the Board's service and financial planning for 2016/17.

1.2 In 2004, the General Medical Services (GMS) contract came into force. This gave General Practitioners (GPs) the opportunity to opt out of providing out of hours care for their patients. The GMS contract means that NHS Greater Glasgow & Clyde is responsible for ensuring all patients can access out of hours care. Access to the GPOOH service was initially intended to be through NHS24, however, over time, a significant number of patients now walk in into the service.

Strategically the new IJBs are responsible for the planning and commissioning of safe and effective OOH services.

1.3 Up until 2015, OOH GPs in the Greater Glasgow Health Board service were independent contractors. In 2015, following a nationwide investigation into the way individual Boards paid out of hours GPs, HMRC implemented a ruling that GPs working in out of hours services required to be on the Board payroll, rather than treated as independent contractors. The result of the changes to the tax treatment of GPs working in out of hours services for GGC has incurred an additional cost of £2.5m per annum. This funding requires to be found on a recurrent basis as to date it has been covered non-recurringly.

Rates of pay are increased at times of peak activity in OOH – namely Public Holidays and the Festive fortnight and this has also resulted in an unfunded cost pressure of c500k.

The service has constantly reviewed its costs and service delivery model and has made cost reducing efficiencies of £300k over the last 5 years.

However with the budget for the entire Board service being £16m, predominately in staff costs, it is not possible for the service to cover these increased staffing costs from within the service

Currently other WOS boards pay GPs higher rates than GGC and this is causing high levels of unfilled shifts. The service are using agency staff consistently for the first time since its inception

1.4 We are undertaking a review of the current GP service model to ensure that we can continue to provide an efficient, responsive service that is sustainable going forward. Ensuring safe, accessible services to patients and staff during the Out of Hours period is a key factor in ensuring high quality services to the population of NHS Greater Glasgow & Clyde.

1.5 In the recently published National Out of Hours Review, out of hours care is defined as care to a patient which cannot wait until the GP surgery is open again.

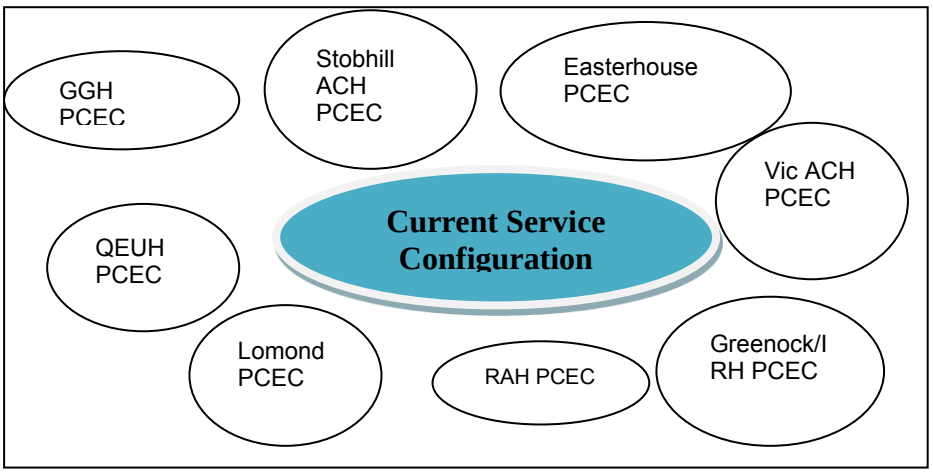
## 2 Current Service Configuration

2.1 A Home Visiting Service – this extends into Lanarkshire to cover Camglen and to Highland to cover Helensburgh and the Lochside .

2.2 A telephone advice service – this is provided from the Hub at Cardonald by the GP advisor who has a wide role in co-ordinating the service.

2.3 A pre-prioritised call service to support NHS24 – this is provided from the Hub at Cardonald utilising GG&C clinical workforce and funded by NHS 24

2.4 8 Primary Care Centres - these are located geographically around the city to support access locally for patients – these centres see patients who are directed by NHS24, or self present and those adjacent to A/E departments will see those redirected by A/E.




The service offers a patient transport service to and from these centres for patients who cannot afford public transport and do not have their own transport. This to minimise the need for home visits.

The service does not operate an appointment system and patients are directed by NHS24 to their nearest PCEC.

- The service is currently adjacent to Emergency Departments at Queen Elizabeth University Hospital, and Royal Alexandra Hospital and overnight at Inverclyde Royal Hospital
- The service is co-located with Minor Injury Units at Stobhill ACH; Victoria ACH and Vale of Leven.
- There are 3 other centres at Gartnavel General Hospital for West Glasgow, Easterhouse Health Centre – North/East Glasgow and Greenock Health Centre – Inverclyde
- There are only three main centres open overnight at RAH, Victoria ACH and Stobhill ACH. An overnight service is provided by the Home Visiting doctor at IRH and at Vale of Leven.

## 3 Summary of Work in 2016/17

3.1 Closure of Western Infirmary and Drumchapel Primary Care Centre and centralisation of West sector service at Gartnavel General Hospital.

3.2 Introduction of nurses into centres to reduce demand for medical staff

3.3 Trial of nurses undertaking home visits to test viability of alternative models

3.4 Other work which is also progressing in reviewing pathways into/out of the out of hours service include :

- **Alternative care pathways:** we are working with NHS 24 to implement changes to care pathways which will reduce pressure on the service e.g.
    - 12 hour disposition – improving use of this which will feed back to in hours GP services
    - Introduction of a self care guide for patients
    - Reinforcing SIGN guidelines on use of antibiotics for self limiting conditions – joint letter from LMC and GPOOH has been distributed to all GPs across GGC
    - Pilot of "speak to doctor" being developed within NHS24
    - Introduction of Prescribing pharmacists within NHS24 – this will support reducing demand on GPs for repeat prescriptions.
    - Prescribing guidelines for Pharmacies – these are being developed nationally for specific pathways e.g. uncomplicated UTI.

- **Nursing homes:** to reduce the numbers of home visits to nursing homes with the purpose of Pronouncing Life Extinct which put pressure in the service we are changing the interface with nursing homes to reduce demand;

- **Patient Transport Service –** initial review of this has been undertaken to improve efficiency of service.

## 4 Activity

4.1 The following provides a description of GPOOH activity which is taken from the published ISD datamart. This reports on all GPOOH services across Scotland with the most recent report scheduled to be published at the end of February 2017.

***Note** – the location within ADASTRA in which GGC activity is recorded is slightly different to the way other Boards record this information. Whilst the service have been working with ISD to try to get as accurate a picture as possible, the reported figures are slightly different to those which the service themselves produce although the trend data is consistent.*

4.2 **Consultations** - ISD 2015/16 reports 246,617 Consultations which was 3.3% higher than the previous year.

In 2016/17 the figures have shown a reduction - the latest monthly activity reported for 2016/17 is to October 2016.

| | April to October | Variance |
|---|---|---|
| 2014/15 | 134,782 | |
| 2015/16 | 139,367 | 3.4 % |
| 2016/7 | 131,830 | -5.4% |

4.3 **Primary Care Centres/Home Visiting**

The following table shows a 2.9% increase in 2015/16 but a 3.7% drop in 2016/17 to Primary Care Centres and a 0.9% drop in 2015/16 and 6% drop in 2016/17 to the Home Visiting service.

| Data Source : ISD | April to October Activity | | | |
|---|---|---|---|---|
| | Primary Care Centres | | Home Visiting Service | |
| | Activity | %age diff | Activity | %age diff |
| 2014/15 | 87701 | | 21360 | |
| 2015/16 | 90238 | 2.90% | 21163 | -0.90% |
| 2016/17 | 86875 | -3.70% | 19892 | -6.00% |

4.4 **Recent Experience : West Glasgow**

In July 2016 Drumchapel PCEC closed and was merged with the Western site (which had closed and relocated in November 2015) at Gartnavel. It was anticipated that the numbers of patients attending the Gartnavel site would be less than the numbers previously attending the separate sites and this has in fact been the experience

| | 13/14 | 14/15 | 15/16 | 16/17 |
|---|---|---|---|---|
| West Glasgow | 19040 | 20514 | 19673 | 16240 |
| %diff in year | | 7.7% | -4.1% | -17.5% |

These initial figures suggest that the initial move to Gartnavel resulted in a significant reduction in OOH attendances. Of note when Western site moved, the walk in rate reduced from almost 30% to 15%. This can be explained by

- lack of accessibility to student and visiting population
- move away from adjacency to an A/E department

The West population may not be typical and this experience might not be mirrored should other services move. The following table provides a description of the mode of arrival of patients to other Primary Care Centres across GGC as a percentage of the total attendances.

| | as %age of attendances at PCEC | | | |
|---|---|---|---|---|
| | NHS24 | Walk-in | Refer MIU/E | Other |
| Easterhouse | 75% | 23% | 0% | 2% |
| Greenock | 87% | 12% | 0% | 1% |
| Inverclyde | 97% | 0% | 0% | 3% |
| Lomond | 32% | 51% | 7% | 10% |
| Renfrewshire | 84% | 9% | 2% | 5% |
| QEUH | 71% | 21% | 6% | 2% |
| Stobhill | 63% | 29% | 1% | 7% |
| Victoria | 67% | 27% | 1% | 5% |

4.5 The following table describes the current daily average attendances to the PCEC's :

| Current Daily average activity | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Vic ACH | QEUH | GGH | Stobhill A | Easterhou | RAH | IRH | Vale |
| Monday | 66 | 18 | 30 | 48 | 26 | 29 | 11 | 26 |
| Tuesday | 64 | 19 | 31 | 49 | 26 | 27 | 12 | 24 |
| Wednesday | 61 | 19 | 29 | 46 | 24 | 28 | 10 | 24 |
| Thursday | 61 | 19 | 29 | 43 | 23 | 27 | 10 | 23 |
| Friday | 65 | 20 | 33 | 47 | 26 | 28 | 11 | 25 |
| Saturday | 202 | 76 | 133 | 133 | 98 | 103 | 47 | 85 |
| Sunday | 197 | 77 | 132 | 133 | 97 | 103 | 43 | 84 |

## 4.6 Postcode analysis of attendances

Of the total attendances, the Greater Glasgow area accounts for 70.4% of attendances, Clyde sector 27.3% and out of board area 2.3%.

- In the out of board area, attendances from the ML (Motherwell) catchment area are highest at 18.5% followed by KA (Kilmarnock) at 18.4%, EH (Lothian) at 9.6% and G74 (East Kilbride) at 8.7%.
- In the Greater Glasgow area – G33 (Blackhill, Riddrie…) account for 6.2% of Greater Glasgow attendances, following by G81 (Dalmuir…) at 4.9%, G32 (Springboig….) at 4.4% and G53 (Pollok…) at 4%
- In the Clyde area – G83 (Balloch) is the highest at 15%, followed by G82 (Dumbarton) at 12.2%, PA2 (Foxbar….) at 9.8% and PA3 (Ferguslie….) at 7%.

| GPOOH POSTCODE DISTRIBUTION OF ATTENDANCES (based on year 2014/15) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Out of Board Area | | | Greater Glasgow Area | | | Clyde | | |
| Postcode | Area | %age | Postcode | Area | %age | Postcode | Area | %AGE |
| overall | | 2.3% | overall | | 70.4% | overall | | 27.3% |
| *following describes highest users of out of board area* | | | *of the Greater Glasgow areas - following is highest postcode areas* | | | *of the Clyde areas - following is highest postcode areas* | | |
| ML | ML Motherwell | 18.5% | G33 | Blackhill, Riddrie, Ruchazie, Garthamlock, Stepps | 6.2% | G83 | Balloch, Luss | 15.0% |
| KA | KA Kilmarnock | 18.4% | G81 | Dalmuir, Faifley, Duntocher | 4.9% | G82 | Dumbarton | 12.2% |
| EH | EH Lothian | 9.6% | G32 | Springboig, Shettleston, Carmyle, Carntyne | 4.4% | PA2 | Foxbar, Glenburn, Hu nterhill | 9.8% |
| G74 | G74 East Kilbride | 8.7% | G53 | Pollok, Nitshill, Darnley | 4.0% | PA3 | Ferguslie, Linwood | 7.0% |
| AB | AB Aberdeen | 6.9% | G21 | Cowlairs, Gargad, Barmulloch, Barlornock, Robroyston | 3.9% | PA16 | Greenock | 6.5% |
| FK | FK Falkirk | 6.3% | G42 | Polmadie, Battlefield, Crosshill, Govanhill | 3.9% | PA4 | Renfrew, Inchinnan | 6.3% |
| DD | DD Dundee | 4.0% | G13 | Jordanhill, knightswood, yoker | 3.8% | G84 | Helensburgh | 6.3% |
| KY | KY Kirkcaldy | 3.4% | G66 | Lenzie, Lennoxtown | 3.7% | PA5 | Johnston, Elderslie | 5.7% |
| | | | G69 | Gartcosh, Chryston | 3.7% | PA1 | Paisley central, Ralston | 5.3% |
| | | | G15 | Drumchapel | 3.6% | PA15 | Greenock | 5.5% |
| | | | G52 | Mosspark, Cardonald, Penilee | 3.6% | G78 | Barrhead, Neilston, Uplawmoor | 5.0% |
| | | | G41 | Shawlands, Pollokshields, Strathbung | 3.5% | PA14 | Port Glasgow | 3.9% |
| | | | G73 | Rutherglen | 3.4% | | | |
| | | | G44 | Cathcart, Kingspark, Croftfoot | 3.1% | | | |
| | | | G64 | Bishopbriggs, Torrance | 3.1% | | | |
| | | | G72 | Cambuslang | 2.9% | | | |
| | | | G20 | Ruchill, N Kelvinside, Woodside | 2.9% | | | |
| | | | G51 | Kinningpark, Ibrox, Govan | 2.7% | | | |

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        - high walk in rate may reduce ;
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    - **Disadvantages**
        - Removes centres from areas with high levels of deprivation and this will reduce ease of access for these vulnerable groups of patients
        - These will be high volume sites, particularly at weekends, which may make it even more difficult to attract GPs to work in such an environment
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        - Challenges to accommodate such a large service on one site
        - Suitable area within GRI would require to be found as service not currently located on this site and at QEUH Children's Hospital as current area not suitable for expansion
        -
- **Option2 - mixture of acute and community based on demand**
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- Opportunity to redesign shift patterns and skill mix mid week
- Moving from an acute site has shown to potentially reduce walk- ins (a/e redirects are counted as walk ins) and overall attendances.

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  - Potential impact on increased attendances to Emergency Departments
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  - **Disadvantages**
    - Will require new locations to be found – Easterhouse only community site currently
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East Dunbartonshire Health & Social Care Partnership

**Chief Officer**
**Susan Manion**

**Agenda Item Number: 18**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Integrated Children's Services Plan (2017-20)** |
| **Report By** | **Sandra Cairney, Head of Strategy, Planning & Health Improvement, East Dunbartonshire Health & Social Care Partnership** |
| **Contact Officer** | **Sandra Cairney, Head of Strategy, Planning & Health Improvement**<br>**0141 232 8233**<br>**Sandra.cairney@ggc.scot.nhs.uk** |

| | |
|---|---|
| **Purpose of Report** | To provide the HSCP Board with the draft Integrated Children's Services Plan (2017-20) |

| | |
|---|---|
| **Recommendations** | The HSCP Board is requested to approve the Plan |

| | |
|---|---|
| **Relevance to HSCP Board Strategic Plan** | Health, social care and health improvement priorities form part of the Integrated Children's Services Plan (2017-20) alongside other community planning partners' contributions to the Local Outcome Improvement Plan (Outcome 3). |

**Implications for Health & Social Care Partnership**

| | |
|---|---|
| **Human Resources** | Nil |

| | |
|---|---|
| **Equalities:** | The Integrated Children's Services Plan (2017-20) has been subject to and informed by an Equality Impact Assessment |

| | |
|---|---|
| **Financial:** | Planned resource is required to deliver commitments of the three year period |

| | |
|---|---|
| **Legal:** | Key priorities include the provision of statutory functions including child protection services. |

| | |
|---|---|
| **Economic Impact:** | Nil |

| | |
|---|---|
| **Sustainability:** | Nil |

| | |
|---|---|
| **Risk Implications:** | Delivery against the key priorities requires resource commitment across community planning partners. |

| | |
|---|---|
| **Implications for East Dunbartonshire Council:** | The integrated nature of the Plan means approval from EDC Education Committee is required. A range of EDC services are integral to the delivery of joint key priorities. |

| | |
|---|---|
| **Implications for NHS Greater Glasgow & Clyde:** | A range of NHSGGC services are integral to the delivery of joint key priorities. |

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

**1.0 MAIN REPORT**

**1.1** Statutory Guidance on Part 3 (Children's Services Planning) of the Children and Young People (Scotland) Act 2014 requires every local authority and its relevant health board to jointly prepare a Children's Services Plan for the area of the local authority, in respect of each three-year period.

**1.2** The East Dunbartonshire draft Integrated Children's Services Plan (2017-20) sets out how community planning partners will work together to plan, develop and provide services over the next three years (April 2017 to March 2020). This includes safeguarding, supporting and promoting wellbeing; ensuring children, young people and families get the right support at the right time; taking action to prevent and meet need; being integrated from the point of view of service users; and constituting the best use of available resources.

**1.3** The Plan embeds local Community Planning Partnership principles including planning for Place; sustainability, fair and equitable public services; prevention and early intervention; and coproduction and engagement.

**1.4** The Delivering for Children & Young People's Partnership (DCYPP) is the mechanism for delivering on Local Outcome 3 '*Our children and young people are safe, healthy and ready to learn*' and the Plan sets out the key deliverables under the SHANARRI framework.

East Dunbartonshire Health & Social Care Partnership

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

NHS Greater Glasgow and Clyde

# East Dunbartonshire Integrated Children's Services Plan

2017-2020


East Dunbartonshire Community Planning Partnership

# Introduction



## Our Vision

The Delivering for Children & Young People's Partnership (DCYPP) directs the strategic planning, development and delivery of children and young people's services on behalf of the East Dunbartonshire Community Planning Partnership (DCYPP structure found on page 15). The DCYPP's vision is that:

> 'all partners will work together with communities and families to ensure children and young people have the best start in life, are confident, healthy, resilient, live in positive and inclusive communities and free from disadvantage.'

To achieve this we place children, young people and families at the heart of all our services and provide support when it is needed throughout childhood and the transition to adulthood.

## Local Outcome Improvement Plan

East Dunbartonshire Community Planning Partnership is required to produce and publish, by October 2017, a Local Outcomes Improvement Plan (LOIP) setting out clear priorities for improving local outcomes and on tackling inequalities. The DCYPP is the mechanism for delivering on Local Outcome 3

'Our children and young people are safe, healthy and ready to learn'.

## Our Approach

The Plan embeds local Community Planning Partnership principles including planning for Place; sustainability, fair and equitable public services; prevention and early intervention; and coproduction and engagement. We recognise the need for excellent universal services that build resilience and provide important protective factors for all children and young people and we will do all we can to strengthen support for families and communities to meet their needs.

Addressing inequalities through targeted interventions is central to achieving our vision in order to mitigate the impact and improve outcomes for our most disadvantaged children, young people and their families. We recognise the need to provide help and/or support as quickly as possible, from services that are responsive, appropriate, proportionate and accessible.

Partners are developing measures to assess our performance in achieving meaningful outcomes for children and young people. this will also assist in assessing progress against our shared outcomes. Key to measuring our progress will involve getting feedback from children, young people and their families about how well we are doing in meeting their needs.

## Our Plan

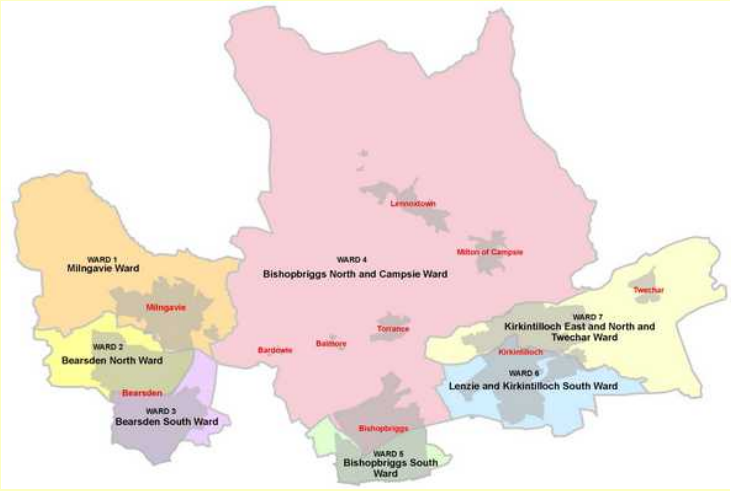
This Plan sets out how we will work together to plan, develop and provide services over the next three years (April 2017 to March 2020) that will:

- best safeguard, support and promote wellbeing;
- make sure that children, young people and families get the right support at the right time;
- take action to prevent and meet need;
- be integrated from the point of view of service users;
- constitute the best use of available resources.

# Population Profile cont...

## Demographics

- East Dunbartonshire is recognised as one of the best places to live in Scotland in terms of health outcomes, educational attainment and levels of employment.
- The overall population is predicted to decrease by 7% by 2037.
- The number of children under the age of 16 years is predicted to fall by 1%, from 17% to 16% of the area's total population by 20137.
- Almost 18% of children aged up to 15 years are living in our three most deprived datazones. This means a significant percentage of children are living in areas of multiple deprivation, with poor economic activity and lower life expectancy.




## Educational Attainment

- Secondary schools SQA examinations are among the highest passes in Scotland and 96% of school leavers going onto positive destinations.
- 60.9% go to university, 16.3% college, 16.6% employment and 2.2% training.
- Audit Scotland (2014) acknowledged East Dunbartonshire as the best performing authority for the lowest 20% in relation to outcomes.

Overall East Dunbartonshire performs significantly better than the National average in relation to the following data, although there are significant variations in certain datazones:

- 7.6% of working age population claim Out of Work Benefits - significant variation showing 14.1% Auchinairn, 15.3% Harestanes and 23.8% Hillhead (DWP 2014).
- 7.8% living in poverty - significant variation showing 28.6% in Hillhead (HMRC 2012).
- 7.7% of the population Income Deprived - significant variation showing 16.3% in Auchinairn, 16.4% in Harestanes and 24.1% in Hillhead (SIMD, Scottish Government 2014).
- 8.2% of working age population Employment Deprived - significant variation showing 14.2% in Auchinairn, 14.7% Twechar & Harestanes East, 15.8% in Harestanes and 22.1% in Hillhead (SIMD, Scottish Government 2014).
- 11.1% of mothers smoking during pregnancy - significant variation showing 37% in Hillhead (ISD Scotland, 3year aggregates 2012/13 – 2014/15).
- 32.6% of babies exclusively breastfed at 6-8 weeks - significant variation showing 13.2% in Hillhead (ISD Scotland).

## Place Communities

The overall positive performance can hide the inequality gaps which exist between communities

- Eight of the 127 data zones are in the 25% most deprived in Scotland.
- Five of the 8 form a cluster around Hillhead, with two of the data zones falling within the most deprived 5% in Scotland.
- Lennoxtown and Auchinairn each have one datazone which falls into the 25% most deprived in Scotland.

# Population Profile cont...

## Secondary Schools Health & Wellbeing Survey (2014/15)

A full copy of the survey can be found at:

*http://www.nhsggc.org.uk/media/237007/nhsggc_ph_east_dunbartonshire_schools_health_wellbeing_survey_2014-15.pdf*

Overall, the survey found that young people are adopting positive, healthy behaviours.

- 87% clean their teeth twice a day or more;
- 84% visited the dentist in the previous six month period;
- 83% received sexual health and relationships education at school;
- 56% never drink alcohol;
- 52% walk or cycle to school;
- 48% eat five or more portions of fruit or vegetables in a day;
- 44% meet the physical activity target of 60 minutes or more of moderate physical activity on five or more days per week;
- 31% have nine or more hours of sleep per night; and
- 75% expect to go on to further education or training.

The survey revealed a number of negative characteristics. In the past year:

- 54% reported being exposed to environmental tobacco smoke;
- 8% are current smokers
- 12% had taken illegal drugs
- 50% engaged in anti-social or risk-taking behaviours;
- 22% had been bullied;
- 18% have more than eight hours of screen based activity on a school day; and
- 15% experienced bullying of others.

## Child Protection

East Dunbartonshire continues to work with a significant number of children in need of care and protection.

During the period 2013/14 to 2015/16:

- there was a slight decrease in the number of children on the Child Protection Register;
- the number of children who were Looked After remained relatively stable with a slight increase overall;
- there has been a significant increase in the number of children being referred to Social Work Services, experiencing 40% increase in referrals to the social work duty service;
- the number of child protection investigations remained steady at around 170 per annum;
- Non-engaging families was the most common area of concern alongside neglect, domestic violence and parental alcohol misuse. However, there has also been a sharp rise in parental mental health being identified as a significant concern;
- The number of children who are looked after by the local authority has stayed at a consistent level over the past three years of around 160 with a slight overall increase of around 5%.

During 2015/2016 specifically:

- 140 of our children and young people were referred to the Children's Reporters;
- Lack of parental care was the single most common ground of referral;
- Police were the main referrer to the Children's Reporter;
- 85% of referrals were on non-offence grounds. The remaining 15% were on offence grounds. The offences were committed in the main by young males aged between13 and 14 years;
- Of the total 160 Looked After children, 125 children were subject to a Compulsory Supervision Order either at home or away from home and the majority of the remaining were Looked After on a voluntary basis.

# Our Children & Young People are SAFE



## Our Approach

We are committed to ensuring that all of East Dunbartonshire's children and young people are protected from abuse, neglect and harm wherever that may occur. We aim to further embed an outcome focussed approach to assessment and planning into practice, ensuring risk assessment and risk management processes are a key feature of our approach.

## Improvement Objectives

- Developments in all areas of Child Protection will reflect the vision of the National Child Protection Improvement Programme and any future guidance.
- The views of stakeholders are used in the development, review and delivery of services supported by a comprehensive quality assurance framework.
- Staff across all agencies will have improved skills and knowledge required to make early identification of children and young people affected by neglect.
- Children and young people have the knowledge and skills to keep safe.
- The public understands how to keep children and young people safe.

## Local Supporting Plan

- East Dunbartonshire Child Protection Committee Business Plan (2017 – 2020) and Child Protection Committee Annual Sub-group Action Plans

## What we will do

- Continue to deliver guidance on a range of practice areas as well as single and multi-agency training for those working with children and young people for example volunteers, teachers, relevant third sector organisations staff, health visitors and other health and social care staff.
- Improve single and multi-agency frameworks for assessment, planning, review and risk management.
- Review early intervention screening groups for: unborn babies; domestic abuse; young people who offend.
- Address the needs of children and young people and their families affected by issues of mental ill-health and/or addiction.
- Develop robust approaches for gathering the views of families, children and young people involved in Child Protection processes in order to make improvements, where necessary.
- Review the information provided to families, children and young people and the wider community to keep children safe and protected.
- Develop a robust multi-agency quality assurance system to identify good practice and embed a culture of learning.
- Implement the reviewed Child Sexual Exploitation Awareness Raising and Training Strategy.
- Improve our approaches for engaging children and families in the Child Protection decision making processes.

- Education and Police work together to ensure all pupils receive preventative safety advice, particularly regarding child protection and online safety.

# Our Children & Young People are HEALTHY



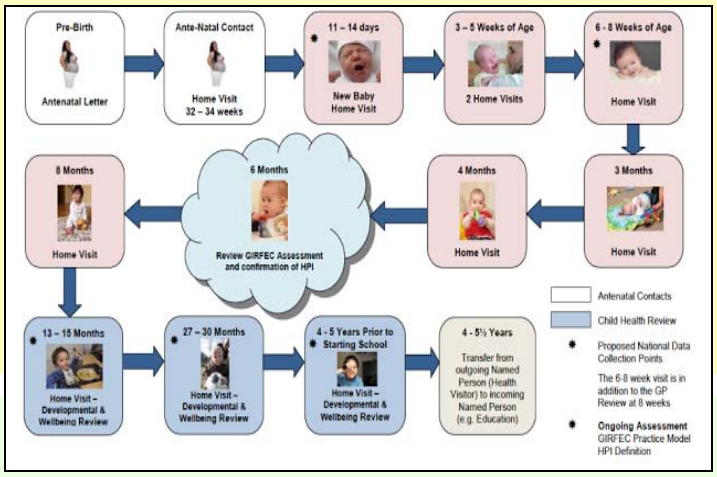
## Our Approach

There is clear evidence that early intervention can promote good health and reduce ill-health and premature death for children and young people. Adopting healthy behaviours in childhood and the teenage years set patterns for later life.

We acknowledge that improving health is not just the responsibility of the health sector. Improving the health of children and young people needs to go beyond healthy life-styles and health care to encompass multi-faceted collaborative action across all sectors.

## Improvement Objectives

- Policies, Strategies and Plans promote and improve the health and wellbeing of children, young people and their families.
- Children, young people and their families live in health promoting environments.
- Children, young people and their families are supported to improve their health through developing personal skills.




*Health Visiting Universal Pathway*

## Local Supporting Plans

- Joint Health Improvement Plan (2013/16)
- Tobacco Alliance, Tobacco Control Strategy (2015/18)
- Financial Inclusion Strategy (2014/17)

## What we will do

- Deliver priorities outlined in the Tobacco Action Plan including smoke free play parks, public buildings and grounds; extending the Second Hand Smoke Programme; delivering smoking prevention programmes in schools; and addressing non-compliance with legislation.
- Work with partners to ensure children, young people and parents have access to sexual health and relationships education and services.
- Improve the provision of alcohol information and education in targeted settings including in nursery and primary schools and young people through Positive Achievements.
- Improve the oral health of pre-five children through the delivery of the ChildSmile Programme.
- Promote and provide practical support with breast-feeding and breast-feeding friendly places, secure ongoing UNICEF Baby Friendly Accreditation.
- Deliver universal and targetted community food & nutrition programmes with children, young people and families.
- Improve access to financial support through local income maximisation services.
- Support children, young people and families to access immunisation.
- Facilitate appropriate access for children, young people and families to general and Specialist NHS Children's Services.
- Deliver the Family Nurse Partnership (FNP) programme for first time mums aged 19 years and under.
- Identify vulnerable pregnant women in order to assess needs and provide appropriate support at an early stage.
- Introduce the Universal Pathway which will offer increased health visitor contact from the antenatal period to school entry, including additional assements to identify individual support needs.

# Our Children & Young People are ACHIEVING



## Our Approach

We want all of our children and young people to be prepared for life, work and learning and to have the highest standards of attainment and achievement. We will work with many partners towards ensuring equity, providing support to children and families who require it. We will support early years establishments and schools to build on the existing good practice to provide a range of more flexible pathways for young people.

## Improvement Objectives

- Raise attainment and wider achievement for all children and young people
- Improve the quality and provision of early learning and child care

## Local Supporting Plans

- East Dunbartonshire National Improvement Framework Plan (2017/20)
- East Dunbartonshire Early Years Strategic Plan (2017/20)
- Developing the Young Workforce Delivery Plan 2017-20

## What we will do

- Support children to achieve age appropriate levels of literacy and numeracy.
- Develop the range and access to wider achievement for all children and young people.
- Continue to raise levels of attainment in the Senior Phase.
- Implement increased entitlement to early learning and child care.
- Improve staff knowledge and confidence in effective practice within early years in line with Building the Ambition.
- Implement National Play Strategy.
- Improve the quality of leadership in local authority and partner providers.
- Raise attainment in literacy and numeracy in areas of high deprivation.
- Improve attainment for the lowest 20%.
- Provide opportunities for young people who have left school to enter further education, training and/or employment.

# Our Children & Young People are NURTURED



## Our Approach

We recognised the need to improve the co-ordination, integration and delivery of our parenting support programmes and their accessibility to families. An innovative "Parenting Pathway" has been developed to ensure all families can access help when they need it, including those families with additional needs and/or who are living in disadvantaged circumstances.

To ensure that our multi-agency practitioners are delivering a common shared message when working with children and families, we agreed to adopt "Triple P" and other parenting interventions that empower and promote a self-efficacy approach to positive parenting.

## Improvement Objective

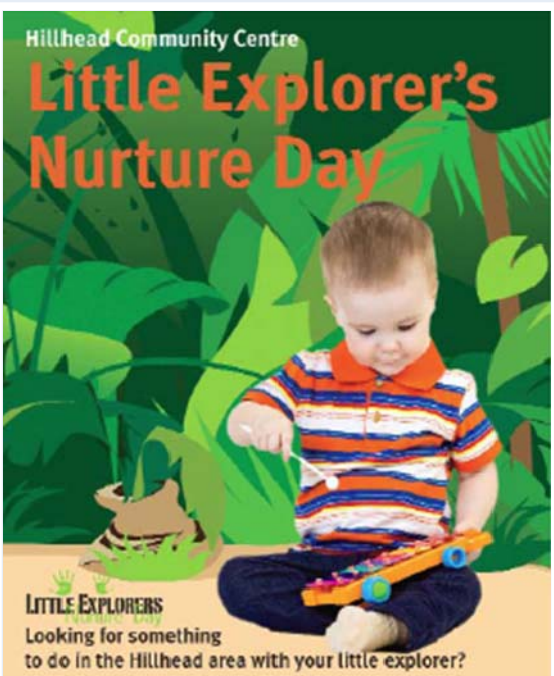
- Staff and parents are empowered to feel confident in supporting their child's development.

## Local Supporting Plans

- East Dunbartonshire National Improvement Framework Plan (2017/20)
- East Dunbartonshire Early Years Strategic Plan (2017/20)

## What we will do

- Ensure children, young people and their families know where to go for help and advice whenever they need it.
- Develop the use of nurture approaches from early years to secondary schools.
- Implement the local Parenting Strategy, providing universal and targeted parenting support.
- Build the resilience of children and young people through developing and implementing mental health improvement actions by a range of organisations across different settings.
- Apply a PLACE approach to planning services which prioritise our geographic areas of greatest need
- Develop and implement Family Learning approaches both targeted and universal
- Work in partnership to ensure young carers wellbeing is not negatively affected by their caring role and ensure they are identified, recorded and supported appropriately.
- Promote improved health and wellbeing outcomes for Looked After Children



# Our Children & Young People are ACTIVE



## Our Approach

Physical activity is a key protective asset for children and young people's health and wellbeing. There are clear health benefits including promoting healthy weight, enhanced cardio-metabolic and bone health and improved psychological wellbeing.

Eating patterns established during childhood and adolescence may remain throughout the life course. Optimising nutritional intake, alongside the development of healthy eating and activity patterns during these early years is vital for building resilience and protecting against chronic disease in adulthood.

We will provide a range of universal and targeted interventions to promote and support families to achieve a health weight.

## Improvement Objective

- Children have increased opportunities and are supported to participate in play, recreation and sport.
- Children, young people and families are supported to maintain a healthy weight.


## Local Supporting Plans

- Joint Health Improvement Plan (2013/16)
- Culture, leisure and sport strategy for East Dunbartonshire (2015/20)

## What we will do

- Maximise the use of schools and playgrounds out-with school hours and ensure children and young people have opportunities to use the outdoor environment as part of the curriculum.
- Deliver Active Schools throughout the school year to enable children to take part in a wide range of sports.
- Provide a range of opportunities for families to participate in low and medium level activities through walking and cycling.
- Support the implementation of the 'Going for Gold' physical activity programme in early year's establishments.
- Provide 'Book Buggy Walks', walking and cultural activities for new parents.
- Support education establishments and a range of partners to provide quality outdoor learning experiences.
- Deliver the 'Active Choices' programme as a core aspect of the Health component within Curriculum for Excellence.
- Deliver family healthy weight and lifestyle programmes, involving parents and children working together.
- Deliver a programme of food and health training including; 'Hale & Hearty' with looked after children, local nursery centres and vulnerable young people and parents; 'Be Healthy on a Budget' with community groups and associations.


- Implement guidance provided by 'Better Eating, Better Learning' to make improvements in school food and food education.

# Our Children & Young People are RESPECTED & RESPONSIBLE



## Our Approach

We are keen to listen to children and young people, to help shape service delivery and to involve them as "citizens" in their local communities. We are engaging in a number of ways including supporting pupil councils which operate in primary and secondary schools and in more specialist education provision; the establishment of Youth Council with representatives from across the area; and through members of the Scottish Youth Parliament who are elected to represent parliamentary constituencies. Arrangements are in place to ensure that children and young people who are looked after also have their voice heard on an individual basis and/or through participation in focus groups

## Improvement Objective

- Children's rights are recognised and their voice in decisions affecting them is listened to and acted upon.
- Children and young people and their families are more engaged in the design and delivery of services.

## Local Supporting Plan

- GIRFEC Delivery Plan 2017/18

## What we will do

- Develop approaches to 'Rights Based Learning' in schools.
- Further develop methods to ensure that children and young people's voices are heard and acted upon.
- Work with families so that they can make positive choices on behalf of their children.
- Support children and young people to develop positive relationships and choose not to bully, discriminate or harm others.
- Further develop advocacy services for children and young people.
- Provide opportunities for young people to access volunteering experiences.
- Develop more robust mechanisms to gather feedback about the experiences of children, young people and their families of the services they receive.
- East Dunbartonshire Police will establish a group within The Police Scotland Youth Volunteers Programme to promote practical understanding of policing; encourage the spirit of adventure and good citizenship; support local policing priorities through volunteering; give young people a chance to be heard; and inspire young people to participate positively in their communities.

# Our Children & Young People are INCLUDED



## Our Approach

There are areas where the quality of life for some residents falls well below the national average and that issues they experience are complex and often compounding.

We work towards to ensuring equity and to provide support to children and families who require it. This is achieved in a variety of ways and by working with partner agencies. The PLACE approach in Hillhead, Lennoxtown and Auchinairn is enabling and empowering parents to be more involved in their child's development.

## Improvement Objective

- Address issues of inequality and discrimination.
- Ensure the additional support needs of children and young people are assessed and support provided.

## Local Supporting Plans

- Review of Additional Support Needs Delivery Plan (2017-20)
- East Dunbartonshire National Improvement Framework Plan 2017-20
- PLACE Action Plans 2017/18

## What we will do

- Build on the success of the family learning approach in Hillhead to extend across Lennoxtown and Auchinairn.
- Develop a new community facility to support existing groups, in Auchinairn to develop new provision to meet local needs.
- Provide a pilot breakfast club to children entitled to free school meals in Thomas Muir Primary.
- Efforts to support and promote volunteering will underpin the work across Place communities.
- Develop a range of interventions and approaches aimed at building community capacity and strengthening social networks in areas of greatest need.
- Support parents to engage in activities to promote their own personal development, such as opportunities for parents and carers to learn and develop their employability skills.
- Implement the strategic review of the 'Provision for Children with Additional Support Needs'.
- Implement GIRFEC in line with the requirements of the Children and Young People's Act.
- Further develop services and support for young carers.
- Develop support to children and young people who are looked after at home or away from home.

# Engaging with Our Children & Young People



## Our Approach

Children and young people have a right to be listened to and be involved in decisions that affect them and this is embedded in law, policy and guidance; the United Nations Convention on the Rights of the Child (1991) and the Children and Young People (Scotland) Act 2014. Partners are committed to supporting children, young people and their families to influence decisions and issues that affect their lives. This requires a culture that recognises and values the contribution they can make and the need to create opportunities for them to meaningfully participate. Our aim is to ensure children and young people feel that their views and experiences are encouraged, valued, respected and most importantly acted upon to shape services and decision making.

## What we are doing

Partner organisations have facilitated a range of engagement activities to ensure children, young people and their families have meaningfully informed our plans and service development. This involves surveys, focus groups and community engagement events.

Some specific examples include:

- Encouraging and supporting young people to participate in school pupil councils and ensure pupil voice is strong in shaping learning and school improvement.
- The East Dunbartonshire Youth Council meets monthly to discuss issues, raise awareness and campaign on areas of concern to the young people they represent. Youth Council Members and MSYPs campaigned and promoted widely throughout East Dunbartonshire and beyond the Scottish Youth Parliament's chosen campaign 'Speak Your Mind'.
- Youth Council members are represented on a number of Council committees including Education.
- In the 2017 Scottish Youth Parliament elections the constituency of Strathkelvin & Bearsden recorded the highest per capita turnout of any Scottish constituency.
- A number of local Council junior and senior youth clubs recently took part in a survey which sought the views of children & young people, parents, carers and staff. The results of the survey will be used to inform future developments in the services.
- Parents have been involved in the evaluation of 0-5yrs drop-in support groups; breast feeding support groups; and First Steps and Triple P Parenting Groups.
- Primary schools have been engaged in the development of Smoke Free Play park and Smoke Free community events.
- Young people are supporting the further development of the Community Asset Map.

## What we will do

Partners will strengthen mechanisms that will:

- better understand satisfaction with the existing services delivered;
- when creating new services, engage with children, young people and families, where appropriate, who might use and shape those services;
- learn and improve services as a result of complaints and compliments received;
- provide and advocate alongside children and young people to support them in putting across their views and wishes while they are receiving services as a Looked After Child.;
- consider and meet children and young people's specialist requirements including language or communication needs and cultural requirements;
- understand and act upon any assessed risk or need; and
- ensure results of the consultation/engagement and any subsequent decisions are fed back in a timely manner to participants.

# Our priorities for 2017-2018



This is a three year plan outlining the ambitions of partners and sets the principles for how we will work together over the period of the Plan.

Partners will focus on those areas where there is the opportunity to work collaboratively to add the value and maximise investment.

The plan will be delivered over a three year period but will focus on the detail of specific priorities through annual delivery plans.

Partners have identified six key areas that will be prioritised over 2017/18 including:

1. Strategic Needs Assessment
2. GIRFEC
3. Mental health improvement
4. Pregnancy and Parenthood in young people
5. Additional Support Needs
6. Corporate Parenting

More detailed annual delivery plans and an associated performance management framework will support the implementation and monitoring of progress for each of the key priorities.

## 1. Strategic Needs Assessment

It is the intention to build on our current knowledge and understanding by undertaking a systematic process to review the needs of our population. The Strategic Needs Assessment will involve pulling information from a range of sources including:

- National and local datasets;
- Public health intelligence;
- Practitioner views; and
- Community views.

This will further determine agreed local priorities that will improve health and wellbeing outcomes for children, young people and their families.

## 2. GIRFEC

We will work to implement the requirements of the Children and Young People's Act. This includes ensuring the systems are in place to support the named person. This requires effective inter-agency working to ensure improved coordination of support for children and families. A GIRFEC delivery plan is in place and is updated regularly.

- Provision of effective training in relation to GIRFEC;
- Develop clear referral processes and systems;
- Develop practice guidelines and information sharing protocols; and
- Develop a format for the Child's Plan across all agencies.

## 3. Mental Health Improvement

Children and young people's mental and emotional health, resilience, self esteem and confidence lie at the heart of improving their ability to manage risk and is fundamental to good physical and mental health and wellbeing.

We are committed to developing a comprehensive multifaceted approach to mental health improvement that aims to foster a nurturing environment and build emotional literacy and resilience. Our focus will also be on developing the skills of partners, including frontline practitioners, to increase their confidence in supporting children and young people in situations of distress.

Our year 1 priorities will include Implementing Seasons for Growth; implementing the Self-Harm 'On Edge' initiative; delivering 'Self-harm and the Scottish Mental Health First Aid'; and involving practitioners & young people in the development of the 'Youth Community Asset Map'.

# Our priorities for 2017-2018



## 4. Pregnancy & Parenthood in Young People

We will begin to develop a local collaborative delivery plan to support the implementation of the National Pregnancy and Parenthood in Young People's Strategy. This will involve all Community Planning Partners in considering the wider determinants that are key, not just for pregnancy but also for supporting young people more widely in relationships, education, attainment, training and employment.

Our short-term, medium-term and longer-term actions will aim to decrease the cycle of deprivation associated with teenage pregnancy and will contribute to a more supportive and less stigmatising environment for young people, a reduction in teenage pregnancy, and improved health and social wellbeing of young parents.

## 5. Additional Support Needs

We will implement the Strategic Review of Provision of Support for Children with Additional Support Needs. An ASN Delivery Plan has been developed.

The main priorities will be:

- Build capacity within mainstream schools to support children with a range of additional support needs;
- Develop clear criteria and assessment for the allocation of places in specialist provision;
- Develop plans for a new build specialist provision.

## 6. Corporate Parenting

We are committed to improving corporate parenting practice across East Dunbartonshire and increase our engagement with care experienced young people and their involvement in service planning. This will be achieved through:

- increasing the number of Corporate Parenting Champions and arranging a conference/training specifically for elected members, senior officers and corporate parenting partners to increase awareness of corporate responsibilities;
- reviewing and progressing the action plan for Corporate Parenting via the Corporate Parenting Steering Group and Board;
- pursuing funding for the Young People's Champions Board from Life Changes Trust and developing a peer mentoring scheme inclusive of care experience young people;
- exploring and developing opportunities for care experienced young people to play an important role in service design across all relevant services.
- Continue to develop a strategy whereby care experienced young people have access to appropriate employment opportunities and free access to local leisure facilities
- Identify and work with those young people who wish to represent the views of care experienced young people and support them to be heard and to engage with their corporate parent.

## Consulting on Our Plan

The priorities outlined in this draft Integrated Children's Plan have already been informed by a plethora of engagement with children, young people and families who are engaged with our services.

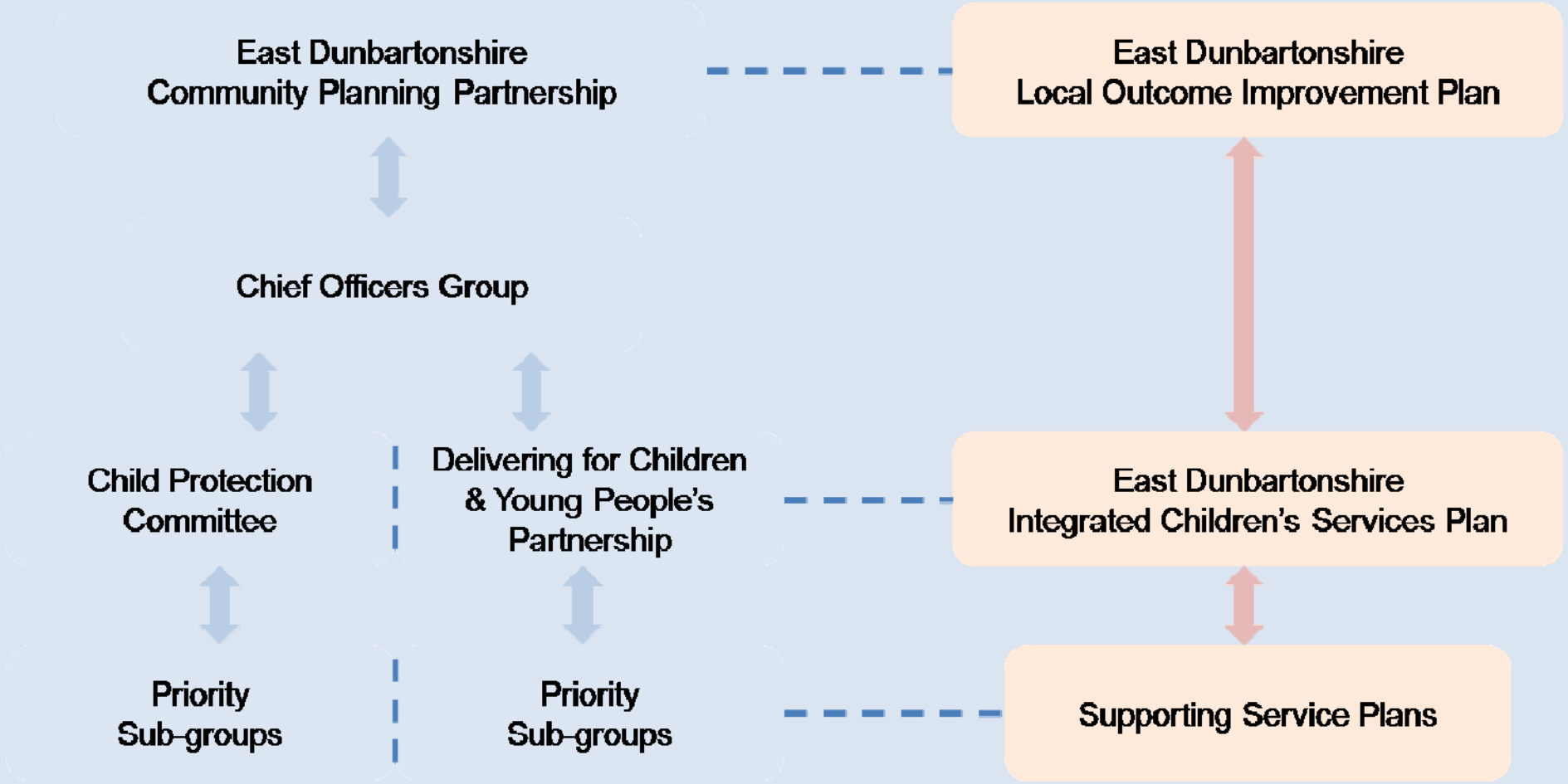
In addition, partners have agreed a consultation process that will involve face-to-face facilitated sessions with different cohorts of children, young people and families.

Feedback from key partner organisations will also form an important aspect of the consultation process. The consultation will be undertaken over a period will allow futher meaningful engagement and participant feedback.

The final Plan will seek approval from East Dunbartonshire Health & Social Care Partnership and relevant East Dunbartonshire Council committees.

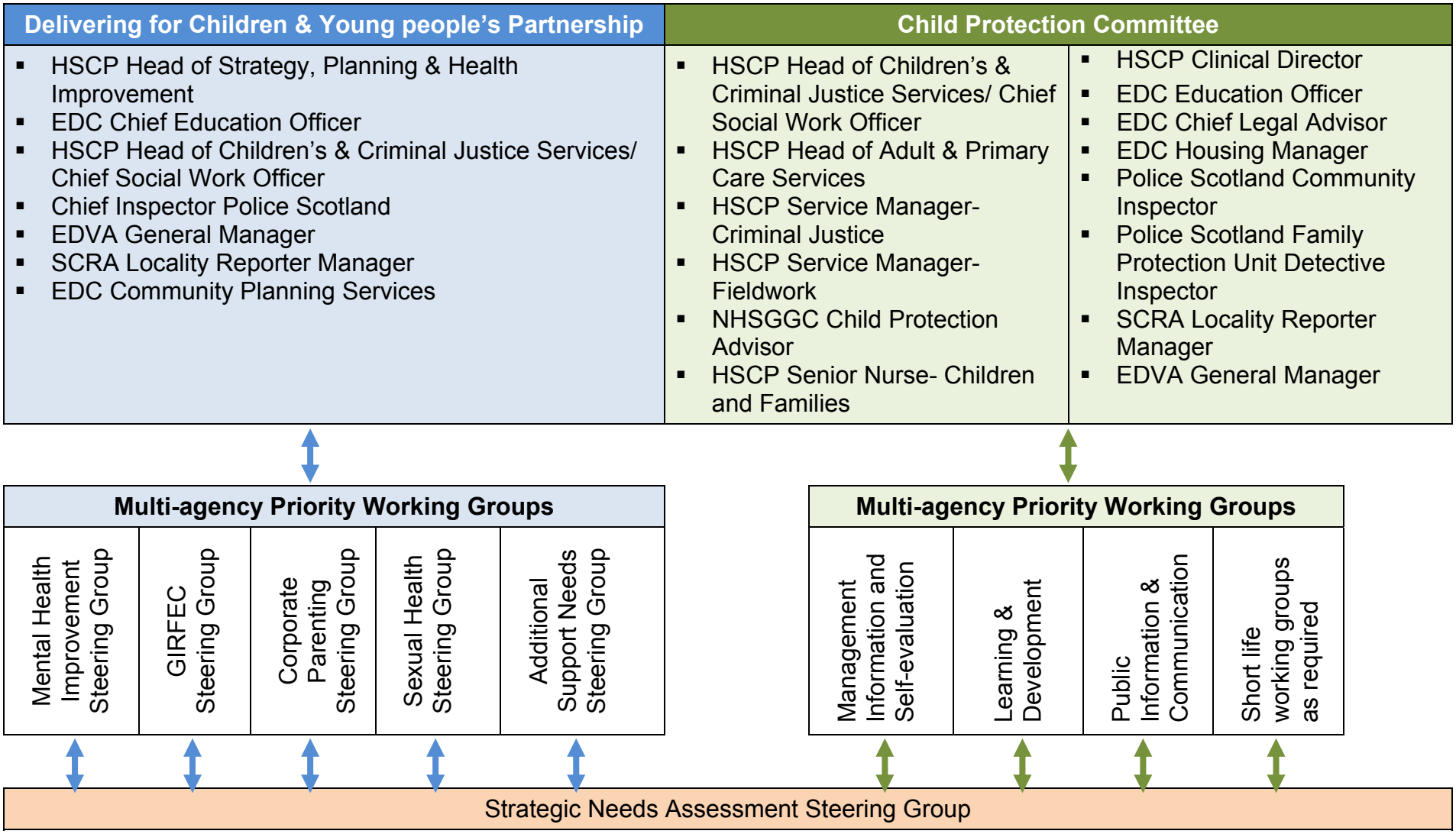
# THE EAST DUNBARTONSHIRE PLANNING LANDSCAPE

The diagram below shows the structure and relationship between the East Dunbartonshire Community Planning Partnership, the Delivering for Children & Young People's Partnership (DCYPP) and its subgroups alongside the associated strategic plans.



# DCYPP STRUCTURE






* HSCP = Health & Social Care Partnership; * EDC = East Dunbartonshire Council;
* SCRA =Scottish Children's Reporter Administration; * EDVA = East Dunbartonshire Voluntary Action

# PLAN AT A GLANCE



| SHANARRI | THEME | IMPROVEMENT OBJECTIVE |
|---|---|---|
| Safe | Children, young people, the public and practitioners have the Knowledge and skills to keep C&YP safe | ▪ Developments in all areas of Child Protection will reflect the vision of the National Child Protection Improvement Programme and any future guidance.<br>▪ The views of stakeholders are used in the development, review and delivery of services supported by a comprehensive quality assurance framework.<br>▪ Staff across all agencies will have improved skills and knowledge required to make early identification of children and young people affected by neglect.<br>▪ Children and young people have the knowledge and skills to keep themselves safe.<br>▪ The public understands how to keep children and young people safe. |
| Healthy | Promote good health and reduce ill-health and premature death for children and young people | ▪ Policies, Strategies and Plans promote and improve the health and wellbeing of children, young people and their families<br>▪ Children, young people and their families live in health promoting environments<br>▪ Children, young people and their families are supported to improve their health through developing personal skills |
| Achieving | Children and young people are prepared for life, work and learning, to have the highest standards of attainment and achievement | ▪ Raise attainment and wider achievement for all children and young people<br>▪ Improve the quality and provision of early learning and child care |
| Nurtured | Co-ordinated, integrated and accessible parenting and family support | ▪ Staff and parents are empowered to feel confident in supporting their child's development. |
| Active | Universal and targeted interventions to promote and support families to achieve a health weight | ▪ Children have increased opportunities and are supported to participate in play, recreation and sport<br>▪ Children, young people and families are supported to maintain a healthy weight |
| Respected & Responsible | Listening to and involving children and young people to help shape services | ▪ Children's rights are recognised and their voice in decisions affecting them is listened to and acted upon.<br>▪ Children and young people and their families are more engaged in the design and delivery of services |
| Included | Ensuring equitable, need led provision and enabling and empowering parents to be more involved in their child's development. | ▪ Address issues of inequality and discrimination<br>▪ Ensure the additional support needs of children and young people are assessed and support provided. |

East Dunbartonshire Health & Social Care Partnership

**Chief Officer**
**Susan Manion**

**Minutes of**
**East Dunbartonshire Health & Social Care Partnership Strategic Planning Group Meeting**
**held at 1:30pm on 1st of March 2017**
**East Dunbartonshire Voluntary Action**
**Unit 4/5, 18 - 20 Townhead, Kirkintilloch, G66 1NL**

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| **Present:** | **Susan Manion (Chair)** | **(SM)** | **Fiona McCulloch** | **(FM)** |
| | **Gillian Notman** | **(GN)** | **Janice Cameron** | **(JC)** |
| | **Diane Meek** | **(DM)** | **John McPherson** | **(JM)** |
| | **David Delaney** | **(DD)** | **Alison Blair** | **(AB)** |
| | **Sandra Cairney** | **(SC)** | **David Aitken** | **(DA)** |
| | **David Radford** | **(DR)** | | |
| **In Attendance:** | **Chris Shepherd on behalf of Avril Jamieson** | | | **(CS)** |
| | **Christina Burns** | **(Minutes)** | | **(CB)** |

| No. | Topic | Action by |
|---|---|---|
| **1.** | **Welcome and Apologies** | |
| | Apologies: Adam Bowman, Avril Jamieson, Steven McIntyre.<br><br>SM introduced herself and provided a brief overview of her previous roles. SM advised that the SPG will be a key group going forward, SM will therefore chair the meetings due to the importance of the SPG in terms of feeding in to future plans. | |
| **2.** | **Presentation – Unscheduled Care** | |
| | FM provided a brief presentation on Unscheduled Care | |
| **3.** | **Unscheduled Care Discussion** | |

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| | SM advised that the full paper will go to the HSCP Board at the end of March.<br><br>The Health & Social Care Delivery plan has been sent out by the Scottish Government and provides clear indicators on measuring performance, including delayed discharges and occupied bed days. This will give both the Partnerships and Scottish Government some insight into the progress being made in relation to indicators and will provide the Scottish Government with an understanding of the issues affecting partnerships. There is an expectation that partnership will work towards resolving issues.<br><br>The group discussed identifying efficiencies, shifting resources and the financial issues affecting both the NHS & Local Authority. HSCP's have been reasonably protected and will receive the same level of funding as last year although the funding from Local authorities may be slightly reduced.<br><br>GN discussed the rapid assessment link (RAL) and explained this to the group.<br><br>The group discussed inappropriate admissions as well as the general awareness of the public in relation to the range of services on offer and how this may reduce unnecessary admissions.<br><br>AB advised that she had been involved in Sign Posting with the health Improvement Team and also discussed enhanced care packages and greater access to services and support at home.<br><br>AB & SC to continue this and will work together to tackle some of the main issues encountered by practices. | **AB, SC** |
| **4.** | **Strategic Plan 2018 - 2021** | |
| | The successive 3 year plan is currently being worked on and the development of the plan will be assisted by the SPG. FM provided a draft plan and confirmed that further templates will follow.<br><br>The group felt that there should be more of a local focus and that the language could be altered to make this more accessible and user friendly.<br><br>DR discussed the PSU&C group and provided a brief update on their structure. The PSU&C will also increase awareness of the strategic plan. | |
| **5.** | **Locality Planning Group** | |

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| | **East Update**<br><br>GN advised that the East LPG have already worked on equalities and are now working with Cancer Research UK who will be attending the next meeting of the group. There has also been some positive work with TCAT and the House of Care development.<br><br>In terms of inequalities the East LPG focused on key areas such as House Bound individuals and what this actually means as well as how this can progress into loneliness and Social isolation.<br><br>GN discussed some of the successes of the group including Dr Gemill's involvement in a low key low level diabetic care and the recently established Walking Group at Regent Gardens.<br><br>**West Update**<br><br>JM explained that the attendance levels at the West LPG have been very good overall however the main constraints are time and money as much of the background work agreed at the meetings sits out with the GP's role.<br><br>JM also advised that Alison Lawrence from ED Council had attended a meeting to discuss planning permission in relation to Health care in the area. Alison is hoping to meet with Health Housing and the planning department to create a better interface.<br><br>JM confirmed that Connie Williamson had also attended the West LPG as have Memory Joggers from Glenkirk. There have been various discussions around creating a community based local group. GN advised that it was clear from the first meeting that there were significant issues for patients prior to a dementia diagnosis. There has been a subsequent review of Day Care services as a result of this and it is hoped that a local coordinator can be appointed to emulate some of the work carried out at Glenkirk. It is hoped that the lead will also attend the next meeting.<br><br>The group agreed that it is important to maintain enthusiasm and that individuals attending need to feel that there are tangible results to the work and input at the meetings.<br><br>SC discussed the 3rd Sector and advised that they will be heavily involved in the joint meeting which will be held on the 20th of September. AB suggested capitalizing on the spring and summer months and arranging a meeting prior to September.<br>SM agreed that it would be helpful to bring together the themes around communication and engagement. | |
| **6.** | **GP Clusters Update & Discussion** | |

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| | There are 3 clusters in total:<br>Dr Val Berg is the chair for the Bishopbriggs & Auchinairn Cluster meetings; they have met once with a further meeting planned in the coming weeks.<br><br>Dr Tracey Secret chairs the Bearden & Milngavie Cluster group; there have been 4 meetings in total.<br><br>Dr David Gilmore chairs the Kirkintilloch and Lennoxtown Cluster group; there have been around 6 meetings to date.<br><br>Over the last couple of months there have been induction sessions with the cluster leads to meet the Senior managers from Lennoxtown. It is expected that this will be a group that evolves. Work is on going to establish a representative from the prescribing team so that there are some links back to the HSCP | |
| **7.** | **PSU&C Update** | |
| | There have been two meetings to date with representatives of the group. Representatives attend various meetings such as the LPG and share information with the other groups they attend. DR advised that work is continuing to gradually build knowledge around the HSCP. The knowledge hub is available to members of this group and provides a platform to facilitate discussions. Meetings take place at Kirkintilloch Health & Care Centre and there has been an agreement that there will be two meetings per year with the wider public service user engagement event workshop around any pertinent issues. | |
| **8.** | **Role of the SPG in the prioritisation process** | |
| | Document for information only | |
| **9** | **Priorities 2017/2018** | |
| | As discussed above. | |
| **10** | Future Meeting Dates:<br><br>• Tuesday 23rd of May<br>• Tuesday 15th August<br>• Wednesday 20th September<br>• Tuesday 14th November | |

**Agenda Item Number: 20**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

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|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Survivor Scotland, The National Strategy For Survivors Of Childhood Abuse: Scottish Child Abuse Inquiry** |
| **Report By** | **Paolo Mazzoncini, Chief Social Work Officer & Head of Children's Services, East Dunbartonshire Health & Social Care Partnership** |
| **Contact Officer** | **Kirsty Kennedy, Adult Protection Coordinator**<br>**0141 355 3086**<br>**Kirsty.kennedy@eastdunbarton.gov.uk** |

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| **Purpose of Report** | The purpose of this report is to update the Board on the progress of the national strategy for survivors of childhood abuse, Survivor Scotland, including in particular the Scottish Child Abuse Inquiry, and to advise the Board of resource implications associated with a response to a formal request from the Inquiry Team. |

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| **Recommendations** | It is recommended that the Board:<br>• Notes the contents of the report<br>• Authorises officers to draw up contingency plans to allocate resources to respond to a S.21 notice from the Scottish Child Abuse Inquiry Team. |

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| **Relevance to HSCP Board Strategic Plan** | The Scottish Child Abuse Inquiry (SCAI) is a statutory public inquiry into the historic abuse of children in care which will raise public awareness of the abuse of children in care and provide an opportunity for public acknowledgement of the suffering of the children and their experience and testimony. The Inquiry will report to Scottish Government Ministers within 4 years with recommendations for the future to improve the law, policies and practices in Scotland. |

**Implications for Health & Social Care Partnership**

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| **Human Resources** | As the SCAI progresses there may be additional information provision requirements and potential implications for service provision and support although unquantifiable this will be kept under review. |

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| **Equalities:** | None |

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| **Financial:** | None |

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| **Legal:** | None |

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| **Economic Impact:** | None |

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| **Sustainability:** | None |

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| **Risk Implications:** | Impact of SCAI on staff & service delivery, and reputational risk to EDC – See draft risk register |

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| **Implications for East Dunbartonshire Council:** | East Dunbartonshire Council will wish to support the SCAI. This paper will be presented to the Chief Officers Group for their consideration. |

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|---|---|
| **Implications for NHS Greater Glasgow & Clyde:** | NHS Greater Glasgow and Clyde will wish to support the SCAI. This paper will be presented to the Chief Officers Group for their consideration. |

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|---|---|---|
| **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

The Scottish Child Abuse Inquiry (SCAI) is a statutory public inquiry into the historic abuse of children in care. It is a product of the Survivor Scotland strategy which is described in more detail below. It was set up on 1 October 2015 and is currently chaired by Lady Smith. The SCAI has a number of objectives. It will raise public awareness of the abuse of children in care. It will provide an opportunity for public acknowledgement of the suffering of the children. It will be a forum for validation of their experience and testimony. The Inquiry will report to Scottish Government Ministers within 4 years with recommendations for the future to improve the law, policies and practices in Scotland. The report must also be presented to the Scottish Parliament. The Inquiry has taken evidence from people who were abused, and commenced the first phase of formal hearings involving care providers in late May 2017.

**SURVIVOR SCOTLAND**

The Scottish Government's national strategy for survivors of childhood abuse, Survivor Scotland, was published in 2005[1]. It reflects the Government's commitment to supporting survivors, highlighting the issues they face, reducing stigma and improving services. Amongst its aims are to:

- raise and improve knowledge and awareness of childhood abuse
- ensure joined-up working in mainstream services
- improve the lives of survivors
- develop training and skills for frontline workers

Survivors themselves have played an important role in developing and implementing the SurvivorScotland strategy through membership of the National Reference Group.

SurvivorScotland has a particular focus on childhood sexual abuse. Childhood sexual abuse happens to girls and boys from all backgrounds and all walks of life. Most people will know someone who was sexually abused as a child, whether they realise this or not. People can be affected in very different ways and many survivors do live successful and rewarding lives. Other adult survivors have enduring physical and mental health problems, alcohol and drug misuse, difficulty with relationships and trust, as well as suicidal feelings, all resulting from the trauma they experienced in childhood, and frequently bringing them into contact with health and social care services in their own right and/or as parents.

Childhood sexual abuse has received considerable public attention since the death of Jimmy Savile and Operation Yewtree, as well as Alexis Jay's report into child sexual exploitation in Rotherham which was the subject of a report to the Social Work Committee on 11 December 2014 (ESW/136/14/FM). These investigations highlighted the particular vulnerability of children and young people in residential or health care settings to various forms of abuse or neglect on the part of people charged with caring for them, as well as institutional factors which created conditions for abuse to take place and/or barriers to abuse being discovered.

An important aspect of SurvivorScotland is to highlight and address the long-term effects for survivors of sexual, physical and emotional abuse and neglect whilst in care. Examples of "in care" settings include local authority children's homes, approved schools, hospital care, kinship care, respite care, foster care placements and residential services run by charities and religious orders. As well as the enduring psychological and social problems referred to above, care abuse survivors can additionally experience a loss of trust and confidence in the integrity and professional competence of support and protection services which can also endure into adulthood, and thus interfere with their ability to engage with services.

[1] http://www.survivorscotland.org.uk/strategy/

Key products of Survivor Scotland in respect of abuse in care include the establishment of the National Confidential Forum in 2014, and the Scottish Child Abuse Inquiry in 2015. Other significant strands of the strategy include the introduction of a Survivor Support Fund and the removal of a 3 year limitation period for civil damages claims made by adult survivors.

**National Confidential Forum**

In 2008, the Scottish Government decided to explore the potential of a so-called "Truth and Reconciliation" approach to survivors of abuse in care. This led to the pilot "Time to Be Heard" forum in 2010 which invited people who had lived in Quarriers homes to share and create a historic record of their experiences, and a subsequent consultation on proposals to set up a National Confidential Forum.

The National Confidential Forum was introduced as part of the Victims and Witnesses (Scotland) Act 2014 which amended the Mental Health (Care and Treatment) (Scotland Act 2003 to allow the Mental Welfare Commission for Scotland to host the Forum and laid out the Forum's statutory functions:

1. To receive and listen to testimony from those who were in institutional care as children with the aim of contributing positively to their current health and wellbeing;
2. To prevent harm to children and young people currently in care by learning lessons from the past
3. To signpost other appropriate service to those who were in institutional care as children - before, during and after hearings.

The National Confidential Forum began hearings in early 2015 and recently published its first report on the experiences recounted by people at hearings (**Appendix 1**). It is not intended as a medium for inquiry or apology, and testimony will be confidential except where issues arise about current or future harm to children, or it is in the public interest to report allegations of historic abuse.

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The Forum's signposting function highlighted that people wishing to give testimony to a hearing might request access to their care records and/or support to deal with the impact of giving testimony. Reports on the establishment of the National Confidential Forum[2] and the introduction of a specific East Dunbartonshire policy to support former residents to access their care records[3] were presented to East Dunbartonshire Social Work Committee in 2015.

**Survivor Support Fund**

In December 2016, the Scottish Government set up a new fund to allow adult survivors of in care abuse in Scotland to access services that they need. The fund is called Future Pathways[4]. The aim is to allow adult survivors across Scotland to identify their own needs and the support that they think will be the most beneficial to them. Support could include:

activities within the local community

- counselling
- psychological trauma support
- housing and benefit advice
- access to records

[2] ESW/10/15/AM SurvivorScotland, The National Strategy for Survivors of Childhood Abuse: National Confidential Forum and Good Practice Guidance for Service Providers (5th February 2015)

[3] ESW/099/15/AM Survivor Scotland, The National Strategy For Survivors Of Childhood Abuse: Responding To Former Residents Including Adult Survivors (3rd September 2015)

[4] https://future-pathways.co.uk/

- work and education.

**Limitation period for civil actions for damages**
Adult survivors' opportunities for financial redress have been restricted by the current 3 year limitation period for civil actions for damages. Following a consultation in 2015, the Scottish Government agreed that a different approach in relation to the time-bar is warranted in cases involving historical child abuse. The circumstances of historical child abuse as alluded to in paragraph 4.3 provide the reason why people do not come forward until many years after the event. The draft Limitation (Childhood Abuse) (Scotland) Bill was introduced to Parliament on 16 November 2016, and the Stage 1 report was published on 20 April 2017. This concludes that adult survivors have been let down by the justice system and denied the opportunity to have their voices heard. The Bill will not permit claims to be brought forward in respect of abuse which took place prior to 1964, or a further action in respect of a claim which has already been heard. Further consideration is required of potential financial and resource implications of the Bill.

**SCOTTISH CHILD ABUSE INQUIRY (SCAI)**
In December 2014, the Scottish Government announced its intention to set up a statutory public inquiry into historical child abuse. After a period of consultation with stakeholders, the inquiry's Terms of Reference were published in May 2015, and Susan O'Brien, QC, was appointed to chair the inquiry. The inquiry began proceedings on 1 October 2015. Lady Smith was appointed chair of the inquiry in July 2016. Formal hearings were commenced in May 2017.

The SCAI has defined "in care" as meaning where a child is in the care of a person or organisation other than their natural or adoptive parents. This definition includes residential care; children's homes; secure care (List D schools), borstals and young offenders institutions; foster care; "boarded out" children; child migrants; independent boarding schools and health care establishments providing long stay care. It therefore differs from the National Confidential Forum, which focusses solely on institutional care.

The SCAI's Terms of Reference have been revised on more than one occasion since they were first published, most recently on 17 November 2016. The overall aim and purpose of the Inquiry is to raise public awareness of the abuse of children in care, particularly during the period covered by the Inquiry. It will provide an opportunity for public acknowledgement of the suffering of those children and a forum for validation of their experience and testimony. The Inquiry will do this by fulfilling its Terms of Reference which are set out below.

1. To investigate the nature and extent of abuse of children whilst in care in Scotland, during the relevant time frame.
2. To consider the extent to which institutions and bodies with legal responsibility for the care of children failed in their duty to protect children in care in Scotland (or children whose care was arranged in Scotland) from abuse (regardless of where that abuse occurred), and in particular to identify any systemic failures in fulfilling that duty.
3. To create a national public record and commentary on abuse of children in care in Scotland during the relevant time frame.
4. To examine how abuse affected and still affects these victims in the long term, and how in turn it affects their families.
5. The Inquiry is to cover that period which is within living memory of any person who suffered such abuse, up until such date as the Chair may determine, and in any event not beyond 17 December 2014.
6. To consider the extent to which failures by state or non-state institutions (including the courts) to protect children in care in Scotland from abuse have been addressed by

changes to practice, policy or legislation, up until such date as the Chair may determine.

7. To consider whether further changes in practice, policy or legislation are necessary in order to protect children in care in Scotland from such abuse in future.
8. Within 4 years (or such other period as Ministers may provide) of the date of its establishment, to report to the Scottish Ministers on the above matters, and to make recommendations.

In late 2016, the Inquiry Team began issuing notices under S.21 of the Inquiries Act 2005 to organisations which provide or previously provided residential care for children. A S.21 notice requires the recipient agency to provide a highly detailed report in four parts on the organisation's past and present characteristics, structure & governance; a current statement of acknowledgement or admission; policy and practice within individual services to prevent and identify abuse; and information on actual abuse and individual service responses. A sample S.21 notice is included at **Appendix 2.** To date, almost all councils and other providers have received at least one S.21 notice. East Dunbartonshire is amongst the tiny minority of agencies which has yet to receive a notice.

Recipient agencies are required to furnish a response to Parts A & B within three months of the date of the notice, and to Parts C & D within six months of the date of the notice. The volume of information and analysis required in the S.21 report and the timeframe suggests that a similar level of resource would be required as to prepare for a themed inspection by the Care Inspectorate.

**EAST DUNBARTONSHIRE COUNCIL SCAI WORKING GROUP**

On 25 October 2015 the Inquiry Team issued a notice to the Chief Executive of East Dunbartonshire Council requesting the preservation of all Council records which may be in the scope of the Inquiry. In response to this notice, the Council's Information and Records manager set up an internal working group to identify personal and service records held by the Council which might fall within the scope of the SCAI, and establish the location of such records (e.g. including Glasgow City Archives). Working group membership comprises Social Work, Archives, Audit & Risk, Legal and Corporate Communications. Other local authorities have responded in a similar fashion, including where required secondment/recruitment of additional staff to resource the audit, cataloguing & indexing of records. An action log has been maintained through the life of the working group.

**Raising awareness**

The Adult Protection Co-ordinator conducted two days of training in 2015-16 to raise awareness of the Inquiry and to support colleagues who may be involved in dealing with records requests to supporting Survivors. Inputs were provided by the Centre of Excellence for Looked-after children in Scotland (CELSIS), Quarriers, City of Glasgow Archives and the Data Protection Officer. An information leaflet on Accessing Care Records (Appendix I) was distributed to all Hubs for members of the public to view, and uploaded to the Council's Data Protection Subject Access Requests webpage https://www.eastdunbarton.gov.uk/council/data-protection/subject-access-request. An IBM Connections community was set up to provide information for staff: **Accessing Social Work Care Records**[5]

[5] https://connections.eastdunbarton.gov.uk/communities/service/html/communitystart?communityUuid=4328e7cc-f291-4d6e-a3db-96fe38a92ca4

**Preparing Records**
The main focus of the preparation in the initial months was on locating looked-after children's records. The Records Management Team and the Archivist met with Social Work and Education Colleagues to gather all children's records in three main locations: the Central Records Store, Southbank House file store and Iron Mountain, the Council's offsite storage company. The Archivist worked with Education to collect school log books, registers and other documents for permanent storage. Destruction of children's records has ceased until the conclusion of the Inquiry.

Initially the Working Group focussed on identifying the range of personal and service records held by the Council which might fall within the scope of the SCAI, and establishing where these records were located. This includes legacy social work records relating to local children who were in the care of Strathclyde Regional Council which have been stored by City of Glasgow in agreement with successor authorities including East Dunbartonshire. This audit exercise revealed a substantial number of social work records were incompletely catalogued following various office moves between 2010 and 2012. An action plan was put in place in July 2016 for social work services to conclude the cataloguing exercise. Progress has been delayed due to the service being unable to release social workers from frontline duties, leaving approximately 80 boxes remaining to be catalogued.

The experience of local authority colleagues elsewhere in Scotland confirms that preparing for the SCAI requires a formal resource commitment. For example, in addition to an internal working group, one local authority recruited one social worker and administrative worker on a fixed term basis to resource the audit, cataloguing & indexing of records, as well as to respond to potential S.21 requests.

**Developing systems and processes**
The Working Group receives updates from the Chief Social Work Officer on any feedback or updates received at regional and national meetings and seminars. The Adult Protection Co-Ordinator and Archivist also update the Group with new information received through their professional bodies or other networks, e.g. the Association of Scottish Local Government Archivists (ASLOG), the National Confidential Forum.

The Group has created a draft process (**Appendix 3**) for the Council to follow when the Inquiry Team request records. This process looks at what should happen from the time of the request to supporting survivors and submitting files to the Inquiry.

Digital Records have also been assessed to ensure relevant information can be obtained as and when required by the Inquiry Team. The Central Records Store Database, Carefirst and SWIS are all available for interrogation should information be requested. The extraction of information from Carefirst and SWIS is supported by the corporate Performance and Research Team and all records which may be in scope have already been identified in Carefirst.

The Data Protection Officer and Archivist have attended sessions in the Glasgow City Council Archives to discuss what records are held there for the East Dunbartonshire area and pre-date the start of the Council. The Glasgow City Archivist will work in partnership to locate any records as requested by the Inquiry Team.

A draft Information Risk Register (**Appendix 4**) was created by the Corporate Risk Manager to ensure risk is considered in all areas such as financial, regulatory, reputational and resource as the Inquiry moves on. Insurance details have been located and consideration is being given to any actions which will be required should there be any claims from survivors.

The legal representative on the Working Group considers the actions and progress and will monitor any requests for records and advise the Council as required. The Corporate Communications representative on the working group will create a Communications Strategy which will look at areas such as press releases, Website information and how the Council will approach negative news generated by the Inquiry.

**Responding to the Inquiry Team**

The Inquiry Team has listed Kenmure St Mary's School as one of the institutions it is investigating. Although this unit currently provides a secure residential facility for young people, the Inquiry Team identified it is investigating the unit when it was operated as a Boy's School by the De La Salle Brothers. The facility is within the boundaries of East Dunbartonshire Council, and the Inquiry Team have requested the Council to identify any records they held or hold. Prior to the inception of the Care Commission, now the Care Inspectorate, in 2001, the unit would have been inspected by the then East Dunbartonshire Quality Assurance Team. The Archdiocese of Glasgow hold the files of all children who resided within the home and the Care Commission confirm that they hold inspection information. East Dunbartonshire Council Central Records Store has no inspection records prior to 2001. The Council does however hold all residential records for the neighbouring Kenmure Cottages unit which was managed by the local authority during the 1990s.

The first 18 months:

# What we have heard so far

National Confidential Forum
A chance to be heard

*"People need to know what happened to us..."*

# Glossary

In this document:

We refer to the National Confidential Forum as **'the Forum.'**

When people come to speak to us, they attend a **'Hearing.'**

The account people give of their experience is a '**Testimony**.'

When we refer to **'Forum Members,'** they are the experienced listeners who hear the Testimony.

Some people may find the content in this booklet distressing. If you are affected by any of the issues raised, please call us on **0800 121 4773,** our website also has information to help **www.nationalconfidentialforum.org**

# Welcome

**What follows is an account of the experiences of children who have been looked after away from home in a variety of institutions, for a variety of reasons, for a variety of length of time: children whose care was Scotland's responsibility regardless if it was one night, several weeks, months or years.**

The National Confidential Forum has been given the privileged task of hearing about those experiences; remembering, acknowledging and learning.

From our first hearing on 19 February 2015 until 31 July 2016, we have heard 78 adults talking about their experience of 117 institutions in Scotland. Twice as many men as women have spoken; participants have come from all parts of Scotland, the rest of the UK and overseas. So far, those who have spoken to us have predominantly been aged over 50, and therefore this account reflects a period of care from the second half of the twentieth century. However, some were in care as recently as five years ago; others are sharing experiences from eighty years ago.

This account captures a period of Scotland's care history that spans seventy-five years, and it is based solely on what people wanted to share. They were not questioned or probed, nor asked for more than they were willing to give. This account is not definitive, nor does it have all the answers. It is powerfully illustrative with no analysis. Yet it is important to begin to share what people are telling us. While those who speak to the Forum remain anonymous, their histories will be remembered.

By taking part, each person is helping to create a national record that will also provide a basis for learning. Most of the former care residents have told us that they have spoken to the Forum to ensure that what happened to them does not happen to other children. Whether this is about vulnerability to maltreatment, lost records or photographs, or dislocation from Scottish identity and personal histories, we honour those who share their experiences by learning all we can from them.

Most people described experiences in residential homes or schools, but we have also heard about hospitals, boarding schools, school hostels and secure facilities. Fifty-nine people described experiences of abuse, and the Forum passed on 38 incidents of abuse to Police Scotland.

Gathering testimonies is an ongoing process, and we encourage all who have experienced childcare in Scotland to add their voice. Our hope is that more adults of all ages feel able to come forward in the coming months because Scotland is listening.

**Dr Rachel Happer,**
Head of National Confidential Forum
December, 2016

*"I realised that I was never going to go home again – no one had ever explained to me..."*

# What we have heard so far

*The following outlines experiences of living and studying while in institutional care in Scotland and then describes adult life after leaving care. The reasons for any child staying in an institution are many and varied, from those deemed to be at serious risk due to home circumstances, to receiving hospital treatment or leaving remote rural areas to access secondary education.*

# Before **care**

Of those who gave testimony, nine people either did not talk about or did not know the reason for being taken into care. A further eight described boarding school or hostel accommodation for schooling at a distance as a decision made within a loving family context.

*"The first thing I remember about care was fear"*

*"Mother did not have a loving bone in her body... she was very violent..."*

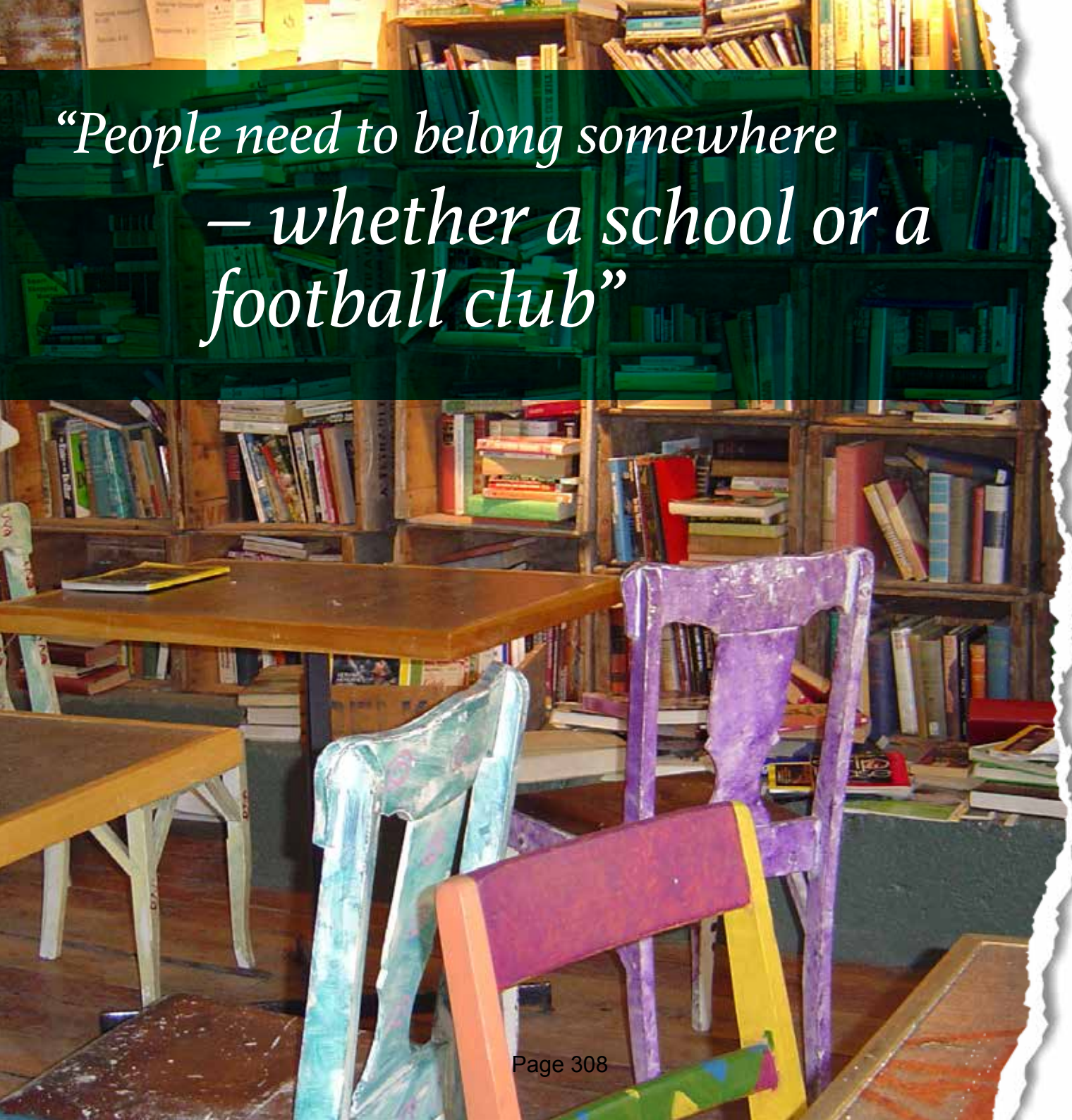
For most, however, common causes for being removed from the family home became clear. We heard about physical and sexual abuse within the family from half the people who have spoken to us, often accompanied by parental alcoholism, parental rejection, or neglect. Parental mental illness was described in several testimonies. Fathers being sent to prison, divorce and maternal death were other reasons given for being taken into care.

In several cases, we heard of children bouncing between parents, foster and residential care placements. About a third of the people who spoke to us did not know how long they would be staying in an institution, why they were there, or whether or not parents wanted to maintain contact. This confusion continued into the care experience. Those who experienced multiple care settings often described short placements suddenly terminated and with little or no involvement in the decision-making. However, one individual described being asked about his preference for a full-time residential setting, reporting this as a positive experience that helped him not to rebel.

*"I was taken away too quickly... Mum and dad did not take drugs, it was a stable family... they took away the only thing that mattered"*

What has been impressed upon the Forum members is the distress, fear and confusion that children and young people coming into care frequently experienced.

*"Children in care are the most vulnerable; they are placed in care to be protected"*


"People need to belong somewhere
— whether a school or a football club"

# During **care**

Descriptions of care varied from single institutional experiences to multiple care settings. Institutions were usually children's homes or residential schools.

### *When care goes well*

Amidst the accounts of abuse and emotional neglect, a small number of people have come forward to talk about positive care experiences. These people have spoken about the care and attention that some members of staff gave them. They spoke of the importance of home-cooked meals, Christmas presents and the value of having adults celebrate their accomplishments. For these people, institutional care saved them from sometimes intolerable home circumstances. They described feeling cared for, safe, and part of a community or surrogate family.

*"How can you expect a child to grow without the basics?"*

In several hearings reference was made to the positive influence of an adult in the absence of a loving family. These individuals included teachers, matrons, nurses and care staff and were clearly valued. Nurturing actions such as listening to and talking with a child, gifting a keepsake or showing interest in a child's potential were described. For many, this was sufficient to show that they were good and had a future worth striving towards.

*"He was a father figure... he stood out... if it wasn't for him I'd be in jail"*

For a minority, their care experiences were a respite from neglectful and abusive parenting, and demonstrate that substitute parenting offered by the state can be successful. Simple practices by properly trained and screened staff of providing love and affection, closeness, and a confiding relationship without fear about what will be expected in return, can dramatically improve the chances of children to achieve their potential. Regular contact with family members can help maintain a sense of connection and build a sense of identity.

# During **care**

*"If you did not eat what was on your plate it would be mixed in with your next meal until everything was eaten..."*

*"[Staff] did not show any love – it was almost a pride of having that power"*

*"... I had my nationality and my country stolen from me..."*

### *Physical and emotional needs*

The testimonies we heard distinguish between physical and emotional needs being met. In comparison to the family home where there might have been extreme poverty or neglect, physical needs such as food, clothing and cleanliness were generally met. However, sometimes food was used to control behaviour such that children could not take access to food for granted.

Emotional needs were less frequently considered, and in many institutions we heard that there appeared to be little recognition of the need for children to feel loved or valued. Instead, people spoke of the importance of institutions valuing treasured objects such as teddies and protecting these for children and young people. Again, however, pocket money, sweet treats and gifts were frequently withheld. Adults described themselves as children, being unhappy much of the time.

### *Identity*

We heard when placements were outside Scotland, some children found the loss of identity from their birth family along with the change in culture and/or religion very distressing. The sense of a lost history was present in many testimonies.

### *Going to school*

A number of people spoke about their experience of education during their time in care, sometimes as a welcome break from their placement.

The school community had the potential to provide security and opportunities, but many spoke of considerable instability, such as attending twelve different primary schools. Others talked about education not being a priority in placement decisions even when they showed natural talent.

*"My happiest hours were at school"*

We heard that the effects of disrupted schooling were not always recognised, with children in care described as 'slow learners'. Specific learning difficulties such as dyslexia were not recognised, and people described being punished rather than supported.

*"You can't learn when you live in fear"*

The disruption caused by changing schools and difficulties in engaging with education and learning meant missed opportunities to sustain meaningful relationships with teachers. It also prevented the making and developing of hobbies and bonds with friends that can protect children and young people from mental health problems, build self-esteem and develop identity.

*"I was subject to regular physical abuse and intimidated by a small group of boys and lived in constant fear of random unwarranted attack"*

### *Life in school hostels*

A small number of people have come forward to describe life on the Scottish islands before coming to live in hostels in order to attend secondary school on the mainland. These accounts described the aspirations of parents for their children to have a better life through education. We have heard about loved children missing their families, having religion imposed upon them as a means of filling spare time, and being bullied. However, we also heard about strong friendships, compassionate matrons, and weekend treats.

*"Nobody was deliberately cruel but... I recall the strict discipline and the general bleakness of our lives"*

# During **care**

*"It was a systematic torture chamber... a systematic abuse... a way of life all the time, morning and night"*

*"I thought I was going to go mad, in a way I think I did... I remember feeling utterly broken"*

### *Institutional abuse*

Physical, sexual and emotional abuse was typically described as happening frequently. For some, abuse was part of a regime of punishment and control that was at the core of the institution in which they lived. We have heard about individual abusers perpetrating systematic and hidden abuse or of whole staff teams abusing or colluding with abuse. People wanted to make sense of the abuse and reflected that untrained care staff were introduced to, and became part of, a culture of bullying and abuse in some institutions.

Testimonies described dehumanising and cruel treatment that people felt were designed to humiliate and degrade them. Examples included children being forced to carry soiled linen, having their hair cut off and of visits being cancelled at the last minute.

*"I was always getting it from the nuns... hit with anything... table leg... the pain never goes away"*

### *Physical abuse*

Physical abuse was common in former care residents' descriptions and presented as either extreme but routine forms of punishment such as beating, force-feeding or withholding food or sleep. It was sometimes described as casual violence apparently delivered for enjoyment. Sometimes this appears to have been part of a culture of bullying by staff. The unpredictability of such violence made it difficult to avoid.

*"I could be shaking in fear. Living under such stress resulted in my bedwetting getting worse"*

### *Bedwetting*

We heard of experiences, within specific institutions, marked by physical maltreatment, bullying, and fear of adults. Punishments were often severe, particularly in the case of the institutional response to bedwetting, a common childhood issue.

We heard of children being forced to sit in a cold bath as punishment for bedwetting, beaten by staff with wet towels, having had their head wrapped in a towel and held under running water, and in some circumstances had to parade around naked with their soiled sheets.

### *Sexual abuse*

Sexual abuse was talked about by several people and often linked to specific members of staff within institutions. A veil of secrecy was described in which other children were similarly victimised, witnessed or knew what was happening, but did not speak up.

We heard that sometimes the only available love and affection were for the purposes of grooming children for sexual abuse. In abusive institutions, people described accepting affection from an adult making them vulnerable to being sexually abused. Those who rejected affection for fear of the consequences described missing out on any chance of love and nurturing.

*"She'd fill a bath with cold water and throw you in it, with the towel wrapped around your head, which I think is called water-boarding...and then pour buckets of water over your head"*

*"When I was about eight, a male member of staff kissed me, it was not just a smack on the lips"*

*"They took me into the night duty room and wanted me to do things... they gave me cigarettes to keep it quiet"*

# During **care**

*"... and they have named a street after this man, I feel so angry I could rip the sign down"*

*"I could tell no one because he had power... can't say nothing. If you say something, you will be in trouble and they will send you to bed"*

*"There was an absolute culture of 'don't tell'... I can easily see how the climate of secrecy and intimidation would have been the perfect environment for abuse"*

### *Hiding the truth*

Most of the experiences the Forum Members heard about were inflicted by those who should have cared for and protected children, some of whom held considerable power and respect within the community. People described being silenced. Either they were too fearful as children of speaking out, or the abuse regime represented normality for them – people described not knowing that adults should not be allowed to behave in abusive ways.

When individuals as children did report the abuse, in the main they rarely recollected any action being taken, but at least one person recalled the abuser being removed. We heard that other responses included the abused child being punished or moved to another institution. This contributed to the child's self-blame and sense of shame. Many people have told us that adults' views and accounts were always believed over children's, and that this reflected a perception of children in care as 'deviant'.

In several of the testimonies, bullying by staff or peers was widespread, reflecting a culture of violence and cruelty. Emotional neglect was described in terms of an absence of caring adults. The threat of physical or sexual abuse was used to control the children psychologically. In several testimonies, it was apparent that constant exposure to others' distress, frightening adults, abuse and bullying severely affected development.

### *Contact with family*

Relationships with parents and/or siblings were critical to many of the people we have heard from, but were frequently overlooked or actively prevented by institutions.

*"The bond that we had before I went in, I could never get back. I regret that so much"*

### *Separating siblings*

Several people talked about the relationship with their brothers and sisters. Whilst a minority described being kept with siblings, and the value of this, several more talked of being separated. This was either because sibling groups were split between institutions, or because brothers and sisters were left in the family home. In some cases, children had not known that their siblings existed until much later, even when they had been placed in the same institution. Some family members were the only one of a group of siblings to go into care, and recounted the negative impact on their self-belief and self-worth.

*"As a little child you try to protect your sibling"*

### *Contact with parents*

Some described unwillingly returning home to abusive and/or neglectful circumstances for holidays or longer periods. In these cases there seems to have been repeated attempts by social services to reunite the family against the wishes of the child. These people talked about being frightened of abusive parents and step-parents or feeling rejected by apparently uninterested parents.

*"Obviously I was pining for my mother all the time"*

# After leaving **care**

Some children in care may have moved away from their home communities or faced the challenge of returning home or moving into the community.

We heard about the experience of people who left care for independent adult life, usually between the ages of 14 and 16 years. A common theme was how ill-prepared young people felt on leaving care. This was reflected in descriptions of their circumstances after leaving care, which included homelessness, crime and substance use problems.

Many talked about not having the social skills to manage and having nobody to turn to for support and help. In some cases, social services were described as reluctant to provide support – financial or otherwise. The absence of a loving family and the support that should have been taken for granted were particularly apparent in these accounts.

Some talked about being institutionalised and not having even basic skills for managing adult life – from managing a budget, running a house, cooking, to dealing with official bodies.

***Homelessness***

Some described being deposited at homeless hostels on leaving care. Well into adulthood, homelessness continued to be a risk for many, leading to loss of precious belongings, substance misuse and unemployment. From the testimonies we have heard, the experience of homelessness further added to feelings of exclusion, stigma and shame.

*[On leaving care] "Nothing made sense out there"*

*"It was as if they never wanted us to have a chance at a better life"*

*"Being booted out… nowhere to go… having to go to the homeless unit"*

# After leaving **care**

*"If someone can write and read it helps them throughout life. I do get embarrassed when I have to write things and helping the children with homework"*

### *Literacy and education*

On leaving care the lack of consistent formal education was felt; for some, the quality had been poor, for others, education was disrupted. Literacy problems made it more difficult to fill in forms required for statutory support. Job opportunities and further education were blocked by lack of educational qualifications. Some described shame and embarrassment at their lack of literacy, but others have gone on to pursue further education and professional training, often with no support from others. The availability of free further education and educational grants was critical to allowing some young adults to create a career and stability in their lives.

Former residents highlighted education as an aspect of childhood that should always be prioritised, as something that can help children to fulfil their potential no matter what their personal circumstances are, and which can make more life opportunities available.

*"They always used to say 'you're leaving here for prison' and I thought 'how do they know that, and if you know it why not do something different?' "*

### *Crime*

Years of exposure to violence and hardship added to these challenges and increased the risk of getting involved in crime – some people have provided testimony to the Forum from prison. A fifth of people who spoke to us described being involved in some kind of criminal activity, often when first leaving care and finding themselves without financial resources or family to rely upon. We also heard reports of adults becoming victims of crime after leaving care, experiencing rape, sexual assault or being exploited and forced into prostitution. Some described their own violent and aggressive behaviour; and the distress at fearing they had become

the adults that ruined their childhoods. Previous experiences of the police, who were often responsible for returning runaway children to institutions, meant that people were reluctant to report crime or seek support. Some spoke of crime as a vehicle to return to institutional life, because surviving day-to-day life was too hard.

### *Relationships and family life*

Several spoke about feeling that their social skills had been badly affected by their experience of being abused, bullied and stigmatised. This led to anxiety in social situations, difficulties building and keeping relationships, and feeling vulnerable. Intimacy and trust have been very difficult to achieve for some – people have described not knowing how adult relationships work or having to get used to being isolated.

However, many have gone on to have families of their own. They have spoken of their fear of passing their own experiences on to their children, and making great efforts to compensate for their own experiences. Some described long-term relationships with partners, children and grandchildren and of the healing effects of a loving relationship. Some described the opportunity to re-connect with siblings and other family members. This was talked about positively in terms of re-discovering birth family, but pain was also expressed in relation to all that had been lost in the interim. We heard about the discovery in adulthood of lies that had been told to children and their families by institutions to prevent ongoing contact. In adulthood, people spoke of discovering the existence of siblings or of reading that family had made contact. Many voiced a profound sadness

*"I didn't have choices or anyone I could turn to. I couldn't call up parents, family, and friends and say 'could you just help me out?' "*

*"If a child in care gets close to someone, try to keep that friendship going"*

*"I still feel guilty over the effect this has had on my children and their lives as they were growing up and believe that everything that happened was my fault"*

# After leaving **care**

at the loss of relationships and family, with many unable to re-establish connections in later life. Others spoke of families fractured by divorce or estrangement, and of children or grandchildren being taken into care. People referred to their own lack of childhood giving them little sense of how to function within a loving relationship.

*"... nowhere to go to, nobody to turn to, just me... I was desperate, I was hopeless, I was helpless, and I thought there was nothing for me"*

*"Even now I feel imprisoned by circumstance, by situation, by poverty, by lack of funds, lack of supports... and I am at this crossroad. I think this all relates back to childhood"*

### *Mental health issues*

Mental health problems were mentioned in nearly half the testimonies. This included experiences such as flashbacks, panic attacks and nightmares. Recurring depression and suicidality were common, including suicidal attempts whilst in care and subsequently. Some described receiving diagnoses of psychosis, personality disorders and bipolar affective disorders linked to childhood experiences. Two-thirds of those experiencing problems described having received input from mental health or community-based services at some point. GPs were often a regular support; however, follow up specialist care at times was mixed. Some described mental health problems as an additional obstacle in getting the support they needed from local authorities, and feeling shame and stigma. The need for authorities to respond sensitively to those with mental health problems was highlighted by some.

A minority described problems with alcohol and drugs, often in relation to mental health problems. Alcohol was described as a way of coping that got out of hand for some.

### *Disabilities*

We heard about developmental disorders such as autism that were not correctly diagnosed until adulthood. Such testimonies were filled with regret for the understanding and support that had been missing during childhood. For those with a disability, we heard that families could have avoided being split up if proper support had been available to parents and schools.

### *Lifelong impact*

Many spoke of the lifelong impact of their experiences on every aspect of life, of constantly living in fear, the loss of potential, and of not being listened to or believed.

The testimonies highlighted the need for robust, well-resourced and long-term through-care and after-care that recollect experiences before and during care. Those who have received counselling or therapy for their childhood experiences spoke of how important the ongoing availability of such support was to them. It was apparent that those who are on a therapeutic journey expected recovery to be a long-term goal, and for recovery to mean being believed and finding a way to survive their adulthood, rather than making everything better.

The Forum was regarded by some as part of a journey of recovery, in which proper acknowledgement on behalf of the state and the public, and the documenting of childhood experiences could contribute to a healing process. For others, contributing to the Forum was part of a process of seeking justice.

*"You live in fear all the time... to put it in a nutshell, it affected self-confidence, my inner strength"*

*"You need to follow [the child's] future... this will haunt them... they will need time, support, guidance... be prepared to help them for many years"*

# After leaving **care**

*"Lost faith... lost trust... I bottled things up and became a one-man band"*

*"... my brother and I think we should have photographs..."*

*"... hated the way they described me in files..."*

### *Seeking justice*

We repeatedly heard about the need for justice, and that justice takes different forms. Some individuals described previously reporting their experiences to the police. This has, in some cases, contributed to prosecutions. However, in other cases, people did not have sufficient details about names and dates, felt they were not taken seriously, or alleged perpetrators had died before a prosecution could be pursued.

Many described the widespread loss of records by institutions as deleting their own history as well as concealing evidence of their experiences. Many described the experience of accessing records and finding them incomplete. The experience of reading records was accompanied by many emotions; anger at how they or their family were portrayed, confusion at not being able to see themselves in what was written, or sadness at the level of negative descriptions of failure. Few spoke of any understanding given in notes around what may be going on for them that may explain their behaviour. Many were searching their records for knowledge of lost family members and expressed grief at the information not being there.

Some have felt unable thus far to take their experiences to the police or other inquiries due to their fear of being disbelieved. Echoes of being ignored and denied in childhood were apparent in these testimonies. The testimonies reflect the power of institutions to act, and the relative lack of power of individual children and adults to challenge institutions or achieve proper acknowledgement of the abuses they felt were perpetrated upon them.

### *Living on the margins of society*

Individuals have described the lack of records (including photos), contact with birth family or acknowledgement by institutions and the impact this has had on their sense of identity. Reflecting back on childhood, the sense of loss in people's testimonies stands out. People have often become upset during the hearing when recalling a lost childhood. In particular, we have heard people grieve for the opportunity to be loved, to play, to live without fear and to fulfil their full potential.

Many described feeling isolated as adults, either because of difficulties building relationships or because it was so hard for others to hear and understand their experiences. Some had carried a sense of stigma and exclusion over from their childhoods, and found that poor education, difficulties in employment, homelessness, low self-esteem and confidence, and lack of family all compounded their experience.

### *Successful outcomes*

Some spoke about achieving success in adult life and the pride they felt at their accomplishments. The 'survivor' label feels particularly important for some, whilst for others they identified small tokens in their childhood that helped them to embrace their potential as adults, such as friendships, positive attention from an adult, or schooling. Some have actively pursued social justice agendas or caring professions in their adulthood, informed by their own experiences – good or bad.

# **Reflections** on what we have heard so far

For all children, early experiences play a significant role in shaping their lives and building their future life chances. Self-confidence and self-esteem, the ability to manage relationships, trust others and build life skills are all rooted in the care and protection that surrounds children from birth. A strong early start guides a sense of self and identity, who you are as a person, that builds resilience for coping with distressing events.

The testimonies we have heard paint a picture of childcare that in some ways might seem alien now. Many of the testimonies describe family, school and institutional life in post-war austerity and the early days of the welfare state.

The abuse that took place in institutions was unequivocally wrong even at the time and cannot be excused by assumptions of 'that's just how it was back then'. The experience of care has often led to lifelong adversity. Some of the consequences of institutional failure are not as obvious as homelessness or unemployment, but are carried as a psychological burden by those who have spoken to the Forum.

Of those who have spoken to the Forum, a large number have described abuse inflicted by those who should have cared for and protected children. Repeated incidents by the same or different adults at varying institutions would have left children with a deep sense of fear

# **Reflections** on what we have heard so far

and mistrust. When the source of fear and harm is also the place that children reach to for comfort and protection, they may engage in a variety of understandable strategies to cope. We have heard about denial, shutting off, and self-blame, which all serve to protect the care-giving relationship that is essential to children. We have heard of the lifelong impact of these experiences and coping strategies in those who describe adulthoods marked by low mood, dissociation, self-harm, suicide and violence. There are costs to dissociation and internalising shame and guilt; costs many adults with these care experiences are carrying to this day.

When the response to disclosure is punishment, disbelief, or moving the child, this can have a further damaging effect. The failure of institutions and responsible adults to make abuse stop can have a profound effect on an individual's beliefs about deserving such treatment. When witnesses are other children, the abuse provides a way of maintaining control and silencing the voices of others through fear of being subjected to the same treatment. Living in an atmosphere of fear and humiliation, of constant threat, makes it hard for any child to focus on anything but survival. Education, enjoyment and a child's belief in its own value will be threatened.

Making abusive practices part of the way things are done can disempower children and young people, making it even more difficult to challenge such practices or believe change is possible. Some have described experiences that, up until now, they considered unspeakable. For some, speaking to the Forum is the first time they have been heard. Giving testimony and being taken seriously have the potential to break a long-held silence, protect others and challenge the hold over people, long after abuse or mistreatment has seemingly ended.

It is essential that we build and maintain services that understand the experiences of people who have lived through abuse and trauma in care, and properly recognise the lifelong impact.

Care settings should be properly resourced to provide a nurturing environment in which children and young people can recover and thrive. Caring for children and young people who have been separated from their families, often repeatedly displaced, and who may have experienced significant trauma before entering care, requires staff with specialist skills. Well-trained, supported and screened staff can experience and manage emotions, support positive, long-lasting relationships, and provide safe contexts for disclosure.

The absence of records is felt deeply by many who have spoken. The Forum has a pivotal role in documenting children's experiences in residential care in Scotland. In doing so, it creates a national record for Scotland that forms a public acknowledgement of experience and ongoing consequences. It is essential that individuals with these experiences have the opportunity for acknowledgement, accountability and appropriate, tailored support. However, we also need to keep in mind the importance of maintaining the progress made, creating care environments where future vulnerabilities to exploitation are tackled, and continually strive to support children and young people who are looked after away from home to reach the same potential, despite the unique circumstances that shape their lives. The care and support that surround young people on leaving care and beyond are pivotal to them continuing to strive and achieve.

# **Learning** from good practice

We can determine from testimonies that there are things that people who worked in residential care did get right. For a minority, institutional care was a respite from neglectful and abusive parenting and shows that substitute parenting can be successful. A child's potential can be dramatically improved through some apparently simple practices carried out by properly trained and screened staff. These include providing love and affection, closeness, and a confiding relationship within safe boundaries. Without doubt, regular safe contact with family members could help maintain a sense of connection and build a sense of identity.

# **Be heard,** make a difference

We invite all people who have experienced residential care in Scotland to think about giving their testimony to the Forum.

You can take part if you spent time as a child in an institution providing a care or health service in Scotland.

**Visit www.nationalconfidentialforum.org.uk or call 0800 121 4773**

# If you would like to **come to the Forum** you might like to know...

Each person who came forward has been helped to take control of the process and made to feel as safe and comfortable as possible. An individual member of staff was assigned to provide consistent and familiar support through the process from beginning to end. This process varied from 3 weeks to 18 months.

The first step in taking part was the completion of a form available on the Forum's website **(www.nationalconfidentialforum.org)**. Once received, support staff made sure each person was fully aware of the Forum's purpose and understood the process. It was entirely each person's decision if he or she wanted to give a testimony at a hearing to be held at a convenient time in the morning or afternoon during weekdays.

Special measures were put in place to remove any barriers to participation, both in terms of emotional needs and on a practical level. For example, overnight hotel accommodation and its costs were provided for those people travelling long distances. For those unfamiliar with Glasgow, support staff were able to arrange transport to reduce the stress of finding the venue. All of this was established by several telephone conversations, the pace and frequency of which were guided by each person.

People were encouraged to bring one or two supporters to the hearing. Support staff made people aware that they could provide testimony by being recorded at the hearing or in a written submission. In the Forum's experience, recording the testimony ensures Forum Members can focus on listening and capture all that is said.

The act of retelling childhood experiences – both positive and negative – can evoke strong emotions. Everyone who took part could stop the process at any stage – they were always in control.

*Some people identified areas where they were struggling with the long-term impact of their care experience. After the hearing, support staff signposted people to organisations, where possible, such as counselling, trauma support services, survivor support services and advocacy.*

# What we have learned and **improvements** to processes

Gathering testimonies is an ongoing process, and the support staff at the Forum are keen to make improvements to procedures as we go along. Specific improvements to date include changes before, during and after giving testimony.

# More **support** after giving testimony

***The situation***

The relationship between the Forum and participants would usually end immediately after the hearing. While the Forum's support staff would signpost information and give details of the Advice and Guidance Helpline, no proactive contact was made with those who had given testimony.

***What we learned***

In general, most who had spoken were relieved and feeling positive immediately after giving their testimony. Support staff would always advise that the feeling may not last and that they may experience more negative emotions further down the line. We encouraged calls, but the numbers were so low as to cause concern. So, we looked at how we could provide more support after the hearing process.

***Improvements***

We introduced follow-up calls; the first call is made two days after giving testimony when feelings are often most heightened. A further follow-up call takes place two weeks later, if necessary.

***Outcome***

According to feedback, the follow-up calls are welcome and effective, giving an opportunity to talk about any issues or concerns. The follow-up calls work well to complement the services provided by the Advice and Guidance Helpline.

# Informed **choice**

***The situation***

Applications were being taken over the phone, at the first point of contact.

***What we learned***

We needed to give people sufficient information about the Forum to allow them to decide if they wanted to give their testimony. This would not necessarily be possible over the phone, particularly if they needed to refer to information that was not easily to hand.

***Improvements***

We no longer take applications at first point of contact. After an initial discussion, we send the information booklet through the post or by email and encourage the completion of the application form in their own time. We will take applications over the phone after this point.

***Outcome***

We can be sure that people have the information they might need to hand, which the support staff can also refer to this during the process.

# Greater **flexibility**

***The situation***

When the Forum started to hear testimonies, the processes and protocols were based on set timeframes. For example, hearings would always be scheduled for two-weeks from receiving a formal application.

***What we learned***

Giving testimony is extremely personal, and many of those involved are vulnerable or may be engaged in other processes, such as other investigations, searching for records or therapeutic treatments. Some people, therefore, need longer between application and participation to have a safe experience, which they feel able to manage.

***Improvements***

Support staff pace the process to each person's needs: individuals can take as long as they need before we schedule a hearing. Support staff also share observations and learning of how it has been for others; the possible impact and how this may affect other areas of their life, particularly if they are dealing with other difficult situations.

***Outcome***

Generally, there are longer periods between the point of application and attendance at a hearing. Those who give testimony are more prepared. The reassurance and sharing of information by support staff helps to build a positive relationship.

In some cases, the Forum has struggled to find appropriate services and identified a need for more extensive support services to navigate the many challenges they face in adult life.

*The Forum continues to listen, learn and review all aspects of our work and to make improvements aimed at providing the best possible outcomes for everybody giving testimony.*

# Contact

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## REPORT REQUEST TEMPLATE

### GUIDANCE FOR COMPLETION

1. The purpose of the report request template is to enable the Inquiry to obtain information about organisations and establishments in the form of a report. The terms "organisation" and "establishment" are defined below. Please do not use the terms "organisation" and "establishment" interchangeably in the report.

2. Some organisations may have operated more than one establishment. If your organisation operated numerous establishments, you may have been asked to provide reports on certain named establishments. Please provide separate reports for each such named establishment.

3. The Inquiry recognises that certain organisations have already supplied information to the Inquiry in response to previous requests. Such information should be provided again as part of the report.

4. The Inquiry also recognises that there is a degree of duplication within the list of questions. This is intended to ensure that no issues are overlooked by virtue of appearing under a heading which the organisation considers not to be applicable, and will help the Inquiry to collate and analyse information more efficiently. Questions should be answered each time, but answers may refer back to previous answers where appropriate.

5. The period to be covered in the report should commence in 1930.

6. In the report, please use the headings and question numbering as per the report request template. Each question should be answered separately. If appropriate, please answer "not applicable" or "not known", with a brief explanation of why this is the case.

7. The questions are subdivided into "past" and "present". The terms "past" and "present" are defined below. In relation to "past", please break the answer down into appropriate periods of time, on a chronological basis, where relevant.

8. In relation to questions which refer to, for example, national or local authority policies, please answer on the basis of organisational knowledge. We do not expect such questions to be answered "not applicable".

9. The parts of the report covering Part A and Part B of the report request template should be provided within three (3) months. The full report covering all parts should be provided within a further three (3) months thereafter. Please refer to the deadlines provided in the accompanying section 21 notice.

10. The questions in Part D of the report request template should be answered in respect of abuse or alleged abuse relating to the time frame 1930 to 17 December 2014 only.

11. Please do not supply any supporting documentation at this stage. The Inquiry may request documentation in due course, either before the expiry of the period within which the report(s) are to be provided, or thereafter.

12. When providing the parts of the report covering Part A and Part B of the report request template, please advise the Inquiry which witness(es) would be best placed to speak those parts. When providing the full report, please advise the Inquiry which witness(es) would be best placed to speak to all parts of the report.

Definitions:

| | |
|---|---|
| Abuse | Primarily physical abuse and sexual abuse, with associated psychological and emotional abuse. The Inquiry will be entitled to consider other forms of abuse at its discretion, including medical experimentation, spiritual abuse, unacceptable practices (such as deprivation of contact with siblings) and neglect, but these matters do not require to be examined individually or in isolation. |
| Abuser | A person who has been convicted of, or who has admitted, abuse of a child in care within the definition contained in the Inquiry's Terms of Reference. |
| Child | A person under the age of 18. |
| Child migrants | Children who were in the care of an organisation in Scotland and who were sent abroad by that organisation and placed in family homes or institutions in the receiving countries. |
| Organisation | A provider of one or more establishment(s) in Scotland, including local authorities and their predecessors. |
| Establishment | An establishment providing residential child care for children. |
| External investigation | Investigation conducted by persons outwith the organisation, for example by a local authority, police or regulator. |
| Internal investigation | Investigation conducted by persons within the organisation or establishment. |
| Inquiry | The Scottish Child Abuse Inquiry. |
| Policy or procedure | Includes both documented and unwritten policies or procedures. |

| | |
|---|---|
| Past | 1930 to 17 December 2014. |
| Present | 18 December 2014 to the date of return of the report(s). |

Scottish Child Abuse Inquiry
PO Box 24085; Edinburgh EH7 9EA
e-mail: [redacted]

25 January 2017

To:

1. Notice is given, in terms of section 21(2)(a) of the Inquiries Act 2005 ("the Act"), that you are required by Rt Hon Lady Smith ("the Chair") to provide at the above address the evidence detailed in the appendix attached to this notice by the following dates:

   - Parts A and B – 28th April 2017
   - Parts C and D –28th July 2017

2. In terms of section 36 of the Act, where a person fails to comply with, or acts in breach of, this notice, or threatens to do so, the Chair may certify the matter to the Court of Session. The Court, after hearing any evidence or representations, may make such order by way of enforcement or otherwise as it could make if the matter had arisen in proceedings before it.

3. In terms of section 35(1) of the Act, a person is guilty of an offence if he fails without reasonable excuse to do anything that he is required to do by a notice under section 21 of the Act. A person who is guilty of such an offence is liable on summary conviction to a fine not exceeding £1000 or to imprisonment for a term not exceeding six months, or to both.

4. If you wish to make a claim in terms of section 21(4) of the Act:
   (a) that you are unable to comply with this notice, or
   (b) that it is not reasonable in all the circumstances to require you to comply with it,
   and that it should be revoked or varied,

you should apply in writing to the Chair no later than by the end of the period within which production is required. When so applying you should:

(a) identify, so far as possible, any particular document in relation to which the claim is being made;

(b) state whether you seek revocation or variation of the notice, and in the latter case specify the variation sought;

(c) give reasons for your claim; and

(d) where it is claimed that it is not reasonable in all the circumstances to require compliance with the notice, the reasons for the claim should address the public interest in section 21(5) of the Act.

.....

The Rt Hon Lady Smith
Chair of the Inquiry

APPENDIX

**Part A – Background**

1. Characteristics

1.1 History of the Organisation and Establishment

Past

i. When, how and why was the organisation founded?
ii. What part did the provision in Scotland of residential care (including foster care) for children play in the organisation's purpose, operation and activities?
iii. When and how did the organisation become involved in the provision of residential care (including foster care) for children in Scotland?
iv. Why did the organisation consider that it had the competence to be responsible for, and manage the care of, children in establishments?
v. How many establishments did the organisation run, where were they located, over what period were they in operation, and what were their names?
vi. When, how and why was each of these establishments founded?
vii. In the case of any establishment which is no longer in operation, when and why did it cease operating?
viii. If the organisation itself is no longer involved in the provision of residential care for children in Scotland, when and why did it cease to be so involved?
ix. If the organisation was founded as a religious order by members of a particular faith or church, what was the precise relationship between the order and the religious hierarchy within that faith or church?
x. Within the faith or church to which the religious order belonged, what degree of autonomy was enjoyed by the order in relation to the provision of residential care for children in Scotland?
xi. In the case of establishments that were run by members of a religious order, what degree of autonomy within the order itself was enjoyed by such members?

Present

xii. With reference to the present position, are the answers to any of the above questions different?
xiii. If so, please give details.

1.2 Funding of Establishment

Past

i. How were the establishment's operations and activities, so far as relating to the provision of residential care for children, funded?
ii. Was the funding adequate to properly care for the children?

iii. If not, why not?
iv. What state support did it receive?

Present

v. If the establishment continues to provide residential care for children, how is that funded?
vi. What state support does it receive?

1.3 Legal Status

(a) Organisation

Past

i. What was the legal status of the organisation since it was founded?
ii. Were there any changes in the legal status of the organisation since it was founded?
iii. What, if any, material changes were there to the legal status of the organisation?
iv. What was the legal basis which authorised or enabled the organisation to become responsible for the provision of residential care (including foster care) for children in Scotland?
v. Did that legal basis require the organisation to meet, or fulfil, any legal and/or regulatory requirements in respect of children in its care? If so, please give details.
vi. Did the organisation have a legal duty of care to each child in its care?

Present

vii. With reference to the present position, are the answers to any of the above questions different?
viii. If so, please give details.
ix. If the organisation is a Scottish local authority, please provide details of the predecessor authorities for the local authority area for which the authority is now responsible, and the time periods during which these authorities were the responsible authority for the area, or any part thereof.

(b) Establishment

Past

i. Did the establishment have a special legal, statutory or other status?
ii. If not, how was the establishment described?
iii. What was the legal basis which authorised, or enabled, the establishment to become responsible for managing the care of children in a residential setting?
iv. Did that legal basis require the establishment, or its management, to meet, or fulfil, any legal and/or regulatory requirements in respect of children in its care? If so, please give details.

v. Did the establishment have a legal duty of care to each child in its care?

Present

vi. With reference to the present position, are the answers to any of the above questions different?
vii. If so, please give details.

1.4 Legal Responsibility

(a) Organisation

Past

i. Did the organisation have any legal responsibility for the children in its care?
ii. If so, what was the nature and extent of that legal responsibility?
iii. Did any other person or organisation have any legal responsibility for the children while they were in the organisation's care?
iv. If so, what was the nature and extent of that responsibility?
v. If the organisation had no legal responsibility for children in its care, where or with whom did legal responsibility lie?

Present

vi. With reference to the present position, are the answers to any of the above questions different?
vii. If so, please give details.

(b) Establishment

Past

i. Did the establishment, or those in charge of the establishment, have any separate legal responsibility (separate from the organisation) for children in its care?
ii. If so, what was the nature of that responsibility?

Present

iii. With reference to the present position, are the answers to any of the above questions different?
iv. If so, please give details.

1.5 Ethos

(a) Organisation

Past

i. What did the organisation see as its function, ethos and/or mission in terms of the residential care service it provided for children?
ii. If the establishment was run by a Catholic religious order, what vows were taken by members of the order and at which point in their training?
iii. What did the organisation see as the establishment's function, ethos and/or mission in terms of the service that the establishment provided to children accommodated there?
iv. Were there changes over time in terms of what the organisation saw as its function, ethos and/or mission in terms of the residential care service it provided for children?
v. If so, what were the changes and when and why did they come into effect?
vi. Were there changes over time in terms of what the organisation saw as the establishment's function, ethos and/or mission in terms of the service that the establishment provided to children accommodated there?
vii. If so, what were the changes and when and why did they come into effect?

Present

viii. With reference to the present position, are the answers to any of the above questions different?
ix. If so, please give details.

(b) Establishment

Past

i. What services were provided at the establishment, in terms of care for children?
ii. Did the establishment care for children of both sexes?
iii. If the establishment cared for children of one sex only, what was the thinking behind that policy?
iv. Were any special child care, or child protection measures, taken in the light of that policy? If so, please provide details.
v. What was the daily routine for boys/girls cared for at the establishment?
vi. What were the on-site activities for children cared for at the establishment?
vii. What were the off-site activities for them?
viii. Did children work manually, either at the establishment, or externally (e.g. farming work or other labour), or both?

ix. If the establishment was run by a Catholic religious order, were any prospective members of the order who were in training permitted to care for children?

Present

x. With reference to the present position, are the answers to any of the above questions different?
xi. If so, please give details.

1.6 Numbers

(a) Organisation

Past

i. How many children did the organisation accommodate at a time and in how many establishments?
ii. Please provide details of any material changes in numbers of children, or numbers of establishments, and the reasons for those changes?
iii. How many children in total were accommodated by the organisation?
iv. What numbers (if any) were placed in foster care by the organisation?
v. In general terms, was the main service provided by the organisation the provision of residential care for children in establishments, or was it the provision of foster care?

Present

vi. With reference to the present position, are the answers to any of the above questions different?
vii. If so, please give details.

(b) Establishment

Past

i. How many children did the establishment accommodate at a time?
ii. Did this change, and if so, what were the reasons?
iii. How many children in total were cared for at the establishment?
iv. What accommodation was provided for the children?
v. How many children occupied a bedroom/dormitory/house?

Present

vi. With reference to the present position, are the answers to any of the above questions different?
vii. If so, please give details.

1.7 Children's Background/Experience

Past

i. Did the children admitted to the establishment generally have a shared background and/or shared experiences?
ii. Were children admitted into the care of the organisation as a whole, or were they admitted into the care of a particular establishment?
iii. If children were admitted into the care of the organisation, did the organisation decide which establishment they would be admitted into?
iv. Who placed children with the organisation?
v. From 15 April 1971 (the date on which the Children's Hearing system was introduced), did the organisation/establishment receive children mainly from the Children's Hearing system?
vi. If not, how generally did children come to be admitted into the care of the organisation?
vii. Was there a gender or other admission policy or practice operated by the organisation or any establishment run by it?
viii. What was the policy/procedure and practice regarding admission of siblings?
ix. How long did children typically remain in the care of the organisation?
x. Were children moved between different establishments run by the organisation?
xi. If so, in what circumstances?
xii. Generally did children typically stay in one, or more than one, establishment?
xiii. What provision was made for contact between siblings while siblings were at the establishment?
xiv. What provision was made for contact between children and their parents and wider family while children were at the establishment?
xv. What provision was made for information sharing/updates about the children to their parents?
xvi. What provision was made for information sharing/updates about parents to their children?
xvii. What provision was made for the celebration of children's birthdays, Christmas and other special occasions?
xviii. What was the process for review of children's continued residence at the establishment, in terms of whether they continued to require to be there?
xix. When children left the care of the establishment, what was the process for discharge?
xx. What support was offered to children when they left the care of the establishment?
xxi. What information was sought by the organisation and/or establishment about what children leaving its care planned to go on to do?
xxii. Was such information retained and updated?
xxiii. What was provided in terms of after-care for children/young people once they left the establishment?

Present

xxiv. With reference to the present position, are the answers to any of the above questions different?
xxv. If so, please give details.

1.8 Staff Background

(a) Organisation

Past

i. How many people were employed by the organisation who had some responsibility for residential care services for children?
ii. How many people were employed by the organisation at any one time who had some responsibility for residential care services for children?
iii. What experience/qualifications did such staff have?
iv. If the organisation is a religious order, how many members of the order had a responsibility for residential care services for children provided by the organisation in Scotland?
v. What experience/qualifications did such members have, to equip them to discharge their responsibilities?

Present

vi. With reference to the present position, are the answers to any of the above questions different?
vii. If so, please give details.

(b) Establishment

Past

i. How many persons were employed in some capacity at the establishment?
ii. How many of those persons had the opportunity of unaccompanied access to a child, or children, cared for at the establishment?
iii. How many were involved in the provision of care to children accommodated at the establishment (child care workers)?
iv. What experience and/or qualifications, if any, did the child care workers require to have?
v. What was the child care worker/child numbers ratio?
vi. What was the gender balance of the child care workers?
vii. Was any attempt made to employ child care workers in looking after children of the same sex as those workers?

Present

viii. With reference to the present position, are the answers to any of the above questions different?

ix. If so, please give details.

## 2. Organisational Structure and Oversight

### 2.1 Governance

Past

i. What were the governance arrangements within the organisation?
ii. How were the members of the governing body selected?
iii. What qualifications and/or training, if any, did the members require to have in relation to the provision of residential care services for children?
iv. Did the members receive remuneration?
v. What was the nature of the accountability and oversight regime between the organisation's governing body and the establishment?
vi. What visits were made by the governing body to the establishment?
vii. What was the purpose of such visits?
viii. How frequently did these happen?
ix. Were children interviewed, or spoken to, by members of the governing body during such visits?
x. If so, were establishment staff present while children were interviewed or spoken to?
xi. Were reports of such visits made and discussed by the governing body?
xii. Did visits result in changes to the organisation's policy, procedure and/or practice? If so, please give examples.

Present

xiii. With reference to the present position, are the answers to any of the above questions different?
xiv. If so, please give details.

### 2.2 Culture

Past

i. What was the nature of the culture within the organisation?
ii. Was that culture reflected in the organisation's policies, procedures and/or practice in relation the provision of residential care services for children?
iii. How can that be demonstrated?
iv. Did the running of establishments reflect the organisation's culture, policies and procedures?
v. If not, please provide a representative range of examples and explain, by reference to those examples, why particular establishments were not, in material ways, run in accordance with the organisation's then culture, policies and procedures and what, if anything, was done to change that state of affairs?

vi. When and why did any changes in the culture of the organisation come about?
vii. Were any changes in culture driven by internal influences, incidents, experiences or events within the organisation, or any of the establishments run by the organisation?
viii. Were there any changes in culture that were driven by abuse, or alleged abuse, of children cared for at the establishment?
ix. If so, when did they occur and how did they manifest themselves?
x. Were any changes in culture driven by any external influences or factors and if so what were those influences or factors?

Present

xi. With reference to the present position, are the answers to any of the above questions different?
xii. If so, please give details.
xiii. To what extent, if any, has abuse or alleged abuse of children cared for at any establishments caused, or contributed to, the adoption of the current policies, procedures and/or practices of the organisation, in relation to the provision of residential care services for children including the safeguarding and child protection arrangements applying to its current establishments?

2.3 Leadership

Past

i. How was the establishment managed and led?
ii. What were the names and qualifications of the persons in charge of the establishment? Please include the dates for when each of the persons was in charge.
iii. What was the oversight and supervision arrangements by senior management within the establishment?
iv. What were the oversight arrangements by the organisation, including visits by or on behalf of the organisation?

Present

v. With reference to the present position, are the answers to any of the above questions different?
vi. If so, please give details

2.4 Structure

Past

i. What was the structure of the organisation?
ii. What was the structure of the establishment?

Present

iii. With reference to the present position, is the answer to the above question different?
iv. If so, please give details.

2.5 Hierarchy and Control

Past

i. What was the hierarchy within the organisation?
ii. What was the structure of responsibility within the organisation?
iii. What were the lines of accountability?
iv. Within the organisation, who had senior management/corporate/ organisational responsibility for the managers/management teams/leadership teams who managed the establishment on a day-to-day basis?
v. What were the reporting arrangements between the establishment and the organisation?
vi. Within the establishment itself, who had managerial responsibility for, or was in overall charge of, those employed there, including in particular those who were involved in the day-to-day care of children, and any other persons who had contact with the children?
vii. To whom were child care workers within the establishment directly responsible?
viii. Who, within the organisation, took decisions on matters of policy, procedure and/or practice in relation to the establishment?
ix. Who, within the organisation, was responsible for the implementation of, and compliance with, the organisation's policies, procedures and/or practices at the establishment?

Present

x. With reference to the present position, are the answers to any of the above questions different?
xi. If so, please give details.

2.6 External Oversight

Past

i. What were the arrangements for external oversight of the organisation and the establishment?
ii. Who visited the organisation and/or the establishment in an official or statutory capacity and for what purpose?
iii. How often did this occur?
iv. What did these visits involve in practice?
v. What involvement did local authorities have with the organisation and/or the establishment in respect of residential care services for children?

vi. What involvement did local authorities have with the organisation and the establishment in respect of the children at the establishment?
vii. If the establishment was run by a Catholic religious order, what actual involvement and/or responsibility, whether formal or informal, did the Catholic Hierarchy/Bishops' Conference have, either directly or at diocesan level, in the creation, governance, management and/or oversight of the establishment?
viii. What was the nature and extent of any pastoral care provided to the establishment, if it was run by a religious order?

Present

ix. With reference to the present position, are the answers to any of the above questions different?
x. If so, please give details.

**Part B – Current Statement**

3. Retrospective Acknowledgement/Admission

3.1 Acknowledgement of Abuse

i. Does the organisation/establishment accept that between 1930 and 17 December 2014 some children cared for at the establishment were abused?
ii. What is the organisation/establishment's assessment of the extent and scale of such abuse?
iii. What is the basis of that assessment?

3.2 Acknowledgement of Systemic Failures

i. Does the organisation/establishment accept that its systems failed to protect children cared for at the establishment between 1930 and 17 December 2014 from abuse?
ii. What is the organisation/establishment's assessment of the extent of such systemic failures?
iii. What is the basis of that assessment?
iv. What is the organisation/establishment's explanation for such failures?

3.3 Acknowledgement of Failures/Deficiencies in Response

i. Does the organisation/establishment accept that there were failures and/or deficiencies in its response to abuse, and allegations of abuse, of children cared for at the establishment between 1930 and 17 December 2014?
ii. What is the organisation/establishment's assessment of the extent of such failures in its response?
iii. What is the basis of that assessment?

iv. What is the organisation's explanation for such failures/deficiencies?

3.4 Changes

i. To what extent has the organisation/establishment implemented changes to its policies/procedures and practices as a result of its acknowledgment in relation to 3.1 – 3.3 above?

## Part C - Prevention and Identification

4. Policy and Practice

4.1 National

Past

i. Was there national policy/guidance relevant to the provision of residential care for children?
ii. If so, to what extent was the organisation aware of such?
iii. If there was national policy/guidance in respect of any of the following in relation to provision of residential care for children, to what extent was the organisation aware of such?
    - Child welfare (physical and emotional)
    - Child protection
    - Complaints handling
    - Whistleblowing
    - Management of residential establishments
    - Child migrants
    - Record retention
    - Recruitment and training of residential care staff
    - Requiring employers to divulge details of complaints etc. to prospective employers
    - Reviewing a child's continued residence at a residential establishment
iv. If the organisation was aware of such, did they give effect to that policy/guidance?
v. If so, how was effect given to such policy/guidance?
vi. If not, why not?

Present

vii. With reference to the present position, are the answers to any of the above questions different?
viii. If so, please give details.

4.2 Local Authority

Past

i. Was there local authority policy/guidance relevant to provision of residential care for children?
ii. If so, to what extent was the organisation aware of such?
iii. If there was local authority policy/guidance in respect of any of the following in relation to provision of residential care for children, to what extent was the organisation aware of such?
    - Child welfare (physical and emotional)
    - Child protection
    - Complaints handling
    - Whistleblowing
    - Management of residential establishments
    - Child migrants
    - Record retention
    - Recruitment and training of residential care staff
    - Requiring employers to divulge details of complaints etc. to prospective employers
    - Reviewing a child's continued residence at a residential establishment
iv. If the organisation was aware of such, did they give effect to that policy/guidance?
v. If so, how was effect given to such policy/guidance?
vi. If not, why not?

Present

vii. With reference to the present position, are the answers to any of the above questions different?
viii. If so, please give details.

4.3 Admissions

(a) Policy

Past

i. What policies and/or procedures did the organisation/establishment have in place in relation to admission of children to the establishment?
ii. Was there a particular policy and/or procedural aim/intention?
iii. Where were such policies and/or procedures recorded?
iv. Who compiled the policies and/or procedures?
v. When were the policies and/or procedures put in place?
vi. Do such policies and/or procedures remain in place?
vii. Were such policies and/or practices reviewed?
viii. If so, what was the reason for review?

ix. What substantive changes, if any, were made to the policies and/or procedures over time?
x. Why were changes made?
xi. Were changes documented?
xii. Was there an audit trail?

Present

xiii. With reference to the present position, are the answers to any of the above questions different?
xiv. If so, please give details.

(b) Practice

Past

i. Did the organisation/establishment adhere in practice to its policy/procedures in relation to the admission of children to the establishment?
ii. How was the adherence demonstrated?
iii. How can such adherence be demonstrated to the Inquiry?
iv. Were relevant records kept demonstrating adherence?
v. Have such records been retained?
vi. If policy/procedure was not adhered to in practice, why not?
vii. If policy/procedure was not adhered to in practice, what was the practice?

Present

viii. With reference to the present position, are the answers to any of the above questions different?
ix. If so, please give details.

4.4 Day to Day

(a) Policy

Past

i. What policies and/or procedures did the organisation/establishment have in place in relation to the day to day running of the establishment?
ii. Was there a particular policy and/or procedural aim/intention?
iii. Where were such policies and/or procedures recorded?
iv. What did the policies and/or procedures set out in terms of the following?
    - Activities for children
    - Off-site activities for children including trips, holidays and visits to family
    - Schooling/education
    - Discipline

v. Who compiled the policies and/or procedures?
vi. When were the policies and/or procedures put in place?
vii. Do such policies and/or procedures remain in place
viii. Were such policies and/or practices reviewed?
ix. If so, what was the reason for review?
x. What substantive changes, if any, were made to the policies and/or procedures over time?
xi. Why were changes made?
xii. Were changes documented?
xiii. Was there an audit trail?

Present

xiv. With reference to the present position, are the answers to any of the above questions different?
xv. If so, please give details.

(b) Practice

Past

i. Did the organisation/establishment adhere in practice to its policy/procedures relating to the day to day running of the establishment?
ii. Did the organisation/establishment adhere in practice to its policy/procedures in terms of the following?
    - Activities for children
    - Off-site activities for children including trips, holidays and visits to family
    - Schooling
    - Education
iii. How was adherence demonstrated?
iv. How can such adherence be demonstrated to the Inquiry?
v. Were relevant records kept demonstrating adherence?
vi. Have such records been retained?
vii. If policy/procedure was not adhered to in practice, why not?
viii. If policy/procedure was not adhered to in practice, what was the practice?

Present

ix. With reference to the present position, are the answers to any of the above questions different?
x. If so, please give details.

4.5 Children

(a) Policy

Past

i. What policies and/or procedures did the organisation/establishment have in place in relation to caring for children at the establishment?
ii. Was there a particular policy and/or procedural aim/intention?
iii. Where were such policies and/or procedures recorded?
iv. What did the policies and/or procedures set out in terms of the following?
    - Safeguarding
    - Child Protection
    - Medical care
    - Children's physical wellbeing
    - Children's emotional and mental wellbeing
v. Who compiled the policies and/or procedures?
vi. When were the policies and/or procedures put in place?
vii. Do such policies and/or procedures remain in place?
viii. Were such policies and/or practices reviewed?
ix. If so, what was the reason for review?
x. What substantive changes, if any, were made to the policies and/or procedures over time?
xi. Why were changes made?
xii. Were changes documented?
xiii. Was there an audit trail?

Present

xiv. With reference to the present position, are the answers to any of the above questions different?
xv. If so, please give details.

(b) Practice

Past

i. Did the organisation/establishment adhere in practice to its policy/procedures relating to the care of children at the establishment?
ii. Did the organisation/establishment adhere in practice to its policy/procedures in terms of the following?
    - Safeguarding
    - Child Protection
    - Medical care
    - Children's physical wellbeing
    - Children's emotional and mental wellbeing
iii. How was adherence demonstrated?
iv. How can such adherence be demonstrated to the Inquiry?

v. Were relevant records kept demonstrating adherence?
vi. Have such records been retained?
vii. If policy/procedure was not adhered to in practice, why not?
viii. If policy/procedure was not adhered to in practice, what was the practice?

Present

ix. With reference to the present position, are the answers to any of the above questions different?
x. If so, please give details.

4.6 Staffing

(a) Policy

Past

i. What policies and/or procedures did the organisation/establishment have in relation to staffing at the establishment?
ii. Was there a particular policy and/or procedural aim/intention?
iii. Where were such policies and/or procedures recorded?
iv. What did the policies and/or procedures set out in terms of the following?
    - Pre-employment checks
    - Recruitment
    - Induction
    - Transfer of staff to or from other establishments within or outwith the organisation
    - References
    - Appraisal/supervision
    - Training
    - Personal/Professional development
    - Disciplinary actions
    - Dismissal
v. Who compiled the policies and/or procedures?
vi. When were the policies and/or procedures put in place?
vii. Do such policies and/or procedures remain in place?
viii. Were such policies and/or practices reviewed?
ix. If so, what was the reason for review?
x. What substantive changes, if any, were made to the policies and/or procedures over time?
xi. Why were changes made?
xii. Were changes documented?
xiii. Was there an audit trail?

Present

xiv. With reference to the present position, are the answers to any of the above questions different?
xv. If so, please give details.

(b) Practice

Past

i. Did the organisation/establishment adhere in practice to its policy/procedures in relation to staffing at the establishment?
ii. Did the organisation/establishment adhere in practice to its policy/procedures in terms of the following?
    - Pre-employment checks
    - Recruitment
    - Inductions
    - Transfers to and from other establishments within or outwith the organisation
    - References
    - Appraisals/Supervision
    - Training
    - Personal/Professional development
    - Disciplinary actions
    - Dismissal
iii. How was adherence demonstrated?
iv. How can such adherence be demonstrated to the Inquiry?
v. Were relevant records kept demonstrating adherence?
vi. Have such records been retained?
vii. If policy/procedure was not adhered to in practice, why not?

Present

viii. With reference to the present position, are the answers to any of the above questions different?
ix. If so, please give details.

4.7 <u>Visitors</u>

(a) Policy

Past

i. What policies and/or procedures did the organisation/establishment have in place in relation to visitors to the establishment?
ii. Was there a particular policy and/or procedural aim/intention?
iii. Where were such policies and/or procedures recorded?
iv. Who compiled the policies and/or procedures?
v. When were the policies and/or procedures put in place?

vi. Do such policies and/or procedures remain in place?
vii. Were such policies and/or practices reviewed?
viii. If so, what was the reason for review?
ix. What substantive changes, if any, were made to the policies and/or procedures over time?
x. Why were changes made?
xi. Were changes documented?
xii. Was there an audit trail?

Present

xiii. With reference to the present position, are the answers to any of the above questions different?
xiv. If so, please give details.

(b) Practice

Past

i. Did the organisation/establishment adhere in practice to its policy/procedures in relation to visitors to the establishment?
ii. How was adherence demonstrated?
iii. How can such adherence be demonstrated to the Inquiry?
iv. Were relevant records kept demonstrating adherence?
v. Have such records been retained?
vi. If policy/procedure was not adhered to in practice, why not?

Present

vii. With reference to the present position, are the answers to any of the above questions different?
viii. If so, please give details.

4.8 Volunteers

(a) Policy

Past

i. What policies and/or procedures did the organisation/establishment have in place in relation to volunteers at the establishment?
ii. Was there a particular policy and/or procedural aim/intention?
iii. Where were such policies and/or procedures recorded?
iv. Who compiled the policies and/or procedures?
v. When were the policies and/or procedures put in place?
vi. Do such policies and/or procedures remain in place?
vii. Were such policies and/or practices reviewed?
viii. If so, what was the reason for review?
ix. What substantive changes, if any, were made to the policies and/or procedures over time?

x. Why were changes made?
xi. Were changes documented?
xii. Was there an audit trail?

Present

xiii. With reference to the present position, are the answers to any of the above questions different?
xiv. If so, please give details.

(b) Practice

Past

i. Did the organisation/establishment adhere in practice to its policy/procedures in relation to volunteers at the establishment?
ii. How was adherence demonstrated?
iii. How can such adherence be demonstrated to the Inquiry?
iv. Were relevant records kept demonstrating adherence?
v. Have such records been retained?
vi. If policy/procedure was not adhered to in practice, why not?

Present

vii. With reference to the present position, are the answers to any of the above questions different?
viii. If so, please give details.

4.9 Complaints and Reporting

(a) Policy

Past

i. What policies and/or procedures did the organisation/establishment have in place in relation to complaints and reporting at the establishment?
ii. Was there a particular policy and/or procedural aim/intention?
iii. Where were such policies and/or procedures recorded?
iv. What did the policies and/or procedures set out in terms of the following?
    - Complaints by children
    - Complaints by staff
    - Complaints by third persons/family of children
    - Whistleblowing
    - Support, including external support, for those who made complaint or those who were the subject of complaint
    - Response to complaints (including response by organisation and/or establishment)
    - External reporting of complaints

v. Who compiled the policies and/or procedures?
vi. When were the policies and/or procedures put in place?
vii. Do such policies and/or procedures remain in place?
viii. Were such policies and/or practices reviewed?
ix. If so, what was the reason for review?
x. What substantive changes, if any, were made to the policies and/or procedures over time?
xi. Why were changes made?
xii. Were changes documented?
xiii. Was there an audit trail?

Present

xiv. With reference to the present position, are the answers to any of the above questions different?
xv. If so, please give details.

(b) Practice

Past

i. Did the organisation/establishment adhere in practice to its policy/procedures in relation to complaints and reporting at the establishment?
ii. Did the organisation/establishment adhere in practice to its policy/procedures in terms of the following?
    - Complaints by children
    - Complaints by staff
    - Complaints by third persons/family of children
    - Whistleblowing
    - Support, including external support, for those who made complaint or those who were the subject of complaint
    - Response to complaints (including response by organisation and/or establishment)
    - External reporting of complaints
iii. How was adherence demonstrated?
iv. How can such adherence be demonstrated to the Inquiry?
v. Were relevant records kept demonstrating adherence?
vi. Have such records been retained?
vii. If policy/procedure was not adhered to in practice, why not?

Present

viii. With reference to the present position, are the answers to any of the above questions different?
ix. If so, please give details.

4.10 Internal Investigations

(a) Policy

Past

i. What policies and/or procedures did the organisation/establishment have in place in respect of internal investigations relating to the establishment?
ii. Was there a particular policy and/or procedural aim/intention?
iii. Where were such policies and/or procedures recorded?
iv. What did the policies and/or procedures set out in terms of the following?
    - Approach to/process of internal investigations
    - Identifying lessons/changes following internal investigations
    - Implementation of lessons/changes following internal investigations
    - Compliance
    - Response (to child and abuser)
    - Response to complaints (including response by organisation and/or establishment)
    - External reporting following internal investigations
v. Who compiled the policies and/or procedures?
vi. When were the policies and/or procedures put in place?
vii. Do such policies and/or procedures remain in place?
viii. Were such policies and/or practices reviewed?
ix. If so, what was the reason for review?
x. What substantive changes, if any, were made to the policies and/or procedures over time?
xi. Why were changes made?
xii. Were changes documented?
xiii. Was there an audit trail?

Present

xiv. With reference to the present position, are the answers to any of the above questions different?
xv. If so, please give details.

(b) Practice

Past

i. Did the organisation/establishment adhere in practice to its policy/procedures in respect of internal investigations relating to the establishment?
ii. Did the organisation/establishment adhere in practice to its policy/procedures in terms of the following?
    - Approach to/process of internal investigations
    - Identifying lessons/changes following internal investigations

- Implementation of lessons/changes following internal investigations
- Compliance
- Response (to child and abuser)
- Response to complaints (including response by organisation and/or establishment)
- External reporting following internal investigations

iii. How was adherence demonstrated?
iv. How can such adherence be demonstrated to the Inquiry?
v. Were relevant records kept demonstrating adherence?
vi. Have such records been retained?
vii. If policy/procedure was not adhered to in practice, why not?

Present

viii. With reference to the present position, are the answers to any of the above questions different?
ix. If so, please give details.

4.11 Child Migration

(a) Policy

Past

i. What policies and/or procedures did the organisation/establishment have in place in relation to child migration?
ii. Was there a particular policy and/or procedural aim/intention?
iii. Where were such policies and/or procedures recorded?
iv. What did the policies and/or procedures set out in terms of the following?
    - Identification and checking the suitability of the places where children were sent
    - Selection of children to migrate including age, gender and background
    - Provision of information to the child and/or his/her parents before migration
    - Provision of information and records to children and/or their parents once child had been migrated
    - Obtaining consent of child
    - Obtaining consent of parents of child
    - Obtaining of consent of others e.g. Secretary of State
    - Responding to requests for information from former child migrants
    - Other issues
v. Who compiled the policies and/or procedures?
vi. When were the policies and/or procedures put in place?
vii. Were such policies and/or practices reviewed?
viii. If so, what was the reason for review?

ix. What substantive changes, if any, were made to the policies and/or procedures over time?
x. Why were changes made?
xi. Were changes documented?
xii. Was there an audit trail?

Present

xiii. With reference to the present position, are the answers to any of the above questions different?
xiv. If so, please give details.

(b) Practice

Past

i. Did the organisation/establishment adhere in practice to its policy/procedures in relation to child migration?
ii. Did the organisation/establishment adhere in practice to its policy/procedures in terms of child migrants relating to the following?
- Identification and checking the suitability of the places where children were sent
- Selection of children to migrate including age, gender, background
- Provision of information to the child and/or his/her parents before migration
- Provision of information and records to children and/or their parents once child had been migrated
- Obtaining consent of child
- Obtaining consent of parents of child
- Obtaining of consent of others e.g. Secretary of State
- Responding to requests for information from former child migrants
- Other issues

iii. How was adherence demonstrated?
iv. How can such adherence be demonstrated to the Inquiry?
v. Were relevant records kept demonstrating adherence?
vi. Have such records been retained?
vii. If policy/procedure was not adhered to in practice, why not?
viii. How many children were sent as child migrants from the organisation's establishments, and where were they sent?
ix. What was their age and gender?
x. Over what time period were children migrated from the organisation's establishments?
xi. Who funded the child migration?
xii. Who received the funding in relation to migrant children?
xiii. In general terms, how much was this funding?
xiv. How did the organisation/establishment respond to requests for information from former child migrants?

Present

xv. With reference to the present position, are the answers to any of the above questions different?
xvi. If so, please give details.
xvii. In hindsight, does the organisation have a view on policies/procedures that were in place in relation to child migration?
xviii. If the organisation accepts that such policies or procedures were flawed, has the organisation provided a specific response e.g. apology, redress or any other type of response?

4.12 Records

(a) Policy

Past

i. What policies and/or procedures did the organisation/establishment have in relation to record keeping?
ii. Was there a particular policy and/or procedural aim/intention?
iii. What did the policies and/or procedures set out in terms of records relating to the following?
- Children in its care
- Staff
- Complaints
- Investigations
- Discipline
- Child migrants
- Responding to requests from former residents for information/records
- Other issues

iv. Who compiled the policies and/or procedures?
v. When were the policies and/or procedures put in place?
vi. Do such policies and/or procedures remain in place?
vii. Were such policies and/or practices reviewed?
viii. If so, what was the reason for review?
ix. What substantive changes, if any, were made to the policies and/or procedures over time?
x. Why were changes made?
xi. Were changes documented?
xii. Was there an audit trail?

Present

xiii. With reference to the present position, are the answers to any of the above questions different?
xiv. If so, please give details.

(b) Practice

Past

i. Did the organisation/establishment adhere in practice to its policy/procedures in relation to record keeping?
ii. Did the organisation/establishment adhere in practice to its policy/procedures in terms of record keeping relating to the following?
    - Children
    - Staff
    - Complaints
    - Investigations
    - Discipline
    - Child migrants
    - Responding to requests from former residents for information/records
    - Other issues
iii. How was adherence demonstrated?
iv. Were relevant records kept demonstrating adherence?
v. Have such records been retained?
vi. If policy/procedure was not adhered to in practice, why not?
vii. Did the establishment undertake any review or analysis of its records to establish what abuse or alleged abuse of children cared for at the establishment may have taken place?
viii. If so, when did the reviews take place, what documentation is available, and what were the findings?
ix. How have the outcomes of investigations been used to improve systems, learn lessons?
x. What changes have been made?
xi. How are these monitored?
xii. Did the organisation/establishment afford former residents access to records relating to their time at the establishment?
xiii. If so, how was that facilitated?
xiv. If not, why not?

Present

xv. With reference to the present position, are the answers to any of the above questions different?
xvi. If so, please give details.
xvii. Please provide details of any records currently held relating to the establishment in respect of the following:
    - Children in its care
    - Staff
    - Complaints
    - Investigations
    - Discipline
    - Child Migrants

- Responding to requests from former residents for information/records

**Part D – Abuse and Response**

*The questions in Part D should be answered in respect of abuse or alleged abuse relating to the time frame 1930 to 17 December 2014 only.*

5. Abuse

5.1 Nature

i. What was the nature of abuse and/or alleged abuse of children cared for at the establishment, for example, sexual abuse, physical abuse, emotional abuse?

5.2 Extent

i. What is the organisation/establishment's assessment of the scale and extent of abuse of children cared for at the establishment?
ii. What is the basis of that assessment?
iii. Against how many staff have complaints been made in relation to alleged abuse of children cared for at the establishment?
iv. How many staff have been convicted of, or admitted to, abuse of children cared for at the establishment?
v. How many staff have been found by the organisation/establishment to have abused children cared for at the establishment?
vi. In relation to questions iii – v above, what role did/do those members of staff had/have within the organisation/establishment?
vii. To what extent did abuse and/or alleged abuse of children cared for at the establishment take place during off-site activities, trips and holidays?
viii. To what extent was abuse and/or alleged abuse of children cared for at the establishment carried out by visitors and/or volunteers to the establishment?
ix. Have there been allegations of peer abuse?

5.3 Timing of Disclosure/Complaint

i. When were disclosures and complaints of abuse and/or alleged abuse of children cared for at the establishment made to the organisation or establishment?
ii. To what extent were complaints and disclosures made while the abuse or alleged abuse was on-going or recent?
iii. To what extent were/are complaints made many years after the alleged abuse i.e. about non-recent abuse?
iv. Are there any patterns of note in terms of the timing/disclosure of abuse and/or alleged abuse?

5.4. External Inspections

i. What external inspections have been conducted relating to children cared for at establishment which considered issues relating to abuse and/or alleged abuse of children?

For each such external inspection please answer the following:

ii. Who conducted the inspection?
iii. Why was the inspection conducted?
iv. When was the inspection conducted?
v. What was the outcome of the inspection in respect of any issues relating to abuse or alleged abuse of children?
vi. What was the organisation/establishment's response to the inspection and its outcome?
vii. Were recommendations made following the inspection?
viii. If so, what were the recommendations and were they implemented?
ix. If recommendations were not implemented, why not?

5.5 External Investigations

i. What external investigations have been conducted relating to children cared for at the establishment which have considered issues relating to abuse and/or alleged abuse of children?

For each such external investigation please answer the following:

ii. Who conducted the investigation?
iii. Why was the investigation conducted?
iv. When was the investigation conducted?
v. What was the outcome of the investigation in respect of any issues relating to abuse or alleged abuse of children?
vi. What was the organisation/establishment's response to the investigation and its outcome?
vii. Were recommendations made following the investigation?
viii. If so, what were the recommendations and were they implemented?
ix. If recommendations were not implemented, why not?

5.6 Response to External Inspections/Investigations

i. What was the organisation's procedure/process for dealing with external inspections and/or investigations relating to abuse, and/or alleged abuse, of children cared for at the establishment?
ii. What was the organisation's procedure/process for responding to the outcomes of such external inspections and/or investigations?
iii. What was the organisation's procedure/process for implementing recommendations which followed from such external inspections and/or investigations?

5.7 Impact

i. What is known about the impact of abuse on those children cared for at the establishment who were abused, or alleged to have been abused?
ii. Where does the organisation/establishment's knowledge/assessment of that impact come from?
iii. What is known about the impact of abuse on the families of those children cared for at the establishment who were abused, or alleged to have been abused?
iv. Where does the organisation/establishment's knowledge/assessment of that impact come from?

5.8 Known Abusers at Establishment

i. Does the organisation/establishment know of specific abusers, or alleged abusers, of children cared for at the establishment?
ii. If so, what are the names of the abusers, and/or alleged abusers?
iii. For each of these persons, please provide as much as possible of the following information:
    - the period (dates) during which they are known or alleged to have abused children cared for at the establishment
    - the role they had in the organisation/establishment during the period of abuse and/or alleged abuse
    - where they worked prior to, and following, their time at the organisation/establishment
    - the knowledge sought or received about them by the organisation/establishment at the point of recruitment, and while they were at the establishment
    - any information sought by, or provided to, future employers or third parties after they left the establishment, including regarding abuse or alleged abuse

iv. Were known abusers, or alleged abusers, of children cared for at the establishment moved from one establishment run by the organisation, to another establishment run by the organisation?
v. If so, why was this considered to be appropriate?
vi. If so, what process of monitoring/supervision followed at the new establishment?

5.9 Specific Complaints

i. How many specific complaints of abuse of children cared for at the establishment have been made to the establishment/organisation?

For each specific complaint, please answer the following:

ii. Who made the complaint?
iii. When was the complaint made?
iv. Against whom was the complaint made?
v. What was the nature of the complaint?

vi. When/over what period was the abuse alleged to have taken place?
vii. What was the organisation/establishment's process and approach in dealing with the complaint?
viii. What was the organisation/establishment's process and approach for investigating the complaint?
ix. What was the outcome of the complaint following that investigation?
x. Did the organisation/establishment provide a specific response to the complaint?
xi. If so, what was the form of response e.g. apology, redress, pastoral response or any other type of response?
xii. If there was no response, why not?
xiii. Was the information/content of the complaint passed to police?
xiv. If not, why not?

5.10 Civil Actions

i. How many civil actions have been brought against the organisation and/or establishment relating to abuse, or alleged abuse, of children cared for at the establishment?

For each such civil action, please answer the following:

ii. Who brought the action?
iii. When was the action brought?
iv. Against whom was the action brought?
v. What was the nature of the abuse, or alleged abuse, to which the action related?
vi. What were the names of the persons said to have, or alleged to have, committed abuse?
vii. When/over what period was the abuse said, or alleged, to have taken place?
viii. How did the action progress?
ix. What was the outcome?
x. Was the action settled on a conditional basis of confidentiality?
xi. Who was/were the organisation/establishment's legal representative(s) in relation to the civil action?
xii. Did the organisation/establishment carry insurance for meeting civil claims at the time the action was live?
xiii. How/where can copies of the court papers relating to the civil action be made available to the Inquiry?

5.11 Criminal Injuries Compensation Awards

i. Has any criminal injuries compensation been awarded in respect of abuse, or alleged abuse, of children cared for at the establishment?
ii. If so, please provide details if known.

5.12 Police

i. How many complaints of abuse of children cared for at the establishment have been made to the police?

In relation to each known complaint to the police, please answer the following questions:

ii. Who was the alleged abuser?
iii. Did the police conduct an investigation in relation to the complaint?
iv. If so, who conducted the investigation and when?
v. What was the outcome of the police investigation?
vi. What was the organisation/establishment's response?

5.13 Crown

i. To what extent has the Crown raised proceedings in respect of allegations of abuse of children cared for at the establishment?

In relation to each time the Crown has raised proceedings, please answer the following questions:

ii. What is the name of the person(s) against whom the proceedings were raised?
iii. What was the nature of the charges?
iv. What was the outcome of the proceedings, including disposal/sentence if there was a conviction?
v. What was the organisation/establishment's response to the proceedings and outcome?

# *Scottish Child Abuse Enquiry*
# *Request For Records*

| | |
|---|---|
| **Date of Request** | |
| **Name of Requester** | |
| **Contact Details** | |
| **Subject of Request** | **Surname:**<br>**Forename:**<br>**Middle Name(s):**<br>**Previous Name(s):**<br>**Other Names(s):** |
| **Subject Date of Birth** | |
| **Priority Elderly Request?** | **Y/N**<br>**Details:** |
| **Approximate Dates Looked after** | **From:** **To:** |
| **Looked After Location(s)** | |
| **Is it possible that there are records prior to creation of EDC in 1996? (Records in Glasgow City Council Archives)** | **Y/N**<br>**Details:** |
| **Request Received By:** | |

# *Scottish Child Abuse Enquiry Request For Records*

| | |
|---|---|
| **Date Actioned (sent to IM Team):** | |
| **Date Received by IM Team:** | |
| **Records Search Requested Date:** | |

| Systems Check Request | | | | |
|---|---|---|---|---|
| | Systems Check Required | Yes / No | Sent to Key Contact | Date Request Received by Key Contact |
| 1 | Central Records Store | | Agree Key contact | |
| 2 | Carefirst | | Agree Key contact | |
| 3 | Seemis | | Agree Key contact | |
| 4 | SWIS | | Agree Key contact | |
| 5 | Iron Mountain | | Agree Key contact | |
| 6 | Southbank File Store | | Agree Key contact | |
| 7 | East Dunbartonshire Council Archives | | Agree Key contact | |
| 8 | Glasgow City Council Archives | | Agree Key contact | |
| | | | | |
| | | | | |
| | | | | |

# *Scottish Child Abuse Enquiry*
# *Request For Records*

| Records Search Process<br>(To be completed by each system contact) | |
|---|---|
| Key Contact Name: | |
| Date of Search: | |
| System Name: | |
| Record Type: | Digital Record / Paper Record / Other (specify) |
| Search Criteria | Please include detail of all checks made |
| Records Located? | Yes / No |
| Details | How many records / files located, in which format – |
| Accuracy information | Are the records / files believed complete? Yes / No<br><br>If no, what measures might be taken to locate more information? |
| Information forwarded to Information Management Team? | |
| Date Forwarded | |
| Signed: | Key Contact: Signature |

# *Scottish Child Abuse Enquiry*
# *Request For Records*

| Information Management Team<br>Records & File Collation | | | | |
|---|---|---|---|---|
| | File(s) / Records received after systems check | Date Received Ny IM Team | Information Complete Yes / No | Comments |
| 1 | Central Records Store | | | |
| 2 | Carefirst | | | |
| 3 | Seemis | | | |
| 4 | SWIS | | | |
| 5 | Iron Mountain | | | |
| 6 | Southbank File Store | | | |
| 7 | East Dunbartonshire Council Archives | | | |
| 8 | Glasgow City Council Archives | | | |
| IM Team Contact<br>(name of team member collating records) | | | | |
| Date of final collation | | | | |
| Social Work Lead contacted for Records Review | | Name: | | |

# *Scottish Child Abuse Enquiry Request For Records*

| Social Work Lead<br>Records Review Checklist | | | |
|---|---|---|---|
| | File(s) / Records received after systems check | Date Received Ny IM Team | Comments |
| 1. | All appropriate systems checked? | Yes / No | |
| 2 | Records Complete? | Yes / No | |
| 3 | Action Required? | Yes / No | |
| 4 | Information & Records Manager Contacted to convene working group meeting? | Yes / No | Invitees required: |
| Social Work Lead (Name): | | | |
| Date of File / Records Review: | | | |

# *Scottish Child Abuse Enquiry*
# *Request For Records*

| Agenda<br>SCAI Working Group Meeting<br>Date:<br>Chair: Information and Records Manager | | |
|---|---|---|
| 1. | Attendees | Information Management Team<br>Social Work Lead<br>Data Protection Officer<br>Archivist<br>Legal<br>Insurance<br>Corporate Communications |
| 2. | Social Work Lead Update: | Update on outcome of checks, searches, completeness of records and actions required |
| 3. | Data Protection Officer Comments | |
| 4 | Legal Comments | Legal Position and Implications |
| 5. | Insurance Comments | Current Position and Implications |
| 6. | Corporate Communications Comments | |
| 7. | Decisions and Next Steps | Further Searches Required?<br><br>Redactions Required?<br><br>Forward to Enquiry Team?<br><br>Other Actions required? |
| 8. | AOCB | |

# *Scottish Child Abuse Enquiry*
# *Request For Records*

| Agenda<br>SCAI Working Group Meeting<br>Date:<br>Chair: Information and Records Manager | | |
|---|---|---|
| 1. | Attendees | Information Management Team<br>Social Work Lead<br>Data Protection Officer<br>Archivist<br>Legal<br>Insurance<br>Corporate Communications |
| 2. | Social Work Lead Update: | Update on outcome of checks, searches, completeness of records and actions required |
| 3. | Data Protection Officer Comments | |
| 4 | Legal Comments | Legal Position and Implications |
| 5. | Insurance Comments | Current Position and Implications |
| 6. | Corporate Communications Comments | |
| 7. | Decisions and Next Steps | Further Searches Required?<br><br>Redactions Required?<br><br>Forward to Enquiry Team?<br><br>Other Actions required? |
| 8. | AOCB | |

# *Scottish Child Abuse Enquiry*
# *Request For Records*

**To be created if required**

**Document Schedule for submission to Enquiry Team**

**Log: Searches done**
**Method of Transmission to the Enquiry Team**

Risk Log: 24-11-16 — Historic Child Abuse Working Group

| Risk Details | | | | Gross Score | | | | Additional Mitigating Action | | Risk | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Risk ID | Risk Category | Risk Description | Risk Owner | Impact 1 - 5 | Likelihood 1 - 5 | Overall Risk Factor | Current Controls | | Action Owner(s) | Date Last Updated | Risk Owner | Mitigating Action Progress | Action Target date | Additional information | Risk Status |
| Unique sequential number | (Eg:Reputational/Financial/Regulatory/Resource | For example - "There is a risk that X occurs because of Y resulting in impact on Z." | Name of person who has authority to be responsible for this risk. | 1 - Minor<br>2 - Marginal<br>3 - Serious<br>4 - Significant<br>5 - Catastrophic | 1 - Rare<br>2 - Unlikely<br>3 - Likely<br>4 - Very Likely<br>5 - Almost Certain | Impact * Probability (auto calculated) | Controls currently in place and managing risks | Description of additional measure(s) to be put in place to reduce/mitigate the risk. | Name | Date this risk was last updated | Name of person who has authority to be responsible for this risk. | Narrative describing progress to implement mitigating action. | Date for delivery Mitigating actions. | Any relevant additional information | Active or Closed |
| 1 | Reputational | There is a risk that the Council are not able to respond effectively to requests for historical information from the Inquiry committee due to incomplete, inaccessable or inaccurate records resulting in censure ?? and adverse publicity. | Information And Records Manager | 3 | 3 | 9 | 1. Partnership arrangements with key Stakeholders (GCC).<br>2. Scottish Council on Archives Records Retention Schedules.<br>3. Catalogue of records in place. | | | 24-Nov-16 | | | | | |
| 2 | Financial | There is a risk that the Council are not able to effectively defend liability claims related to the inquiry due to missing or inaccurate records resulting in adverse publicity and potentially increased insurance premiums. | Information And Records Manager | 3 | 3 | 9 | 1. Partnership arrangements with key Stakeholders (GCC).<br>2. Scottish Council on Archives Records Retention Schedules.<br>3. Catalogue of records in place. | | | 24-Nov-16 | | | | | |
| 3 | Regulatory | There is potential for a breach of DataProtection and Information Management legislation due to lack of understanding of, or an inability to comply with, the disclosure requirements of the inquiry. | Information And Records Manager | 3 | 2 | 6 | 1. Inquiry Disclosure criteria guidance documentation.<br>2. Inter-departmental communication strategy. | | | 24-Nov-16 | | | | | |
| 4 | Resource | There is a risk that the Council are not able to provide information in a timely manner to the Inquiry due to inadequate resourcing and lack of experienced trained staff to manage requests. This could result in lowered staff morale, increased absence and adverse publicity. | Chief Social Work Officer | 4 | 2 | 8 | | | | 24-Nov-16 | | | | | |
| 5 | Resource | Council could receive an increased volume of complaints,SAR's ,FOI requests and media or general enquiries regarding Social Care service provision due to publicity around the inquiry increasing awareness. This could result in increased workloads, associated additional pressure on staff and adverse publicity. | Chief Social Work Officer<br>Information and Records Manager | 3 | 3 | 9 | | | | 24-Nov-16 | | | | | |
| 6 | Reputational | Council could be subject to adverse publicity due to unauthorised or inaccurate communication to external bodies such as legal representatives, Police, Service Users and the Media. | Information And Records Manager<br>Corporate Communications Manager | 3 | 3 | 9 | 1. Communication and Response Strategy<br>2. Targetted training and Awareness sessions. | | | 24-Nov-16 | | | | | |
| 7 | Financial | Failure to notify insurers of potential claims in a timely manner could result in policy coverage being denied with associated adverse Financial impact on the Council. This could happen due to lack of experience in staff resulting in an inability to recognise intimation of a claim. | All | 4 | 3 | 12 | 1. Details of Historical insurance providers,contact details and policy information have been reviewed and are available. | Procedure Guidance Documentation to be prepared and issued. | | 24-Nov-16 | | | | | |
| 8 | | | | | | - | | | | | | | | | |
| 9 | | | | | | - | | | | | | | | | |
| 10 | | | | | | - | | | | | | | | | |

| Likelihood | | |
|---|---|---|
| Level | Descriptor | Descriptions |
| 5 | Almost Certain | The event is expected to occur in most circumstances |
| 4 | Very Likely | The event will probably occur in most circumstances |
| 3 | Likely | The event might occur at some time. |
| 2 | Unlikely | The event is not expected to occur |
| 1 | Rare | The event may only occur in exceptional circumstances |

| Impact | |
|---|---|
| Descriptor | Level |
| Catastrophic | 5 |
| Significant | 4 |
| Serious | 3 |
| Marginal | 2 |
| Minor | 1 |

**Agenda Item Number: 21**

# EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

| | |
|---|---|
| **Date of Meeting** | **22nd June 2017** |
| **Subject Title** | **Local Review of Winter 2016-17** |
| **Report By** | **Sandra Cairney, Head of Planning, Strategy & Health Improvement, East Dunbartonshire Health & Social Care Partnership** |
| **Contact Officer** | **Fiona McCulloch, Planning, Performance & Quality Manager**<br>**0141 355 2395**<br>**Fiona.mcculloch@ggc.scot.nhs.uk** |

| | |
|---|---|
| **Purpose of Report** | The purpose of this report is to present the HSCP review of the Winter Plan 2016-17 as submitted to the Scottish Government in May 2017. |

| | |
|---|---|
| **Recommendations** | It is recommended that the Health & Social Care Partnership Board:<br><br>Notes the content of the Local Review of the Winter 2016-17 report. |

| | |
|---|---|
| **Relevance to HSCP Board Strategic Plan** | A key priority in the Strategic Plan is to prevent emergency admissions to hospital, as far as reasonably practicable. 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, and this review comments on the effectiveness of the Plan. |

**Implications for Health & Social Care Partnership**

| | |
|---|---|
| **Human Resources** | None |

| | |
|---|---|
| **Equalities:** | None |

| | |
|---|---|
| **Financial:** | None |

| | |
|---|---|
| **Legal:** | None |

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|---|---|
| **Economic Impact:** | None |

| | |
|---|---|
| **Sustainability:** | None |

| | |
|---|---|
| **Risk Implications:** | None |

| | |
|---|---|
| **Implications for East Dunbartonshire Council:** | The Winter Plan is prepared annually in partnership with East Dunbartonshire Council colleagues including Roads, and Civil Contingencies. |

| | |
|---|---|
| **Implications for NHS Greater Glasgow & Clyde:** | The Winter Plan is describes local measures to relieve winter pressures on acute hospital services. |

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

**1.0 MAIN REPORT**

# Health & Social Care: Local Review of Winter 2016/17

| | | | |
|---|---|---|---|
| NHS Board, HSCP/s | East Dunbartonshire HSCP | Winter Planning Executive Lead | Fiona McCulloch Planning & Performance Manager |

## Introduction

Last year we asked for local winter reviews to be shared with the Scottish Government. This was a beneficial exercise which helped to identify key pressures and performance, which fed into the 'National Health & Social Care: Winter in Scotland 2015/16 Report'. The lessons learned and key priorities for improvement were also used to help develop the 'Preparing for Winter 2016/17 Guidance' - http://www.sehd.scot.nhs.uk/dl/DL(2016)18.pdf

To continue to improve winter planning across Health & Social Care we are asking local systems to lodge a draft of their local winter review for 2016/17 with the Scottish Government to support winter planning preparations for 2017/18. Local reviews should have senior joint sign-off reflecting local governance arrangements.



We expect this year's review to include:

- the named executive leading on winter across the local system
- key learning points and future recommendations / planned actions
- top 5 local priorities that you intend to address in the 2017/18 winter planning process
- comments on the effectiveness of the wider winter planning process and suggestions as to how we can continuously improve this process. We are particularly keen to hear the views of Health & Social Care Partnerships.

Local systems should also consider the recommendations made in the 'National Review of Primary Care Out of Hours Services' (http://www.gov.scot/Publications/2015/11/9014) when conducting their local reviews. Completed reviews should be sent to **Winter_Planning_Team_Mailbox@gov.scot** by no later than close of play on **Friday 12 May.**

Sir Lewis Ritchie is also currently conducting a review of Health and Social Care four day weekend public holiday services and we will be sharing information from these local reviews with Sir Lewis.

Thank you for your continuing support.

**Alan Hunter**

**Director of Performance NHSScotland**

**Alison Taylor**

**Head of Integration Division**

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East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

| 1 | **Business continuity plans tested with partners.** |
|---|---|
| | *Outcome:*<br>*The local system has fully tested business continuity management arrangements / plans in place to manage and mitigate against key disruptive risks including the impact of severe weather.*<br><br>*Local indicator(s):*<br>*progress against any actions from the testing of business continuity plans.* |

| 1.1 | **What went well?** |
|---|---|

- The HSCP Business Continuity Plan (BCP) is updated annually. In January 2017, a table-top exercise was undertaken to test the BCP. This was lead by NHSGG&C's Head of Civil Contingencies.
- A Winter Planning action plan was reviewed and updated at the monthly operational managers meeting.



| 1.2 | **What could have gone better?** |
|---|---|

| 1.3 | **Key lessons / Actions planned** |
|---|---|

- Key actions from the table-top exercise are being progressed
- Future exercises will be planned to include wider partners

## 2 Escalation plans tested with partners.

*Outcome:*
*Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes.*

*Local indicator(s):*

- *attendance profile by day of week and time of day managed against available capacity*
- *locally identified indicators of pressure (i.e.) % occupancy of ED, utilisation of trolley/cubicle, % of patients waiting for admission over 2, 4 hours*
- *all indicators should be locally agreed and monitored.*

### 2.1 What went well?

- Escalation plans are included in the BCP and Departmental Plans.
- Acute pressures were considered by the SMT in preparation to action as appropriate

### 2.2 What could have gone better?

### 2.3 Key lessons / Actions planned

- Escalation not required

## 3 Safe & effective admission / discharge continues in the lead-up to and over the festive period and also in to January.

*Outcomes:*

- *Emergency and elective patients are safely and effectively admitted and discharged over the Christmas - New Year holiday period.*
- *The numbers of patients receiving elective treatment reduces and the risk of boarding medical patients in surgical wards is minimised.*
- *Patients do not have unnecessary stays in hospital; hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January.*

*Local indicator(s):*

- *daily and cumulative balance of admissions / discharges over the festive period*
- *levels of boarding medical patients in surgical wards*
- *delayed discharge*
- *community hospital bed occupancy*
- *number of Social Work assessments including variances from planned levels.*

### 3.1 What went well?

- 45 referrals were received by the Hospital Assessment Team during the festive period.
- Weekly Delayed Discharge meeting enabled patients to be discharged into care home placement.
- Patients were also discharged into intermediate care placements.
- During the festive period, 25 patients were safely discharged from hospital.

### 3.2 What could have gone better?

- Intermediate care pilot model demonstrating positive outcomes but will analyse full impact when evaluation completed.

### 3.3 Key lessons / Actions planned

- Evaluation will inform future developments

## 4 Strategies for additional surge capacity across Health & Social Care Services

*Outcome:*

- *The risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised. The staffing plans for additional surge capacity across health and social care services is agreed in October. The planned dates for the introduction of additional acute, community and social work capacity are agreed and that capacity is operational before the expected surge period. It is essential that additional capacity is developed alongside appropriate arrangements to create a safe and person centred environment.*

*Local indicator(s):*

- *planned additional capacity and planned dates of introduction*
- *planned number of additional staffed medical beds for winter by site and the planned date of introduction of these beds;*
- *planned number of additional intermediate beds in the community and the planned date of introduction of these beds;*
- *levels of boarding.*
- *planned number of extra care packages*
- *planned number of extra home night sitting services*
- *planned number of extra next day GP and hospital appointments*



### 4.1 What went well?

- Introduction of intermediate care beds, November 2016 within the East Dunbartonshire.
- Weekly delayed discharge meeting to enable the early identification of patients, known to community staff, who have required admission and may require more complex discharge planning.
- Worked with Private providers in relation to care at home services to ensure capacity.
- Negotiations with private provider's outwith framework agreement to ensure contingency measures were available over the festive period.

### 4.2 What could have gone better?

### 4.3 Key lessons / Actions planned

- Contingency plans are included in contracts with private providers
- Identification and maximisation of all resources available.

## 5 Whole system activity plans for winter: post-festive surge / respiratory pathway.

*Outcome:*
The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. Hospital models will include flows between front doors, receiving units, and downstream wards.

*Local indicator(s):*

- daily number of cancelled elective procedures;
- daily number of elective and emergency admissions and discharges;
- number of respiratory admissions and variation from plan.

### 5.1 What went well?

- HSCP Winter Plan includes measures to support Acute service pressures and set out actions that would be put in place
- Emergency Care weekly planning data received from Acute services

### 5.2 What could have gone better?

- Acute data provided by hospital so unable to determine HSCP activity

### 5.3 Key lessons / Actions planned

- A better understanding of HSCP contribution to Acute pressures so that appropriate actions can be considered in response to local activity

## 6 Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

*Outcome:*

- *Local systems have, and use, a range of analysis to effectively plan for and monitor winter capacity, activity, pressures and performance at board and site levels.*

*Local indicator(s) :*

- *Agreed and resourced analytical plans for winter analysis.*

## 6.1 What went well?

- An established HSCP Winter Planning group contributed to the preparation of the Winter Plan and agreeing the action plan. The Winter Plan was shared with the North Glasgow Acute Unscheduled Care/Winter Planning Group
- The action plan was monitored monthly by the Operational Managers to ensure actions were completed, including:
  - Partnership working with relevant East Dunbartonshire Council Departments.
  - Agreeing NHS staff use of Social Care 4x4 vehicles to ensure vulnerable patients could be accessed in severe weather.
  - Embedding mechanisms that identify vulnerable and at risk health and social care service users



## 6.2 What could have gone better?

## 6.3 Key lessons / Actions planned

- Continue with well established local system of regular monitoring and reviewing winter plan actions.

## 7 Workforce capacity plans & rotas for winter / festive period agreed by October.

*Outcomes:*

- *Rotas and workforce capacity plans for all disciplines are agreed for the winter (and particularly the 4 day festive holiday) period by October to underpin safe and effective admission and discharge of emergency and elective patients. This should encompass all relevant health and social care services.*
- *Maintain discharges at normal levels over the two 4 day festive holiday periods*

*Local indicator(s):*

- *workforce capacity plans & rotas for winter / festive period agreed by October;*
- *effective local escalation of any deviation from plan and actions to address these;*
- *extra capacity scheduled for the 'return to work' days after the four day festive break factored into annual leave management arrangements;*
- *number of discharges on each of the 4 day festive holiday periods compared to number if normal daily discharges.*

### 7.1 What went well?

- All service leads submitted assurance emails to confirm all staff rotas were completed and ensured appropriate staff coverage over the festive period, including post holiday surges.

### 7.2 What could have gone better?

### 7.3 Key lessons / Actions planned

- System worked well. No interruptions to service were noted.

## 8 Discharges at weekends & bank holidays

*Outcome:*

- *Patients are discharged at weekends and bank holidays to avoid unnecessary stays in hospital and to improve flow through the hospital. Medical and Nurse Directors provide monthly report on weekend (pre-noon) discharge rate progress and performance.*

*Local indicator(s):*

- *% of discharges that are criteria led on weekend and bank holidays;*
- *daily number of elective and emergency admissions and discharges.*

### 8.1 What went well?

- Referral Single Point of Access at weekends for District Nursing and rehab staff

### 8.2 What could have gone better?

### 8.3 Key lessons / Actions planned

- No issues were raised

## 9 The risk of patients being delayed on their pathway is minimised.

*Outcome:*

- *Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflect the arrival patterns and potential waiting times for assessment and/or transfer/discharge. Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital. There is early engagement with SAS for ambulance discharge and transfer. Medical and Nurse Directors provide monthly report on ward by ward, in/out balance, daily discharge progress and performance.*

*Local indicator(s):*

- *distributions of attendances / admissions;*
- *distribution of time to assessment;*
- *distribution of time between decision to transfer/discharge and actual time;*
- *% of discharges before noon;*
- *% of discharges through discharge lounge;*
- *% of discharges that are criteria led;*
- *levels of boarding medical patients in surgical wards.*



### 9.1 What went well?

- Intermediate care model supported patient discharge
- Contract in place with the Red Cross to transport resettle patients from hospital to home. Approximately 70% of patients were aged 75+yrs

### 9.2 What could have gone better?

### 9.3 Key lessons / Actions planned

- Intermediate care pilot model demonstrating positive outcomes but will analyse full impact when evaluation completed.
- Red Cross data will analysed when received

## 10 Communication plans

*Outcome:*

- *The public and patients are kept informed of winter pressures, their impact on services and the actions being taken.*

*Local indicator(s) :*

- *daily record of communications activity;*
- *early and wide promotion of winter plan*

## 10.1 What went well?

The HSCP participates in the organisation and delivery of annual Public Winter Awareness events which are held in various locations across East Dunbartonshire and involve a number of partner agencies

Activity included;

- Winter Preparedness Roadshows
- Key messages for public posted on both NHS and Council website with useful links
- Key messages for all staff posted on intranet and within staff newsletter



## 10.2 What could have gone better?

- Earlier planning of events with partner agencies
- Identification of further sites to reach wider audience of East Dunbartonshire

## 10.3 Key lessons / Actions planned

- The roadshows were well received by the public and will be repeated next winter

| 11 | **Preparing effectively for norovirus.** |
|---|---|

*Outcome:*

- *The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised through the effective implementation of the HPS Norovirus Outbreak Guidance (2016/17).*

*Local indicator(s):*

- *number of wards closed to norovirus;*
- *application of HPS norovirus guidance.*

| 11.1 | **What went well?** |
|---|---|

- Local Care Homes received national guidance

| 11.2 | **What could have gone better?** |
|---|---|

| 11.3 | **Key lessons / Actions planned** |
|---|---|

## 12 Delivering seasonal flu vaccination to public and staff.

*Outcome:*

- *CMO uptake targets for seasonal flu vaccination for those aged 65 and above, at risk groups and front line staff are delivered in accordance with CMO Guidance.*

*Local indicator(s):*

- *% uptake for those aged 65+ and 'at risk' groups;*
- *% uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.*

## 12.2 What went well?

- GPs within the area offered flu vaccination clinics in the evenings and Saturday mornings.
- Staff were encouraged and supported to attend flu vaccination sessions run by Occupational Health.



## 12.3 What could have gone better?

- Unable to offer peer vaccination clinics this winter due to staffing issues. Health staff were informed of all sessions being held by Occupational Health across GG&C
- Social Care staff were advised to attend their GP for vaccination of they were within one of the eligible groups.

## 12.4 Key lessons / Actions planned

- Social Care frontline staff are not offered routine flu vaccinations
- Data for staff vaccinations are unavailable through Occupational Health system
- Final uptake data for GP vaccinations will not available or distributed to each HSCP until June 2017.

## 13 Additional Detail

*Include detail around when this review is likely to be considered by the Boards senior management team.*

- This paper will be reviewed and discussed by the SMT and HSCP Board by June 2017

## 14 Top Five Local Priorities for Winter Planning 2017/18

- Increase involvement with Acute Planning Service for winter planning
- Continue with our priority actions to reduce unscheduled admissions
- Further develop delayed discharge group to expedite discharge
- Evaluate Intermediate Care pilot and further develop model using lessons learned.
- Continue public awareness and preparedness road shows with Community Planning partners



## 15 Views on Wider Winter Planning Process & Suggestions for Improvement

East Dunbartonshire Health & Social Care Partnership

**SCHEDULE OF TOPICS FOR HSCP BOARD 2017-2018**

**SUBSEQUENT HSCP BOARD MEETINGS**

| **ALL BOARD MEETINGS** |
|---|
| **STANDING ITEMS (every meeting)** |
| Minutes of last meetings (SM) |
| Chief Officers Report (SM) |
| Finance (JC) |
| Delayed Discharges (AM) |
| Service User & Carer Representative Group Progress Report & Action Notes (SC) |
| **31st August 2017** |
| Finance: Approval of Budgets (JC) |
| Business Continuity Assurance (SM) |
| Corporate Risk Register (JC) |
| Performance Improvement Report – Quarter 1 (SC) |
| Winter Plan (SC) |
| Strategic Pan – Draft 2 (SC) |
| Clinical Care Governance Report (LW) |
| Chief Social Work report (PM) |
| Communications Plan (SC) |
| Strategic Planning Group/Locality Planning Groups Strategic plan consultation event (SC) |
| HSCP Risk Management Policy |
| HSCP Social Work Complaints Handling Policy and Procedure |
| Child Protection Development Nationally |
| **9th NOVEMBER 2017** |
| Clinical and Care Governance Annual Report (LW) |
| GP Clusters Update (LW) |
| Locality Planning Groups Update (AM) |
| OHD Performance Report (FMcL) |
| Chief Social Work Officer Report (PM) |
| Strategic Pan – Draft 3 (SC) |
| **12th JANUARY 2018** |
| Performance Improvement Report – Quarter 2 |
| Draft Carer Eligibility Criteria |

| |
|---|
| Records Management Plan |
| Draft Joint Health Improvement Plan |
| Strategic Needs Assessment - Children & Young People |
| **15th MARCH 2018** |
| Workforce Plan |
| Annual Governance Documents / Control Lists |
| Performance Improvement Report – Quarter 3 |
| Strategic Plan Final Draft |
| Final Draft JHIP |
| **10th MAY 2018** |
| Register of Interests |
| |
| **28th JUNE 2018** |
| Annual Performance Report |
| Performance Improvement Report (SC) – Quarter 4 |
| Carer Strategy Draft |

**OTHER DOCUMENTS REQUIRED FOR EACH MEETING**

| **GROUP ACTION NOTES (for noting at each meeting)** |
|---|
| Strategic Planning Group Action Notes |
| Audit Committee Minutes |
| Clinical & Care Governance Minutes |
| Joint Staff Partnership Minutes |
| Joint H&S Minutes |
| PAG Minutes |

*Equality Mainstreaming – 3 year report (March 2017 went to Board, possibly due March 2020?)

**UPDATED**

**15th May 2017**

# East Dunbartonshire Health & Social Care Partnership Board

Distribution List:

| Name | Designation | |
|---|---|---|
| Councillor Sheila Mechan | EDC - Elected Member | 1 |
| Councillor Susan Murray | EDC - Elected Member | 1 |
| Councillor Alan Moir | EDC - Elected Member | 1 |
| Ian Fraser | CHAIR Non-Executive Board Member | 1 |
| John Legg | Non-Executive Board Member | 1 |
| Ian Ritchie | Non-Executive Board Member | 1 |
| | | |
| Susan Manion | Chief Officer - East Dunbartonshire HSCP | 1 |
| Adam Bowman | Acute Services Representative | 1 |
| Fiona Borland | HSCP Communications | 1 |
| Sandra Cairney | Head of Strategy, Planning & Health Improvement | 1 |
| Jean Campbell | Chief Finance & Resources Officer | 1 |
| Fiona McCulloch | Planning & Performance Manager | 1 |
| Andy Martin | Head of Adult & Primary Care Services | 1 |
| Paolo Mazzoncini | Chief Social Work Officer | 1 |
| Lisa Williams | Clinical Director for Health & Social Care Partnership | 1 |
| Linda Tindall | Organisational Development Lead, HSCP | 1 |
| Jamie Robertson | Chief Internal Auditor HSCP | 1 |
| Karen Donnelly | EDC Chief Solicitor & Monitoring Officer | 1 |
| Martin Cunningham | EDC Corporate Governance Manager | 3 |
| Wilma Hepburn | Professional Nurse Advisor - NHS | 1 |
| Gordon Thomson - Ceartas | Voluntary Sector Representative | 1 |
| Martin Brickley | Service User Representative | 1 |
| Chris Shepherd | Carers Representative | 1 |
| Andrew McCready | Trades Union Representative | 1 |
| Gillian Cameron | Trades Union Representative | 1 |
| | | |
| | | **27** |

For Information (Substitutes):

| Name | Designation |
|---|---|
| Councillor Mohrag Fischer | EDC - Elected Member |
| Councillor Graeme McGinnigle | EDC - Elected Member |
| Councillor Rosie O'Neil | EDC - Elected Member |
| A. Jamieson | Carers Rep |
| I. Twaddle | Service Users Rep |