For meeting on

25 JUNE 2020

Agenda 2020

East Dunbartonshire Health & Social Care Partnership Board

East Dunbartonshire Health & Social Care Partnership

East Dunbartonshire Health & Social Care Partnership

A meeting of the East Dunbartonshire Health and Social Care Partnership Integration Joint Board will be held within the **Committee Room, 12 Strathkelvin Place, Kirkintilloch, G66 1XT on Thursday 25th June 2020 at 9.00am** or via remote access during COVID Pandemic restriction arrangements to consider the undernoted business.

Chair: Susan Murray
East Dunbartonshire Health and Social Care Partnership Integration Joint Board

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

A G E N D A

Sederunt and apologies

Any other business - Chair decides is urgent

Signature of minute of meeting for the HSCP Board held on; 26th March 2020

Item	Report by	Description	
STANDING ITEMS			
1.	Chair	Declaration of interests	
2.	Caroline Sinclair	Minute of HSCP Board held on 26th March 2020	**1-4**
3.	Caroline Sinclair	Chief Officer's Report	
STRATEGIC ITEMS			
4.	Derrick Pearce	Un Scheduled Care Commissioning Plan	**5-106**
GOVERNANCE ITEMS			
5.	Jean Campbell	Draft Annual Accounts 2019/20 and Financial Outturn Year End	**107-164**
6.	Caroline Sinclair	Quarter 4 / Annual Performance Report 2019-20	**165-206**
7.	Val Tierney	Clinical and Care Governance Sub Group Minutes of meeting held on 13th May 2020.	**207-222**
8.	Tom Quinn	East Dunbartonshire HSCP Staff Partnership Forum Minutes of meeting held on 13th February 2020.	**223-230**

Item	Report by	Description	
9.	Jean Campbell	East Dunbartonshire Draft Performance, Audit & Risk Committee Minutes of meeting held on 17th March 2020	**231-238**
10.	Caroline Sinclair	East Dunbartonshire HSCP Board Agenda Planner	**239-240**
	Chair	Any other competent business – previously agreed with Chair	

FUTURE HSCP BOARD DATES

Date of next meeting – 9.30am to 1pm if Seminar schedule start time will be 9am.

Thursday 17th September 2020

All held in the Council Committee Room, 12 Strathkelvin Place, Kirkintilloch, G66 1XT or via remote access during COVID Pandemic restriction arrangements

Interim Chief Officer
Caroline Sinclair

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 2

Minute of meeting of the Health & Social Care Partnership Board held within Room S1, Kirkintilloch Health & Care Centre, 10 Saramago Street, Kirkintilloch on **Thursday, 26th March 2020.**

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

NHSGGC Non-Executive Director **FORBES, McGUIRE & RITCHIE**

Non-Voting Members present:

C. Sinclair	Interim Chief Officer - East Dunbartonshire HSCP
J. Campbell	Chief Finance and Resource Officer - East Dunbartonshire HSCP

Councillor Susan Murray (Chair) presiding

Also Present:

C. Carthy	Interim Head of Children's Services & Criminal Justice
J. Robertson	East Dunbartonshire Council Director of Finance
D. Rice	Primary Care Development Officer

APOLOGIES FOR ABSENCE

There was no apologies to note.

ANY OTHER BUSINESS WHICH THE CHAIR DECIDES IS URGENT

The Chair advised that there was no urgent business.

1. LIFE CHANGES TRUST: NATIONAL HOUSE PROJECT

A report by the Interim Head of Children's Services & Criminal Justice, copies of which had previously been circulated, updated the Board on work that is currently underway with Life Changes Trust and the HSCP. The purpose of this report is to seek approval to progress with a partnership working arrangement with the Life Changes Trust in respect of the delivery of the Health and Social Care Partnership's strategic planning responsibilities for services to children and young people and delivery of Corporate Parenting duties and responsibilities.

The HSCP were successful in gaining a grant for 75,000 for the first year of the partnership which continued for a further 2 years. Moving forward, the partnership has the opportunity to bid to be involved in the National Housing Project with the sole aim to support young people who are entitled to continuing care to move to their own

tenancy and to live independently. This is currently being evaluated in England and a grant has been given to the Life Changes Trust to pilot this in Scotland.

The Interim Head of Children's Services & Criminal Justice was heard in response to questions relating to the above points. Following further discussion, the Board agreed:

a) approval to progress with a partnership working arrangement with the Life Changes Trust, as outlined in this report, in respect of delivery of the Health and Social Care Partnership's strategic planning responsibilities for services to children and young people through a bid to the National Housing Project; and
b) to seek an update on progress of delivery at the end of the first 12 months of the partnership arrangement.

The Board members present noted that this has been valuable work worth continuing and congratulated all stakeholders involved.

2. MAY 2020 MEETING ARRANGEMENTS

A report by the Interim Chief Officer, copies of which had previously been circulated. The purpose of this report is to seek approval to suspend the planned May 2020 meeting of the Health and Social Care Partnership Board in the event that social distancing measures and business continuity measures are in place as a result of the Covid-19 pandemic at this time, and to propose how any urgent matters of HSCP Board business will be addressed at that time, if required.

The Interim Chief Officer was heard in response to the report. An amendment to the recommendations was put forward which sees the delegation extended to include the Chief Finance and Resources Officer in so far as it is appropriate to their role which was agreed by members.

Following further discussion, the Board agreed:

a) Approve the recommendation suspend the planned May 2020 meeting of the Health and Social Care Partnership Board in the event that social distancing measures and business continuity measures are in place as a result of the Covid-19 pandemic at that time; and
b) To delegate decision-making to the Chief Officer and Chief Finance and Resources Officer in line with recess arrangements set out in the Scheme of Delegation to Officers, in consultation with the Chair and Vice Chair of the HSCP Board, until such time as meetings can recommence.

3. FINANCIAL PLANNING & BUDGET SETTING 2020/21

A Report by the Chief Finance and Resources Officer, copies of which had previously been circulated, updated the Board on the financial planning for the partnership and budget setting for 2020/21.

The Board noted their concerns and sought clarification on several matters including the reporting of a negative financial closing position, timescales of transformational activity during and current and post pandemic situation and the need for further discussion to be had with Council to agree terms of underwriting the Partnership's overspend.

The Board members also noted that that during the pandemic situation delegation was to the Chief Officer and Chief Financial Officer, however, asked that a framework for updating Board members be established and reviewed every 3 months. This was agreed by all members and virtual / telephone conferences will take place if required.

The Chief Officer and Chief Finance Officer were heard in response to these points Following further discussion, the Board agreed:

a) Note the position within the financial planning assumptions and acknowledge that these have been formed following partnership collaboration.
b) Note that this reflects the most up to date financial position for both the Council and the NHS Board for 2020/21.
c) Note the impact that this will have on the Partnerships ability to deliver its strategic priorities and agree to accept the indicative budget settlement for 2020/21 from the NHS (Para 1.10) and Council (1.11-13) while noting the caveats arising from the current situation as it relates to the Health and Social Care Partnership's necessary response to Covid-19 and the risks associated with the uncertain landscape of service delivery, with associated costs, arising from this.
d) Agree those management actions outlined in Appendix 5 to mitigate the financial challenges to the partnership.
e) Approve the transformation programme for 2020/21 to deliver a balanced budget position for the partnership outlined in Appendix 6.
f) Accept that the actions above will impact on the Partnership's reserves position for 2020/21 and beyond.
g) Note that the risks to the Partnership in meeting the service demands for health & social care functions and in the delivery of the strategic priorities set out in the Strategic Plan.
h) Approve the Directions to East Dunbartonshire Council and NHS Greater Glasgow & Clyde for 2020/21 in respect of the delivery of the functions delegated to the East Dunbartonshire Integration Joint Board as set out in **Appendix 7** of this report.

Agenda Item Number: 4.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	**Thursday 25 June 2020**
Subject Title	**Draft GG&C Unscheduled Care Commissioning Plan**
Report By	**Derrick Pearce, Head of Community Health and Care Services**
Contact Officer	**Fiona Munro, Team Manager/ Lead for Unscheduled Care** **Fiona.Munro@ggc.scot.nhs.uk Tel: 0141 23 2833**
Purpose of Report	To report on progress in developing the Greater Glasgow and Clyde-wide strategic commissioning plan for unscheduled care, to update on the development of an associated East Dunbartonshire action plan and to propose for approval a number of indicative local performance targets in pursuance of the Ministerial Steering Group (MSG) unscheduled care national indicators.
Recommendations	The Integration Joint Board is asked to: a) consider the draft Greater Glasgow and Clyde-wide commissioning plan for unscheduled care attached at **Appendix 1** b) note that further work is underway to consult on the plan and bring a final draft to the HSCP Board for consideration and approval in September 2020, recognising the significant impact of Covid-19 on the original intentions of the plan; c) note the content of the NHS GG&C Acute Division Unscheduled Care Escalation Work stream SBAR **Appendix 2** d) consider the draft East Dunbartonshire Unscheduled Care Action Plan 2020-21 at **Appendix 3**, which adopts the structure of the Greater Glasgow and Clyde-wide approach; e) Agree to the interim implementation of the draft East Dunbartonshire Unscheduled Care Action Plan 2020-21, subject to update in line with wider consultative process; f) Approve the East Dunbartonshire Ministerial Strategic Group unscheduled care performance targets for 2020-21 at **Appendix 4**, progress against which will be reported to the HSCP Board on a quarterly basis.

Relevance to HSCP Board Strategic Plan	Fulfils the HSCP Boards responsibilities in respect of the strategic planning of acute unscheduled care services, and in particular to the following key priorities: • Priority 3 – Keep people out of hospital when care can be delivered closer to home • Priority 5 – People have a positive experience of Health and Social Care services. • Priority 6 – Promote independent living through provision of suitable housing, accommodation and support • Priority 8 – Optimise efficiency, effectiveness and flexibility

Implications for Health & Social Care Partnership

Human Resources	None
Equalities:	None at this stage
Financial:	The HSCP Board's budget for 2020/21 includes a "set aside" amount for the commissioning of acute hospital services within scope (e.g. accident & emergency services). This is currently estimated to be £32.9m for East Dunbartonshire. The Ministerial Strategic Group for Health and Social Care's report in February 2019 included proposals on implementation of the set aside arrangements. Work to progress the plan will be met in the main within existing resources available with any investment to come from earmarked reserves available for transformation and service redesign. The extent of this has yet to be quantified with work progressing across NHS GG&C HSCPs to collectively quantify what this might be. However a potential financial gap is anticipated that will need discussion before the final plan can be approved. A finalised financial plan will be incorporated in the final plan to be reported to the HSCP Board in September 2020.
Legal:	The integration scheme for the HSCP Board includes specific responsibilities for the strategic planning of certain acute hospital services.
Economic Impact:	None
Sustainability:	None
Risk Implications:	A risk analysis will be developed alongside the detailed unscheduled care plan
Implications for East Dunbartonshire Council:	None
Implications for	The approach outlined in the Greater Glasgow and Clyde

NHS Greater Glasgow & Clyde:	unscheduled care commissioning plan and the East Dunbartonshire-specific action plan will have implications for the planning and delivery of acute hospital services for East Dunbartonshire residents, and residents in other HSCPs. These are currently being discussed with the NHS Board as part of the Moving Forward Together programme and in the West of Scotland Regional Planning apparatus.	
Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	☐
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☒
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

MAIN REPORT

1. Draft Greater Glasgow and Clyde Unscheduled Care Commissioning Plan

1.1 Since 2017 work has been undertaken by all six HSCPs in Greater Glasgow and Clyde (GG&C) to develop a system wide strategic commissioning plan in partnership with the NHS Board and Acute Services Division, and in line with the IJB's Strategic Plan. The draft plan attached builds on the GG&C Board wide Unscheduled Care Improvement Programme (http://www.nhsggc.org.uk/media/245268/10-unscheduled-care-update.pdf.) and is integral to the Board-wide Moving Forward Together programme (https://www.nhsggc.org.uk/media/251904/item-10a-paper-18_60-mft-update.pdf).

1.2 An early version of the draft plan was intended to be presented to the HSCP Board for consideration in March, but was delayed due the Covid Pandemic. The draft plan is included at **Appendix 1**. It is recognised that further work is required on key aspects as outlined below. There is yet further work that now needs to be considered as a result of the Covid Pandemic.

1.3 One key aspect of that work is learning from the pandemic which has seen a dramatic impact on unscheduled care activity. While the bulk of the draft plan itself is still relevant, the learning from what has worked well during the pandemic will be incorporated in the key actions in the final version. This learning is outlined below.

2. Draft Unscheduled Care Plan

2.1 The purpose of the plan is to outline how we aim to respond to the continuing pressures on health and social care services across GG&C and meet future demand. The draft explains that with an ageing population and changes in how and when people chose to access services, we need to change services so that we can meet patients' needs in different ways with services that are more clearly integrated and improved public understanding of how to use them.

2.2 The draft plan explains that simply providing more of what we currently have (e.g. more emergency departments) is not possible within the resources we have nor does this fit with our longer term ambition of providing care closer to where patients live, and reducing our reliance on hospitals. The direction of travel is to meet people's needs in community settings with primary care as the corner stone of the health and social care system.

2.3 The draft outlines how we plan to support people better in the community and develop alternatives to hospital care so that we can safely reduce the over reliance on unscheduled care services. The draft describes the delivery of an integrated system of health and social care services that we believe will better meet patients' needs. While this is a strategic plan outlining improvements for patients to be implemented over the next five years, the plan also includes some immediate actions that can be delivered in the short term in response to current imperatives.

2.4 The programme outlined in the plan is based on evidence of what works, and our estimate of patient needs across GG&C. The programme is focused on three key themes:

- **early intervention and prevention** of admission to hospital to better support people in the community and includes actions on:
  - implementing anticipatory care plans within specific patient groups e.g. COPD, care home residents etc.;
  - working with GPs through the national frailty collaborative to better manage frailty within the community;
  - work with care homes to reduce hospital admissions;
  - work with the Scottish Ambulance Service (SAS) to reduce the number of falls conveyed to hospital as part of a wider falls prevention strategy;
  - continue to develop the palliative care fast track service;

- **improving hospital discharge** and better supporting people to transfer from acute care to community supports, and includes actions on:
  - expansion of the hospital discharge team;
  - intermediate care improvement programme designed to reduce length of stay and improve the number of people returning home;
  - additional Red Cross transport capacity purchased to assist with hospital discharge; and,
  - continued robust performance management of delays.

- **improving the primary / secondary care interface** jointly with acute to better manage patient care in the most appropriate setting and includes actions on:
  - reviewing acute assessment unit referrals discharged on the same day to explore scope for managing this activity as part of planned care;
  - reducing the number of frequent A&E attenders to explore scope for early intervention approach to reduce attendances;
  - introduction a re-direction policy;
  - introducing a test of change involving consultant geriatricians and GPs to better manage care home patients; and
  - introducing Consultant Connect to improve GP to Consultant liaison.

2.5 The changes proposed will not take effect immediately or all at the same time. Some need testing first and others need time to bed in. Change will be gradual but should be fully implemented by 2022/23. While the challenge is to change to respond to current and future demand, it is also maintaining the direction outlined in the plan over the longer term so that we can better meet the needs of the people we serve.

2.6 We also need to communicate more directly with patients and the general public to ensure people know what service is best for them and can access the right service at the right time and in the right place.

2.7 Progress on these actions is reported regularly to the HSCP Unscheduled Care Planning Group and performance is reported in the quarterly performance reports to the IJB and

the Finance, Audit and Scrutiny Committee.

3. Learning from the Pandemic

3.1 Unscheduled care services have seen dramatic changes as a result of the pandemic. As well as there being an unprecedented drop in A&E attendances, emergency admissions and delays (see below), there has also been significant changes in primary and secondary care services. These changes include the opening of Covid Assessment Centres, GPs operating by telephone triage and new Covid pathways introduced in secondary care. These changes together with the lockdown measures and a strong public messaging and information campaign have impacted on unscheduled care activity. It is important therefore going forward that we learn lessons from what has worked well during the pandemic and might be followed through as part of our system wide approach to improving patient services and better managing demand.

3.2 Key examples of what has worked well and, subject to further testing, could be included in our unscheduled care plan include:

- the introduction of the GG&C wide community respiratory service to better manage COPD in the community and reduce hospital admissions;
- building on our approach to shielding to improve community support to vulnerable patients with specific conditions including working with the third sector, and integrating this with our approach to ACPs;
- embedding actions to improve delays so this becomes standard practice across GG&C e.g. discharge to assess;
- learning from the operation of the CACs to introduce an appointment based model in GP assessment units with same day and next day appointments;
- aligned to this, accelerating the introduction of appointment based "hot clinics" for specific conditions as part of an integrated primary / secondary care pathway; and,
- re-freshing and updating our re-direction protocol to coincide with the re-opening of MIUs and a wider public awareness raising campaign on unscheduled care services.
- Consideration of key learning from the acute sector as articulated in **Appendix 2**.

Next steps include:

- engagement on the draft with key partners and stakeholders;
- further work on the in-scope Acute beds plan and financial framework; and,
- the key impact measures to be used in reporting on progress.

3.3 Originally the plan will be subject to a period of **engagement** with key stakeholders and clinicians in primary and secondary care over the coming months. Key stakeholders include the Scottish Ambulance Service, NHS24, the third and independent sectors, GPs and other primary care contractors, acute clinicians and staff, and neighbouring HSCPs / NHS Boards. The draft will be discussed at various events and fora across GG&C. The engagement process will take place while the draft is being considered by the six HSCPs

in GG&C and by the Moving Forward Together programme. A period of public, patient, service user and carer engagement is planned in late summer and co-ordinated with other public engagement exercises to ensure a joined up and consistent message is given publicly. This is now likely to be towards the Autumn.

3.4 Further work is also required on the **financial framework** to support delivery of the plan – see section 8 of the draft. The draft identifies a number of key actions that require financial investment to deliver. These are summarised in the plan and work to identify the annual investment over the life of the plan is in hand.

3.5 Work is also in hand on the key **impact measures** to be used to demonstrate improvements in performance – see section 9 of the draft. Among the indicators to be used will be:

- emergency admissions;
- acute unscheduled hospital bed days;
- A&E attendances; and
- bed days lost due to delayed discharges.

4. East Dunbartonshire Unscheduled Care Action Plan

4.1 The GG&C-wide unscheduled care planning activity is essential to ensure that plans and actions are coordinated across the Health Board area as a whole. However, improvement activity is an ongoing strategic obligation for the HSCP and one that cannot wait for the conclusion of a wide-ranging consultative process taking place across GG&C.

4.2 It is therefore proposed to establish an East Dunbartonshire Unscheduled Care Action Plan for 2020-21, to give focus to the delivery of these obligations. This action plan continues the good work already underway through the East Dunbartonshire Unscheduled Care Group and structures this and future improvement activity under the priority areas set out in the draft GG&C plan. This provides a clear programme of work for the year ahead, aligned to the wider GG&C agenda. It also provides for improvement activity aligned to our Strategic Plan and the particular circumstances of our local population. This action plan can be updated to ensure it works in tandem with the evolving GG&C framework. With these caveats, a draft East Dunbartonshire Unscheduled Care Action Plan 2020-21 is attached at **Appendix 3** for consideration and approval by the HSCP Board.

5. East Dunbartonshire Unscheduled Care MSG Performance Targets

5.1 Each HSCP is required to set annual targets in relation to the Ministerial Strategic Group (MSG) objectives around unscheduled care. The targets proposed for 2020-21 for East Dunbartonshire HSCP are appended to this report at **Appendix 4**, together with our recent performance against targets. Progress for 2019-20 is projected based on complete months. The MSG has this year moved to using 2018-19 as its baseline year for target setting, whereas previously it was 2015-16 as the last year pre-integration. Targets and actual performance have been illustrated with both baselines visible, to assist with overview. Progress against these performance targets will continue to be reported to the HSCP Board on a quarterly basis.

NHS GREATER GLASGOW AND CLYDE
HEALTH AND SOCIAL CARE PARTNERSHIPS

D R A F T

Moving Forward Together.

The challenge is change

D R A F T

Strategic Commissioning Plan for Unscheduled Care Services in Greater Glasgow & Clyde 2020-2025

March 2020

SUMMARY

- **Unscheduled care services in Greater Glasgow & Clyde are facing an unprecedented level of demand**
- **The wider health and social care system, including primary and social care, has not seen such consistently high levels of demand before**
- **While we are performing well compared to other health and social care systems nationally, and the system is relatively efficient in managing high levels of demand we are struggling to meet key targets consistently and deliver the high standards of care we aspire to**
- **We need major change if we are to meet the challenge of rising demand**
- **This draft plan charts a way forward over the next five years to 2025**
- **Essentially it aspires to patients being seen by the right person at the right time and in the right place**
- **For hospitals that means ensuring their resources are directed only towards people that require hospital-level care**
- **At present, an unsustainable number of people are accessing hospital resources on an unplanned basis when their needs can and should be met in a different way**
- **Therefore the emphasis in this strategy is on seeing more people at home or in other community settings when it is safe and appropriate to do so**
- **The plan includes proposals for a major public awareness campaign so that people know what services to access when, where and how**
- **We will work with patients to ensure they get the right care at the right time**
- **Analysis shows that a significant number of patients who currently attend emergency departments could be seen appropriately and safely by other services. A number of services could be better utilised by patients**
- **We also need to change and improve a range of services to better meet patients' needs**
- **Not all the changes in this plan will take effect at the same time. Some need to be tested further and others need time to be fully implemented. That is why this is a long term plan with some short term actions we need to take soon**
- **The challenge is change**
- **A summary of the key actions in this plan and timescales are shown on the next page. Work to measure the overall impact of the programme is in hand**

KEY ACTIONS

Below is a summary of the key actions in the plan and the timescale for implementation.

Key Actions	Timescale
Communications plan (page 26)	
1) We will take forward a major campaign across a range of media to better inform the public about which service to access for what and when. The campaign will also raise awareness about issues such anticipatory care plans, and key health promotion initiatives. The aim will be to have a more informed public consumer of health and care services.	**Through 2020/21 and updated for future years**
Prevention & early intervention (pages 30-37)	
2) We will implement a systematic programme of anticipatory care plans across GG&C with aim of supporting a reduction in emergency admissions	**2020/21**
3) We will work with the Scottish Ambulance Service (SAS) and patient groups to develop a care pathway to safely manage the care of patients who have had a fall but do not need to be seen in an A&E department.	**2020/21**
4) We will through the frailty collaborative develop an integrated frailty pathway with secondary care, GPs and community teams to provide alternatives to hospital or to reduce length of stay for patients admitted with frailty and that contributes to a reduction in emergency admissions.	**2021/22**
5) We will increase support to carers as part of implementation of the Carer's Act	**2020/21 and ongoing**
6) We will increase the number of community links workers working with primary care to 50 by the end of 2020/21	**2020/21**
7) We will develop integrated pathways for the top six conditions most associated with admission to hospital with the aim of better supporting patients in the community	**By end 2020**
8) We will develop a range of alternatives to admission for GPs such as access to consultant advice, access to diagnostics and "hot clinics" e.g. community respiratory team advice for COPD and promote consultant connect – that enable unscheduled care to be converted into urgent planned care wherever possible.	**By end 2020**
9) We will further pilot access to "step-up" services for GPs as an alternative to hospital admission.	**By end 2020**
10) We will continue the work with the independent sector, GPs and others to further reduce avoidable emergency department attendances and admissions from care homes.	**2020/21**
11) We will explore extending the care home local enhanced service to provide more GP support to care homes	**By end 2020**
Primary and Secondary care interface (pages 38-52)	
12) We will develop and apply a policy of re-direction to ensure patients see the right person, in the right place at the right time.	**2020/21**

Key Actions	Timescale
13) We will test a service in emergency departments that offers patients who could be seen elsewhere advice and assistance in getting the most appropriate service.	**2020/21**
14) To improve the management of minor injuries and flow within emergency departments and access for patients, separate and distinct minor Injury Units (MIUs) will be established at all main acute sites.	**2020/21**
15) We will incentivise patients to attend MIUs rather than A&E with non-emergencies through the testing of a 2 hour treatment targets	**2020/21**
16) We will explore extending MIU hours of operation to better match pattern of demand	**2020/21**
17) We will assess the feasibility of opening an MIU on the Gartnavel site	**By the end of 2020**
18) We will continue to improve urgent access to mental health services	**2020/21**
19) We will reduce the number of A&E attendances accounted for by people who have attended more than five times in the previous twelve months equivalent to 2% of total attendances	**2020/21**
20) We will reduce the number of people discharged in the same day from GP assessment units through the implementation of care pathways for high volume conditions such as deep vein thrombosis and abdominal pain. To enable this we will review same day discharges and signpost GPs to non-hospital alternatives that can be accessed on a planned basis.	**2020/21**
21) We will develop hospital at home approaches that strengthen joint working between consultant geriatricians and GPs in order to better support patients in the community at most risk of admission to hospital. Specific populations will be prioritised, including care home residents and people living with frailty.	**2020/21**
Improving hospital discharge (pages 53-61)	
22) We will work with acute services to increase by 10% the number of hospital discharges the number of discharges occurring before 12.00 noon and at weekends and during peak holiday seasons, including public holidays.	**By end of 2020**
23) Working closely with Acute Teams, HSCP staff will proactively begin care planning as soon as possible after a patient is admitted to hospital with the aim of expediting discharge at the earliest opportunity once the person is medically fit	**2020 / 21**
24) We will undertake a programme of continuous improvement in relation to HSCP intermediate care and rehabilitation and re-ablement services in an effort to optimise efficient and effective use of these resources which are critical to the overall acute system performance.	**2020/21**
25) We will reduce delayed discharges so that the level of delays accounts for approximately 2.5%-3.00% of total acute beds, and bed days lost to delays is maintained within the range of 37,000 – 40,000 per year.	**2020/21**

CONTENTS

List of tables and figures

1. INTRODUCTION

1.1 The health and social care system in Greater Glasgow & Clyde (GG&C) – the largest in Scotland – is facing unprecedented levels of demand. Demand for acute hospital services continues to rise and has increased by 4.3% since 2017/18 and shows no sign of reducing. Whilst the whole system is working hard to deliver more quality care to people than ever before, our performance against some key performance targets has deteriorated in line with this increased demand for example, the percentage of patents seen within 4 hours at emergency departments at currently at 90%, and bed days lost due to delayed discharges has increased by 9,323 since 2017/18. There is also evidence that people are using A&E services more now than they used to in the past.

1.2 Despite this the health and social care system in GG&C performs well compared to other systems nationally, and is relatively efficient in managing high levels of demand and dealing with complexity. However, an over-reliance on unscheduled care services can indicate that a health and social care system is not performing optimally in helping people to know where to go to for help.

1.3 The health and social care system can be confusing for patients, and complicated to navigate for clinicians, staff and the general public. It is often not clear to patients and families which service should be accessed for different needs, how and when. This is an inherent challenge when there are such a broad range of needs, specialisms, professional groups and varying levels of health literacy amongst the general population.

1.4 We must adapt our service model in response to an ageing population, and changes in how and when people choose to access services, so that we can meet patients' needs in different ways, ensure services are more clearly integrated and that the public understand better how to use them. The challenge is change.

1.5 Providing more of what we currently have (e.g. more emergency departments) is neither possible within the resources we have nor does it fit with our longer term ambitions of providing care closer to where patients live, and reducing our reliance on hospitals. We believe people's needs should be met in community settings whenever possible with primary care as the corner-stone of the health and social care system.

1.6 This draft strategy outlines how we as Health and Social Care Partnerships (HSCPs) in Greater Glasgow & Clyde, in partnership with secondary care colleagues and other partners plan to support people better in the community, developing alternatives to hospital care that ensure hospitals are utilised only by those that require that level of medical care. This plan describes the delivery of an integrated system of health and social care services that we believe will better meet patients' needs. While this is a strategic plan outlining improvements for patients to be implemented over the next five years, we also include some immediate actions that can be delivered in the short term in response to current imperatives.

1.7 We will require patients and the wider public to share responsibility for achieving the improvement in service performance and experience we all want to see over the next 5 years. A key element of that will be working with the public to increase general knowledge and understanding of which services to access for what and when.

1.8 In developing this strategy we recognise that the health and social care system operates in a wider social and economic context which often drives demand for health and care support. This plan has been developed at a time when significant changes are taking place in the population we serve, and in society as a whole, that will have an impact on health and social care services. According to the National Records Office "In recent years … increases in life expectancy have stalled"[1], and the Institute for Fiscal Studies has reported that "average household income [in the UK] growth stalled in 2017-18 and is still only 6% above its pre-recession levels"[2].

1.9 Both these factors, and others, will influence the shape and pattern of demand over the next few years. Therefore whilst we make estimates of the potential impact of our programme, it is impossible to provide guarantees of future impact. There are many complex and unpredictable factors involved in being able to predict future impacts with certainty, particularly into the long term. The estimates of potential impact should therefore be viewed with this qualification in mind.

What is unscheduled care?

1.10 Unscheduled care has been defined as:

"… any unplanned contact with health and / or social work services by a person requiring or seeking help, care or advice. Such demand can occur at any time, and services must be available to meet this demand 24 hours a day. Unscheduled care includes urgent care and acute hospital emergency care."[3]

Integration Joint Boards' responsibilities

1.11 As part of the legislation on health and social care integration, Integration Joint Boards were given a statutory duty for the strategic planning of unscheduled care services. The integration scheme for Integration Joint Boards includes the following statement and which forms the statutory basis for our strategic planning responsibilities:

"The Integration Joint Board will assume lead responsibility jointly with the five other Health and Social Care Partnerships within the Greater Glasgow and Clyde area for the strategic planning of the following:

- accident and emergency services provided in a hospital.

[1] Life Expectancy in Local Areas 2015-17, National Records for Scotland, December 2018,
[2] Institute for Fiscal Studies, March 2019, Briefing note: No growth in household incomes in the last year – for only the fourth time in the last 30 years
[3] *Commissioning a new delivery model for unscheduled care in London,* Healthcare for London, 2016

- in-patient hospital services relating to the following branches of medicine:
i. general medicine;
ii. geriatric medicine;
iii. rehabilitation medicine;
iv. respiratory medicine; and
- palliative care services provided in a hospital."

National picture

1.12 Audit Scotland in their recent report on the NHS in Scotland stated that:

"***The healthcare system faces increasing pressure from rising demand and costs, and it has difficulty meeting key waiting times standards. Without reform, the Scottish Government predicts that there could be a £1.8 billion shortfall in the projected funding for health and social care of £18.8 billion by 2023/24. So far, the pace of change to address this, particularly through the integration of health and social care, has been too slow."***[4]

1.13 Audit Scotland recommended that the Scottish Government in partnership with health boards and integration authorities should:

"develop a new national health and social care strategy to run from 2020 that supports large-scale, system-wide reform, with clear priorities that identify the improvement activities most likely to achieve the reform needed"[5]

1.14 In 2015 Scotland's Deputy First Minister in his budget speech stated that:

"The nature and scale of the challenges facing our NHS – in particular the challenge of an ageing population – mean that additional money alone will not equip it properly for the future. To be blunt, if all we do is fund our NHS to deliver more of the same, it will not cope with the pressures it faces. To really protect our NHS, we need to do more than just give it extra money - we need to use that money to deliver fundamental reform and change the way our NHS delivers care."[6]

This draft plan

1.15 The purpose of this draft plan is to set out the six NHSGG&C HSCPs' collective response to Audit Scotland's recommendation, and how we aim to fulfil the statutory requirement for strategic planning of unscheduled care services laid down in Integration Joint Boards' integration schemes.

[4] NHS IN Scotland 2019, Audit Scotland
[5] Op cit
[6] John Swinney, MSP, Deputy First Minister, Budget Speech, December 2015

1.16 The draft plan looks at where we are now, assesses the demographics and needs of our population, and current trends in unscheduled care activity in Greater Glasgow & Clyde. We then move on outline our vision for unscheduled care services to respond to the pressures and demands within the health and social care system. We go on to outline specific changes we wish to introduce working with acute colleagues, GPs and others and the estimated impact these changes might have, together with the benefits for patients. Finally we outline the resource framework that will support this work and the implementation arrangements to ensure success.

1.17 This plan should be read together with other plans being taken forward by the NHS Board and Health and Social Care Partnerships including:

- the wider Moving Forward Together programme[7] ;
- our digital and eHealth programme[8];
- our local primary care improvement plans[9] ;
- our Board-wide adult mental health strategy and older people's mental health strategy [in development];
- our redesign of out of hours services[10] ;
- our wider programme of integration of health and social care services[11] ; and,
- our partners' plans such as the Scottish Ambulance Service, NHS24, Strategic Housing Investment Plans and Community Planning plans.

1.18 Before we move on we need to clarify who we are serving when describing the changes we want to see. HSCPs are responsible for delivering health and social care services for their resident populations. Acute services in GG&C however serve a much larger population than those who live in GG&C – approximately 10% of the total acute service activity in GG&C comes from out with the Board area. So while some changes in this plan will affect the wider population e.g. minor injury services, others will only affect HSCPs' resident population e.g. anticipatory care plans. In the main we use Health Board data as it relates to our resident population and where we use data that relates to the totality of activity in GG&C serving the wider catchment population we will explain this in the appropriate section. For any national comparisons that are used we will use national data.

1.19 This plan is a draft because we want to hear your views. We will outline separately how comments may be made as part of our engagement process.

[7] https://www.movingforwardtogetherggc.org/
[8] https://www.nhsggc.org.uk/about-us/digital-as-usual/digital-strategy-outlook-2018-2022/
[9] https://www.nhsggc.org.uk/media/250803/item-12-primary-care-improvement-plans-18-49.pdf

[10] https://glasgowcity.hscp.scot/sites/default/files/publications/IJB%2026%2004%202017%20Item%20No%2011%20-%20Out%20of%20Hours%20Reform%20Update.pdf
[11] https://glasgowcity.hscp.scot/strategic-and-locality-plans

2. WHY WE NEED CHANGE

Introduction

2.1 In this section we look at where we are now, current and projected needs and demand for unscheduled care services. A comprehensive needs analysis was undertaken to inform NHSGG&C's *Moving Forward Together* programme, including a literature search of the available evidence on best practice and system wide change. This analysis is not repeated here and can be found at[12] .

Changes in Demand

2.2 The health and social care system in Greater Glasgow & Clyde is experiencing a period of sustained high demand. The reasons for this are considered to be changes in patient expectations and behaviour (see page 46 below), and changes in our population with an increase in the number of people aged over 75 (see page 13 below) and increases in levels of deprivation[13]. Some of this demand is also due to advances in treatments and technology. A key factor in looking at the pattern of demand in GG&C appears to be an over-reliance by some patients on emergency departments (EDs) for non-urgent conditions. This is sometimes associated with adverse life circumstances and ageing.

2.3 At a headline level in 2018/19 there was:

- a continued growth in emergency department attendances at all main acute sites (a 4.3% increase on 2017/18);
- which creates difficulties in meeting the national 4 hour waiting time target on a consistent basis (at the time of writing performance was at 80.9%[14]). During 2018/19 in emergency departments in GG&C the percentage of patents seen within 4 hours at main sites was 88% compared to the national value of 90%;
- a slight decrease in GP referrals to assessment units year on year (-1.3%) with no change in the percentage of patients discharged on the same day (45%-48%);
- a slight increase emergency admissions (0.5%) and a decrease in emergency admission bed days (-1.2%);
- an increase in delayed discharges with, in 2018/19, 36,968 acute hospital bed days lost due to delays; and,
- heightened levels of activity in all services over the winter period and on public holidays.

[12] https://www.movingforwardtogetherggc.org/media/248682/mft-top-100-transformational-articles.pdf

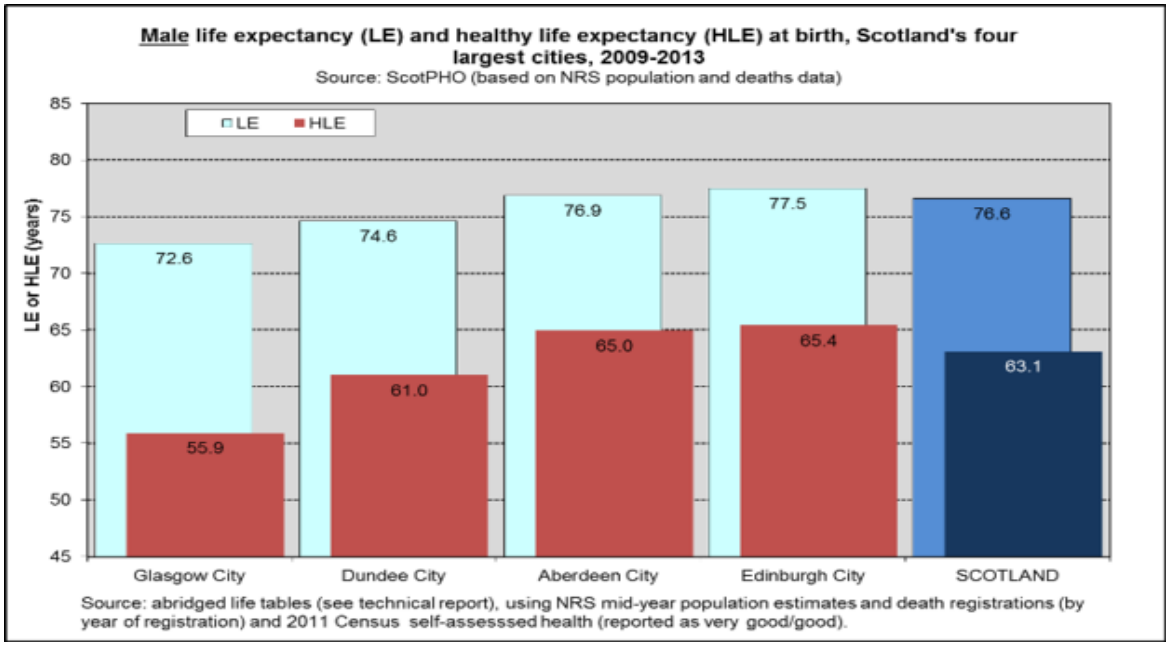
[13] https://www.gov.scot/publications/scottish-index-multiple-deprivation-2020/

[14] https://www.nhsperforms.scot/hospital-data?hospitalid=20

Changes in our population

2.4 Coupled with these changes in demand we have also seen changes in our population. We are now seeing for the first time a reversal in the increase in life expectancy for women and men; due it is thought to social and economic reasons[15] . People are still living longer than they were but when looking at healthy life expectancy (life expectancy adjusted to take account of health) we see that for many this is significantly lower than life expectancy (see figure 1)[16].

Figure 1: Male life expectancy and healthy life expectancy at birth 2009-2013

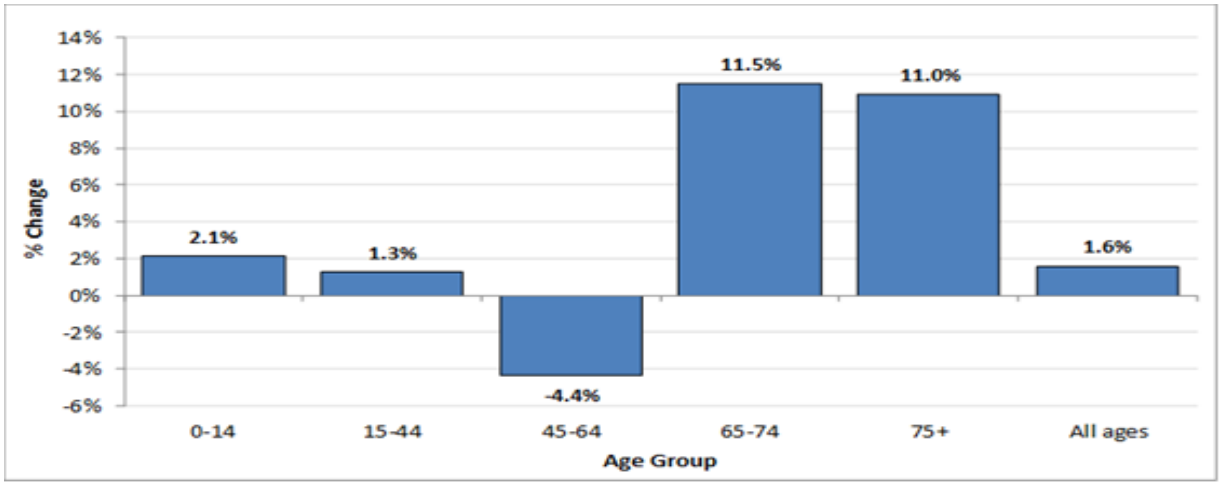


2.5 In addition it is projected that over the next ten years to 2030 in Greater Glasgow & Clyde we will see a 24% increase in the number of people aged over 65 and a 32% increase in the number of people aged over 90. There are also more immediate increases over the next five year with a projected 11% increase in those aged over 75 (see figure 2 below).

[15] *Mortality and Life Expectancy trends in the UK: stalling progress,* The Health Foundation, November 2019 *https://www.health.org.uk/publications/reports/mortality-and-life-expectancy-trends-in-the-uk*

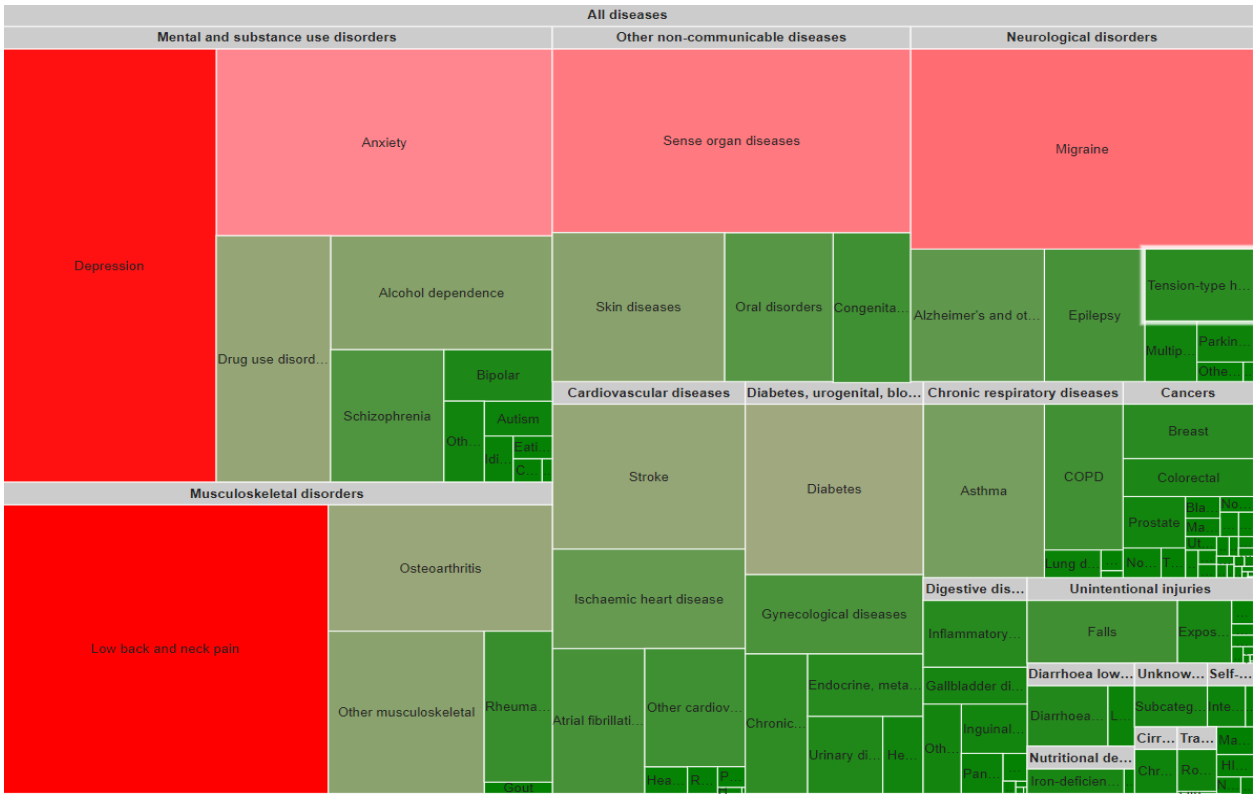
[16] http://www.understandingglasgow.com/indicators/health/trends/male_healthy_life_expectancy/scottish_cities/males

Figure 2: Projected GG&C population change 2019 to 2025



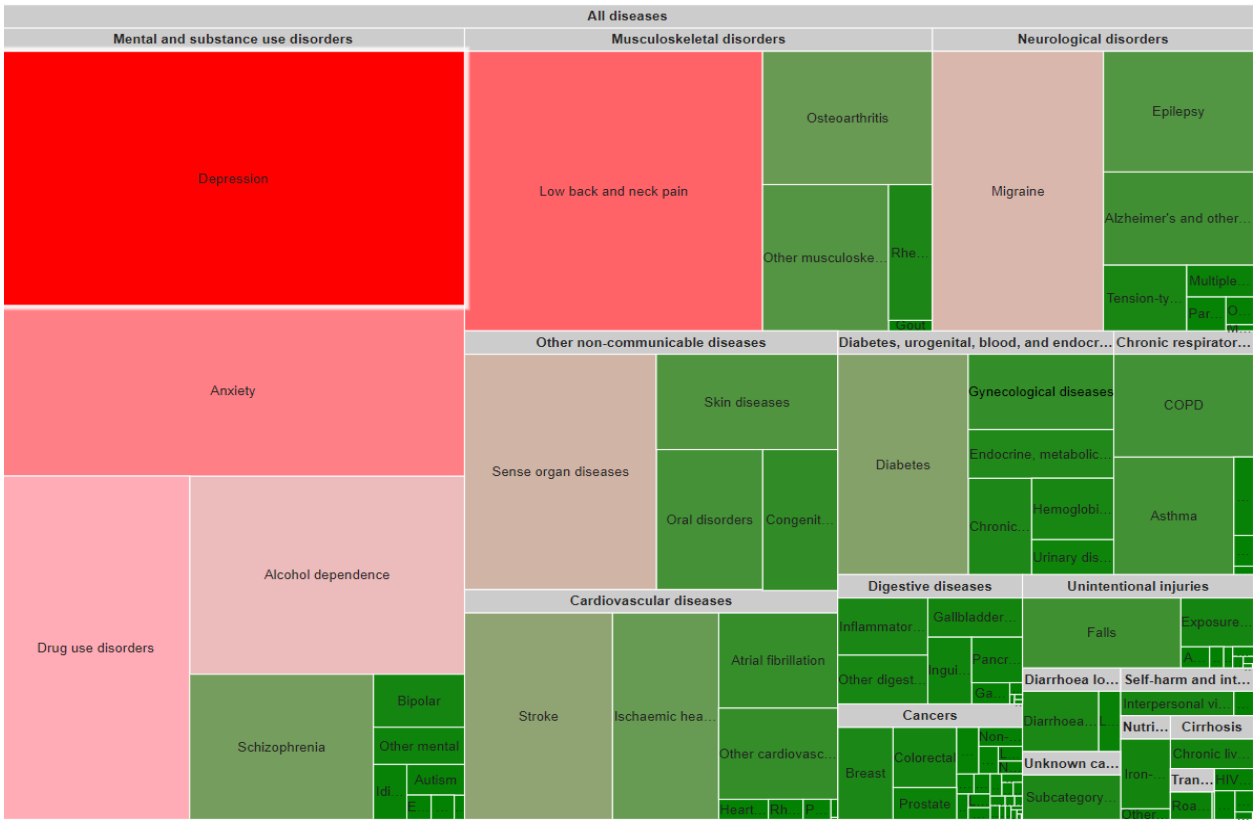
2.6 We can also look at the profile of disease in our population and while this shows considerable changes in the causes of ill health from ten years ago, it also shows differences within our population. The figure 3 below shows the burden of chronic illness and disability in the population as a whole in Scotland and figure 4 shows the picture for the poorest 10% of the population.

Figure 3 – Chronic illness and disability all Scotland



Source: ISD

Figure 4 – Chronic disease and disability Scotland poorest 10%



Source: ISD

2.7 For more information on the health population of Greater Glasgow & Clyde see https://www.nhsggc.org.uk/your-health/public-health/the-director-of-public-health-report/dph-report-2017-2019/

Understanding Current Trends[17]

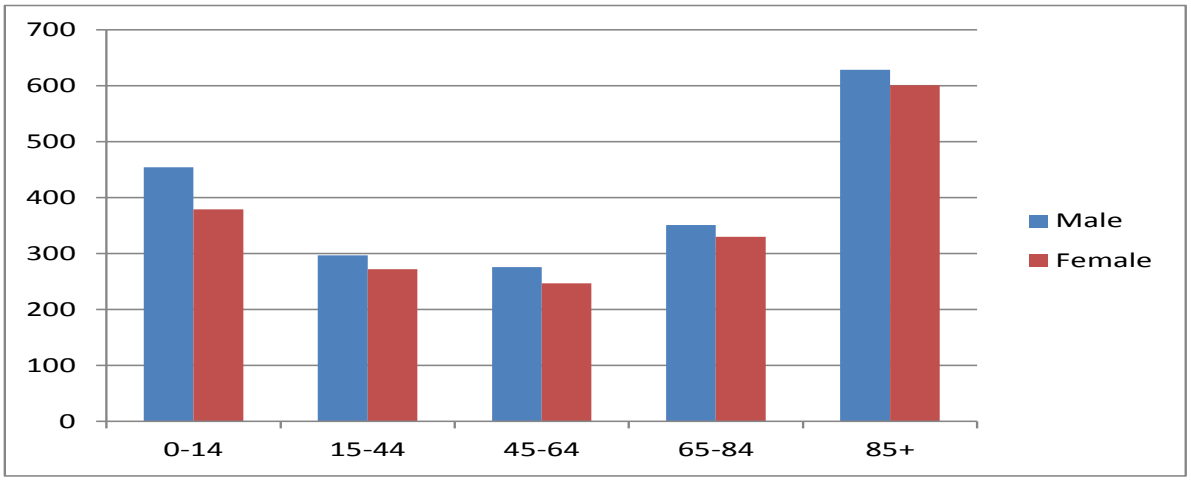
2.8 The current levels of unscheduled care activity in GG&C are unprecedented, and have been driven by demographic changes and the health of our population.

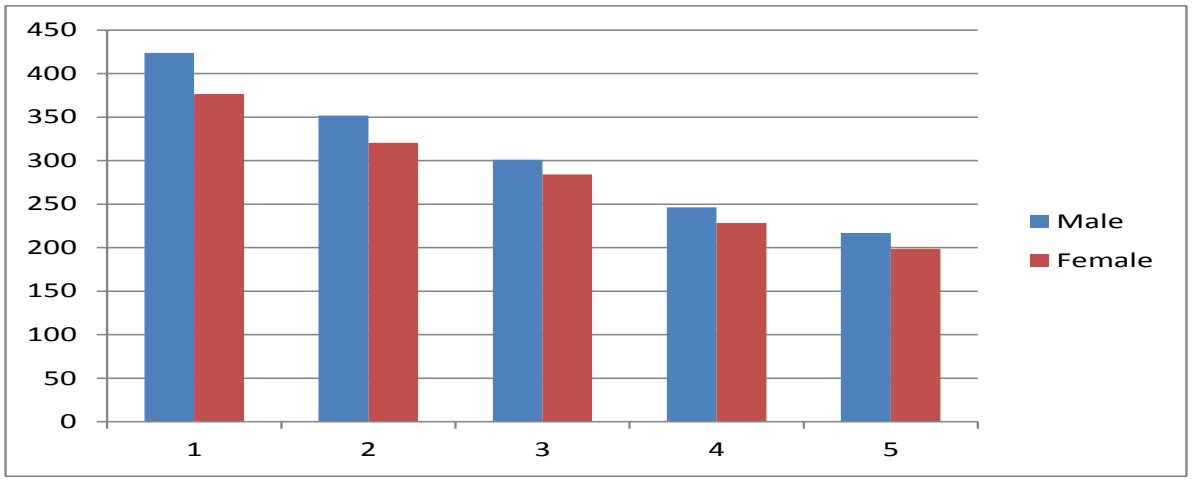
2.9 In 2018/19 there were a total of 517,730 unscheduled care attendances in secondary care. This includes attendances at emergency departments (EDs), GP assessment units (AUs) and minor injury units (MIU). This is a 4.3% increase on total attendances in 2017/18. Of these attendances 448,803 were GG&C residents (87%). The overall attendance rate per 1,000 residents for GGC was 338.2 compared to 285.7 nationally. The rate of attendance varies greatly by age, with higher rates among the young and older age groups. Furthermore attendance rates are higher for those who live in the most deprived areas when compared with the least deprived (see figures 5a and 5b below).

[17] Thanks to John O'Dowd for most of this analysis

This pattern is similar to other parts of the UK but is a particular factor in NHSGGC given the relatively high levels of deprivation in our communities.

Figure 5a. Rates of unscheduled care at hospitals for males and females by age-band. (2018/19). 5b. Rates of unscheduled care for males and females by SIMD quintile for deprivation, (2018/19), where 1 is most socio-economically deprived.





2.10 Of the total number of acute hospital attendances the proportion that requires admission is relatively low at 24% of all hospital attendances. When analysed by source of referral, this varies from 55% of attendances coming via 999 calls, to 37% from GP out of hour's calls, 15% from NHS24 calls, and 11% of patients who self-refer. Of unscheduled care attendances the majority of patients who attend self-refer (66% of all attendances). Of those who do attend emergency departments in GG&C analysis has shown that a significant number could been safely seen and treated elsewhere.

2.11 Based on current trends, and using ISD data, if nothing else changes we can expect a 14.6% increase in ED attendances (see figure 6 below) and a 4.8% increase in emergency admissions over the next five years (see figure 7 below) – this is essentially a do minimum option as it does not take into account the impact of population changes.

Figure 6: Projected total number of emergency department attendances 2020/21 to 2025/26

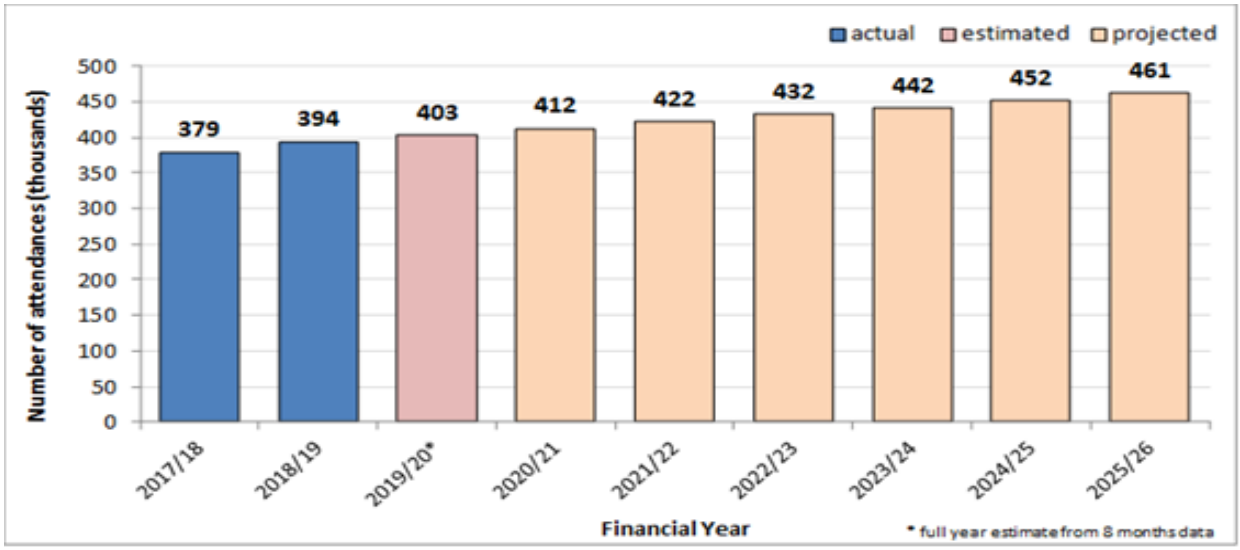
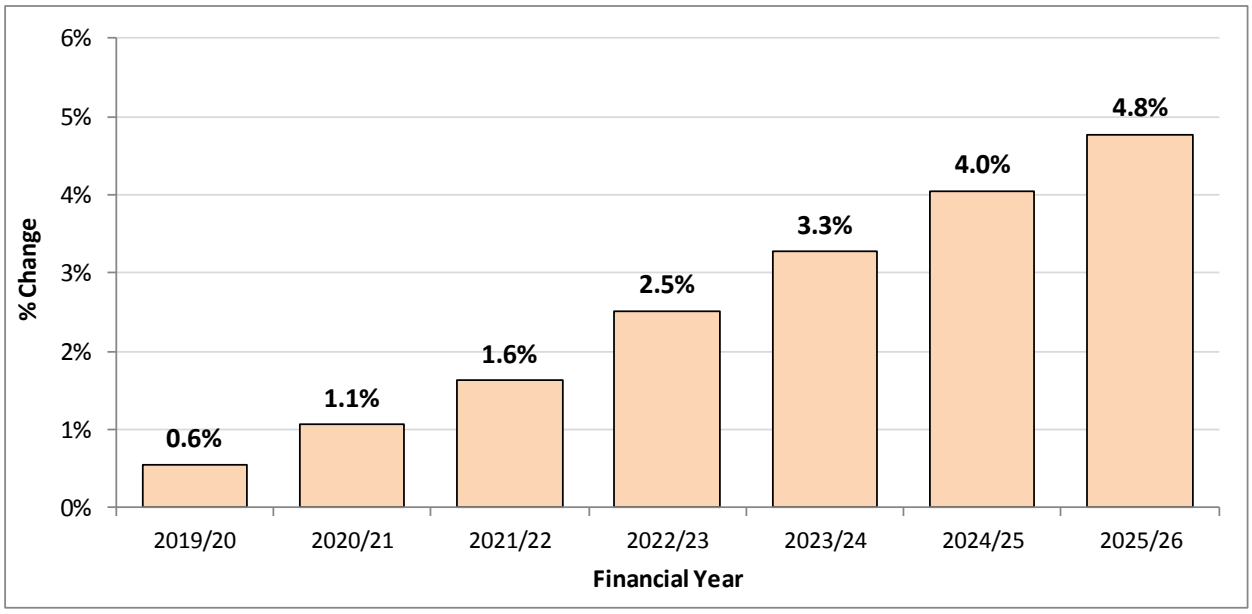


Figure 7: Projected percentage increase in emergency admissions from latest year 2018/19



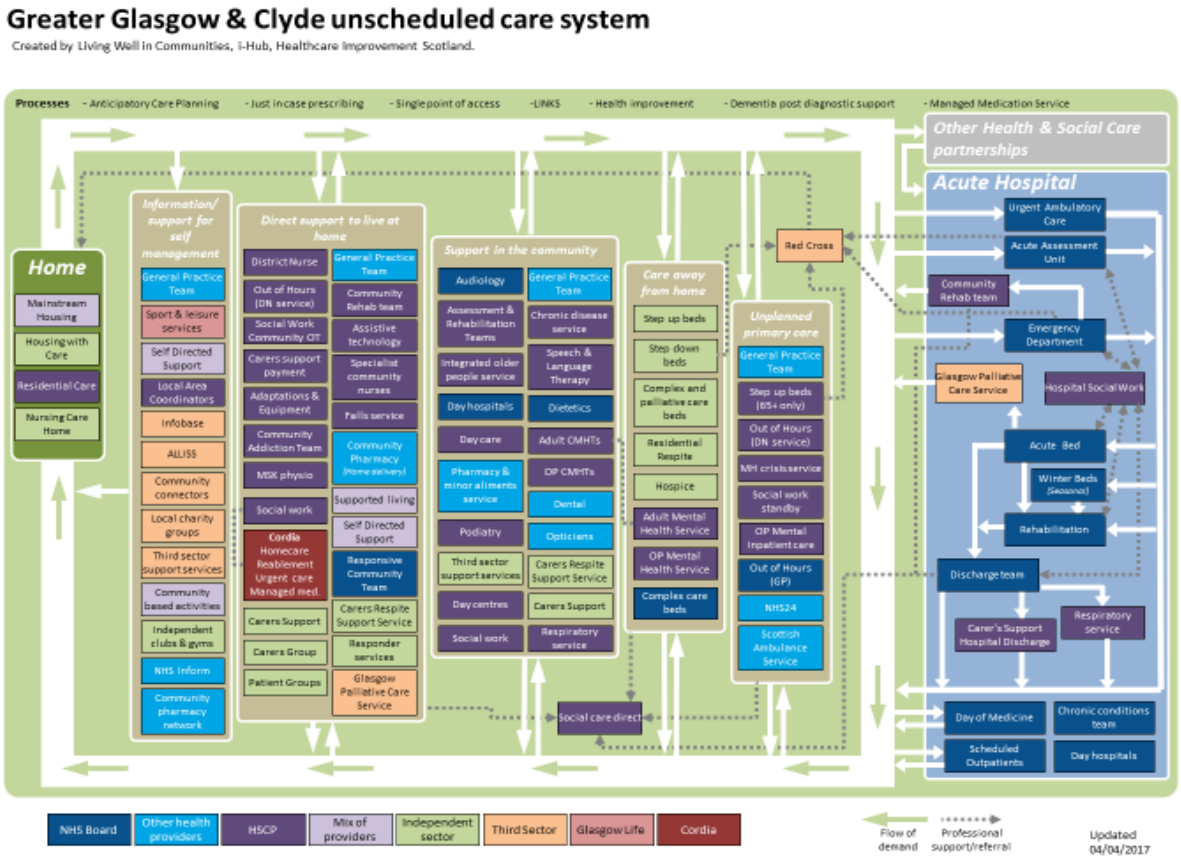
2.12 Unscheduled care is not just a secondary or acute care issue. Unscheduled care attendances also occur within primary care although data on this is not as readily available. We do however have data on GP out of hours activity (OOH). In 2018/19 there were 219,985 OOH consultations, at a rate of 187.2 per 1,000 residents. In hours

consultations can be estimated using English data[18], which shows consultation rates vary from 3.64 to 9.88 consultations per patient per annum nationally. This equates to a range of 4.69 to 12.74 million consultations per annum. The most reliable estimate is considered to be 6.33 million consultations per year. A significant proportion of this in hours work will also be urgent, though it is not yet possible to ascertain the proportion. Most GP practices will have provision for urgent same day appointments, and GPs will be called out to attend patients urgently at home. The Primary Care Improvement Plans have proposals to provide support to unscheduled care in primary care such as advanced practice based physiotherapy and advanced nurse practitioners.

Unscheduled care system

2.13 As explained in the introduction, the current unscheduled care health and social care system is complex (see figure 8). There are many entry and exit points and many interacting services provided by different organisations but all serving the patient. It is also clear that there is a wide range primary care and community based services actively working to support patients.

Figure 8 – Greater Glasgow & Clyde unscheduled care system
[19]



[18] https://www.kingsfund.org.uk/publications/pressures-in-general-practice

[19] Chart produced by iHub and reproduced with thanks

2.14 Our ambition is to change this so that this complex system operates in a more integrated way, supported by new technology. We aim to make it a more straight forward system to navigate for patients and clinicians alike. We will plan a major public awareness campaign to support patients access the right service for their needs, and which enables people to use services wisely. We also plan a co-ordinated approach to health and healthcare literacy skills as this will help people make informed choices about their care.

Primary Care

2.15 Significant changes are taking place in primary care too. GPs have a new contract that came into force in 2018/19 and aims to substantially improve patient care by maintaining and developing the role of primary care as the 'cornerstone of the NHS system'. The essence of the contract is to create conditions that enable GPs to operate as expert medical generalists by diverting from them work that is capable of being carried out by others, thereby allowing GPs more time to spend on more complex care for vulnerable patients and as senior clinical leaders of extended primary care teams.

2.16 The new contract outlines a range of changes that should take place between now and 2021. In the first phase the key priorities include changes in:

- vaccination services;
- pharmacotherapy services;
- community treatment and care services;
- urgent care services;
- additional professional services, including acute musculoskeletal physiotherapy services, community mental health services; and,
- community link worker services.

2.17 While there is limited data on activity within primary care, analysis in GG&C has estimated that there were 3.77 million face to face consultations with GPs and 1.77 million consultations with practice nurses, or 5.55 million face to face consultations in general practice in 2012/13 (the year the analysis was done). The King's Fund has reported a 13% increase in face to face contacts within general practice over the past five years[20]. If this change is reflected across Scotland, and applies equally to GPs and practice nurses, this equates to 4.26 million contacts with GPs and 2.0 million contacts with practice nurses, a total of 6.26 million face to face contacts per annum.

2.18 Changes are taking place in community pharmacy services too with the introduction of pharmacy first[21]. The new NHS Pharmacy First Service will be available from all community pharmacies in Scotland from April 2020. The service will promote community pharmacies as the first port of call for patients seeking care and support on self-limiting

[20] https://www.kingsfund.org.uk/publications/pressures-in-general-practice

[21] https://www.nhsggc.org.uk/patients-and-visitors/know-who-to-turn-to/pharmacist/pharmacy-first/

illnesses and stable long term conditions utilising the ease of access to clinical expertise within this setting available over extended hours of opening.

2.19 Pharmacy First has the potential to become an integral part of the local service provision as the first point of entry to health and social care provision for the majority of residents within a locality. Changes are required to be developed within the community pharmacy network to allow the service to progress due to new ways of working. This service development will lay the foundations for further extensions to local and potential national services and could lead to delivery of other services e.g. treatment of common clinical conditions, shingles, COPD, skin infections etc. It will be important to align these future developments with the demand coming from the GP practices, out of hours, emergency departments etc. to assist with identifying unscheduled care requirements

Out of Hours Redesign

2.20 Following the publication of the Professor Lewis Ritchie report[22] a local review of health and social care out of hour's provision was agreed by all six NHSGG&C Health and Social Care Partnerships, led by Glasgow City HSCP. The Review commenced in September 2017 and was completed in June 2019. A key output of the review process was that an Urgent Care Resource Hub (UCRH) model would be developed to facilitate integrated, person-centred, sustainable, efficient and co-ordinated health and social OOHs services throughout GG&C.

2.21 We plan to implement an Urgent Care Resource Hub model in the summer of 2020 in Springburn, Glasgow. Other hubs in GG&C will follow in a phased approach. This will enable a whole system approach to the provision of scheduled (where planned needs change and require something beyond what the service can provide) and unscheduled (where a patient / service user contacts NHS 24) Health and Social Care. The UCRH will provide a vehicle to enhance and develop integration and co-ordination across a wide range of services. The hub will also have a role to improve and co-ordinate the connection of contacts back into day time services and vice versa. The UCRH provides a single point of access across the health and social care system to support co-ordinated support from multiple services based on need.

2.22 There are currently many access points to out of hour's services including NHS 24, SAS and GPs. The UCRH will provide a whole system response via a single point of access.

2.23 Following the implementation of the UCRH model for the OOHs period we will evaluate the impact of the resource and determine which further opportunities could be considered to support the system, e.g. expand the hours of operation of the UCRH to cover daytime hours.

GP Out of Hours (OOHs)

[22] https://www.gov.scot/publications/main-report-national-review-primary-care-out-hours-services/pages/0/

2.24 GP OOHs services in Greater Glasgow and Clyde are currently facing a number of challenges which impact on delivering a sustainable service. These include:

- ensuring that that there are appropriate levels of GPs and other staffing across the service to respond safely to current demand;
- recruiting and retaining staff to work in the OOHs period;
- current workload and demand pressures in day time practice adversely impact on recruitment to work in OOHs;
- ensuring that the public are aware of how and when to use the service; and,
- reinforcing that GP OOHs is not an extension of in-hours general practice when patients are struggling to / do not attempt to obtain an appointment.

2.25 The service sees a significant number of patients every year in eight primary care emergency centres in GG&C and a home visiting service is also provided for patients who are unable to come to a centre – this is usually frail older people or people at the end of their lives. Centres are closed when the service has insufficient staff and patients are directed by NHS 24 to their nearest available centre. A home visiting service is always provided and transport is provided if people do not clinically require a home visit and do not have transport.

2.26 During 2017/18 and 2018/19 a series of key stakeholder engagement events, were undertaken which included a wide ranging exploration of the challenges faced by the service and identification of the opportunities which helped to shape a programme of work. The key changes are outlined below:

- **developing a sustainable workforce** – ongoing recruitment of GPs (including salaried GPs, ANPs and Primary Care Nurses to support the service);
- **developing professional to professional support** – another health professional working in the out of hours period, who required to speak directly to a GP who is working in the out of hours service require to contact via NHS 24. District Nurses can now contact the GP OOHs service direct during weekend days. There are plans, when resources allow, to extend this facility to cover the OOHs period.
- **frequent attenders** - it is recognised that there are people who frequently attend the GP OOH service. Some of these may also attend in hour's services and the Emergency Departments. Others may have made no effort to contact their GP or NHS 24. Details of these patients are provided to the HSCPs to incorporate into their work on people who frequently attend Emergency Departments.
- **self-referrals** - the service has always seen patients who arrive at a centre even if they have not called NHS 24 – self referrals or "walk-ins". Services elsewhere in Scotland do not provide this option. An element of this will be appropriate – patients who are experts in their own condition, who recognise their deterioration and know that it needs action. However, some could be given advice from NHS 24 and do not needed to not be seen, some could wait to see their own GP the next day and some could be seen by another service such as community pharmacy, dentistry or optometry. An implementation plan to support people to call NHS 24 has been

developed with the aim that the service will not see people unless they have called NHS 24 or have been directed by another heath professional such as the Emergency Department or Community Pharmacy.

2.27 The impact of this work will lead to a revised profile of demand on the service. Therefore further development work has been identified to:

- determine the number and location of centres from which GP out of hours urgent care is available. The hours of operation of these centres and the implementation of an appointment system to support the management of patient flow to the service. The workforce model of the GP OOHs service also needs to be considered as part of this work. This work will also describe the links to the Urgent Care Resource Hub (UCRH) through which links to other out of hours health and social care services may be available. The patient transport service should also be considered as part of this work;
- the changes that will be delivered in the six HSCP Primary Care Implementation Plans through to March 2021 and beyond will bring a clear focus on ensuring the use of day time, planned care services are maximised;
- develop a communication and engagement strategy which supports the recommendations of the site options appraisal and the service re-branding;
- develop a risk management framework, as part of a site options appraisal which considers all possible consequences of reconfiguration of GP OOHs services, e.g. increased attendances at Emergency Departments and work in partnerships with services across the system to describe and establish appropriate mitigation actions; and,
- work collaboratively with neighbouring NHS Boards/HSCPs to better understand how to reduce demand for Greater Glasgow and Clyde GP OOHs service from outside NHSGG&C.

Public Health Strategy

2.28 The Public Health strategy *"Turning the Tide through Prevention"*[23] sets the strategic direction for public health in Greater Glasgow and Clyde to improve public health outcomes through collaboration. The aim of the strategy is that NHS Greater Glasgow and Clyde (GGC) "becomes an exemplar public health system which means there would be a clear and effective focus on the prevention of ill-health and on the improvement of well-being in order to increase the healthy life expectancy of the whole population and to reduce health inequalities". The aim of the strategy is that by 2028, NHSGGC healthy life expectancy (HLE) should be equal to the rest of Scotland with a narrowing of the inequality in life expectancy within GGC.

2.29 The strategic objectives of the strategy are to:

[23] https://www.nhsggc.org.uk/media/251914/item-8-paper-18_59-update-on-turning-the-tide-through-prevention-board-paper-final-version.pdf

- reduce the burden of disease through health improvement programmes and a measureable shift to prevention;
- reduce health inequalities through advocacy and community planning;
- ensure the best start for children with a focus on early years to prevent ill-health in later life;
- promote good mental health and wellbeing at all ages;
- use data better to inform service planning and public health interventions; and,
- strengthen the Board and the Scottish Government's ability to be Public Health Leaders

Summary

2.30 The key points from this section are:

- there has been a continued growth in attendances at emergency departments in GG&C in recent years;
- we have also seen changes in our population with a projected increase of 11% in those aged over 75 over the next five years;
- if we do nothing it is projected that emergency admissions will increase by 4.8% over this period;
- our unscheduled care system is complicated to navigate both for patients and clinicians, and we need to change this so it is more integrated and straight forward;
- unscheduled care is not just an acute hospital issue as primary care and community services are facing increased demand too;
- changes are planned in GP services, community pharmacy and out of hours services to better meet patients' needs; and.
- our public health strategy aims to address the longer term issues of healthy life expectancy, tackling inequalities and reducing the burden of disease.

3. OUR VISION

3.1 Our ambition is to improve the health of our population, and meet people's health and social care needs better, by improving access to health and social care support when and where they need it. In order to do this we must transform the way we deliver health and social care services and work collaboratively with key partners in the third and independent sectors, SAS, NHS24, housing, GPs and other primary care contractors, our staff, and users and carers. Each Partnership has published a strategic plan that describes the specific programmes we plan to take forward to realise these ambitions over the next three years.

3.2 The *Moving Forward Together* programme[24] was launched in 2017 as a wide range transformation programme in response to changes in needs and demands, advances in technology and changes in the way health care is delivered. The programme culminated in a report published in June 2018 that set out a strategic direction for health and care services over to next five to eight years. That report stated that in respect of unscheduled care:

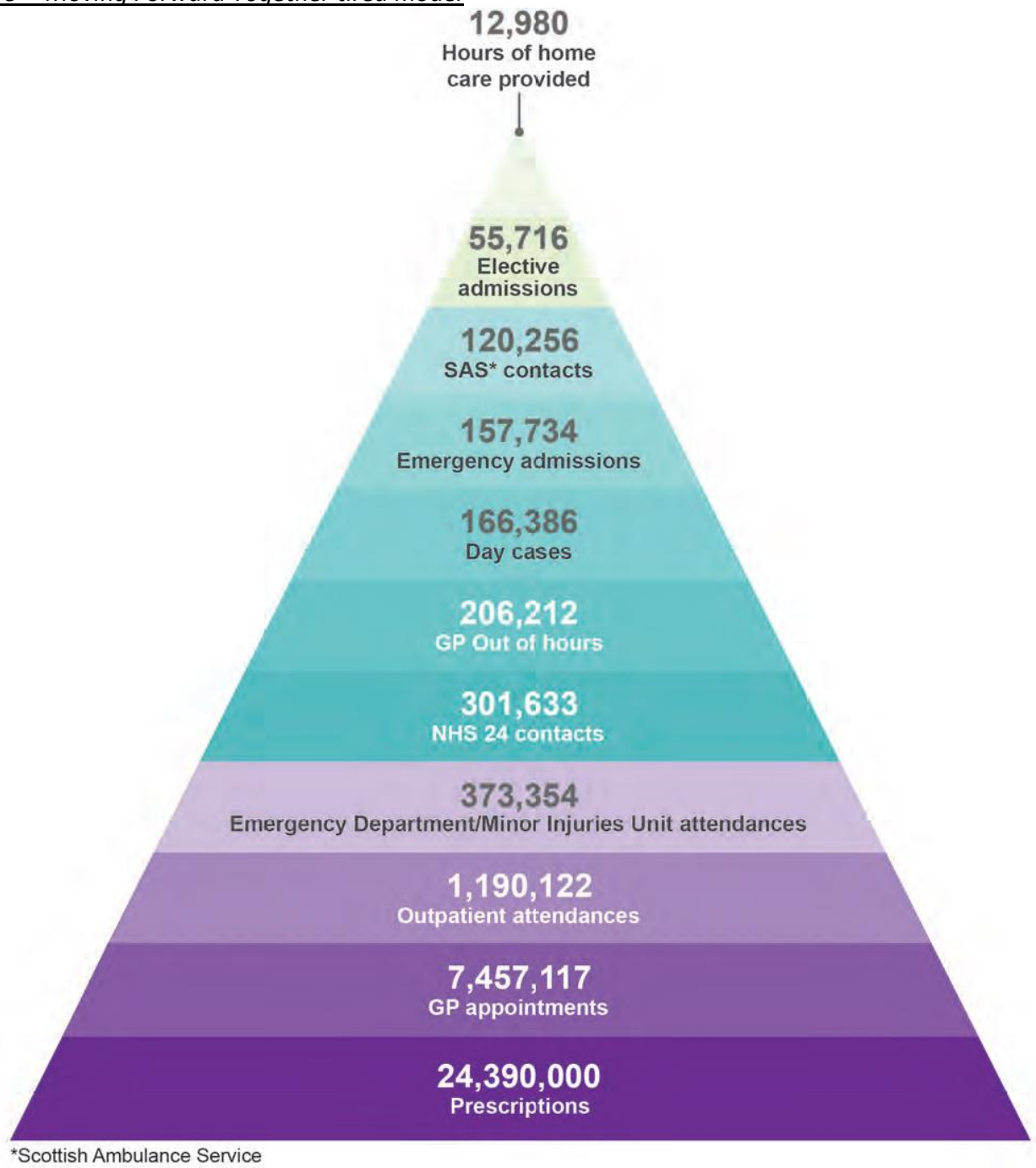
> ***"Our approach … should ensure people are admitted to hospital only when it is not possible or appropriate to treat them in the community. Admissions should be reduced whenever alternatives could provide better outcomes and experiences.***
>
> ***We should develop our system wide approach to unscheduled care in which:***
>
> - ***people have access to a range of alternatives to attendance at their GP surgery or local hospital emergency department;***
> - ***care is better coordinated between community and hospital services at crisis/transition points;***
> - ***services are tiered to provide an appropriate level of care;***
> - ***some specialist services are provided on fewer sites in order to achieve a higher volume of cases and better outcomes;***
> - ***local access to emergency care is at a level that is clinically safe and sustainable;***
> - ***the enhancement of community-based services provide a more appropriate alternative to hospital care;***
> - ***IT systems enable the rapid exchange of up-to-date information between services and support integrated working;***
> - ***ambulatory care services reach out into the community-based networks with jointly designed and delivered pathways across the whole system with specialist support and diagnostic services provided when required;***
> - ***there is better connectivity with community services and participation in agreed ambulatory care pathways across the whole system, involving also NHS 24, GP out of hours services and the [Scottish Ambulance Service, to ensure the***

[24] https://www.movingforwardtogetherggc.org/

most appropriate care for individuals by the most appropriate person or service at the right time and in the right place."

3.3 This can be illustrated in the model shown below.

Figure 9 – Moving Forward Together tired model



3.4 In step with this approach is the maximising independence programme being developed by Glasgow City HSCP which has echoes in approaches by other HSCPs for example compassionate Inverclyde. The maximising independence programme proposes a step change in individual, family and community independence from statutory support, a focus

on prevention and early intervention approaches in partnership with local community organisations and third, independent and housing sector partners. This assets based approach is in recognition that the tolerance of the health and social care system to absorb increasing demand is limited and change is needed[25]

3.5 Our vision is that self-care and prevention is prioritised, so that a greater proportion of needs are met in a planned way. This approach involves a number of elements working together to maximum effect including:

- health education and promotion at both a population level and individual level;
- strengthened community-based services to respond to urgent care needs in-hours and out of hours; and
- a sophisticated ongoing public awareness campaign advising patients which service to turn to when.

[25] https://glasgowcity.hscp.scot/publication/item-no-19-maximising-independence-glasgow-city

4. CHANGING THE BALANCE OF CARE

Introduction

4.1 If we are to respond to the current increases in demand and pressures across the health and social care system described above, and to better meet patients' needs, we need to make some changes. In this section we focus on the key improvements we plan to take forward over the next five years.

4.2 In our view it is highly improbable that the health and social care system can absorb continuous year on year increases in demand without making some fundamental key changes. More importantly we would not be acting in patients' best interests, and getting the best from the resources we have available, if we did nothing to change the services we deliver and commission. The challenge is change.

Long term direction

4.3 We need to present these changes as part of a much longer term strategic direction of travel for the whole health and social care system. *Moving Forward Together* [26] describes the strategic direction for health and social care is to move away from hospital based or bed based services to providing more support to patients in community settings. And to work with primary care, NHS24, the Scottish Ambulance Service, the third and independent sectors, including housing, to develop preventative approaches. This is coupled with an approach that seeks to manage patient care so that patients are seen by the right person, in the right place at the right time.

4.4 This means that each part of the health and social care system should focus on what it does best, and the links and connections between services should be as smooth and efficient as possible so patients receive care when and where they need it. For example emergency departments will function best if they are to focus on accidents and emergencies, and primary care will function best if GPs are supported by other community based professionals to be expert medical generalists.

4.5 There is evidence that a significant proportion of patients may be attending secondary care unnecessarily and could be seen safely and more appropriately elsewhere. For many, their care could be better treated through scheduled care approaches in the community or through supported self-care or care and treatment as outpatients. A number of different explanations for the use of unscheduled care for non-urgent problems have been identified in the literature. These relate to lack of knowledge of healthcare use or confidence in accessing this in the community, and barriers to using in hours care due to work or stigma.

[26] https://www.movingforwardtogetherggc.org/

4.6 To achieve such changes means that we must develop both short term and longer term responses, and test new approaches on the way to see what might work best. In order to support these changes we will develop a major public awareness campaign the purpose of which will be to inform patients and professionals on how best to access the right service at the right time. A consistent message we receive when we engage with the public is that people do not know what service to turn to for what and when. We need to do more to support people become aware of what service to access and when.

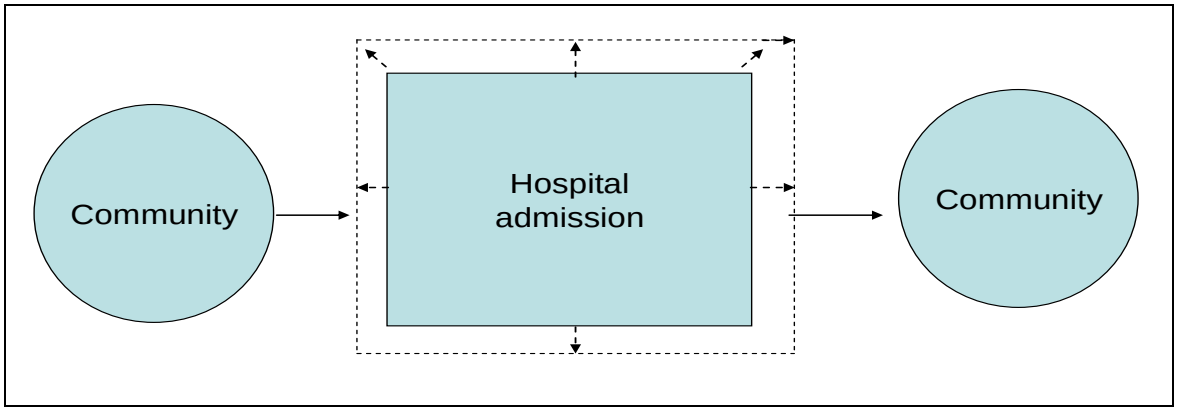
Our priorities

4.7 What follows is our plan to do this by focusing on three key areas each with their distinct but linked programmes of activity:

- ***prevention and early intervention*** to better support people receive the care and treatment they need at or close to home and to avoid hospital admission where possible;
- so that our health and social care system works more smoothly and efficiently in patients' interest we aim to ***improve the interface between primary and secondary care services***; and,
- for people who are admitted to hospital for whatever reason we aim to ***improve hospital discharge*** and better support people to transfer from acute care to appropriate support in the community.

4.8 This reflects the patient pathway as shown in figure 10, below, and is based on the best available evidence of what works – this is described in the 2017 Nuffield Trust report[27] on shifting the balance of care and is summarised in annex A.

Figure 10 – current system of care



[27] *Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), Shifting the balance of care: great expectations. Research report. Nuffield Trust.*

4.9 Prevention and early intervention, and improving hospital discharge, involve programmes that are in the main led by HSCPs working closely with other partners such as GPs, the third and independent sectors and the Scottish Ambulance Service. The primary / secondary care interface programme is a joint endeavour between HSCPs, acute hospitals and clinicians working in primary and secondary care, to test and introduce improvements and will therefore require specific arrangements to take these forward.

4.10 In presenting our programme we have identified the short term actions we intend to take over the period to 2022, in response to current pressures (see section 2 above) and the longer term actions we will work towards up to 2029 to fulfil our vision and the ambitions set out in *Moving Forward Together*. Examples are given of where some of these initiatives are already underway in GG&C or elsewhere.

4.11 In section eight we outline the financial framework to support these changes, and in section nine we identify the impact and outcomes of our programme.

5. PREVENTION AND EARLY INTERVENTION

Introduction

5.1 In this section we outline the actions we have in place to better support people receive the care and treatment they need at or close to home and to avoid hospital admission where possible. We include here our early intervention and prevention strategies and their impact on reducing unscheduled care activity and managing patients in the community. This programme also forms part of the broader early intervention and prevention agenda that is key to delivering the ambitions in the Board's public health strategy outlined in section 2 above.

5.2 The programme is based on the conclusions drawn from a review of the evidence (summarised in annex A), and with reference to the recent iHub review [28] and the framework for community health and social care integrated services published by Health and Social Care Scotland[29]. It is important to note that the reviews of the evidence base are not conclusive about what works in reducing admissions to hospital although they do give us a valuable base from which to plan our programmes. That said the iHub review report stated that:

> ***"It is not possible to draw firm conclusions or recommend implementation of specific interventions for NHS Scotland based on this review [of the evidence] but there was at least some moderate evidence of effectiveness relating to broad groups of interventions***."

Anticipatory care planning

5.3 Anticipatory care plans (ACPs) are key to supporting people with specific needs in the community, including those with long term conditions. A national model for ACPs was introduced in 2017 (www.myacp.scot). In GG&C HSCPs have developed a standardised approach to ACPs that involves a summary of the patient led ACP being completed by community teams and shared with GPs (with the patients' consent) so that relevant information can be included in the Key Information Summary (KIS). The KIS is vital information that is seen by out of hours services, SAS and A&E and crucial to support decision making should a patient attend emergency services.

5.4 By 2021/22 we plan that all people in Greater Glasgow and Clyde over 65 with a chronic condition, who would benefit from an ACP because of a high risk of admission to hospital, will have been introduced to anticipatory care planning and asked to consent to a summary of their ACP being shared with their GP and other relevant care providers via Clinical Portal and KIS. There will be a far greater number of people, families and carers who have been introduced to ACPs and may take up an ACP at a later stage. ACPs are still

[28] https://ihub.scot/improvement-programmes/evidence-and-evaluation-for-improvement/review-of-literature-and-evidence-summaries/reducing-unplanned-admission-to-hospital-of-community-dwelling-adults/
[29] https://hscscotland.scot/resources/

a new concept for the most people and it will take time for the message about the benefits of ACPs to be widely understood. ACPs will be promoted as part of our wider communications strategy to support this plan.

5.5 Through this programme we estimate that over a number of years the take up of ACPs will contribute to a reduction in emergency admissions for those aged over 65. In future years we will further extend this programme to other patients groups (e.g. care home residents) targeting those who may be at risk of admission or re-admission.

Example – Glasgow City HSCP
Glasgow City HSCP is leading on the development of an electronic ACP tool in Riverside Residential Care Home and other care homes to support timely information sharing in decision making in residential care settings.

Falls prevention

5.6 In 2018/19 there were 8,948 people aged over 65 who attended hospital because of a fall. There is a strong link between falls and frailty, although not everyone who experiences a fall is frail. Frailty can contribute to falls and result in a person making a slower or poorer recovery following a fall, and a fall can trigger or accelerate the progression of frailty. Most people who attend hospital because of a fall are aged 85 and over.

5.7 The Scottish Government has launched a new draft *"Falls and Fracture Prevention Strategy"*[30] . In Greater Glasgow and Clyde we have taken action to prevent falls working with other agencies such as the Scottish Fire & Rescue Service, housing and leisure services on early risk identification and promotion of positive messages about physical activity and bone health. We support all staff to be aware of the risk factors and where appropriate to assess patients for falls risk or start a conversation with individuals that could identify that risk. We also work with Scottish Care to support care homes in falls prevention strategies and promoting physical activity, reducing sedentary behaviour to improve strength and balance. We also promote strength and balances classes through our rehabilitation teams and by the community falls team.

5.8 We also aim to work with the Scottish Ambulance Service to reduce the number of people who have had a fall needing to be conveyed to hospital. Not all falls need to attend hospital as other alternatives are available. We are working with the SAS and patient groups to develop a care pathway to safely manage the care of patients who have had a fall but do not need to be seen in an A&E department.

Frailty

[30] https://www.gov.scot/publications/national-falls-fracture-prevention-strategy-scotland-2019-2024/

5.9 Supporting people living with frailty is an increasingly urgent issue for health and social care services. Approximately 10 per cent of people aged over 65 years, and 25 to 50 per cent of those aged over 85 years, are living with frailty. Frailty (see definition below[31]) is associated with age. Older people living with frailty are often at risk of adverse outcomes following a relatively minor event and often fail to recover to their previous level of health.

5.10 Hospitals admit older people more frequently than other age groups and so an ageing population creates additional demand for health and social care services. These admissions are often unplanned and older people who are frail are more susceptible to healthcare associated infections, falls, delirium and difficulties in maintaining good nutrition, hydration, and skin care. As a result frail older people often have longer hospital stays, higher readmission and mortality rates, and are more likely to be discharged to residential care.

5.11 Frailty identification and management to support people is therefore an important part of our early intervention and prevention strategy. There are 23 GP practices in GG&C who have joined the national frailty collaborative to better identify and support people living with frailty[32] . By the end of 2020/21 we aim to have identified all patients whose frailty score has changed from 'moderate to severe' and develop an ACP with information uploaded onto KIS. As a result we estimate that people who are frail will:

- spend more time living in the community with fewer moments of crisis;
- experience fewer incidents of unplanned care, including GP home visits; and,
- be more involved in decisions about their care through ACPs.

5.12 We will also develop, as part of the collaborative, an integrated frailty pathway with secondary care so that there is a seamless service for those patients who require admission to hospital. We will also manage frailty more proactively for those admitted and to optimise pre hospital management where appropriate for this patient group

Carer support

5.13 Carers play a crucial and important role in supporting people at home or other community settings. Carers are key to any strategy that aims to shift the balance of care towards more support and intervention in the community. It is vital therefore that this plan recognises and supports carers in their caring role. Each Partnership has its own carer's strategy as required by the Carers Act 2017[33]

[31] "a geriatric syndrome of decreased reserve and resistance to stressors, resulting from cumulative declines across multiple physiologic systems, causing vulnerability to adviser health outcomes including falls, hospitalisation, institutionalisation and mortality" Fried, 2018

[32] https://ihub.scot/news-events/new-living-and-dying-well-with-frailty-collaborative/

[33] https://www2.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Implementation/Carers-scotland-act-2016

5.14 In total we estimate that Partnerships will support each year, through one means or another, over 4,000 new carers in their caring role.

Primary care based community links workers

5.15 Links workers support people through strengthening connections between community resources and primary care services. Links workers work with patients to identify issues and personal outcomes and then support patients to overcome barriers to addressing these by linking with local and national support services and activities. Links workers support GP practice teams to become better equipped to match support services to the needs of individuals attending primary care. They will also build relationships between the GP practice and community resources, statutory organisations, other health services and voluntary organisations to better support patients. Links workers can therefore play a vital role in the community based network of support to prevent people needing to access hospital services.

5.16 In Greater Glasgow and Clyde we aim to have over 50 link workers in post by the end of 2020/21 focused on GP practices with the most deprived patient populations. In total we estimate that by the end of 2020/21 links workers will have supported 17,500[34] people registered with GP practices in the most deprived areas of GG&C.

5.17 These new posts will be aligned with other similar roles such as community connectors, Local Area Co-ordinators and the community orientated primary care initiative. Community connectors, Local Area Co-ordinators, and others also help people access community supports to improve well-being.

Avoidable admissions[35]

5.18 Ambulatory Care Sensitive Conditions (ACSCs) also known as Primary Care Sensitive Conditions (PCSCs) have been used as a way of assessing what proportion of hospital admissions could potentially be avoided through other interventions, including stronger community management and early intervention / prevention. The thrust of this plan is to better support people at home or in community settings. So if we can do more to prevent hospital admissions and provide care and treatment in the community we should do so, particularly where there is an evidence base to support such an approach. We need to avoid circumstances where decisions to admit a patient to hospital are taken for largely social reasons rather than clinical reasons

5.19 In 2018/19 in GG&C the main reasons for admission to hospital were:

- COPD & pneumonia
- sepsis
- cerebral infarction

[34] Calculated on the basis that each worker receives 350 referrals per annum based on caseload in East Ren
[35] Thanks again to John O'Dowd for this analysis

- fracture of femur, and
- other disorders of the unitary system

Table 1 – main reasons for hospital admission 2018/19

2018-19 non elective inpatient activity		
Reason for admission	**Occupied Bed days**	% of Total OBD
Pneumonia	**43,776**	4.5%
Sepsis	**43,742**	4.5%
Cerebral Infarction	**37,102**	3.8%
Fracture of Femur	**36,465**	3.7%
COPD	**34,518**	3.5%
Other Disorders of Urinary System	**33,125**	3.4%
TOTAL	**228,728**	**23.5%**

Notes:
1. Discharges of Non elective IP only
2. Excludes other HSCP
3. Includes all ages

5.20 Of these COPD & Pneumonia accounts for 8% of total occupied bed days following an emergency admission. We will continue to develop our community respiratory services across GG&C that have proven effective in supporting people with COPD in the community and prevent admission to hospital. In this way we estimate that in 2020/21 we will have avoided a significant percentage of these admissions.

5.21 In 2020/21 we will also introduce a revised model of care for heart failure utilising the skills of the specialty nurse practitioners and other professionals within a multi-disciplinary team construct to develop alternatives to admission.

5.22 For the other conditions we will develop new care pathways with primary care to ensure that wherever possible patients can avoid attending hospital. Our aim will be to start patient pathways in primary care and community services supported by access to diagnostics and secondary care clinical advice as an alternative to an overnight stay in hospital.

Example – Glasgow Community Respiratory Service
The Community Respiratory Team is a nationally unique service that supports the needs of people living with COPD in their own home and is made up of physiotherapists, respiratory nurses, pharmacists, occupational therapists, dieticians and rehabilitation support workers. GPs refer to the service as an alternative to patients going into hospital by accessing the specialist service to support the patient in their own home. The service also facilitates early discharge from hospital by closely linking with secondary care colleagues and providing responsive follow

up and support.

The ethos of the service is to provide a personalised approach to care, enabling self-management by those affected by COPD including:

- *increasing their own knowledge of their condition.*
- *knowing what to do when they are unwell.*
- *improving knowledge of inhaled therapies.*
- *knowing how to clear secretions from their chest.*
- *increasing their physical activity and independence through the provision of home pulmonary rehabilitation and equipment.*

An evaluation has shown a reduction in the impact of disease, an improvement in quality of life and a reduction in hospital admissions.[36]

Hospital at Home

5.23 Hospital at Home is being promoted as an innovative initiative to support older people with frailty who would ordinarily require admission to hospital to receive treatment in their home[37]. The i hub guidance points out however that while the evidence base identifies potential benefits from this approach there are "areas of uncertainty". Further work is needed to test the benefits of introducing this model in GG&C alongside existing services such as the FIT team in West Dunbartonshire and the Glasgow Community Respiratory Team. Glasgow City HSCP is developing a trial of the Hospital at Home model within a care home in the North East of the City. A number of GP practices in HSCPs are also involved in the frailty collaborative (see above).

Alternatives to admission

5.24 We also need to look at potential alternatives to admission so that GPs have a range of options available to manage patient care in the community. There are five specific measures we wish to test with acute clinicians and GPs to assess the impact on patient care. These are:

- **GP access to consultant advice:** the facility for GPs to obtain direct and timely consultant or senior clinical advice on an individual patient's care has the potential to reduce the need for patients to attend hospital and thus avoid the transport and other arrangements that might need to be put in place in enable this to happen. Consultant Connect piloted at the QEUH has shown some benefits in this respect, and it is now been rolled out to other specialities and hospitals. Experience in Tayside has shown that this also has benefits for emergency departments and GP assessment units. We plan to further test its benefits in

[36] CRT final evaluation report, 2018
[37] https://ihub.scot/project-toolkits/hospital-at-home/hospital-at-home/

2020/21.

- **GP direct access to diagnostics:** access to diagnostic tests is crucial in determining a patient's treatment and care plan. Currently GPs have to refer patients to GP assessment units or ambulatory care clinics for an acute clinician to then order the appropriate tests and review the results. If GPs had access directly to an agreed range of tests and the results, such as CT and MRI, with the facility to discuss the results with a senior acute clinician if need be, then patients may not need to be referred and care and treatment could be managed within primary care. We wish to test this approach with acute diagnostics and evaluate its potential impact on GP referrals and acute activity.

- **next day outpatient appointments:** GP direct access to next day out patient appointments or "hot clinics" in line with an agreed care pathway, supported by patient transport, would provide GPs with a further alternative to referral to GP assessment units. Here we would be seeking the freeing up of an agreed number of appointments to allow GPs to book these direct instead of referring a patient to an assessment unit and potentially being admitted overnight. Essentially this would move some unscheduled care activity to being dealt with in a more planned way. A test of change to evaluate this should be set up involving acute clinicians on the main acute sites.

- **referral for assessment:** the ability for GPs to refer for assessment via SCI gateway with a view to preventing admission is another potential alternative that could be explored. We will set up a test of change to evaluate the potential for such a facility to be introduced across GG&C.

- **step-up care:** we have piloted step up care in care homes that GPs can access for patients who are unwell and need nursing care and observation but don't need to be admitted to hospital. The GPs who use these beds find them helpful in providing patients with care in a community setting for a short period of time before they go home again. If these beds were not available it is highly likely that such patients would have been admitted to hospital via a GP assessment unit (see below). In 2020/21 we will work with GPs and others to review this service as part of a wider review of intermediate care (see below) to determine if this is something we should develop further.

Example – West Dunbartonshire Focused Intervention Team (FIT)
West Dunbartonshire introduced the FIT team in July 2019 with the aim of providing an integrated community based service to support people to remain at home or homely setting as an alternative to hospital admission. The team provide a rapid response service to avoid admission, a care home liaison service to support care homes and COPD. It is estimated that to date, of the referrals received by the team nearly 60% have avoided a hospital admission.

Reducing admissions from care homes

5.25 In 2017/18 across Greater Glasgow and Clyde care homes accounted for 5,900 emergency admissions – 5% of total emergency admissions. Since then Partnerships have developed programmes with care homes to reduce emergency admissions by:

- providing training;
- support to GP practices covering care homes;
- introducing anticipatory care planning; and
- implementing the red bag scheme to safely transfer patients to and from hospital.

5.26 We have also in our residential care homes in Glasgow introduced advanced nurse practitioners covering approximately 550 beds who have already made an impact on both reducing GP call outs and admissions to Hospital.

5.27 By further developing this whole programme we estimated that by the end of 2020/21 we will have reduced emergency admissions from care homes by 2.5% from the level it was in 2018/19.

Summary

5.28 The aim of our prevention and early intervention programme is to reduce emergency hospital admissions particularly for those aged over 65, and support more patients in the community. Our programme based on the evidence of what works includes:

- extending anticipatory care plans;
- falls prevention strategies;
- work to manage frailty in the community;
- link workers to support GPs;
- support to carers;
- developing more integrated patient care pathways for the top key conditions that result in admission;
- assessing Hospital at Home;
- providing GPs with alternatives to admission and more options and support to manage patient care in the community; and,
- work with care homes to reduce admissions to hospital.

5.29 This is an extensive programme and will take time to be fully implemented in its entirety across GG&C. In section 9 we give an indication of the potential impact of the programme on the system as a whole.

6. PRIMARY AND SECONDARY CARE INTERFACE

Introduction

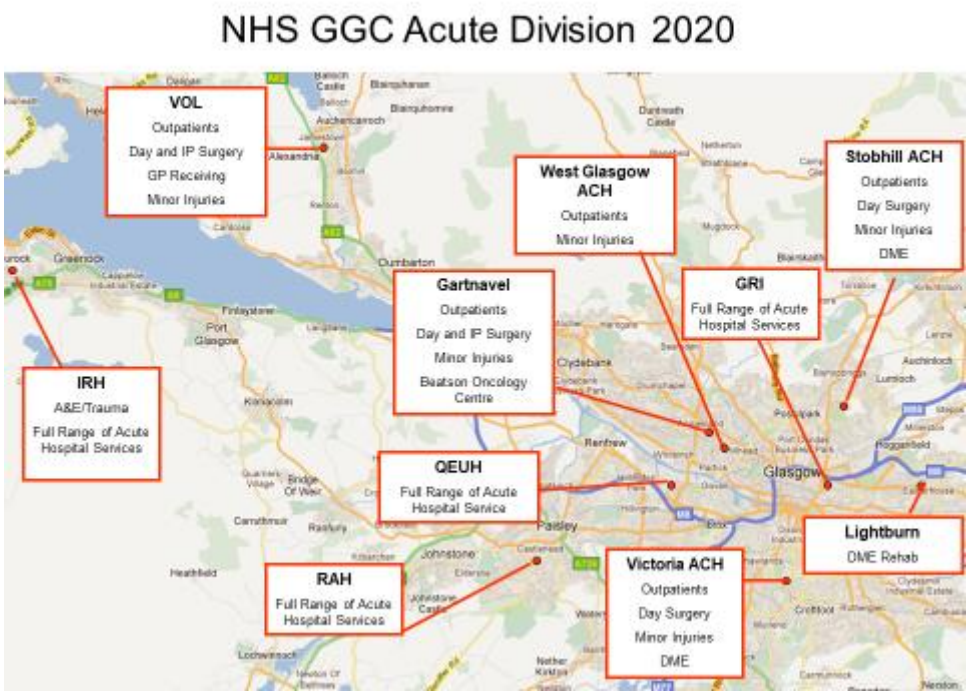
6.1 The interface between primary care, where most patients are seen, and secondary or acute hospital care, where patients attend for specialist treatment and investigations, is important in delivering a quality service to patients. It is in everyone's interest that the communications and links between primary and secondary care work smoothly and efficiently so that patients receive the right care in the right place at the right time.

6.2 In this section we focus on our priorities to improve the interface between primary and secondary care, including actions to reduce demand on our emergency departments as these have seen a significant growth in attendances in recent months (see section 2 above). Actions to address pressures in primary care are included in each HSCPs' Primary Care Improvement Plan.

6.3 Our proposals here focus on what has emerged from our analysis of the population's health and the balance of care, key issues highlighted by GPs and secondary care clinicians, and are set within the context of the strategic direction outlined in *Moving Forward Together*.

6.4 Patients in Greater Glasgow & Clyde access acute emergency and unscheduled care services at the four main acute hospitals – GRI, IRH, QEUH and the RAH (see figure 11 for location of acute hospital services including other hospitals).

Figure 11 – main acute hospital sites in GG&C



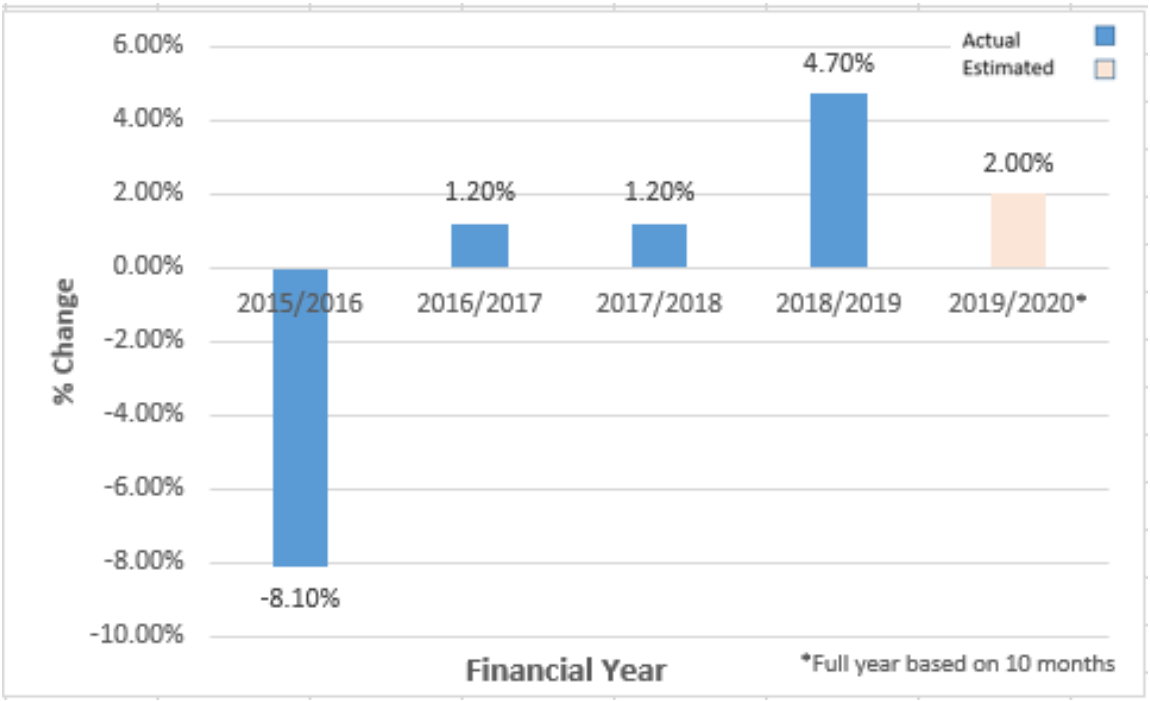
Information sharing

6.5 Information sharing between clinicians and primary and secondary care is vital in reaching decisions about patient care. Great strides have been made in improving information sharing between GPs and secondary care and the eHealth strategy outlines further developments[38] planned in the future. At a micro level improving access to EMIS for secondary care clinicians and the role of ECAN nurses pulling together patient information to inform decision making can make a difference. HSCPs are also encouraging GPs to update the Key Information Summary with summary ACPs to assist managing patients who attend emergency services.

Emergency department attendances

6.6 Emergency department (ED) attendances (see figure 12) have risen steadily in recent years and all EDs in GG&C have struggled recently to achieve the national 95% target for four hour waits (see figure 13). During 2018/19 in emergency departments in GG&C the percentage of patents seen within 4 hours at main sites was 90% against the national target of 95%.

Figure 12: Percentage change in ED attendances from previous year, 2015/16 to 2019/20



[38] https://www.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/

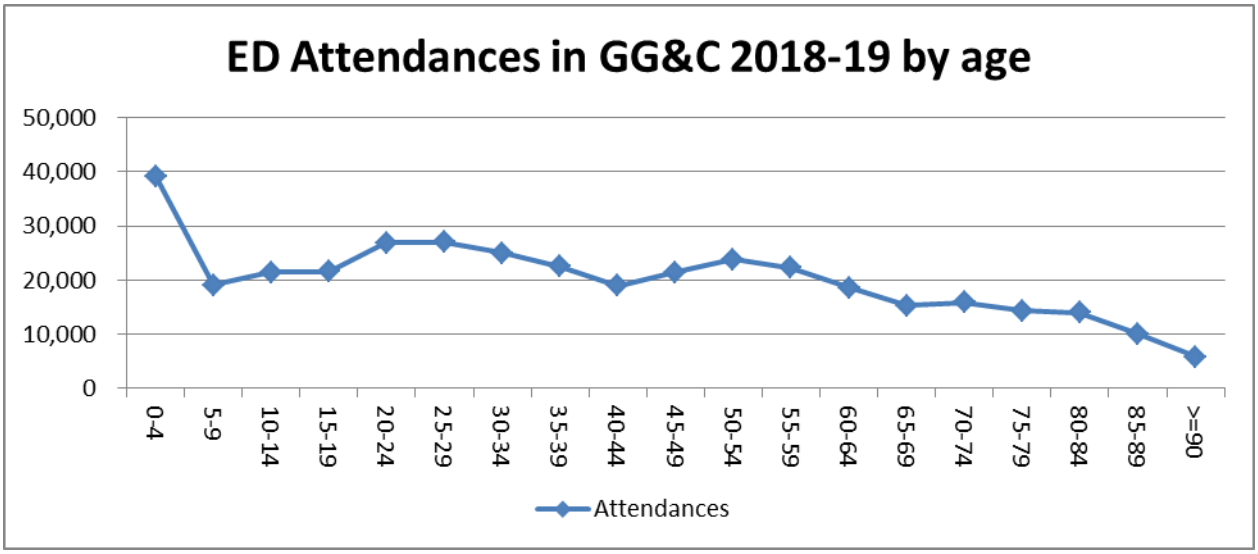
Table 2 – Emergency attendances and 4 hour target – GG&C

Year	% Compliance
2014/2015	87.7%
2015/2016	92.3%
2016/2017	91.9%
2017/2018	89.7%
2018/2019	90.0%
2019/2020 (to February)	85.2%

6.7 Analysis also shows that:

- the highest proportion of emergency department attendances were very young children and those in their twenties;

Figure 13 – ED attendances in GG&C 2018/19 by age



- in 2018/19 there were more than 300 attendances at the four main emergency departments for every 1000 people aged over 65;

Table 3 – Total attendances at 4 major emergency departments in NHS GG&C (2018/19) and rate per 1,000 population

Age	Number of attendances	2018 Population Estimate	Rate per 1,000 population
Age 65+	65,546	181,637	360.9
All attendances	265,514	1,174,980	226.0

- the proportion of attendances for over 65s at the main emergency departments has increased. One in 4 attendances at main emergency departments are over 65;

Table 4 - Attendances at 4 major emergency departments in NHS GG&C (2018/19) by age

Age	Attendances	% attendances
65+	65,546	24.7%
All Attendances	265,514	100.0%

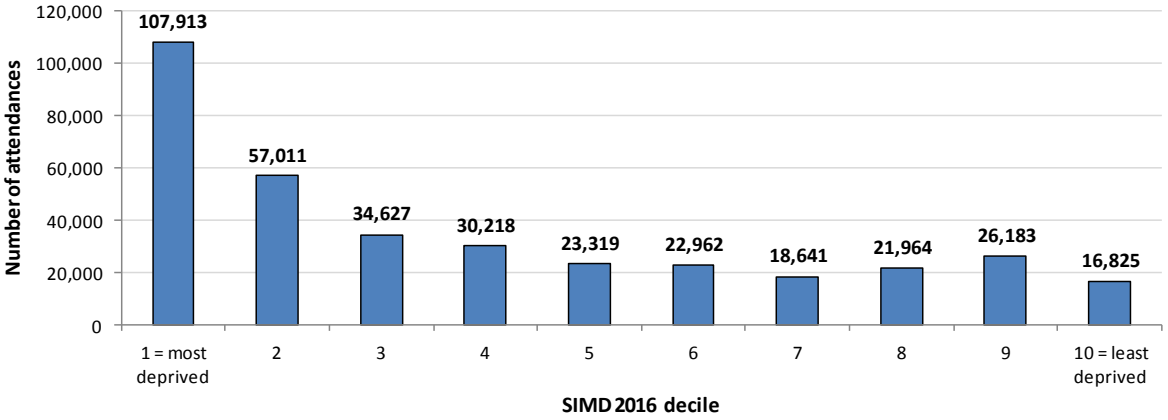
- in 2018/19, on average 58% of attendees referred themselves to ED while 8% were referred by a GP;

Table 5 - Attendances at all emergency departments in NHS GG&C (2018/19) – source of referral

Source of referral	Attendances	% attendances
GP	37,200	8%
Self-referral	256,803	58%
All attendances	440,007	100%

- a patient living in one of the most deprived areas in GG&C is more than six times likely to attend ED than a patient one of the least deprived areas (see figure 14);

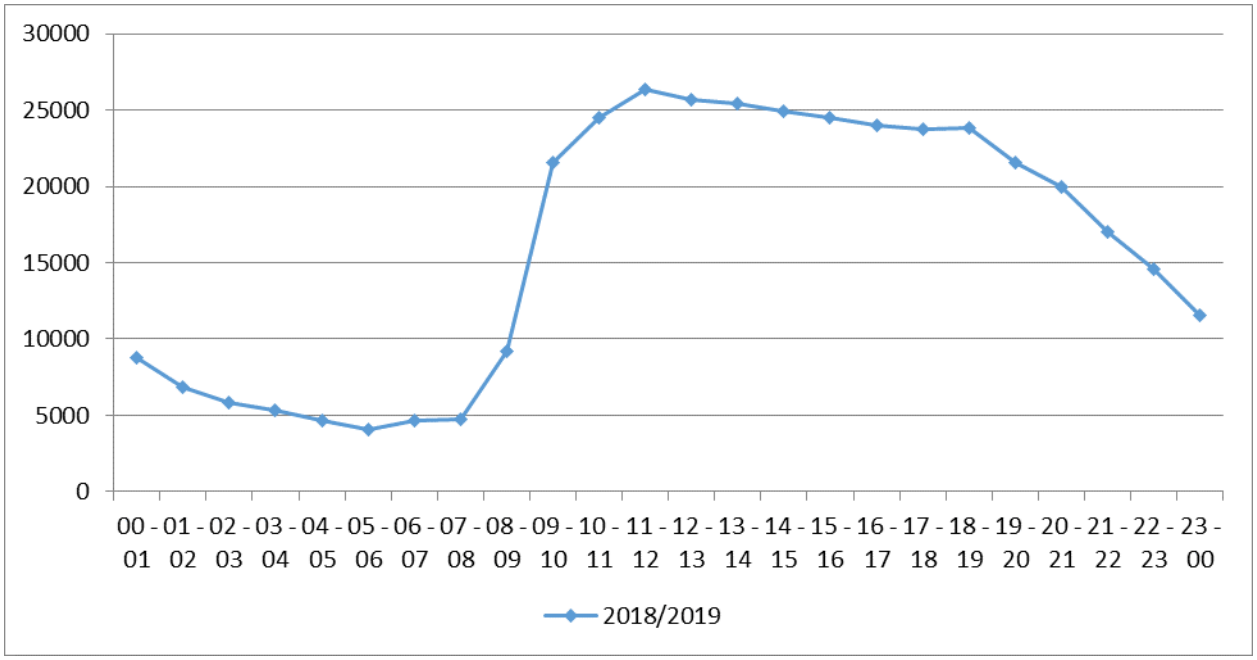
Figure 14 - attendances at all emergency departments in NHS GG&C (2018/19) by SIMD



- users of mental health services were more than twice as likely to have attended ED as non-users. They were also likely to attend more frequently;

- the pattern of arrival time by hour of day has remained consistent over the past five years with most attendances occurring between the hours of 10:00 and 18:00 (see figure 17 below);

Figure 15 - attendances at all emergency departments in NHS GG&C by time of day (2018/19)



- more than one in four of all ED attendances ended with admission to hospital.

Table 6 - attendances at all emergency departments in NHS GG&C (2018/19) percentage admitted

Discharge Destination	Number of attendances	Proportion of all attendances
Admitted	105,126	28.5%
All attendances	368,993	100%

- over half of all ED attendances for people aged over 65 ended with admission to hospital. Compared to nearly one in three for people aged under 10.

Table 7 - attendances for those aged 65+ at all emergency departments in NHS GG&C (2018/19)

Discharge Destination	Total attendances (all ages)	% of attendances (all ages)	Total attendances (64+)	% of total attendances (64+)
Admitted	87,848	23%	35,250	47%
All attendances	383,298	100%	75,390	100%

Table 8 - attendances for those aged under 10 at all emergency departments in NHS GG&C (2018/19)

Discharge Destination	Number of attendances (65+)	Proportion of all attendances (65+)
Admitted	92,715	31.0%
All attendances	299,540	100%

6.8 Further analysis of attendances also shows that approximately 51% of self-presentations are as a result of a minor illnesses or ailments[39]. It is possible then that a significant proportion of self-presentations at emergency departments could be treated by other services such as primary care, pharmacy or minor injuries units[40]. Currently there are no national or GG&C policies in place to support front line staff to direct patients to other services, therefore all individuals who attend ED are seen and assessed. We wish to develop a policy of re-direction to support patients accessing the right service in the right place at the right time.

Public attitudes to A&E

6.9 In putting such a policy in place we need to understand why some people attend ED instead of other services. Recent research[41] into public attitudes to accident and emergency services found that:

- **People living in deprived areas** are more likely to prefer A&E departments over their GP to get tests done quickly, find it more difficult to get an appointment with their GP and think A&E doctors are more knowledgeable than GPs;
- **Parents with children under 5** are most likely to have used A&E in the last year, to think it is hard to get an appointment with their GP, less likely to trust their GP but are also more likely to use the internet to try to decide what the problem might be; and,
- **Men** are less knowledgeable about how to contact a GP out of office hours and less likely to use the internet to research a health problem.

6.10 The study also found that in the main people believe that A&E is overused, and a clear majority (86%) think that too many people unnecessarily use A&E services. This increases to 94% for people aged 65 to 74 years old and drops to 79% for those aged 18 to 24 years.

[39] Demand and Capacity Model for NHS Greater Glasgow and Clyde, Final Report and Recommendations, NECS, 2019

[40] Richardson M, Khouja C, Sutcliffe K, Hinds K, Brunton G, Stansfield C, Thomas J (2018). Self-care for minor ailments: systematic reviews of qualitative and quantitative research. London: EPPI-Centre, Social Science Research Unit, UCL Institute of Education, University College London.

[41] National Centre for Social Research (August 2019)

When asked whether they had actually accessed A&E services in the previous 12 months for themselves or others, 32% of the public and more than half of parents with a child under 5 (54%) report they have done so at least once. 29% of those without young children in the household say they have visited A&Es in the same period.

6.11 Around half (51%) the population agrees that it is hard to get an appointment with a GP. Those with children under 5 (65%) and those living in the most deprived areas (59%) are most likely to agree. While over one third (36%) of the public report that they prefer NHS services where they do not need to make an appointment, those living in the most deprived areas (48%) and those with no educational qualifications (48%) are most inclined to say so. Only 27% of people living in the least deprived areas and 30% of graduates express this sentiment.

6.12 17% prefer A&Es to GPs because they can get tests done quickly. The figure rises to 29% when looking at people in the most deprived areas. This view is held by just 11% of people who live in the least deprived areas. By the same token those with no qualifications are twice as likely (26%) as degree holders to prefer A&Es to GPs to get tests done quickly (13%).

6.13 65% of the total population have confidence in GPs, while 11% state they do not have much confidence. This compares to 18% of those living in the most deprived areas, 16% of people with no qualifications and 20% of parents with a child aged under 5 who do not have much confidence. In contrast, 10% of those without young children and 8% of degree holders and 8% of those living in the least deprived areas feel the same.

6.14 Overall just 19% agree that doctors at A&Es are more knowledgeable than GPs. However, this jumps to a third for those without any qualifications (32% compared with 14% of graduates) and 28% of those in the most deprived areas (compared with 15% living in the least deprived areas).

6.15 58% of people with internet access say they would look online to help understand a health problem, while 47% would use the internet to decide what to do about it. Nevertheless, substantial gaps between demographic groups exist. Young people aged 18 to 24 are twice as likely (62%) to research health problems online than those aged 75 and over (30%). Those without children under 5 (56% compared with 72% of those with young children) and people with no qualifications (42% compared with 71% of graduates) and men (54% compared with 62% of women) are less likely to turn to the internet for health advice.

6.16 When it comes to awareness and confidence to access the right NHS services, most people (90%) report being confident that they know when to see a doctor regarding a health problem. Men (76% compared with 85% of women) and young people (64% compared with 79% of those 75 and over) emerged as the groups least confident in knowing how to contact a GP out of hours. And while 85% of people say they could rely on family and friends to care for them in the case of a non-life-threatening health

problem, this drops to 76% for those in the most deprived areas and rises to 91% for those living in the least deprived areas.

The challenge is change

6.17 So taking public attitudes into account and looking at our performance and recent trends shown above it is clear we need to do two things - change services to meet rising demand and change public awareness and attitudes. The data shows (see figure 6 above) that if emergency departments continue to operate as it stands they will not be able to cope with annually increasing demand[42]. If we do not change either, and ideally both, then primary and secondary care services are going to struggle to keep pace with demand and we will not be able to deliver the best we can for patients.

6.18 We outline our plans to raise public awareness and change attitudes in section 3. The challenge is change.

Patient advice - right service right place

6.19 From the analysis presented above it is possible some patients who are not an accident or an emergency could in theory be seen appropriately by other services rather than having to wait to be seen in A&E. We will test the potential for a service in emergency departments that offers patients who could be seen elsewhere advice and assistance in getting the most appropriate service. This could operate at peak periods and assist in easing pressure on emergency departments and ensuring patients are seen by the most appropriate professional.

6.20 As part of a comprehensive whole-system strategy for unscheduled care, helping patients with minor ailments navigate to alternative sources of support can also be an important change. There is evidence from other health and social care systems that supporting patients who attend A&E and who could more appropriately and safely be seen in primary care can work; e.g. Tayside. Such a policy has been implemented at GRI for certain conditions; e.g. COPD. Patients triaged are provided with information on alternative sources of community support for their condition. The policy has relatively modest aims and follows guidance from the Royal College of Emergency Medicine[43].

6.21 It is important we look at what can be done to guide patients safely and smoothly to alternative services where we can. We wish to work with acute clinicians to test re-direction arrangements at all the main acute sites so that emergency departments can focus on treating patients who need acute care. We will discuss with primary care how this might be done to ensure appointment slots are available timeously for patients re-directed from emergency departments. We estimate the impact of such a policy, supported by a public awareness campaign, the use of Consultant Connect and improved

[42] Demand and Capacity Model for NHS Greater Glasgow and Clyde, Final Report and Recommendations, NECS, 2019

[43] https://www.rcem.ac.uk/docs/SDDC%20Intial%20Assessment%20(Feb%202017).pdf

pathways, could be that potentially in a full year in GG&C 8,000 attendances could be seen within primary care either by GPs or community pharmacies (see table 9). For GP practices this could mean an additional two appointments per week.

Table 9 – potential impact of re-direction

	Total
Non Urgent - 80%	8,711.2
Standard - 10%	9,332.9
Total	**180,44.1**

Note estimate based on 2018/19 data and assumes a reduction of 80% of activity triaged as "non-urgent" and around 10% of "standard" activity.

Minor injuries

6.22 Minor injuries units offer a safe and effective service to patients. The units at Stobhill and the New Victoria see a large number of patients year on year and regularly achieve the four hour waiting time target (see table 10 below). They offer a good model for how we can serve patients better. We think that there should be similar dedicated minor injury units at the main acute hospital sites in addition to those at Stobhill and the New Victoria. Such units would relieve pressure on busy emergency departments and improve the flow within A&E departments and access for patients, separate and distinct MIUs should be established at all main acute sites

Table 10 – MIU attendances

Year	**Total attendances**	**No. under 4 hours**	**% Compliance**
2018/2019	46,575	108	99.8%
2019/2020 (to February)	44,215	129	99.7%

6.23 We will test developing further the MIU service model to deliver shorter waiting times consistently and reliably to increase attendances, and encourage patients to attend MIUs for appropriate cases instead of A&E e.g. patients seen and treated within 2 hours at MIUs versus the 4 hour A&E target. We will also test a change in the hours of operation to better match pattern of demand with MIUs open to 11.00 pm at weekends and Bank Holidays. We also wish to explore the costs and benefits of opening an MIU at Gartnavel.

6.24 If minor injuries were seen in dedicated units rather than being seen in emergency departments we estimate this could significantly reduce A&E attendances with no detrimental impact on patient safety.

Frequent attenders at Emergency Departments

6.25 In 2018/19 there were 1,188 patients who had attended an A&E department in Greater Glasgow and Clyde more than ten times. In total these patients accounted for 17,918 A&E attendances – 3.5% of the total attendances in GG&C. Each Partnership has a programme of work with GPs and other services such as mental health and addictions, to review individual cases to see what early intervention or preventative measures can be taken to support these patients.

6.26 Through this programme we estimated that by the end of 2020/21 the number of A&E attendances accounted for by people who have attended more than ten times in the previous twelve months will have reduced by 2.5%. Through further extension of this programme beyond 2020/21 we estimate will reduce the number of frequent attenders as a percentage of total A&E attendances from the current level to approximately 2%.

Example – Inverclyde HSCP
Data suggests that in Inverclyde the largest group of frequent attenders either have Alcohol & Drugs issues or poor mental wellbeing. Inverclyde HSCP set a target to reduce number of frequent attenders the aim being to work with individuals on a partnership basis to reduce attendances with the provision of appropriate community services. Alcohol and Drugs Recovery Service implemented a test of change in September 2019, involving an MDT and assessment and care management approach.

Mental Health

6.27 Individuals with mental health problems have been identified nationally to be as likely to breach the four-hour emergency access target as those with any other presentation. Action 13 of the national mental health strategy highlights the unnecessary delays experienced and aims to streamline care pathways irrespective of the patient's mental health problem. The recommended model for all unscheduled care services is one part of the *Moving Forward Together* programme matching demand to a prompt and effective response. 2020 sees the proposed implementation for a more standardised approach to maximise effectiveness and efficiency. The identified actions include:

- psychiatry liaison services – rolling out a single adult mental health liaison service across NHSGGC, with designated teams working into each acute hospital during working hours and a coordinated out of hours response via a single point of access to emergency departments 24/7. Services will operate to defined response and accessibility criteria. The ability to provide a 24 hour timeous response will be coordinated across liaison and out of hours Community Psychiatric Nursing services.
- Acute Psychiatric Liaison for Older People will commence enhancing capacity of older people's liaison services to the acute sector and to care homes. This will be implemented by Liaison Services using a range of low level interventions and support for people suffering with dementia. These will target people who access

services and their families/carers at an earlier stage, help people live longer in the community and reduce attendance at emergency departments.

- Crisis Resolution and Home Treatment - enhanced Board-wide access to crisis resolution and home treatment teams as an alternative to hospital admission. The service will implement intensive home treatment coordinated across Crisis and OOH CPN services, close an identified gap in response to Emergency Departments and will be available from 8am to 11pm, 7 days a week and will offer home-based care visits up to three times daily.
- Out of Hours – Implementing in 2020 a single point of access that will coordinate care across all unscheduled activity arising outside normal working hours. This will include provision of CRHT (Crisis Resolution & Home Treatment Teams) and Liaison Services to Emergency Departments as well providing access for emergency and urgent care assessment for people presenting in distress. A senior clinician will be available to offer telephone advice to referrers and to coordinate responses from Community Mental Health Teams and Crisis Resolution & Home Treatment Teams (CRHTs) as needed. Access as identified has also been increased to OOH CPNs from 5.00pm to 9.00am which will improve accessibility and be connected to the broader OOH review.
- Mental Health Services and emergency departments have established a standardised response time to EDs from point of referral to Mental Health Services. Both Mental Health Services and EDs are promoting a supportive joint working ethos and shared responsibility to ensure that people with a mental health presentation get the most appropriate care treatment response. The standard target response time is to carry out a face to face mental health assessment within one hour from point of receipt of referral (time of initial telephone call). Prioritisation of all referrals are based on individual patient risk factors, current demand/activity within the service, current risk factors within Emergency Departments, medical fitness, ability to engage in psychiatric assessment due to substance intoxication or availability of interpreting services.

6.28 The focus of implementation during 2020 will be on the following:

- GGC wide approach to Crisis Resolution and Home Treatment (CRHT) service 8am-11pm x 7 days. HT up to 3 x visit/treatment daily;
- Provide single point of Out of Hours access co-ordinated across all unscheduled care services arising outside normal working hours;
- One coordinated single board wide adult mental health liaison service;
- Dedicated liaison teams working in to each of the 5 acute hospital sites GRI; VOL; QEUH; RAH & IRH;
- Coordinated Out of Hours response to 4 x Emergency Departments 24/7;
- Implement an SOP describing input to the EDs and inpatient wards;
- Development in partnership with third sector, a tender for Safe Haven Crisis outreach model to provide an alternative response to people in distress (away from EDs);

- Evaluating pathways and safe response models as an element of a partnership with a commissioned 3rd Sector Safe Haven hub approach across Glasgow City to support distressed people to access care and prevent attendance at accident and Emergency Units; and,
- Test the concept of new health and social care assessment model for older adults.

GP assessment units

6.29 At each main hospital site in GG&C there are assessment units located close to emergency departments where GPs can refer patients to be assessed. Such referrals are usually unplanned and made on the same day when a patient has been seen by a GP, and a decision taken that they need assessment in secondary care. These units provide an essential service to patients and support to GPs and are extremely busy departments. Prior to these units being introduced referrals such as these would be made straight to emergency departments. The current rate of referral to assessment units is shown in table 12.

Table 11 – GP referrals to assessment Units

	2017/2018	2018/2019	2019/2020 (to February)
GP referrals	13,030	12,587	10,040
Total attendances	55,705	56,709	49,152
% GP referrals	23%	22%	20%

6.30 There is a variation across the main hospital sites in the ratio of attendances at assessment units and the number of admissions. We will work with assessment units and GPs to explore the reasons for this variation with a view to improving overall ratios and in particular reduce the number of people discharged in the same day by the development of care pathways for such conditions such as DVT and abdominal pain (see above). Providing alternatives to admission as described above will assist in achieving such improvements.

Table 12 – GP Assessment Units - ratio of attendance to admission

	2017/2018	2018/2019	2019/2020 (to February)
Total admissions	31,106	31,022	25,929
Total attendances	55,705	56,709	49,152
% admissions	56%	55%	53%

6.31 A significant proportion (45-48%) of GP referrals to AUs are discharged on the same day and not admitted. Most attendances occur between the 4pm and 6 pm with same day discharges often taking place in the evening. As well as being inconvenient for patients and their families there is a risk that patients are admitted overnight because of

difficulties in getting patients home safely. Work will be undertaken to review same day discharges and what alternatives could be offered to GPs on a planned basis, and what the impact might be if discharge to assess was scaled up. It is also suggested that the contact telephone number of the consultant in charge should be shared to encourage GPs to contact the consultant to seek advice before making a referral.

6.32 We will look at potential alternatives for GPs for this group of patients where advice and or tests are needed and can be managed the next day. The potential here might be we give GPs the ability to book patients directly into next day clinics for advice and treatment. This would alleviate pressure on assessment units and give patients and GPs assurance that they will be seen quickly and on a more planned basis.

6.33 Initial analysis indicates that the effect of such a programme could be a significant reduction in admissions from assessment units although clearly some of this activity would be converted into planned activity in other services such as diagnostics.

Advice to secondary care clinicians

6.34 In seeing patients who attend emergency departments it is important secondary care clinicians can access support and advice in order to make decisions about the next steps. Currently emergency departments can access advice from CPNs, community rehab, hospital discharge teams and others for support in managing patients. HSCPs will review these arrangements with acute clinicians to see what improvements can be made to respond to an increase in the numbers attending. We are conscious that in a busy ED department when decisions about a patient need to be taken quickly it can be confusing to know who to turn to in HSCPs for advice and support.

Day of care survey

6.35 A national Day of Care survey was carried in October and May 2019 out to provide an overview of in-patient bed utilisation across NHS Scotland. In GG&C the survey involved 3,038 patients in 3,216 beds and an overall occupancy level of 94.7%. The results of the survey were that:

- 13.8% of in-patients did not meet survey criteria for acute hospital care;
- the main three reasons identified for patients not being discharged were:
  - awaiting social work allocation/assessment/completion of assessment;
  - awaiting consultant decision/review; or,
  - legal or financial reasons.

6.36 The audit also concluded that the older the patients were, the less likely they were to meet the criteria for acute care.

6.37 These numbers compare well with previous audits although the number of patients and beds surveyed, and occupancy levels were higher than in May 2019 when the last survey was conducted.

6.38 HSCPs are keen to work with the NHS Board and the acute division to take forward the results of the survey. Our programme to improve discharge and our proposals to provide GPs with alternatives to admission should positively impact on these results going forward. We would wish to see an improvement in performance from current 14% of bed days not meeting the acute care criteria to 10% in 2022/23.

Length of stay

6.39 One area highlighted in the day of care survey that impacts on patient flow within the acute hospital system is the length of time patients spend in a hospital bed. There are variations in length of stay across specialties and hospital sites. When comparing GG&C hospitals performance there is significant variation (see table 9 below).

Table 13 – length of stay by specialty by hospital compared with Scotland – general, geriatric & respiratory medicine 2018/19

Hospital	All specialties	General Medicine	Geriatric Medicine	Respiratory Medicine
Glasgow Royal Infirmary	5.2	3.3	10.8	7.4
Inverclyde Royal Hospital	7.2	5.9	20.6	*2.6
Queen Elizabeth University Hospital	6.3	5.1	12.2	5.9
Royal Alexandra Hospital	6.1	6.1	16.1	*1.9
Vale of Leven General Hospital	6.6	4.5	14.7	*1.1
NHS Greater Glasgow & Clyde	**6.2**	**4.9**	**15.5**	**6.1**
NHS Scotland	**6.3**	**4.9**	**16.7**	**5.9**

* - denotes small number of spells

Source: NSS Discovery dashboard

Notes:

Description: Analysis of the variation in LOS based on Total LOS and number of spells

Numerator: Total LOS (days)

Denominator: Number of spells

6.40 There is a need for fast access to investigation, diagnostic services and pharmacy services to shorten lengths of stay and prevent potentially avoidable admissions. We need also to optimise bed use given demand pressures generated by scheduled and unscheduled care needs, and delivery of waiting time targets. Implementation of the NHS Board's 2017 unscheduled care improvement programme is key to this and the following should contribute to delivering these improvements for patients.

Consultant geriatricians and GPs

6.41 Considerable progress has been made in joint working between HSCPs, GPs and consultant geriatricians. Further development of these links is desirable to better support patients in the community. Particular areas of focus for the next stage of this work would be:

- geriatrician support to GPs who cover care homes potentially utilising Attend Anywhere for MDTs;
- defining the geriatrician's role in anticipatory care planning, the management of complex cases and involvement in MDTs;
- introducing telephone or virtual clinics between GPs and geriatricians including advising GPs before referrals to AUs;
- considering the role of day hospitals in the provision of community based older people's services including the potential for the urgent / rapid review of patients referred by GPs; and,
- improving the management of frailty in the community as part of the frailty collaborative and the development of an integrated primary / secondary care frailty pathway.

6.42 Consultant geriatricians currently undertake a number of sessions in the community at a day hospital or other community setting. These sessions are important in supporting patients in the community after discharge or preventing potential future hospital admission and providing integrated care with community based services including GPs. As part of this plan we would like to explore the potential for more community sessions as part of developing an integrated approach to managing frailty within community settings, working with the third and independent sectors, including housing. We will work with consultant geriatricians to explore the opportunities to take further steps to develop more integrated care pathways.

Summary

6.43 In this section we have focused on our priorities to improve the interface between primary and secondary care, including actions to reduce demand on our emergency departments. This programme requires a whole system approach to make progress, and further discussion particularly at a clinical level between GPs and secondary care clinicians to move these proposals forward. Improving links between primary and secondary care is a long term agenda recognising the changes taking place within general practice and the scale and size of the health and social care system in GG&C. Nevertheless some important key steps can be made early to impact on emergency care such as:

- introducing dedicated minor injury units at each emergency department to improve flow and performance against the four hour target;
- introducing a re-direction policy to support patients access appropriate emergency services;
- reducing the number of frequent attenders at A&E;
- improving the proportion of patients seen on a planned basis as an alternative to attendance at GP assessment units;
- improving length of stay; and,
- improving links between GPs and consultant geriatricians.

7. IMPROVING HOSPITAL DISCHARGE

Introduction

7.1 The plan is about taking a 'whole system approach' to unscheduled care and outlines a range of community alternatives to hospital admission. We recognise that hospitals provide valued and essential assessment, treatment and care and patients are often admitted because the necessary care and treatment they need cannot be provided safely and effectively at home or in the community. It is important that all potential options are explored with patients and their carers before a decision is taken to admit someone to hospital. Anticipatory care plans have a role to play here.

7.2 A prolonged stay in hospital however is often not associated with a good outcome so we must do as much as we can to speed up the discharge process. Being in hospital can disconnect people from their family, friends and social network and can result in a sense of isolation, loss of confidence and depression. Visiting hospital for a long period may heighten an already stressful situation for family carers. Older people experience functional decline as early as 72 hours after admission and are more likely to have an episode of delirium or infection. The risk of a poor outcome increases every time a frail patient is moved from ward to ward.

7.3 Every unnecessary day in hospital increases the risk of an adverse outcome for the individual, drives up the demand for institutional care and reduces the level of investment that is available for community support.

Improving discharge

7.4 Achieving safe, timely and person centred discharge from hospital to home is therefore an important indicator of quality and a key measure of effective and integrated care. Once a patient is fit for discharge it is in their best interest that this takes place as quickly as possible so that they can settle safely and comfortably at home or other appropriate setting. For those patients who need further support in the community from health and / or social care it will often be the HSCPs' discharge teams that make sure that support is in place. For most patients discharge will be followed up by community services and / or their GP. We want to ensure that people get back into their home or community environment as soon as appropriate and with minimal risk of re-admission to hospital.

7.5 On a typical day there are over 250 discharges from acute hospitals in GG&C. Most of these discharges occur during the hours of 14.00 and 17.00. The pattern of discharges varies during the week with most discharges occurring towards the end of the week. Ideally we would like to see this pattern spread more evenly throughout the week, including weekends, and increase the number of discharges occurring before 12.00 noon and at weekends as this easies pressure on home care, community services and others who follow up patients in the community.

7.6 We will aim to routinely discharge patients home from hospital in days not weeks. We believe that when a patient no longer requires to remain in hospital, they should be discharged home and their post hospital rehabilitation, care and support needs met by the local community services. If return home is not possible in the short term, they should transfer to a step down bed in the community for a period of Intermediate care and rehabilitation.

Example - Home for Me, East Dunbartonshire
In East Dunbartonshire Home for Me is working closely with orthopaedics to support early discharge with follow up rehabilitation and home care re-ablement

Example – Home First, Inverclyde
In Inverclyde Home First tracks patients in hospital and once a discharge date is agreed early referral is made so patients can be discharged to assess with an appropriate risk assessment. The Home1st team brings together ACM, reablement, in reach team and discharge team to move the emphasis of discharge planning from hospital to community provision. Discharge planning begins in the community and assessments completed in the service users home. The discharge to assess approach, when an individual is medically fit to be discharged they return home where an assessment for future needs is completed by the Home 1st (Reablement) Team. In this way Inverclyde ensure a smooth patient pathway, early referral for social care assessment and reduce duplication. Care Home Liaison Nurses are also involved in supporting care homes to maintain residents in community and avoid hospital admission

Discharge process

7.7 We will begin care planning as soon as possible after a patient is admitted to hospital and involve the appropriate members of the multi-professional team at the earliest opportunity. Planning for discharge with clear dates and times reduces a patient's length of stay, potential re-admission and therefore pressure on acute hospital beds. The multi-disciplinary team should meet ideally within 12 hours of a patient's admission to consider the patient's discharge plan so that patients can be discharged safely onto the next appropriate area of care.

7.8 Key to a successful discharge is:

- specifying an estimated date and/or time of discharge and discharge planned from the point of admission (or before) with the norm being discharge within hours and days of readiness rather than weeks;
- identifying early what a patient's discharge needs are and how they will be met;
- taking a personal outcomes approach that tackles every delay, every day and uses data to examine performance and challenge causes of variation;
- active participation by patients and their carers ensuring that they understand and are able to contribute as appropriate to care delivery and discharge planning;

- identifying a named person with responsibility for co-ordinating all stages of discharge planning throughout the patient's journey including engagement with housing where appropriate;
- an acute hospital bed is not the best place for assessing an individual's need for long term care and support so, unless unavoidable, no-one should move directly from an acute bed to a long-term care home placement; and,
- most importantly we will adopt of a culture of 'Home First' as a default position - wherever possible and safe, patients should return to the home they were admitted from and only explore alternatives if this is not possible.

Discharges before 12.00 noon

7.9 This plan proposes more discharges before 12.00 noon – currently less than 10% of discharges are before midday. Earlier in the day discharges would be better for patients allowing them time to settle beck at home or other setting, and also ease pressure on wards. We propose an improvement of 10% over the next 12 months.

Intermediate care

7.10 Intermediate care acts as a bridge between hospital and home for those deemed medically fit for discharge but who are delayed in hospital. In this way it ensures that acute hospital capacity is used appropriately and individuals achieve their optimal outcome and has been shown to be effective[44] .

7.11 There are a number of intermediate care places in GG&C commissioned by HSCPs from the independent care sector. The function of this service is to create a stable non-acute environment where individuals being discharged from hospital with enduring complex care needs can have their long-term social care assessments undertaken.

7.12 Most intermediate care resources are of this 'step down' type of provision for patients transferred from an acute hospital. However, the model also lends itself to 'step up' intermediate care where a patient might be referred to avoid a potential hospital admission. This aspect of the model needs further development and has the potential to offer GPs another option for patients even in an emergency or urgent situation. We will explore this further with GPs and the independent care sector and how this service might operate.

Adults with Incapacity (AWI)

7.13 At the time of writing there were 57 patients in acute hospital beds who have been identified as AWI patients within the definition of the Act[45]. AWI patients typically have a

[44] Implementing a step down intermediate care service, Kate A. Levin, Martine A. Miller, Marion Henderson, Emilia Crighton, Journal of Integrated Care, ISSN: 1476-9018, 10 October 2019

[45] https://beta.isdscotland.org/find-publications-and-data/health-and-social-care/delayed-discharges/delayed-discharges-in-nhsscotland-monthly/

longer length of stay than other patients and therefore consume more acute bed days than other patients. In 2018/19 AWI patients accounted for 10,037 bed days in GG&C – over a quarter of all bed days. HSCPs will bring a dedicated focus and resources to monitoring and expediting guardianship process as far as their authority extends

7.14 Following a legal challenge to the Health Board policy on AWI by the Equalities and Human Rights Commission we have ceased admitting AWI patients to specific care home places. Currently alternative pathways are being explored. In the interim the number of AWI delays in acute hospital beds is likely to rise.

Improving Delayed Discharges

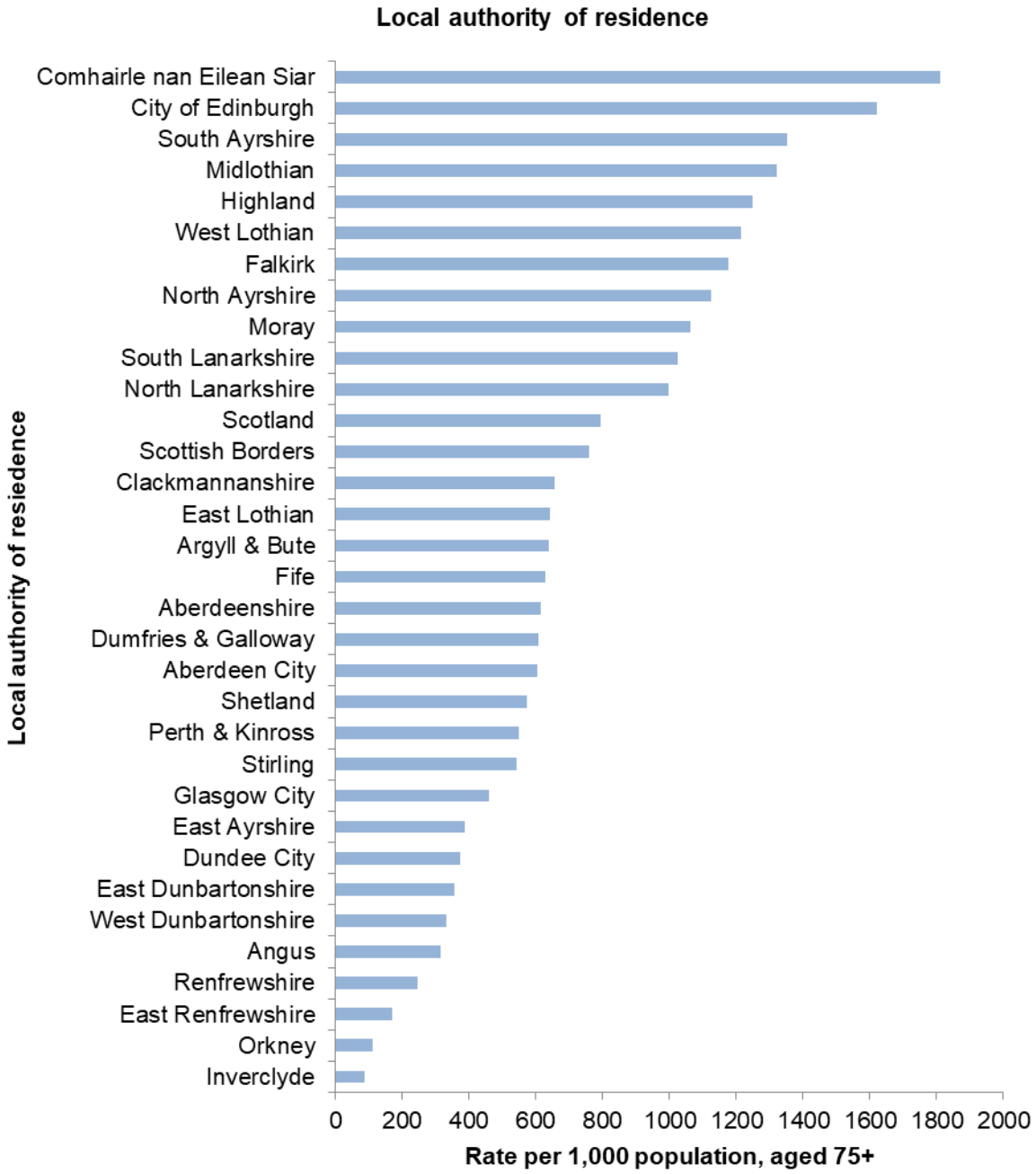
7.15 HSCPs have performed well in recent years in managing delayed discharges which have been on a downward trajectory since 2016. However, reflecting pressures in the wider health and social care system our performance has declined over the past 12 months. While this mirrors a trend nationally, GG&C performance as a whole continues to compare favourably with other Health Boards. HSCPs and the Acute Services Division have robust processes in place to manage delays on a day-to-day basis, and a range of actions are currently being implemented designed to improve hospital discharge arrangements and patient outcomes.

7.16 It is widely acknowledged that delays in patients being discharged from hospital can be detrimental to patient care. No patient ideally wants to remain in hospital any longer than they need to. A long delay can often lead to a patient falling ill again, or losing vital life skills, independence or mobility. It could ultimately result in the patient having to be admitted to a care home due to the deterioration in their health and mobility. There is clear evidence that an unnecessary, prolonged stay in hospital can be detrimental to a person's physical and mental wellbeing.

7.17 In GGC acute patients who are declared fit for discharge are immediately recorded as such and "the clock starts ticking" with reports generated daily on the number of delayed patients in the health and social care system and into which category they fall e.g. AWI, mental health etc. The discharge planning process will begin much before this date, and this is now further improved with the introduction of the Estimated Date of Discharge on admission to an acute ward, and availability to HSCPs of inpatient data via dashboards.

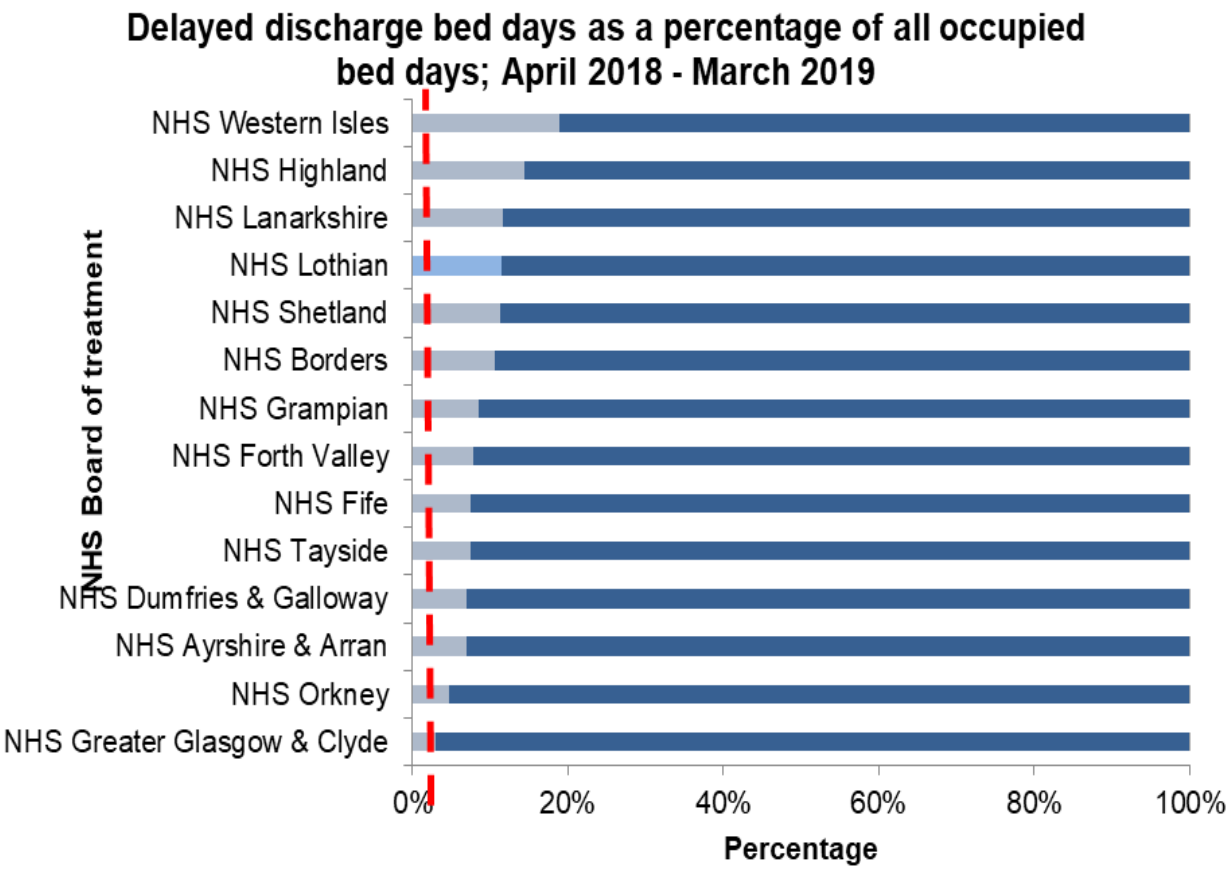
7.18 The current rate of delays (i.e. all delays) for all patients aged 75 plus per head of population by HSCP for 2018/19 is shown in figure 24 below and illustrates that the performance of GG&C HSCPs compares favourably with other HSCPs nationally.

Figure 16 – Delayed discharges per 1,000 population aged over 75 by HSCP – April 2018 to March 2019



7.19 This is further illustrated when considering the percentage of acute beds in GG&C (3.1%) occupied by people who were delayed in their discharge (see figure 17 below);

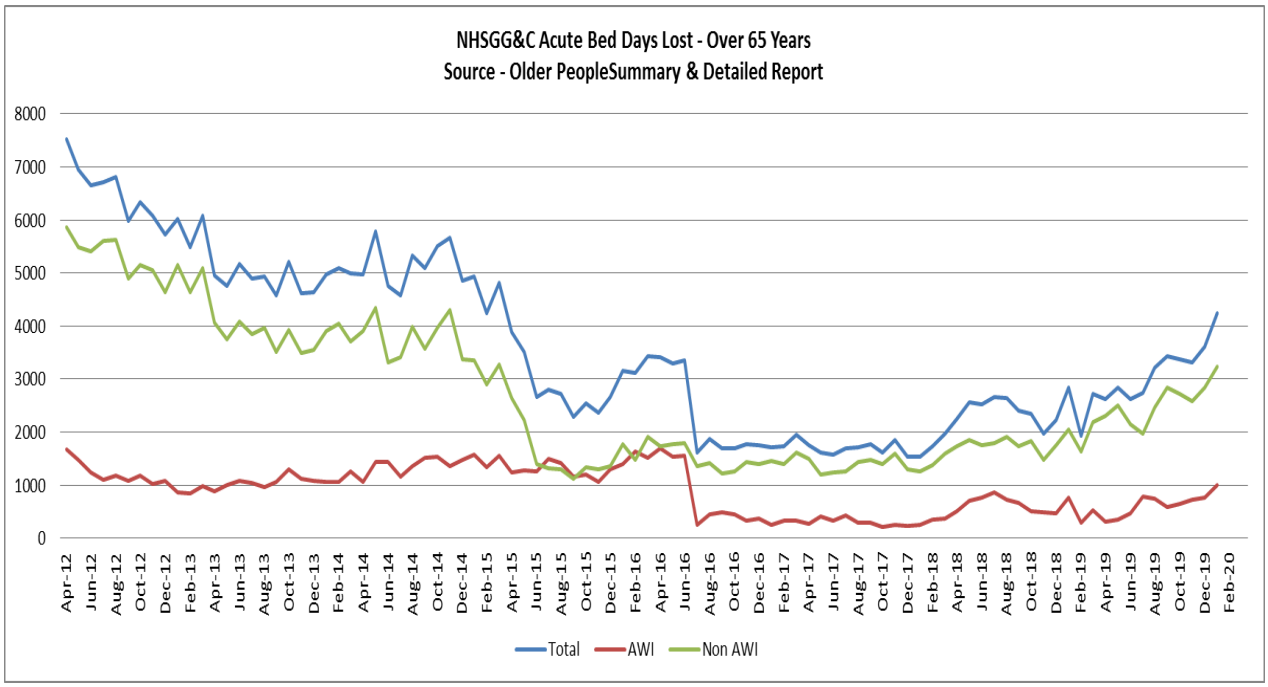
Figure 17 – delays as a percentage of acute beds – 2018/19



7.20 The number of delayed discharges in GG&C and the associated bed days due to delays has increased in recent months:

- the number of acute delays for patients aged over 65 in GG&C has risen from 352 in January 2019 to 472 in January 2020 – the highest since 2012/13;
- total acute delays for all ages in GG&C has risen from 342 in September 2018 to 527 in January 2020 (this is the highest it has been for some years);
- in 2018/19 there were 36,968 bed days occupied by people delayed in their discharge, and of these 29,072 were occupied by people aged 65 years and over (see figure 26 below); and,
- there has been an increase of 9,323 in delayed discharge bed days between 2017/18 and 2018/19.

Figure 18 – Acute hospital bed days lost due to delays – over 65 – AWI and none AWI - April 2012 to February 2020



7.21 The main reasons for delay in GG&C are:

- awaiting place availability (28.4%);
- awaiting completion of care arrangements (22.4%);
- complex delay reasons (21.5%);
- awaiting community care assessment (20.6%); and,
- other reasons including funding, transport, patient and family related reasons (6.8%).

7.22 Recent analysis has shown that there is a significant variation across hospital sites in the timing of referrals to social work services as part of the discharge process. This variation creates an added challenge to respond effectively to the assessment of individuals in a time sensitive manner. There is a clear relationship between early referral to social work and a reduction in delays. Where referral occurs earlier in the patient pathway, the data shows that delays are mitigated or reduced. The average delay following same day referral to social work for those who become delayed discharges is eight days. A third of referrals were made with less than three days of the patient being reported as 'Ready for Discharge' (RFD). The average length of stay for those referred on the same day was 26 days at the point of referral. This would suggest that for many people, there could be opportunities for earlier signposting of patients in areas of high activity in advance of referral and for referrals to be made earlier in the patient stay.

7.23 All HSCPs have action plans in place to reduce delays (see annex B). Additional staffing is being recruited to Glasgow City HSCP's hospital discharge team. East Dunbartonshire

have substantiated the Social work resource within the Home for Me service to improve relationships, communication and consistency within the wards. Inverclyde HSCP has additional assessment staff for the Home1st Assessment and Rehabilitation Service. West Dunbartonshire HSCP are re-aligning staff within the Hospital Discharge Team to place greater emphasis on in-reach/ early assessment. In addition, West Dunbartonshire's new Focussed Intervention Team is responding to referral where a hospital admission is being considered, and through intense support, avoid these admission in 60% of cases.

7.24 The aim of these actions at a GG&C level is to reduce delays so that they account for approximately 2.5% to 3% of total acute beds, and that bed days lost due to delays (non AWI patients) are maintained within the range of 37,000 to 40,000 per year. In summary these actions include:

- increased intermediate care capacity;
- discharge teams linked more closely to acute wards;
- estimated date of discharge planning;
- direct access to home care or same day response to care packages;
- increased support within hospital discharge teams; and,
- improvements to the process for managing AWI patients

Managing capacity at peak times – seasonal planning

7.25 The health and social care system experiences peaks of demand at certain periods during the year usually over the winter period and at bank holidays, and also when conditions such as flu affect large sections of the population. It is essential that we review the capacity of the system to meet these peaks in demand and ensure patients continue to receive a consistently high quality service throughout the year. We must plan additional supports during these key points of the year, and scale up services quickly where we need to. In doing so we will be guided by our strategic direction to manage patient care in the community and avoid the need for hospital admission. Each year we will develop a capacity plan informed by the latest projections of future demand.

7.26 We also need to consider managing services on a 52 week annual cycle. At present we scale services down for several days over annual holiday periods. As demand is 24/7 all year round we do put strain on the system by managing 52 weeks demand over a 51-50 week year. We fully recognise that staff need a break and are entitled to annual leave, but we do need to look at ways we can deliver services throughout 52 weeks of the year.

7.27 Our aim is that we have a coherent system wide plan capable of adapting to seasonal or system pressures so we can flex capacity and service responses as needed. Traditionally our response has been to open additional beds over the winter period the consequence of which is to place additional demands on other parts of the health and social care system. Our aim starting in 2020/21 will be not to open any additional beds in line with our overall approach in this plan to prevent admission and build capacity within community services. As part of our seasonal planning we will continue to:

- proactively manage a flu immunisation campaign both to staff and the general public to encourage increased uptake, including capitalising on the role of community pharmacies;
- proactively deliver a public awareness campaign on what services to access for what over the holiday period and alternatives to accident and emergency such as minor injuries;
- implementation of the re-direction protocol in emergency departments to advise patients on appropriate services;
- seven day working to support improving weekend discharges and discharges earlier in the day;
- introducing "hot clinics" for quick access for GPs for specific conditions such as abdominal pain; and,
- take forward actions to improve communication between GPs and secondary care clinicians e.g. consultant connect for GP to consultant advice

Summary

7.28 In this section we have outlined our priorities for improvements in unscheduled care services to ensure patients receive the right care in the right location and at the right time. We have outlined proposals we intend to test with secondary care clinicians and primary care to provide GPs with alternatives to admission and other actions that can be taken to better respond the changes in demand that can yield further improvements in our health and care system.

7.29 In summary the key actions to improve the discharge process planned are:

- take a personal outcomes approach and encourage the active participation by patients and their carers in the discharge planning process;
- identify a named person with responsibility for co-ordinating all stages of discharge planning;
- as early as possible following admission, including agreeing an estimate date of discharge;
- adopt a home first default position;
- better managing community capacity by increasing the number of discharges earlier in the week, before 12.00 noon and at weekends;
- improving our management of delays; and,
- better manage capacity over the winter period and at other times of the year.

8. RESOURCING THE CHANGES

Introduction

8.1 In this section we outline the financial framework to support delivery of the plan. A number of the proposals in this plan are already funded in HSCPs or the Acute Services Division. Others will need additional or a shift in resources to support implementation.

Financial Framework

8.2 This commissioning plan represents the first step in moving towards delegated hospital budgets and set aside arrangements within Greater Glasgow and Clyde. In 2019/20 unscheduled care is estimated to cost Greater Glasgow and Clyde £438.7m. With a budget of £409.3m identified by Greater Glasgow and Clyde Health Board. This is a shortfall in funding of £29.4m and represents a significant financial risk to Greater Glasgow and Clyde Health Board and the six IJB's with strategic responsibility for this area.

8.3 This budget shortfall impacts on the IJB's ability to strategically plan for unscheduled care. Nationally there is an expectation that IJB's, through commissioning plans, can improve outcomes and performance in relation to unscheduled care, which in turn will support the release of resources to support investment in primary care and community services. This was reiterated in the Scottish Government's Medium Term Financial Plan[46] which assumes that 50% of savings released from the hospital sector will be redirected to investment in primary, community and social care service provision. The ability to achieve this in Greater Glasgow and Clyde is hindered by the existing financial position outlined at 8.3 above.

8.5 The commissioning plan identifies a number of key actions and investments which require financial investment to deliver. Work is in hand with all HSCPs and the acute division to identify the level of resource needed across the life of the plan. Until this is complete only projects which can be funded within existing resources will be progressed.

Acute Inpatient Beds Plan

8.6 There is a requirement that this Commissioning Plan outlines an inpatients beds plan for the specialities included in the set aside arrangements (see 1.11 above). Annex C shows the changes in inpatient beds across the main acute hospital sites in GG&C since 2010. These numbers show that the potential to significantly reduce further acute beds capacity in NHSGGC is limited given the current and projected future demand for acute hospital care.

[46] https://www.gov.scot/publications/scotlands-fiscal-outlook-scottish-governments-medium-term-financial-strategy-2019/

8.7 Further the acute system in NHSGGC already benchmarks favourably with the rest of Scotland in terms of its efficiency KPIs, reflected in average length of stay (ALOS) and day of care audit data (see table 14).

Table 14 – acute inpatient beds benchmarks 2019

Indicator	Pan-Scotland Acute (28 Sites) Oct 2019	Pan-Scotland Acute (29 sites) May 2019	NHSGG&C Oct 2019	NHSGG&C May 2019
Bed Occupancy %	**96%**	95%	94.7	96.29
Day of Care - criteria not met %	**19%**	21%	13.8	14.12

8.8 NHSGGC has also given effect to the Scottish Government's Hospital Based Complex Clinical Care (HBCCC) guidance from May 2015, which saw all acute continuing care capacity in the Board area phased out over the past 3 years (see annex c).

8.9 As the scope to deliver a further significant reduction in future acute inpatient bed capacity is limited we will take action to support the acute hospital system to manage growing demand without having to expand bed capacity (the thrust of the actions in section 5) and specifically we will work with the acute system to reduce the requirement to open additional winter beds over the winter period to zero over the lifetime of this plan (see annex D).

8.10 As per the set aside arrangements, this would require funds to be directed towards community alternatives to hospital, in line with the programme detailed in this plan. The ability to do this will be dependent on the level of funds available for investment over the life of the plan and represents a risk to delivery.

9. MEASURING IMPACT AND PROGRESS

Introduction

9.1 In this section we look at the potential impact of the programme outlined in this draft plan and the key measures we will use to monitor progress.

9.2 In a large and complex system such as GG&C with many moving parts estimating and forecasting the impact of specific interventions is not an exact science. There are many external factors that can influence the impact of any given intervention – some of which are not in our control. Forecasting or estimating impact is even more difficult when looking into future years. The numbers presented below should therefore be viewed with caution and should not be considered as a firm guarantee of future impact; they are a guide and our best estimate based on what the evidence says and our knowledge of the health and social care system in GG&C. These numbers will also need regular review and updating following implementation.

Key Measures

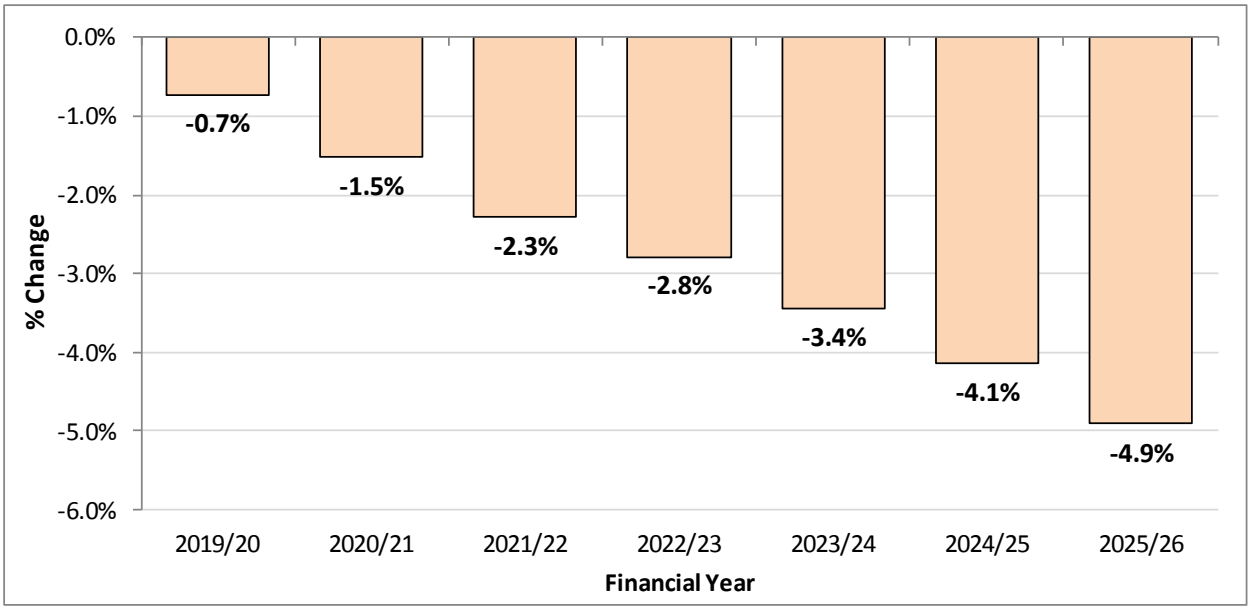
9.3 The key indicators we propose to use to measure the impact of our programme are:

- emergency departments attendances:
  - delivery of the four hour target
  - total attendances by age, sex and deprivation
  - total attendances per head of population
  - rates of admissions and discharges
  - frequent attenders
- minor injury units attendances:
  - delivery of the four hour target
  - total attendances by age, sex and deprivation
  - total attendances per head of population
  - rates of admissions and discharges
- GP assessment units attendances:
  - total attendances by age, sex and deprivation
  - total attendances per head of population e.g. 65-74, 75+
  - rates of admissions and discharges
  - GP referral rates
- emergency hospital admissions:
  - admissions by age, sex and deprivation
  - rates per head of population e.g. 65-74, 75+
  - length of stay
  - rates per GP practice
- acute unscheduled care bed days
  - rates per head of population e.g. 65-74, 75+
- acute bed days lost due to delayed discharges

- rates by age e.g. e.g. 65-74, 75+
- AWI and non AWI rates
- bed days lost as % of total acute beds

9.4 In assessing the impact of the programme outlined in section 5 to prevent admissions, and based on current rates of admission per head of population and for different age groups (e.g. 65-74, 75 plus) we estimate that the full implementation of this programme will likely result in a reduction in the rate of emergency admissions for over 65s by 4.9% by 20205 (see figure 19 below). This estimate takes into account the demographic changes forecast over this period.

Figure 19 – projected percentage change in emergency admissions (based on 2018/19 data)



9.5 An important caveat to these projections is that other changes in the population e.g. changes in life expectancy, wider society and the economy highlighted in section 1, will affect these numbers in ways that are difficult to predict at the present time.

9.6 Work is underway to identify the potential impact of all the actions outlined in this draft plan. Through this further work we aim to demonstrate that if plans are delivered in full by 2021/22 as envisaged this will not only enable increases in demand anticipated from changes in our population to be met, it will also result in a reduction in current costs.

10. CONCLUSION

10.1 The purpose of this plan is to outline how the six NHSGG&C HSCPs in partnership with Acute Division and other partners aim to respond to the continuing pressures on health and social care services in Scotland's largest Health Board. For a number of reasons health and social care services are stretched and we are struggling to meet key targets. In a large system such as GG&C a large number of patients are seen by health and social care professionals in a variety of different settings on a daily basis. When looking to the future we can see that demand will increase as the number of people aged over 75 is forecast to rise over the next five years. We need to change therefore if we are to both meet current and future demand.

10.2 The challenge is change. We need to do somethings differently (e.g. out of hours services) and we need to change some services (e.g. mental health services) to respond better to patients. We need to scale up some of what we are already doing (e.g. anticipatory care planning) and we need to try new things (e.g. "hot clinics" for GPs). We also need to look at putting new additional services in place (e.g. minor injury units) and changing how emergency departments operate more effectively.

10.3 We also need to communicate more directly with patients and the general public to ensure people know what service is best for them and can access the right service at the right time and in the right place.

10.4 The programme outlined in this plan is based on evidence from elsewhere of what works and our estimate of patient needs in GG&C. We believe it is the right way forward. The changes proposed will not take effect immediately or all at the same time. Some need testing and others need time to bed in. Change will be gradual but should be fully implemented by 2022/23. While the challenge is change to respond to current and future demand, the challenge is also maintaining the direction outlined in this plan over the longer term so that we can better meet the needs of the people we serve.

Annex A

SUMMARY OF THE EVIDENCE[47]

Redesigning elective care pathways

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Improved GP access to specialist expertise
Mixed evidence, particularly on overall cost reduction	• Peer review and audit of GP referrals • Shared decision-making to support treatment choices • Shared care models for the management of chronic disease • Direct access to diagnostics for GPs
Evidence of potential to increase overall costs	• Consultant clinics in the community • Specialist support from a GP with a special interest • Referral management centres

Redesigning urgent and emergency care pathways

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Ambulance/paramedic triage to the community
Emerging positive evidence	• Patients experiencing GP continuity of care
Evidence of potential to increase overall costs	• Extending GP opening hours • NHS 111 (NHS24 in Scotland) • Urgent care centres including minor injury units (not co-located with A&E)

Avoiding hospital admission and accelerating discharge

Relative strength of evidence of reduction in activity and whole-system costs	Initiative

[47] *Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), Shifting the balance of care: great expectations. Research report. Nuffield Trust.*

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence Emerging positive evidence	• Condition-specific rehabilitation • Senior assessment in A&E • Rapid access clinics for urgent specialist assessment
Mixed evidence, particularly on overall cost reduction	• Intermediate care: rapid response services • Intermediate care: bed-based services • Hospital at Home

Managing 'at risk' populations

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Additional clinical support to people in nursing and care homes • Improved end-of-life care in the community • Remote monitoring of people with certain long-term conditions
Emerging positive evidence	• Extensive model of care for high risk patients
Mixed evidence, particularly on overall cost reduction	• Case management and care coordination • Virtual ward

Support for patients to care for themselves and access community resources

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Support for self-care
Emerging positive evidence	• Social prescribing

Annex B

HSCP DELAYED DISCHARGE ACTION PLANS
SUMMARY

Each HSCP, working closely with the acute services division, has a number of actions in train to improve outcomes for patients and current performance. Progress on actions plans and performance is routinely reported to IJBs. Key actions being taken by HSCPs are summarised below.

East Dunbartonshire:

- Linked Mental Health Officer to Hospital Assessment Team to lead improvement in relation to AWI focusing on timeous completion of reports, local authority guardianship applications etc.;
- Dedicated Intermediate Care Unit;
- Palliative and Complex Care beds;
- Hospital attached Social Workers linked to wards who proactively engage with discharge co-ordinators and MDT discussions;
- Proactive use of unplanned inpatient activity dashboard to identify those who have been inpatient for 10 days+ and those with an EDD of 1 month+ to facilitate early referral and allocation of case;
- Same day response to care packages

East Renfrewshire:

- continued use of the inpatient dashboard to identify at earliest point East Renfrewshire residents in acute wards to support early referral;
- continue to strengthen relationships between our Hospital to Home Social Work Assistants aligned to acute sites, staff in acute wards and discharge co-ordinators;
- Proactive planning by Hospital to Home multidisciplinary team to support safe, early discharge collaborating with Care @ Home services and wider RES team;
- Further development of Intermediate bed capacity model as a result of Local Authority Care Home refurbishment over the winter period;
- Unscheduled Care daily huddles to identify those at risk of admission and planned discharges; and,
- Implementation of pan Greater Glasgow & Clyde AWI approach.

Glasgow City:

- a continuing programme of improvement in relation to intermediate care with a focus on reducing average length of stay;
- additional capacity recruited to the HSCP hospital social work team;
- for under 65s, a named Adult Service Manager in each locality to hold accountability and ensure progress with complex adult delays daily;

- improved links with complex wards to improve early referral and effective communication;
- the sharing of estimated day of discharge information to a give early indication of potential future discharges; and,
- a management focus on everyday activities, including:
    - a reduction in same day (as fit for discharge) referrals from Acute – which automatically generate delays;
    - more assiduous prioritisation of delays by HSCP community staff – these are marginal, as most cases are held by the hospital-facing Home Is Best team; and,
    - improved communication arrangements between ward staff and the hospital discharge team around individual patients i.e. single points of contact, more effective networks.

Inverclyde:

- 7 Day Service - we will continue to work in partnership with local Care Homes to accept safe weekend and evening discharges for new admissions;
- Following last Winter's successful Pilot we wish to again increase capacity in our Home care Service to cover 175 hours per week to focus upon evening and weekend discharges for new service users as well as restarting existing packages;
- Test of Change Care Coordination - Coordination of Emergency Department Frequent Re-Attenders will utilise existing Locality Meetings to identify people at risk of hospital re-attendance and implement review and development of appropriate support to address unnecessary presentation. This will be across Health and community Care (including OPMHT) and have similar process in place to address frequent attendances of people known to Alcohol and Drugs Service and Community Mental Health Team;
- Day Care Services - a further Test of Change is to utilise Day Care Services to prevent Unscheduled Attendance's at Hospital This will identify 10 Frailty Day Places which will help to address Isolation and Anxiety amongst Older People which we have identified as a factor for some attendance's and admissions. These will be short term placements with clear link to reablement and accessing community supports;
- Assessment and Care Coordination at Emergency Department - we also intend to support the strengthening decision making at Emergency Department with greater knowledge of community resources and services to allow safe return home rather than admit. To support this we are requesting funding for 6 months to cover a Care Management post who would link directly to IRH Emergency Department complete assessments and return people home with necessary support thus avoiding unnecessary admissions;
- Choose the right Service - we have also extended our local Choose the Right Service campaign to cover attendance at emergency department and families with children.
- Purchase of step up beds on call off basis to prevent inappropriate admissions and also short term placements to facilitate discharge as required.

Renfrewshire:

- Discharge Coordinator post created from November 2019. This dedicated role solely focuses on working with Families, Acute and HSCP Services to manage the discharge process;
- when available, beds at Hunterhill Care Home are used for the reablement of delayed discharged patients;
- Hospital discharge protocol to be finalised and implemented;
- Acute and HSCP meet 3 times a day to discuss discharge planning and review active cases/delayed discharges and agree appropriate actions;
- Hospital Social Work Team attending daily huddle including bank holidays; and
- Weekly meetings with the Care at Home Service Delivery Team Manager; Acute; and the Royal Alexandra Hospital Social Work Team to discuss delayed discharges

West Dunbartonshire:

- Full use of inpatient dashboard to identify patients with admissions of 10 days+
- Dedicated early assessment cohort (Social Care, Nursing, OT) undertaking assertive in reach in wards
- Continuing programme of robust review in relation to use of s13za for AW patients.
- Refresh of hospital discharge homeless policy in conjunction with WDC Housing to ensure streamlined approach
- Refinement of engagement by colleagues in mental health and learning disability services to support safe and timely discharge

Annex C

Acute Inpatient Beds Totals by Hospital site 2010-2025

2010	Beds	2015	Beds	2020	Beds	Projected 2025	Beds
Southern General	900	QEUH campus	1450	QEUH campus	1400	QEUH campus	1400
Victoria Infirmary	370	New Victoria	60	New Victoria	60	New Victoria	60
Western Infirmary	500						
Stobhill Hospital	440	Stobhill ACH	60	Stobhill ACH	60	Stobhill ACH	60
Glasgow Royal	930	Glasgow Royal	910	Glasgow Royal	870	Glasgow Royal	870
Gartnavel General	450	Gartnavel G	360	Gartnavel G	360	Gartnavel G	360
RHSC Yorkhill	230	RHC	215	RHC	215	RHC	215
RAH	650	RAH	550	RAH	550	RAH	550
IRH	320	IRH	300	IRH	300	IRH	300
VOL	90	VOL	80	VOL	80	VOL	80
Total	**4880**		**3985**		**3895**		**3895**

2008 – publication of QEUH business case
2015 – opening of QEUH/ closure of Victoria Infirmary, Southern General Hospital, Western Infirmary, conversion of Stobhill Hospital to ACH
2020 – year 1 of Joint Unscheduled Care Commissioning Strategy – figures include additional winter beds
2025 – year 5 of Joint Unscheduled Care Commissioning Strategy (will be the same as 2020 minus the winter beds)

Notes:

All numbers are rough estimates. Bed numbers fluctuate seasonally and for other operational pressures
2010 figures include total bed numbers in the catchments of each hospital, including continuing care beds, e.g. Drumchapel, Blawarthill, etc.
QEUH campus includes QEUH, Institute of Neurological Sciences, Maternity & Gynaecology, and the Langlands building. RHC shown separately
GRI numbers exclude Lightburn
Gartnavel campus is GGH and BWOSCC only

Annex D

Proposed Reduction of Use of Additional Winter Beds

	2019/20	2020/21	2021/22	2022/23	2024/25	2025/26
South	**88**					
North	**51**					
Clyde	**89**					
Total GG&C	**228**	**200**	**175**	**100**	**75**	**0**

NHS Greater Glasgow and Clyde	**ACUTE DIVISION** **Unscheduled Care Escalation Workstream** **21 May 2020**
Purpose	The purpose of this paper is to: • Outline achievements and plans for unscheduled care performance and process improvement within NHSGGC, and • Agree next steps in the Unscheduled Care Escalation Workstream
From **Reviewed with:**	*Jonathan Best, Chief Operating Officer, NHSGGC Acute Division* *Susanne Millar, Chief Officer HSCP* *Scott Davidson, Deputy Medical Director Acute Division*
To	*Escalation Oversight Board*
Situation	Performance against the 4 hour A&Esstandard across NHSGGC has shown a sustained improvement since the social distancing measures were introduced in mid-March. The year to date position at 17th May 2020 was 94.4% compared to 86.6% for the same period last year. The National trend of reduced attendances has also been reflected in NHSGGC's unscheduled care activity. Between 1st April 2020 and 17th May 2020 our core Emergency Departments have seen 45% of attendances reported for the same period to 17th May 2019. Covid-19 has presented a number of challenges in relation to patient streaming and we have introduced a number of incremental changes to ensure we continue to deliver safe and effective emergency care within the context of the pandemic. A number of these are process changes that in part were identified as priorities within the Project Initiation Documents developed as part of the Escalation workstream and have proven successful. Work us underway to plan and implement a number of key projects to ensure that learning from this experience is embedded in our system wide management of unscheduled care demand. Our aim is to demonstrate a clear focus from all services that provides reassurance that NHSGGC has plans in place that will continue to deliver improved and sustainable performance against the 4 hour A&E Standard.
Background	On 24 January 2020 NHSGGC was escalated to Stage 4 for a number of areas including unscheduled care performance. NHSGGC delivered 85.7% compliance for 2019/20 and has been on a downward trajectory with 2011/12 the last year the Board achieved 95.4% compliance overall. To respond to COVID-19 all NHSGGC hospitals and HSCP's have developed new processes to ensure patients are directed to the most appropriate care provider. This work has been developed at pace and we have been able to deliver technology enabled pathways to reduce demand on face to face consultations where appropriate, fundamentally changing the traditional model of unscheduled care provision. We will continue to make progress in these areas and working in collaboration with HSCP colleagues to deliver a sustained improvement in unscheduled care performance

Assessment	A wide range of work has been agreed, some aspects of which are nearing completion whilst others are in the process of developing a clear plan to continue to conclusion. These include: • **A revised NHSGGC Redirection Policy:** the previous policy currently remains in place whilst work progresses on two phases: ➢ Patient Signposting – the introduction of a Band 7 nurse to undertake 'signposting' of patients who attend the Emergency Departments. This has been partially introduced at GRI and QEUH and will be formalised by the end of May 2020 with a process in place for GRI, QEUH and RAH. ➢ New Multi-Disciplinary System Wide Redirection/Direction Policy • The leadership/clinical teams will build on the established ED redirection work in both NHS Ayrshire and Arran and NHS Tayside where consistent and reliable redirection has been in place for a number of years. These policies are already underpinned with robust governance, scrutiny and monitoring of redirection pathways that are both safe and effective. • In addition HSCP's will incorporate the learning from the Community Assessment Centres to establish a system where a planned urgent care protocol and appointment system is established for some conditions to manage patients in the community as an alternative to GP Practices and ED. We will build on learning from the NHS24 and advanced GP Triage pathway to promote patient self-care and self-management of conditions through advice over the telephone or via video consultation and escalation to acute services as appropriate. • **A revised Discharge to Assess Policy:** Develop and implement an NHSGGGC (Acute & 6 x HSCPs) delayed discharge policy that includes Zero tolerance of code 11B and 27A delays. The aim is to ensure that no patient with a hospital episode of 7 days or less can be subject to social work assessment in a hospital bed (see NHS Lanarkshire policy for reference). The policy will reflects Scottish Governments Choice protocol and include an escalation process for non-compliance. This will reflect system wide responsibilities and associated process improvements to be delivered in partnership with the Hospital Discharge Team. • **Mental Health Assessment Units:** Introduction of two mental health assessment units (MHAUs) at Stobhill and Leverndale to reduce demand of Emergency Departments (EDs). The assessment suites will assess all patients presenting in a psychiatric emergency or with significant mental health needs who would previously have presented to the ED's at GRI, QEUH and RAH and offer direct patient access through ED, SAS and Police. • **Social Work Referral Process:** Introduce a single referral process for all social work discharges (home care and non-home care) in Glasgow City initially; thereafter to develop a single process across 6x HSCPs. Aligned to the Discharge to Assess Policy this will streamline the process between hospital and home and reduce unnecessary administrative delays and reduce overall bed day utilisation • **Alternatives to Assessment Units:** Develop and promote a number of

	alternatives to admission for GPs; e.g. access to consultant advice through Consultant Connect, introduce next day urgent 'hot clinic' appointments with access to labs/diagnostics; taking a whole system approach to alternative methods of delivering patient consultations with AU's through development of advanced GP triage and Attend Anywhere appointments. • **Community Frailty Service 'single point of contact'**: Develop standard approach to supporting Frailty within the community across all 6 HSCP's taking similar approach to the West Dunbartonshire Focused Intervention Team and the Community Respiratory Team. To be developed in co-ordination with the development of GHSCP's Urgent Care Resource Hub, given the potential OOH demand generated by this test of change. • **Public Messaging**: Develop a public messaging campaign to support citizens to access support in the right place at the right time which includes self-help and self-care and thereby reducing culture of dependency on health care services where appropriate. Develop an associated communications and engagement strategy directed towards the whole NHSGGC health and care system and staff; to include key strategic partners (SAS, NHS24, Police Scotland).
Recommendation	It is recommended that: • NHSGGC will restart governance arrangements under the direction of the Chief Executive as soon as the current COVID-19 position allows • The Chief Officer for Acute and Glasgow City HSCP will establish an Unscheduled Care Delivery Group to progress the work plans for the above projects with support from the Escalation PMO

DRAFT STRATEGIC COMMISSIONING PLAN FOR UNSCHEDULED CARE SERVICES IN NHS GREATER GLASGOW AND CLYDE 2019-2029

East Dunbartonshire HSCP specific aspects

The draft strategic commissioning plan sets out a number of activities which will contribute to the HSCP achieving the targeted reduction in unscheduled care. The activities need to be seen as the collective response to achieving the targets and therefore we have not attributed reductions to each of the specific actions. Eg. Increasing ACP completion may impact on a care journey however there are too many variables such as quality and availability to quantify the impact. Where we are able to measure activity projected impact has been quantified.

There are a number of workstreams noted in the plan which are not directly linked to HSCP activity eg. Changes to MIU's however the HSCP is committed to work in partnership with acute to support any change in pathways and requirement for a community response.

The plan needs to be considered in the context of increasing demands on community services as well as acute. Services across the HSCP have seen significant year on year increases in referrals which have been absorbed with current resources. The shrinkage of the complex and continuing care beds across GGC, aging population increases has led to rising number of people with complex health and social care needs being supported within the community.

DRAFT STRATEGIC COMMISSIONING PLAN FOR UNSCHEDULED CARE SERVICES IN NHS GREATER GLASGOW AND CLYDE 2019-2029

EAST DUNBARTONSHIRE ACTION PLAN 2020/21

Note: the following template reflects activity described in the NHSGG&C Unscheduled Care Commissioning Plan which is being specifically taken forward in East Dunbartonshire HSCP.

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
Communications plan						
1) We will take forward a major campaign across a range of media to better inform the public about which service to access for what and when. The campaign will also raise awareness about issues such as anticipatory care plans, and key health improvement initiatives. The aim will be to have a more informed public.	Y	All practices have been trained as case navigators and have sign posting notices. We are rolling out self management posters to council and third sector organisations We aim to do training with practice and HSCP staff on the role of social media in the next few months Will support delivery of Board wide media campaign.	There is a test for change in one practice to see how much they will signpost to other services away from the practice. This may not evidence activity related to unscheduled care, but there could be lessons learned. Reduce reliance on acute care services. Increased	Training to be completed by May 2020	Contribution to overall reduction in unscheduled care activity across the Board	**PCIP and core finance**

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
		Increase staff engagement with the electronic ACP and encourage ACP discussions to be part of routine service delivery.	population awareness of alternatives to secondary care and/or statutory care in the community. .			
Prevention & early intervention						
1) We will implement a programme of anticipatory care plans across GG&C with aim of delivering 350 plans by 2020/21 with the aim of supporting a reduction in emergency admissions	Y	Rollout commenced within community health teams. Initially targeting those individuals with Rockwood frailty score of 7 and above and those identified through MDT discussion as part of the frailty collaborative work. Focus on increasing number of eKIS summaries for Care Home residents	ACP shared electronically with GP Practice and request for GP to upload information to eKIS. Increased availability of up to date and relevant info to assist acute clinicians and SAS to make decisions with regard to admission and/or alternatives	Initially commencing within older people's health services. Further engagement with GP's required to encourage completion of eKIS. Need to consider use within adult services, and roll out in care at home.	Assist in decision making re admission, conveyance to hospital.	Core – elements of all community care teams across health and social work/care
2) We will work with the SAS and patient groups to develop a care pathway to	Y	Local work through Falls Lead to reinforce use of agreed falls pathway. There is ongoing	Reduction in admission of non injured fallers, appropriate	On going	24 admissions avoided 120 bed days avoided	Core - elements of all community care teams

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
safely manage the care of patients who have had a fall but do not need to be seen in an A&E department.		engagement through the unscheduled care delivery groups to embed SAS pathways across GGC and reduce conveyance of non injured fallers through referral to community rehab services. Offer of shadowing opportunities for SAS with rehab team and feedback from referrals to help build confidence in process. Referrals from SAS to rehab remain consistently low – average 2 per month.	community input to reduce incidence of further falls.			across health and social work/care
3) We will through the frailty collaborative reduce emergency admissions by X[d1]% and develop an integrated frailty pathway with secondary care so that there is a seamless services for those patients who require	Y	Engaged with 2 GP Practices to begin focussed frailty work. Aim with one practice is to increase no of completed eKIS for those with severe frailty. (-target is 75% of severely frail will have eKIS) With the other practice identifying those with escalating frailty to facilitate	Evaluate the impact of the two tests of change and then look at scaling up across the partnership. Looking at partnership specific data around hospital admissions, bed days and GP/or	Will look at results in next 6 months to see if any impact noted and results shared via the GP Forum to encourage further engagement.	GG&C-wide target yet to be confirmed. East Dunbartonshire will target its share in this.	Core - elements of all community care teams across health and social work/care

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
admission to hospital.		proactive intervention including an eKIS summary. Routine sharing of Rockwood frailty scales to enable early identification of frailty at points of interface. We are exploring plans to have a frailty PLT within one cluster to complement the above work	other home visits. Increase number and quality of eKIS summaries to assist decision making at points of change.			
4) We will increase support to carers as part of implementation of the Carer's Act	Y	East Dunbartonshire HSCP has introduced a dedicated Carers' Strategy, Short Breaks Statement and Carers' Eligibility Criteria Policy	All identified carers are offered an Adult Carer Support Plan to identify areas of support that can implemented for them or the cared for person. This provides support for the carer to continue in their caring role.	The activities associated with the Carers' Act have been fully implemented in East Dunbartonshire.	No specific unscheduled care target set for this activity	Core - elements of all community care teams across health and social work/care
5) We will increase the	Y	Two wellbeing workers	By undertaking		No specific	PCIP 80K

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
number of community links workers working with primary care to 50 by the end of 202/21 (note, Glasgow action)		will be in post by April 2020	wellbeing assessments, it is hoped that they will support and signpost service users to services which meets their needs. By empowering and the enhancement of skills, the aim is that their issues will be resolved and prevent any further increase of symptoms.	April 2020 There is also a potential to work with MacMillan on the integrated cancer journey locally, but these discussions are at an early stage.	unscheduled care target set for this activity	McMillan funding – still to be confirmed
6) We will develop integrated pathways for the top six conditions for admission to hospital with the aim of better support patients in the community	Y	Dedicated falls pathway with all services carrying out level one assessments and pathways for more intensive assessment and intervention established. Support to Care Homes to deliver falls bundle. Using of care home dashboard to monitor falls reported within care homes and follow up as appropriate.	Reduce hospital admission. Early intervention to reduce relapse.	Falls work established and supported. Respiratory work to be implemented through 2020/21	No specific unscheduled care target set for this activity	Core

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
		Scoping skilling up staff to proactively manage COPD presentations.				
7) We will develop a range of alternatives to admission for GPs such as access to consultant advice, access to diagnostics and "hot clinics"	Y	Roll out of Consultant Connect. Engage with Acute colleagues re alternative use of Day Hospital. Being taken through HSCP Unscheduled Care Delivery Group	Contributes to achievement of reducing admissions	Consultant Connect roll out in South completed, phasing of North ongoing.	No specific unscheduled care target set for this activity	Central Funding
8) We will further develop access to "step up" beds for GPs as an alternative to admission	N	Invested in delivery of intensive rehab and Home Care reablement to support someone to remain at home with additional input and prevent an avoidable hospital admission. No plans to invest in bed based step up care.	Prevention of avoidable admission	Current model fully implemented. Needs evaluation and impact shared across HSCP to consider options for scale up.	300 admissions avoided 1500 Bed Days avoided	ICF and delayed discharge monies 500k
9) We will continue the work with the independent sector, GPs and others to further reduce admissions from care homes.	Y	Dedicated Care Home Liaison service. Working directly with Care Homes to improve ACP/eKIS quality and compliance. Review admissions data and explore possible	Proactive management and prevent escalation. Upskilling of staff to enable them to be better manage situation and	Service has been implemented but subject to ongoing review and evaluation to maximise impact.	Contribute to the overall unscheduled care targets	Core supplemented by ICF and delayed discharge funding 288K

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
		alternatives and future management plans. Training and implementation support for falls bundles for Care Homes. Delirium escalation plans and stress and distress formulation. Use of the dashboard to monitor care home attendances and enable targeted input to care homes to avoid hospital conveyance where possible.	prevent escalation. Reduce incidences of falls and other care acquired harm.			
10) We will improve emergency departments' access to mental health services.	Y	Link in with the wider Mental Health Unscheduled Care review and ensure any local plans are implemented and staff are communicated any changes. Teams will look at improving interface with the unscheduled care teams. The Mental Health dashboard is utilised across the teams	Sharing of management support plans to facilitate decision making and encourage patient to seek alternative support.	Implementation will be in line with the recommendations of the wider mental health unscheduled care review	Contribute to unscheduled care attendances	Core

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
		to identify 'repeat attendees' theses are discussed with wider team and care/management plans adapted accordingly. Use electronic ACP to enable sharing on management plans.				
Primary and Secondary care interface						
1) We will develop a policy of re-direction to ensure patients see the right person, in the right place at the right time.	Y	Would look to support direction of travel and consider alternatives at a local level based on what is agreed for use across GG&C.	Contributes to achievement of reducing demand on unscheduled care	This initiative will be led by NHSGGC, implementation plan to follow.	This initiative will be led by NHSGGC, any associated targets to follow.	Not known
2) We will test the potential for a service in emergency departments that offers patients who could be seen elsewhere advice and assistance in getting the most appropriate service.	N	Link with planned work in acute to enable community input/support to facilitate alternative service delivery.	Contributes to achievement of reducing demand on unscheduled care	This initiative will be led by NHSGGC, implementation plan to follow.	This initiative will be led by NHSGGC, any associated targets to follow.	Not known
3) To improve the management of	N	This work is being led by acute and is related to	Unknown	Unknown	This initiative will be led by	Not known

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
minor injuries and flow within emergency departments and access for patients, separate and distinct MIUs should be established at all main acute sites.		the internal flow within the emergency department.			NHSGGC, any associated targets to follow	
4) We will test setting a shorter target for MIUs that encourages patients to attend MIUs instead of A&E e.g. patients see and treated within 2 hours at MIUs versus the 4 hour A&E target.	N	Acute site action	Unknown	Unknown	Unknown	Unknown
5) We will also test a change the hours of operation to better match pattern of demand with MIUs open to 11.00 pm at weekends and Bank Holidays.	N	Acute site action	Unknown	Unknown	Unknown	Unknown
6) We will assess the feasibility of opening	N	Acute site action	Unknown	Unknown	Unknown	Unknown

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
an MIU at Gartnavel						
7) We will reduce the number of A&E attendances accounted for by people who have attended more than ten times in the previous twelve months will have reduced by 2% of total attendances	Y	Lists are shared with the partnership every 3 months to enable local MDT review of repeat attenders to maximise use of community supports and ensure that eKIS are informative to enable robust clinical decision making.	Contributes to achievement of reducing demand on unscheduled care	Process has been established but subject to review to maximise impact.	Contributes to reduction in attendances	Core
8) We will reduce the number of people discharged in the same day from GP assessment units by the development of care pathways for such conditions such as deep vein thrombosis. Work will be undertaken to review same day discharges and what alternatives could be offered to GPs on a planned basis.	Y	Review of day hospital and potential for diagnostic clinics. Community services will support this work to ensure seamless pathways for any ongoing support/input.	Contributes to achievement of reducing demand on unscheduled care	Action for acute in the first instance and then include HSCP to develop pathways	Contributes to reduction in attendances	Not known

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
9) We will assess the feasibility of introducing a single point of access for acute clinicians to support access to HSCP services.	Y	Work has begun to move towards delivering services on a locality basis. As part of this work we will look to introduce a locality SPOA to enhance access to community based services.	A consistent and easily accessible option to enable discussion about HSCP response to support someone to remain within the community.	Progressed through 2020/21	Contributes to reduction in attendances	To be determined
10) We will further develop links between consultant geriatricians and GPs in order to better support patients in the community particularly those in care homes and those in the community who are frail	Y	Review current arrangements with aligned Geriatrician support to community rehab tTeam and ensure that the benefits of this are maximised.	Contributes to achievement of reducing demand on unscheduled care	Full implementation in 2020/21	Will be subject to full evaluation	Central
Improving discharge						
1) We will work with acute services to increase the number of discharges the number of discharges occurring before 12.00 noon	Y	Review local process within Care at Home services to scope potential for new care packages to commence at weekends.	Availability of care packages to support weekend discharges	Ongoing through 2020/21	Contribute to reducing length of stay and delayed discharges	Core

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
and at weekends						
2) We will begin care planning as soon as possible after a patient is admitted to hospital and involve the appropriate members of the multi-professional team at the earliest opportunity.	y	Improved information sharing through clinical portal of community notes which include details of home supports etc. Increased number of ACP's through other workstream will enhance info sharing. Early referral to care at home to enable timely scheduling of care package.	Facilitate timely discharge and reduce length of stay.	Implemented	Contribute to reducing length of stay and delayed discharges	Core and delayed discharge monies 230K
3) We will further develop our models of intermediate care and rehabilitation and re-ablement.		Further develop Homecare reablement in conjunction with rehab services. Ensure regular and timely review of care packages to promote independence and confidence and reduce reliance on services. Use of dashboard to identify those admitted who are known to services and explore opportunities to support early discharge. Community Rehab to continue links with AHP's	Optimise level of independence and build resilience and reduce reliance on care delivery.	Implemented	Contribute to reducing length of stay and delayed discharges	Core, delayed discharge and ICF 500k

Key Actions	Activity in EDHSCP (Y/N/I)	Describe planned service or process changes in EDHSCP	How specifically will these changes further reduce unscheduled care	Specify timescale for full implementation and any phasing in 2020/21	Estimate contribution to relevant MSG targets in 2020/21	Finance
		in acute ortho to support early discharge and continued rehab within the community.				
4) We will reduce delayed discharges to 4838 by end of March 2021 so that the level of bed days lost to delays in GG&C is maintained at 2015/16 Baseline levels.		Use of dashboard to identify those admitted and focus on those with an EDD of 10days+ All services need to introduce discussions around PoA within their assessment processes. Review local processes to ensure timely compliance for those in acute delayed as a result of AWI.	Early referral to SW to enable proactive discharge planning. Reduction in AWI through increased uptake of PoA.	Implemented	Contribute to reducing length of stay and delayed discharges	Core and Delayed discharge monies 230K

Appendix 4

Ministerial Strategic Group (MSG) Targets 2020-21

East Dunbartonshire Health & Social Care Partnership

Target Area	2015/16 Baseline	East Dun HSCP target 19/20 (%/N reduction from 2015/16 baseline)	Indicative performance 2019/20 (ave. per month of April - Dec)	*New* 2018/19 Baseline	East Dun HSCP Proposed Target 2020/21 (%/N reduction from 2018/19)
Emergency Dept Attendances (A&E / MIU combined)	19,674 (18+)	19,674 (0% variance from 2015-16 baseline)	20,137 (2.4% variance from 2019/20 target)	20,665 (18+)	19,674 (18+) (-4.8% variance from 2018-19 baseline)
Emergency Admissions	11,754	9,918 (-16% variance from 2015-16 baseline)	9,428 (-5% variance from target)	10,694	9,403 (-12% of 2018-19 baseline)
Unscheduled Hospital Bed Days	83,220	76,927 (-7.6% variance from 2015-16 baseline)	85,471 (11% variance from 2019-20 target)	83,118	80,723 (-3% variance from 2018-19 baseline)
Bed Days Lost to Delayed Discharge	4,838	4,838 (0% change from 2015-16 baseline)	5,299 (9.5% variance from target)	5,031	4,838 (-3.8% change from 2018-19 baseline)

Agenda Item Number: 5

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	**25th June 2019**
Subject Title	**Unaudited Draft Annual Accounts 2019/20**
Report By	**Jean Campbell, Chief Finance & Resources Officer** **Tel: 0300 1234510 Ext 3221**
Contact Officer	**Jean Campbell, Chief Finance & Resources Officer** **Tel: 0300 1234510 Ext 3221**

Purpose of Report	To update the Board on the financial out turn for 2019/20 and present the draft Annual Accounts.

Recommendations	The Integration Joint Board is asked to: a. Note the unaudited Accounts for 2019/20.

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 deficit on budget to the extent that the partnership has had to rely on the use of limited general reserves available and a re-designation of elements of earmarked reserves to support a balanced budget for the financial year. This has not required an additional contribution from East Dunbartonshire Council as anticipated, however leaves the partnership with no general reserve provision moving forward to manage unforeseen circumstances that may arise. The partnership continues to hold a level of earmarked reserves through Scottish Government funding to meet specific priorities which align to the delivery of the Strategic Plan.

Legal:	None.

Economic Impact:	None

Sustainability:	The financial position of the partnership provides no resilience in the short term to meet the ongoing financial challenges in relation to demand and cost increases throughout the year and any delays in delivering the level of transformation agreed to deliver a balanced position for 2020/21, albeit elements of this have been attributed to and included within Covid mobilisation plans. Work will continue in collaboration with Council Transformation colleagues to identify opportunities for future transformation and service redesign which ensure services are delivered within the financial framework available to the HSCP.

Risk Implications:	There are a number of financial risks moving into future years given the rising demand and cost pressures in the context of reducing budgets which will require effective financial planning and transformation activity to ensure financial balance as we move forward.

Implications for East Dunbartonshire Council:	The lack of partnership reserves to meet unexpected in year financial pressures will increase the likelihood that the partnership will have to rely on additional contributions from the statutory partners in line with the terms within the Integration Scheme.

Implications for NHS Greater Glasgow & Clyde:	The lack of partnership reserves to meet unexpected in year financial pressures will increase the likelihood that the partnership will have to rely on additional contributions from the statutory partners in line with the terms within the Integration Scheme.

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

MAIN REPORT

1.0 2019/20 Annual Accounts

1.1 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.

1.2 This will be the fifth set of Annual Report and Accounts produced for the HSCP Board.

1.3 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.

1.4 Audit Scotland have also produced a good practice note on improving IJB Accounts and this has been reviewed in preparing the annual report and accounts.

1.5 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.

1.6 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 Chief Officer
Statement of Responsibilities	Chair of the IJB Chief Financial & Resources Officer
Annual Governance Statement	Chair of the IJB Chief Officer
Remuneration Report	Chair of the IJB Chief Officer
Balance Sheet	Chief Financial & Resources Officer

1.7 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.

1.8 The main messages from the Annual Report and Accounts in relation to the financial performance of the HSCP during 2019/20 are:

- The partnership incurred a deficit during 2019/20 of £0.2m. This includes the impact of additional Scottish Government Funding throughout the year which will be taken to ear marked reserves and allocated for the purpose the funding was provided. The actual over spend on services is therefore nearer £0.6m, after adjusting for the impact of this specific funding.
- This represents a positive movement from that reported in Month 10 of £1.3m (Month 10 projected a £1.9m deficit) and relates in the main to :

    - Fleet Recharges for use of vehicles to support aspects of social work service delivery were less than anticipated - £141k
    - The outcome of audits related to direct payments for individuals directing their own care provided a number of refunds of monies in the final stages of the year - £217k
    - Housing recharges for Private Sector Housing Grants and Care & Repair services were lower than budgeted levels - £386k
    - Recharges for bad debt provision were less than anticipated due to a lower level of outstanding debt in the final periods of the year - £265k
    - Prescribing costs saw a further downturn in the final months of the year with the impact of Covid_19 costs assumed to be met from funding through the SG - £98k.
    - A downturn in care packages for social work services in the final periods of the year - £90k
    - A downturn in kinship, fostering and residential costs in the final periods of the year - £37k
    - Other positive movement in relation to NHS community expenditure as a result of further vacancies, equipment and additional funding to support smoking cessation - £70k

- In order to balance the budget for 2019/20, the HSCP had already provided for the re-designation of earmarked reserves in respect of Prescribing (£145k) and Oral Health (£200k) and following a review of earmarked reserves at year end , re-designated a further(£218k) related to monies set aside to support transformation and service redesign. The HSCP also applied the limited general reserves available of (£41k) which provides a total of £0.6m applied from reserves to balance the year end position.
- There are no remaining general reserves and the level of earmarked reserves remaining is £0.8m and covers specific funding provided by the SG in relation to:

o Self Directed Support (SDS)	£0.077m
o Integrated Care Funding	£0.307m
o Primary Care Improvement Plan	£0.195m
o Primary Care Cluster Funding	£0.039m
o Action 15 Mental Health Strategy	£0.108m
o Alcohol and Drugs Partnerships	£0.038m
o Technology Enabled Care	£0.011m
o Infant Feeding	£0.013m
o CHW Henry Programme	£0.015m
o **TOTAL**	**£0.803m**

- The main areas of budget pressure for the HSCP during the year are set out below:

Older People Services (£2.8m over spend)

The overall pressures relate to ongoing demand and cost pressures exceeding the available budget for 2019/20, particularly in the area of older people's social care.

These were a result of adverse payroll variances particularly in relation to homecare as a consequence of reliance on overtime and use of agency to ensure continuity of service delivery to cover vacancies, sickness and absence; challenging savings plans predicated on the redesign of homecare services and which were not achieved in year; increased activity levels placing demand pressures on older people care homes, homecare, supported living and day-care (alternatives) and contractual increases in relation to the care at home framework and national care home contracts beyond that which was provided for within the budget. These pressures arose as a direct result of the growing demand from an ageing population requiring support from social work services to maintain independent living within the community or within a care home setting.

A review of care at home services during the year has determined that a locality based approach supported through a balance of usage of externally purchased services will deliver a sustainable care at home service going forward. This is in the process of being implemented internally with external provision subject to re-tendering exercise with resort to the national Scotland Excel Framework to deliver this element of the service.

Adults – Learning Disability, Mental Health, Addiction Services (£0.1m under spend)

There were some pressures in the area of learning disability in relation to the impact of the delay in delivering savings within the Pineview service, taxi provision to support individuals with a learning disability to access services and costs associated with agency staff to cover statutory mental health officer functions. This was offset through a downturn in residential accommodation within addiction recovery services, recharges for fleet provision and savings achieved through vacancies across community health services within this care group area. The implementation of the new Access to Transport policy and progression of the learning disability review will mitigate pressures in this area going forward.

Children & Families (£0.3m under spend)

There were some pressures in relation to externally purchased foster placements, kinship payments and health visiting staff costs, this was offset through robust vacancy management across Children's social work and residential services.

Business Support (£1.3m under spend)

There were some pressures on accommodation costs within the Kirkintilloch Health & Care Centre and Lennoxtown Hub, this was offset through additional funding above anticipated levels in relation to the improved health offer, continuing care, support to veterans, carers funding and the positive impact of improved bad debt provisions.

Prescribing (£0,5m under spend)

There are a number of points to note in respect of prescribing, namely:-

- The cost per drugs is increasing on average by 9.36% for East Dunbartonshire based on the types of drugs being dispensed and this is expected to continue.
- The overall performance on prescribing is being driven largely by volumes with an average decline in volumes over the year of 6% compared to that forecast at the budget planning stage.
- This is set in the context of increasing list sizes for East Dunbartonshire having seen an increase of 1.06% since the same period last year.

- o There were savings from discounts (patented drugs) and discount clawback (generic drugs) in 2019/20 which had a positive impact on this budget

Other Services (£0.4m under spend)
There was a positive variation on other budgets delegated to the partnership relating to private sector housing grants and care & repair services delivered through the Council's housing service.

1.9 A copy of the Draft Annual Accounts 2019/20 including the Annual Governance Statement is attached as **Appendix 1.**

East Dunbartonshire
Health & Social Care
Partnership

EAST DUNBARTONSHIRE
INTEGRATION JOINT BOARD

Commonly known as the

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

ANNUAL ACCOUNTS

2019/20

CONTENTS

MANAGEMENT COMMENTARY

Introduction

This document contains the financial statements for the 2019/20 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.

East Dunbartonshire

East Dunbartonshire has a population of 108,640 and is a mix of urban and rural communities. It has frequently been reported in quality of life surveys as one of the best areas to live in Scotland based on people's health, life expectancy, employment and school performance. Economic activity and employment rates are high and the level of crime is significantly below the Scottish average. Despite this, inequalities exist across the authority and there are pockets of deprivation where the quality of life falls well below the national average.

East Dunbartonshire has eight datazones which fall into the top 25% most deprived in Scotland; these datazones are located in Hillhead, Lennoxtown, Auchinairn, Kirkintilloch West and Milngavie (Keystone / Dougalston). The most deprived area in East Dunbartonshire is Hillhead, certain parts of which are among the 5% most deprived areas in Scotland according to the Scottish Index of Multiple Deprivation 2020 (SIMD).

Compared with the rest of Scotland, people living in East Dunbartonshire are relatively healthy. More people take part in sports, fewer smoke and breast feeding rates are higher than the Scottish average. Although East Dunbartonshire is in the highest decile for life expectancy in Scotland for both men and women, there is a 10 year gap of life expectancy in favour of the Westerton area, compared to Hillhead. We also know from Census and population health analysis that the prevalence of disability and long term conditions in considerably higher for people in the areas of relative deprivation. The rate of hospital emergency admissions is also significantly greater amongst East Dunbartonshire's more deprived populations.

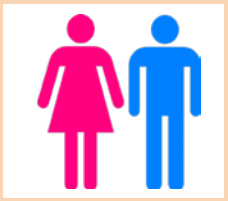
In the 2011 Census, 5.6% of the adult population in East Dunbartonshire reported a disability, with hearing impairments and/or physical disability being the main disabilities reported.

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

The estimated population of East Dunbartonshire in 2019 predicts a higher proportion of older people than the Scottish average.

Figure 1 Estimated Population in 2019

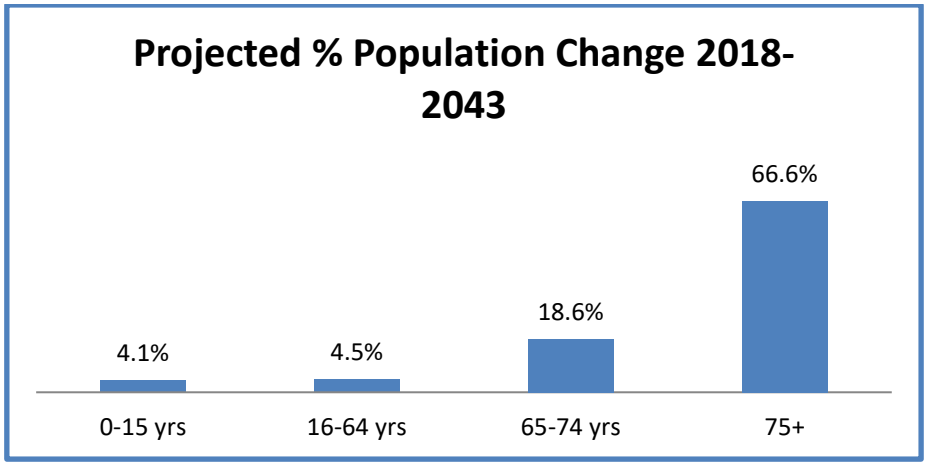
All People
108,640



Age	No.	Percent	*Scotland*
0-15	19,398	17.9%	*16.9%*
16-44	33,138	30.5%	*36.6%*
45-64	31,628	29.1%	*27.5%*
65-74	12,750	11.7%	*10.6%*
75-84	8,373	7.7%	*6.2%*
85+	3,353	3.1%	*3.1%*

Source NRS

East Dunbartonshire has seen a 40% increase in people over the age of 75 since 2002, which is a positive reflection of advances in health and social care, but has placed considerable pressure on services during a period characterised by public sector reform and diminishing resources. With an increase in the frail older population, service pressure has been experienced in both the community and secondary healthcare settings.



Between 2015 -17 there was a reported 11% rise in the number of people with diagnosed dementia and this trend has also been experienced with other age-related conditions.

There has been a significant increase in the number of children being referred to Social Work Services, with 40% increases in referrals reported in the Integrated Children's Services Plan. Non-engaging families was the most common area of concern alongside neglect, domestic violence and parental alcohol misuse. There has also been a sharp rise in parental mental

health being identified as a significant concern. This is an area of cross-cutting focus between children and adult services.

Demand on services for other adult care groups and for children's disability services has also increased. The number of young people with disabilities transitioning to adult services is experiencing a notable increase, both numerically and in terms of complexity. This can be demonstrated by an anticipated increase in the Adult Joint Learning Disability Team over the next three years' as children move on into adult services equivalent to over 7% of its total caseload.

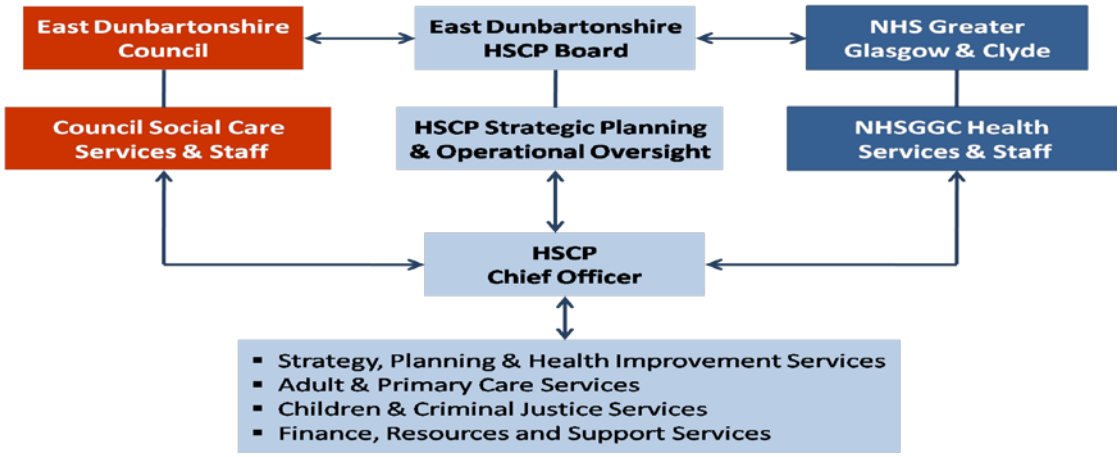
The Health & Social Care Partnership

East Dunbartonshire Health and Social Care Partnership (HSCP) is the common name of East Dunbartonshire Integration Joint Board. It 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 partnership's remit was expanded from an initial focus on services for adults and older people to include services for children and families, and criminal justice services in August 2016.

The HSCP Board, East Dunbartonshire Council (EDC) and NHS Greater Glasgow & Clyde (NHS GG&C) 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.

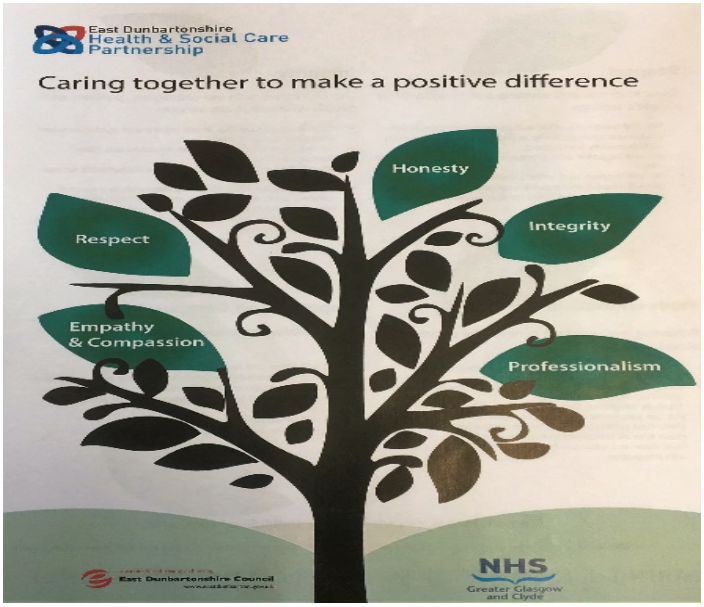
East Dunbartonshire HSCP Board has responsibility for the strategic planning and operational oversight of a range of health and social care services whilst EDC and NHS GG&C retains responsibility for direct service delivery of social work and health services respectively, as well as remaining the employer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

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



Our partnership vision is “Caring Together to make a Positive Difference” and is underpinned by 5 core values as set out below.

Exhibit 2



Our current Strategic Plan covers the period 2018 – 2021 and sets out eight strategic priorities which describe our ambitions to build on the significant improvements already achieved and to further improve the opportunities for people to live a long and healthy life, provide early support to families and young children and focus service on those most vulnerable in our communities.

These priorities are:-

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

This is further supported by a HSCP Transformation Plan outlining the key priorities for service redesign and transformation in delivery of the Strategic Plan and is supported by a range of operational plans, work-streams and financial plans to support delivery. This is also the vehicle

through which the HSCP will seek to deliver financial sustainability over the short to medium term by reconfiguring the way services are delivered within the financial framework available to it.

The Strategic Plan also links to the Community Planning Partnership's Local Outcome Improvement Plan whereby the HSCP has the lead for, or co-leads:

- Outcome 3 – "Our children and young people are safe, healthy and ready to learn",
- Outcome 5 – "Our people experience good physical and mental health and well being with access to a quality built and natural environment in which to lead healthier and more active lifestyles" and
- Outcome 6 – "Our older population and more vulnerable citizens are supported to maintain their independence and enjoy a high quality of life, and they, their families and carers benefit from effective care and support services"..

Performance is monitored using a range of performance indicators outlined in a performance management framework with 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 OPERATIONAL PERFROMANCE FOR THE YEAR 2019/20

A full report on performance will be outlined within the East Dunbartonshire HSCP Annual Performance Report 2019/20. Publication of the Annual Performance Report (APR) is normally in place by the end of July each year, but production of APRs have been delayed by agreement nationally due to the impact of the Covid-19 pandemic. At present there has been no agreement on a date by which APRs should be available for publication. As an interim measure, a summary of key performance across HSCP functions and services will be reported to the HSCP Board in June 2020.

Notwithstanding the delay in the production of HSCP APRs, the timing of the preparation of this set of Annual Accounts is ahead of the publication of national performance data for Core Integration Indicators. The performance data provided below is therefore the most up to date annual data available, which relates to the 2018-19 financial year. However transformational change and other qualitative performance updates do relate directly to the 2019-20 period.

Headline performance is summarised below under the following headings:

- *National Core Indicators (most recent published data)*
- *Local Transformational Change and Best Value Improvement Activity*
- *Progress against the "Features Supporting Integration" improvement proposals by Audit Scotland and the Ministerial Strategic Group*
- *Progress against the Joint Strategic Inspection of Adult Services Action Plan*

National Core Indicators (collected biennially: 2019/20 awaited)

National Outcome Indicators	2015/16	2017/18	National Rank
Percentage of adults able to look after their health very well or quite well	96%	96%	1st
Percentage of adults supported at home who agree that they are supported to live as independently as possible	86%	84%	1st
Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	84%	86%	1st
Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	73%	84%	3rd
Total percentage of adults receiving any care or support who rated it as excellent or good	86%	84%	6th
Percentage of people with positive experience of the care provided by their GP practice	89%	90%	2nd
Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	85%	83%	7th
Total combined % carers who feel supported to continue in their caring role	43%	41%	3rd
Percentage of adults supported at home who agreed they felt safe	84%	87%	4th
National Data Indicators	**2017/18**	**2018-19**	**National Rank**
Premature mortality rate for people aged under 75yrs per 100,000 persons	312.5	274	1st
Emergency admission rate (per 100,000 population)	10,787	11,454	17th
Emergency bed day rate (per 100,000 population)	109,384	110,137	14th
Readmission to hospital within 28 days (per 1,000 population)	73	74	2nd
Proportion of last 6 months of life spent at home or in a community setting	89%	89	11th
Falls rate per 1,000 population aged 65+	22	25	25th
Proportion of care services graded ‘good’ (4) or better in Care Inspectorate inspections	82%	81%	27th
Percentage of adults with intensive care needs receiving care at home	67%	63%	18th
Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	231	357	7th
Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	21%	23%	14th

Local Transformational Change and Best Value improvement activity during 2019/20

Initiative	National Outcome
Review of Service and Transport Charging	9
Review of Transport Policy	9
Review of 3rd Sector Grants	9
Review of Sleepovers	4, 9
Development of Enhanced Day Care for adults with a Learning Disability to reduce out of area provision	2, 3, 4, 9
Development of the Smart Flat /TEC	1, 4
Review of Day Care Services	2, 9
Implementation of the new HSCP Fair Access to Community Care Policy	3, 4, 5, 9
Review of Respite for Older People	2, 9
Review of Blue Badge processes	9
Reduction in Mental Health Officer Agency Spend	9
Reduction in Older People services Agency Spend	9
Maximising Use of Equipment	9
Application of Ordinary Residence to re-designate financial accountability	2, 9
Increase in community based options for looked after and accommodated children	2, 7, 9
Review of Allotment Scheme	9
Review of Learning Disability resource allocation model	5, 9
Vacancy Resourcing	9
Continuing Care (one off)	2

Progress during 2019-20 in support of "Features Supporting Integration" improvement proposals by Audit Scotland and the Ministerial Strategic Group

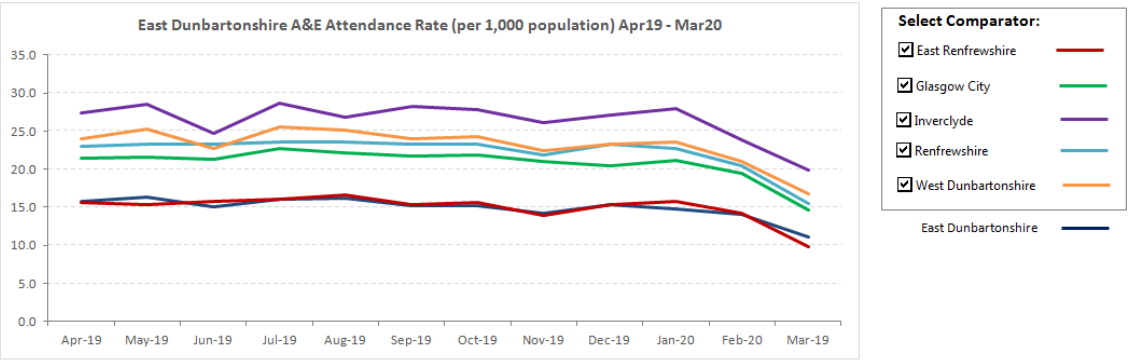
Collaborative leadership and building relationships – completed by March 20
• Reviewing all leadership course/training opportunities delivered across, or available to, East Dunbartonshire Council and NHSGGC staff to identify ones that should be made available to partnership staff regardless of employing organisation • Finalising and publishing a formal Commissioning Strategy that sets out areas of development and commissioning intention linked to the delivery of the HSCP's Strategic Plan. • Engaging, through our Providers' Forum, with providers to develop an approach to cross-market facilitation that delivers on the priorities set out in the Commissioning Strategy, supported by colleagues from iHub. • Further developing our Providers' Forums by ensuring meetings are set, agendas are developed with input from providers, and there is attendance of senior managers to update / engage on key priority areas under development. • Working with our local Third Sector Interface to improve engagement with larger national third sector providers who find it difficult to engage directly with the local Providers' Forums
Integrated finances and financial planning - completed by March 20
• Reviewing the financial monitoring and reporting framework to support operational delivery across the NHS, HSCP and Council • Working across the partnership to understand expected future capital requirements for community services further and develop our mapping of the potential contribution of all agencies to delivering on a capital programme for fit for the future facilities in local communities, as far as possible, regardless of ownership of the asset.
Effective strategic planning for improvement - completed by March 20
• Finalising and publishing a formal Commissioning Strategy that sets out areas of development and commissioning intention linked to the delivery of the HSCP's Strategic Plan.
Governance and accountability arrangements - completed by March 20
• Working in partnership with the HSCP Board Chair to develop a programme of briefing and discussion opportunities with the Chair and senior management team of the HSCP to support effective agenda, Board business and whole system planning. • Developing a formal quality improvement framework and embedding this is the work of the clinical and care governance group's scrutiny processes.
Meaningful and Sustained Engagement - completed by March 20
• Develop and present to the HSCP Board a refreshed HSCP engagement strategy that outlines our engagement opportunities for local communities in relation to strategic, local planning and transformation activities.

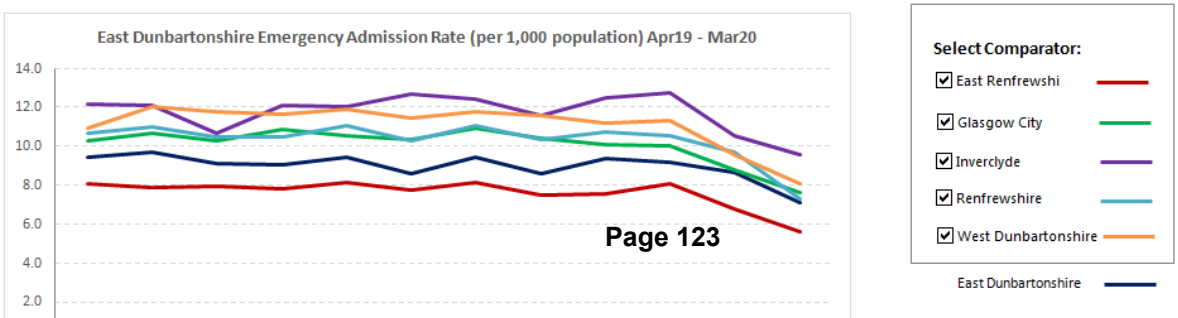
Progress against the Joint Strategic Inspection of Adult Services Action Plan

Actions Completed By March 2020
Implemented the Performance Framework approach developed during 2018 – 2019
Developed an ISD work plan to support data reporting and analysis
Worked with Council Performance Team via the Operational Reporting Requirements Group to put reporting actions in place to address areas ISD are unable to contribute to.
Developed and implement a Quality Assurance framework for use across the partnership and embed process for quality improvement across partnership team
Worked with the Council Performance Team and Carefirst Team to explore how information in relation to meeting outcomes for individuals can be collated /aggregated and reported to inform service review and planning processes
As part of our Quality Improvement Framework established expectations around formal updating of needs assessments to inform service planning and ensure scrutiny and reporting of same to Clinical and Care Governance Group
Developed a refreshed engagement strategy within the HSCP that includes engagement expectations in relation to strategic and local planning, and transformation
Contributed to the Council's 10 stage service redesign review process to consider opportunities within process for engagement with service user / carers and care providers
Finalised the Commissioning Strategy

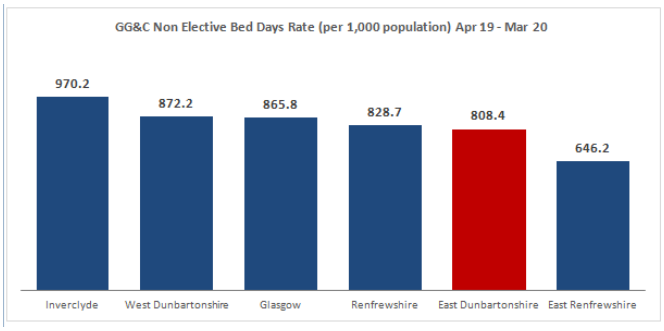
Performance Highlights and Improvement Areas

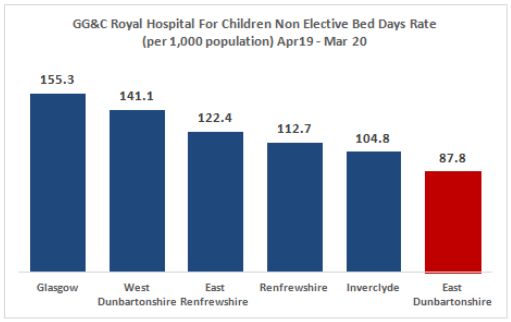
There is a delay of some months for published national unscheduled care performance by Public Health Scotland, so full year performance data is not yet available for this. However, NHS Greater Glasgow and Clyde (GG&C) records more up-to-date unscheduled care activity and performance data, which can be used at this stage to report performance locally. Using this local data, East Dunbartonshire is shown to have recorded the second lowest A&E attendances across GG&C, with the second lowest admissions for over age 65, as a rate of population.



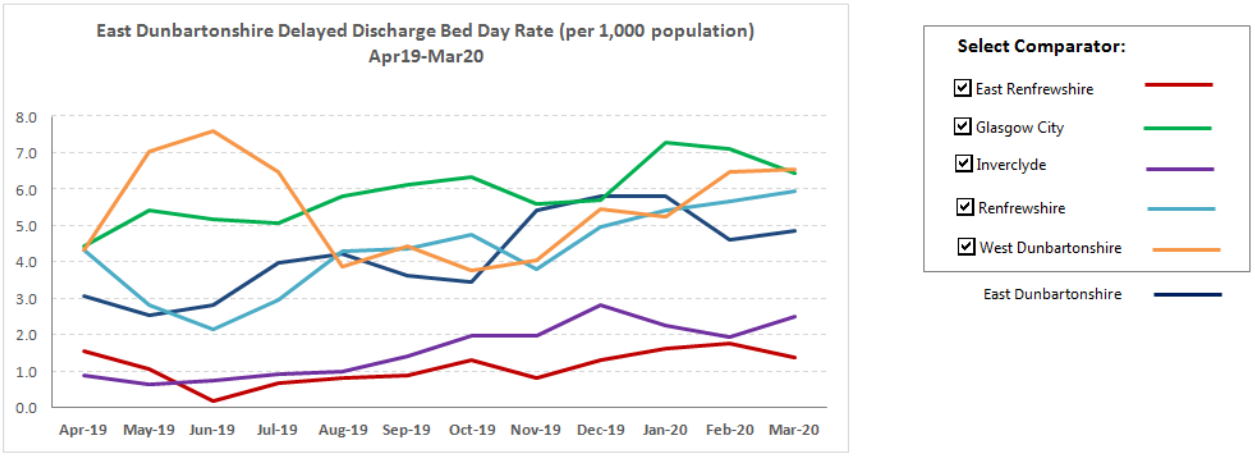


Bed days associated with emergency admissions were the second lowest for 18+ and the lowest for under 18s.



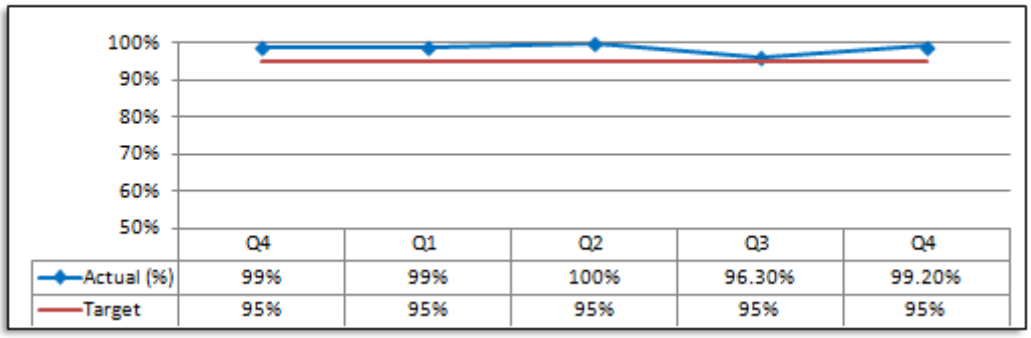


After a strong start to the year, East Dunbartonshire experienced a gradual increase in bed days lost to delayed discharge, with a particular spike occurring during the wonder period. This placed East Dunbartonshire with the highest rate in GG&C by the end of Quarter 3, in significant part due to local home care provider pressures and an increase in referrals to the Social Work Hospital Assessment team of 20% year-on-year. In response to these challenges, the HSCP introduced a new Care at Home model, and introduced a change in culture and practice with the introduction of Local Area Coordinators. The Home for Me team reduced care calls post discharge by 66% and care hours from an average of 11 per week to 2 per week. Importantly, levels of discharge before 72 hours were sustained despite increased delays and referrals to the Hospital Assessment Team. By the end of the financial year, the delayed discharge levels were significantly reduced from the winter spike, which was also a consequence of the coronavirus emergency planning arrangements.



With adult social work services, the completion of community care assessments within the target 6 week period exceeded 95% in each quarter of 2019-20.

Percentage of service users (65+yrs) meeting 6wk target

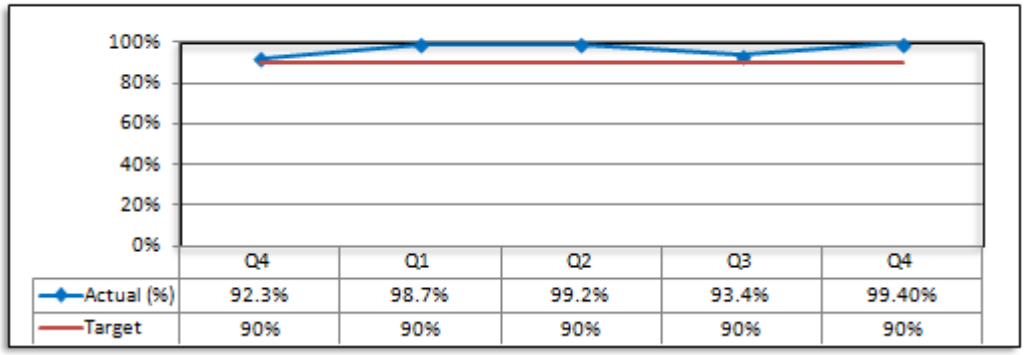


	Q4	Q1	Q2	Q3	Q4
Actual (%)	99%	99%	100%	96.30%	99.20%
Target	95%	95%	95%	95%	95%

Satisfaction with the level of customer involvement in the design of their care and support also exceeded target, achieving 98% satisfaction scores through annual review. After a challenging year in 2018-19 in the face of a trebling of referrals for older people, the achievement of adult protection timescales exceeded 90% for each quarter in 2019-20.

Alcohol and Drugs treatment waiting times began 2019 with target achievement of 76%, but through improved resourcing and operational processes, this was increased to 86% by the end of the reporting year. Mental Health psychological therapy targets were fully met over the same period. There was also a positive roll out by Primary Care Mental Health Service of E-CBT and E-health initiatives and wider multidisciplinary digital health group to progress HMHM and Attend Anywhere development.

Percentage of People Waiting <18wks for Psychological Therapies



	Q4	Q1	Q2	Q3	Q4
Actual (%)	92.3%	98.7%	99.2%	93.4%	99.40%
Target	90%	90%	90%	90%	90%

Social Work Children's Services achieved very good performance across the full range of child protection, looked after children and assessment waiting times. Achieving target on the balance of care for looked after children in the community was more challenging, but this improved quarter-on-quarter over the year due to successful initiatives to increase foster care capacity in the East Dunbartonshire area. The number of children on the child protection register increased by 36% over the reporting year. Children's community nursing services secured SG Funding for a Breast Feeding Project to reduce attrition rates and achievement of UNICEF Breast Feeding Gold Sustainability Status as a result of excellent work in this field.

A fuller report on HSCP performance is available in the HSCP Board's Quarter 4 Performance Report and will be further developed in the Annual Performance Report 2019-20.

HSCP BOARD'S FINANCIAL POSITION AT 31 MARCH 2020

The activities of the HSCP are funded by EDC and NHS GG&C who agree their respective contributions which the partnership uses to deliver on the priorities set out in the Strategic Plan. The scope of budgets agreed for inclusion within the HSCP for 2019/20 from each of the partnership bodies were:-

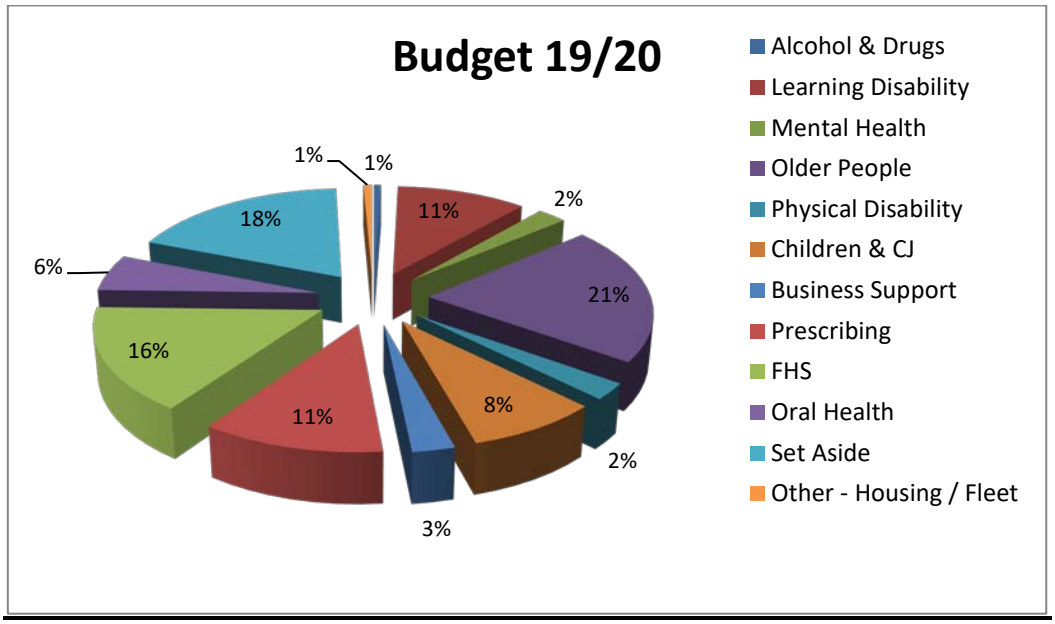
HSCP Board Budgets 2019/20 (from the 1st April 2019 to the 31st March 2020)

	Original Budget 19/20 £000	In Year Adjustments £000	Final Budget 19/20 £000
Functions Delegated by East Dunbartonshire Council	55,154	606	55,760
Functions Delegated by NHS GG&C	78,364	9,896	88,260
Set Aside – Share of Prescribed Acute functions	19,602	12,645	32,247
TOTAL	**153,120**	**23,147**	**176,267**

The increases to the original budget for 19/20 relate largely to non recurring funding allocations during the year relating to oral health, family health services and Scottish Government funding to support alcohol & drugs, primary care improvements and mental health monies. The increase to the set aside allocation relates to NHS GG&C now being in a position to report the set aside figures based on actual expenditure which has resulted in the restatement of 18/19 figures which were previously based on a notional budget figure. The notional budgets for set aside were based on NRAC activity and information from the cost book and were very high level. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

The budgets include an element of funding provided by the Scottish Government to deliver on the key outcomes for the Partnership in the form of delayed discharge (£0.5m), integrated care funding (£0.7m) and Social Care funding (£6.1m).

The budget is split across a range of services and care groups as depicted below:-



HOSTED SERVICES

The Health Budget includes an element relating to Oral Health Services (£9.8m) which is a service hosted by East Dunbartonshire HSCP and delivered across the other five partnership areas within NHS GG&C's boundaries.

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

The extent to which these services are consumed by the population of East Dunbartonshire is reflected below:-

2018/19 £000	Service Area	2019/20 £000
518	MSK Physio	556
62	Retinal Screening	59
563	Podiatry	578
333	Primary Care Support	342
357	Continence	372
633	Sexual Health	637
	Learning Disability – Tier 4	42
793	Mental Health Services	825
	Augmentative & Alternative Communications	25
800	Oral Health	809
907	Addiction	912
155	Prison Healthcare	164
193	Healthcare in Police Custody	193
2,361	General Psychiatry	2,301
	Learning Disability – In Patient	154
1,389	Old Age Psychiatry	1,204
9,064	**Total Cost of Services consumed within East Dunbartonshire**	**9,173**

SET ASIDE BUDGET

The set aside budget relates to certain prescribed acute services including Accident & Emergency, General Medicine, Respiratory care, Geriatric long stay care 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.

Work continues to be progressed in relation to the sum set aside for hospital services; however, arrangements under the control of Integration Authorities are not yet operating as required by the legislation and statutory guidance. Each Health Board, in partnership with the Local Authority and Integration Authority, must fully implement the delegated hospital budget and set aside budget requirements of the legislation, in line with the statutory guidance published in June 2015. To date work has focused on the collation of data in relation to costs and activity. Moving forward work has now commenced on the development of commissioning plans to support the implementation of set aside arrangements.

An allocation has been determined by NHS GG&C for East Dunbartonshire of £32.2m for 2019/20 in relation to these prescribed acute services. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

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. This is compounded by the impact on public sector budgets of the Covid-19 pandemic which is expected to continue throughout 2020/21.

The planning and delivery of health and social care services has had to adapt to meet the significant public health challenge presented by the Covid-19 pandemic. In response to the pandemic the IJB has been required to move quickly and decisively.

There has been significant disruption to how health and social care services across East Dunbartonshire are currently being delivered and experienced by service users, patients and carers and this is likely to continue in the short to medium term. The HSCP has also had to implement new service areas in response to the pandemic, examples of which have included the establishment of an assessment centre to support assessment and testing of potential COVID-19 patients and the creation of a hub to support the distribution of PPE to our social care services and those delivered by the third and independent sector and personal assistants and carers.

The financial impact of implementing the required changes to services and service delivery models (e.g. to support social distancing requirements, support staff with the appropriate protective equipment, and manage the new and changing levels of need and demand) is significant and likely to be ongoing and evolving. The Governance Statement on page x outlines

the governance arrangements which are in place during this challenging time. These accounts have been prepared on the assumption that the Scottish Government will meet the additional costs experienced by the IJB and this is also the assumption which has been made moving forward into 2020/21.

Future Scottish Government grant settlements remain uncertain with further reductions in government funding predicted to 2020/21. The EU referendum result on the 23rd June 2016 continues to create some further uncertainty and risk for the future for all public sector organisations and this continues with negotiations ongoing and due to conclude during 2020/21.

The Partnership, through the development of an updated strategic plan, has prepared 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 through the use of earmarked reserves. This was presented on the basis of "business as usual", ongoing and developing COVID-19 issues highlight that this is not the case. It should be recognised that extraordinary costs are being incurred and will continue to be incurred for the foreseeable future. For accounting purposes, these costs will be recorded separately, with the assumption that costs will be covered by partners, and ultimately by government

Additional funding of £100m has been provided to HSCPs for 2020/21 to support continued implementation of the Carers Act, Scottish Living Wage to care providers, delivery of health and social care integration, increases to the FPC allowances and delivery of school counselling. There has also been additional Investment in the Primary Care Fund to support the implementation of the GP contract and development of new models of primary care (£50m), Mental Health and CAMHs (£28m) and Alcohol and Drugs services (£12.7m)

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 75+ set to increase by 67% over the period 2018-2043 (source: NRS). Even more significantly given the age profiles of people receiving the greatest proportion of services, numbers of older people aged 85+ are set to increase by 119% over the same period.
- East Dunbartonshire has a higher than national average proportion of older people aged 75+, therefore these projected increases will have a significant, disproportionate and sustained impact on service and cost pressures.
- The cost and demand volatility across the prescribing budget which has been significant over the years as a result of a number of drugs continuing to be on short supply resulting in significant increase in prices as well as demand increases in medicines within East Dunbartonshire.. While these issues were not as significant during 2019/20, the impact on the demand and supply of medicines following the Covid-19 pandemic in mid March will be felt during 2020/21.This represents the HSCP's singular biggest budget area.
- The achievement of challenging savings targets from both partner agencies that face significant financial pressure 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 and development of a Performance, Audit & Risk Committee to ensure the adequacy of the arrangements for risk management, governance and the control of the delegated resources.

The HSCP approved a risk management strategy in August 2017 and we continue to maintain a corporate risk register for the HSCP which identified the key areas of risk that may impact the HSCP and the range of mitigating actions implemented to minimise any associated impact. This is subject to regular review with the latest version presented to the IJB in November 2019. This has been supplemented by a specific Covid-19 risk register following the pandemic outbreak in March 2020 and will be in place specifically to manage these risks throughout this period.

The key areas identified (as at September 2019, updated in April 2020 for the Covid-10 pandemic) are:

Key Strategic Risks	**Mitigating Actions**
Inability to achieve financial balance	Liaison with other Chief Finance Officers network. Monitoring of delivery of efficiency plans for the coming year through the HSCP transformation board. Financial recovery plan in place and work with staff and leadership teams to identify areas for further efficiencies / service redesign to be escalated in year.
Risk of failure to achieving transformational change and service redesign plans within necessary timescales	Transformation Board oversees progress. Performance reporting framework established to support tracking of progress. Support through Council and NHS transformation teams to progress priorities. Early collaborative planning with ED Council and NHS GG&C re support requirements.
Inability to recruit and retain the appropriate numbers of trained staff to meet requirements resulting in reduction in service or failure to meet statutory duties.	Develop workforce plan for 2018-21 in line with HSCP Strategic Plan. Revised recruitment protocol in place to support SMT overview of workforce issues.
Brexit risk - may negatively impact service delivery as a result of staff, equipment, medication or food shortages	Ongoing engagement with Brexit risk assessment and planning groups across ED Council and NHS GG&C
Covid - Failure to deliver services to all those vulnerable and complex individuals to allow them to remain safely at home	Monitoring of absence levels and adherence to health protection Scotland advice, additional overtime on offer for staff at work, ongoing recruitment, staff re-direction to frontline care at home service, purchase of appropriate PPE to support staff to deliver safely, management of demand through reliance on

	carers / family members. Additional contract monitoring and commissioning support and liaison to support business continuity of care providers.
Covid - Increased demand for services to support individuals within the community in the context of reduced capacity.	Additional support provided to individuals / carers to support those at risk and shielding to remain safely at home, training ongoing for staff re-directed to care at home and other critical service areas.
Covid - Lack of funding available through the Scottish Government (SG) to support the significant additional costs arising from managing Coronavirus locally	Development and contribution to GG&C Mobilisation plan, financial templates completed and submitted for East Dunbartonshire, weekly updates on anticipated and actual expenditure as planning progresses. Chief Officer representation on GG&C and national groups to make representation for adequate funding, representation through COSLA.

FINANCIAL PERFORMANCE 2019/20

The partnership's financial performance is presented in these Annual Accounts. The table, on page 39, shows a deficit of £0.182m against the partnership funding available for 2019/20. This includes unspent investment (to be carried forward to future years) during the year in relation to Scottish Government funding for specific priorities including Primary Care Improvements (PCIP), delivery of the Mental Health Strategy (MH), and Alcohol and Drugs partnership monies (ADP). This masks the full extent of in year pressures. Adjusting this position for in year additions or re-statement of earmarked reserves provides the true extent of these pressures, totalling nearer £0.6m for 2019/20.

As part of the approval of the 2019/20 Budget in March 2019, the HSCP Board approved a Transformation and Service Redesign programme of £3.9m to deliver a balanced budget for the year. This was a hugely challenging programme to deliver in year and required a process of service review across a number of work-streams, consultation and engagement with key stakeholders and dependencies with complimentary work across a number of fronts. This led to slippage within the programme which caused budget pressures across the range of HSCP services but primarily within Older Peoples services where the focus of service redesign was targeted. In addition the demand increases for Older People's services resulted in this presenting as a significant area of budget pressure for the partnership during 2019/20.

The pressures on the partnership budget relate in the main to social work services of £1.9m which were mitigated in part through under spends on community health budgets of £1.3m with reserves applied to manage the remaining gap to deliver a balanced budget at the year end.

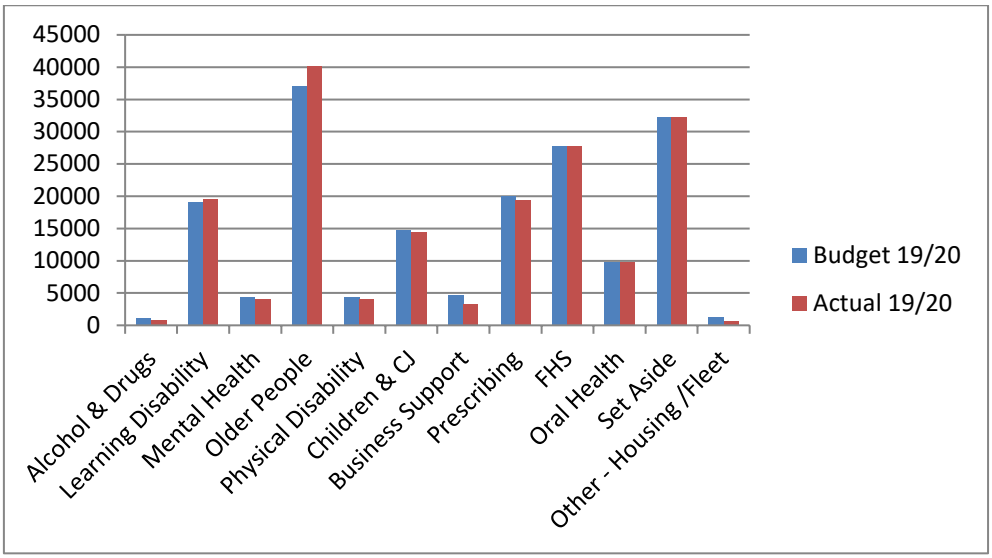
A recovery plan was approved by the HSCP Board in September 2019 comprising robust vacancy management, limits to essential areas of spend only across the range of services delivered through the HSCP and identification of additional efficiency measures to be implemented throughout the year. The recovery plan did not extend to measures which delivered reductions in service provision, cessation of services or which would lead to a diminution in service performance such as in the areas of bed days occupied and delayed

discharges. The recovery plan delivered a positive contribution towards mitigating the anticipated budget pressures, however did not manage this completely. The partnership therefore relied on the use of limited general reserves (£0.041m) and the re-designation of a number of earmarked reserves to deliver a balanced budget position for this financial year (£0.561m).

This has had a significant impact on the available reserves of the partnership moving into future years with no general reserve available to act as a contingency to manage delivery of transformation and in year unplanned budget pressures, and earmarked reserves limited to those where funding has been made available by the Scottish Government for specific initiatives such as PCIP, Mental Health Action 15 and support to alcohol and drug services. A small balance remains to lever in transformational change, however this is limited and seed funding to deliver transformation will need to be sought from other sources where available. Limited reserves also increases the risk of having to rely on partner agency additional contributions beyond that agreed at the setting of the annual budget in March 2020. Any additional contribution may be on the basis of a loan which requires to be repaid in future years which only serves to further the risk to the financial sustainability of the partnership and places a reliance on identifying extensive transformation activity or service reductions / cessations to deliver a balanced budget.

The movement in reserves can be seen within the Reserves Statement detailed on page 40.

The partnership's financial performance across care groups is represented below:



The main areas of budget pressure for the HSCP during the year are set out below:

Older People Services (£2.8m over spend)

The overall pressures relate to ongoing demand and cost pressures exceeding the available budget for 2019/20, particularly in the area of older people's social care.

These were a result of adverse payroll variances particularly in relation to homecare as a consequence of reliance on overtime and use of agency to ensure continuity of service delivery to cover vacancies, sickness and absence; challenging savings plans predicated on

the redesign of homecare services and which were not achieved in year; increased activity levels placing demand pressures on older people care homes, homecare, supported living and day-care (alternatives) and contractual increases in relation to the care at home framework and national care home contracts beyond that which was provided for within the budget. These pressures arose as a direct result of the growing demand from an ageing population requiring support from social work services to maintain independent living within the community or within a care home setting.

A review of care at home services during the year has determined that a locality based approach supported through a balance of usage of externally purchased services will deliver a sustainable care at home service going forward. This is in the process of being implemented internally with external provision subject to re-tendering exercise with resort to the national Scotland Excel Framework to deliver this element of the service.

Adults – Learning Disability, Mental Health, Addiction Services (£0.1m under spend)

There were some pressures in the area of learning disability in relation to the impact of the delay in delivering savings within the Pineview service, taxi provision to support individuals with a learning disability to access services and costs associated with agency staff to cover statutory mental health officer functions. This was offset through a downturn in residential accommodation within addiction recovery services, recharges for fleet provision and savings achieved through vacancies across community health services within this care group area. The implementation of the new Access to Transport policy and progression of the learning disability review will mitigate pressures in this area going forward.

Children & Families (£0.3m under spend)
There were some pressures in relation to externally purchased foster placements, kinship payments and health visiting staff costs, this was offset through robust vacancy management across Children's social work and residential services.

Business Support (£1.3m under spend)
There were some pressures on accommodation costs within the Kirkintilloch Health & Care Centre and Lennoxtown Hub, this was offset through additional funding above anticipated levels in relation to the improved health offer, continuing care, support to veterans, carers funding and the positive impact of improved bad debt provisions.

Prescribing (£0,5m under spend)
There are a number of points to note in respect of prescribing, namely:-

- The cost per drugs is increasing on average by 9.36% for East Dunbartonshire based on the types of drugs being dispensed and this is expected to continue.
- The overall performance on prescribing is being driven largely by volumes with an average decline in volumes over the year of 6% compared to that forecast at the budget planning stage.
- This is set in the context of increasing list sizes for East Dunbartonshire having seen an increase of 1.06% since the same period last year.
- There were savings from discounts (patented drugs) and discount clawback (generic drugs) in 2019/20 which had a positive impact on this budget

Other Services (£0.4m under spend)

There was a positive variation on other budgets delegated to the partnership relating to private sector housing grants and care & repair services delivered through the Council's housing service.

Partnership Reserves

As detailed above, there was additional funding allocated during the year from the Scottish Government to support the development and implementation of a number of key initiatives which have been earmarked within reserves with planned expenditure during 2020/21. These provide for balances on earmarked reserves as set out below:

- Self Directed Support (SDS) £0.077m
- Integrated Care Funding £0.307m
- Primary Care Improvement Plan £0.195m
- Primary Care Cluster Funding £0.039m
- Action 15 Mental Health Strategy £0.108m
- Alcohol and Drugs Partnerships £0.038m
- Technology Enabled Care £0.011m
- Infant Feeding £0.013m
- CHW Henry Programme £0.015m
- **TOTAL** **£0.803m**

There was an overall reduction in the level of earmarked reserves of £1.05m over the course of the year due to the review and re-designation of a number of earmarked reserves related to Oral Health, Prescribing and Integrated Care Funding (£0.56m). This supported the general reserve position and ability to support a balanced position in year. Further monies were used in the delivery of the Scottish Government initiatives outlined above during 2019/20 (£0.49m).

There is a nil balance on partnership general reserves at the end of 2019/20.This provides no resilience for future years for managing in year financial pressures and any slippage in savings targets.

The total level of partnership reserves is now £0.803m as set out in the table on page 40.

Financial Planning

The HSCP continues to face significant financial pressures from demographic growth particularly amongst the elderly population placing demand on care at home and care home provision, pressures in relation to increasing numbers of children moving on into adult services generating demand, and increased cost pressures across a range of adult social care services. This will be compounded during 2020/21 due to anticipated costs associated with the re-tendering of the Care at Home Framework, increased costs associated with the national care home contract, pressures in the delivery of the Scottish Living wage, continued prescribing

demand and cost pressures and extremely challenging savings plans associated with service redesign, income generation, fairer access and eligibility to services.

In setting the budget for 2020/21, the partnership had a funding gap of £6m following an analysis of cost pressures set against the funding available to support health and social care expenditure in East Dunbartonshire, this is set out in the table below:

	Delegated SW Functions (£m)	Delegated NHS Functions (£m)	Total HSCP (£m)
Recurring Budget 2019/20 (excl. Set aside)	54.838	81.802	136.640
Financial Pressures	7.645	1.942	9.587
2020/21 Budget Requirement	62.483	83.744	146.227
2020/21 Financial Settlement	56.768	83.405	140.173
Financial Challenge 20/21	5.715	0.339	6.054
Budget Savings 19/20 - F/Y Impact	(1.020)	(0.200)	(1.220)
Financial Challenge Measures	(0.577)	(0.339)	(0.916)
Efficiency Measures			
- turnover analysis	(0.445)	0.000	(0.445)
Transformation Plan 20/21	(0.701)	0.000	(0.701)
Residual Financial Gap 20/21	**2.973**	**(0.200)**	**2.773**

Savings plans of £3.2m were identified to mitigate the financial pressures which left a remaining gap of £2.8m to be funded through a process of collaborative working with Council Transformation Leads to identify further transformation activity to address the gap in full.

The Council continues to underwrite the delivery of the transformation programme. In the event of this being unachievable suitable provision will need to be made by the Council with the reserves position serving as the ultimate backstop.

The IJB may be asked to consider a recovery plan at a future date in order to achieve a balanced budget in the event that pressures extend beyond the assumptions set out in the financial plan for 2020/21. A range of options have been developed which focus on service reductions, extension to waiting times, placement management, staffing reductions, funding reductions to 3rd sector to align with statutory minimums and further charging options.

There has been a significant delay in progressing this work as a result of resources re-directed to manage the effects of the covid-19 pandemic and this is expected to continue.

The HSCP, along with other HSCPs across Scotland, have developed a mobilisation plan to manage the impact of the pandemic along with a financial assessment of the likely costs associated with these planned responses. This includes the anticipated shortfall in the HSCP transformation planning for 2020/21.

This also includes an assessment of the impact of the national agreement on the level of uplift to be provided to support delivery of the Scottish Living Wage to staff within purchased care at home, housing support and daycare services. The level of funding provided through the Scottish Government to fund this initiative provided a cost pressure within East Dunbartonshire and an element of this has been reflected within mobilisation plans related to the difference between what would normally have been provided as an uplift and that agreed nationally.

The other areas of cost pressures arising from the pandemic relate to personal, protective equipment (PPE), additional costs to social care providers including staffing, PPE and sustainability support, development of a local assessment centre and cost to support carers, alternatives to daycare. It is assumed that the cost implications associated with managing the Covid-19 pandemic will be met through funding form the Scottish Government. However this remains a key risk to the HSCP for 2020/21.

Both partner organisations continue to face significant financial challenge and these impact the consideration of the financial settlement to the partnership in the delivery of its key strategic priorities and the delivery of the services delegated to it.

The NHS settlement to the HSCP provided an uplift of 3%.on pays and general expenditure which provides a real terms increase on 2019/20 baseline funding.

The EDC settlement to the HSCP provided a flat cash position for pays and general expenditure with specific funding from the Scottish Government in relation to funding for health and social care totalling £100m across Scotland representing an additional £1.9m for the HSCP.

The challenging levels of savings on Partnership budgets is expected to continue for future years given the challenging financial settlements expected to both EDC and NHS GG&C.

The partnership is therefore planning for the period 2019/20 to 2024/25 for a potential funding gap of £3.4m to £21.4m (being best and worst case scenarios) in the context of reducing resources set against increasing cost and demand pressures and a ‘do nothing’ approach to service redesign. This represents the scale of the challenge to be met through transformation over the next 5 years.

The partnership will focus on a Transformation Plan for 2020/21 and beyond based upon a set of fundamental principles initiating a new way of working within health and social care services in East Dunbartonshire based around:

- Local and community led.
- Digital first.
- Shared ownership and shared care.
- Sustainable.
- Empowered practice
- Maximised independence.

Mrs S Murray

HSCP Board Chair 28h September 2020

28h September 2020

Mrs C Sinclair

Interim HSCP Chief Officer

Ms J Campbell 28th September 2020

Chief Finance & Resources Officer

STATEMENT OF RESPONSIBILITIES

Responsibilities of the HSCP Board

The HSCP 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 Finance & Resources 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 Performance, Audit & Risk Committee on the 28th September 2020.

Signed on behalf of the East Dunbartonshire HSCP Board.

Mrs S Murray
IJB Chair 28th September 2020

Responsibilities of the Chief Finance & Resources Officer

The Chief Finance & Resources Officer is responsible for the preparation of the HSCP Board's Annual Accounts in accordance with proper practices as required by legislation and as set 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 Finance & Resources 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 Finance & Resources 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 HSCP Board as at 31 March 2020 and the transactions for the year then ended.

Ms J Campbell
Chief Finance &
Resources Officer

28th September 2020

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 HSCP Board 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: HSCP BOARD Chair and Vice Chair

The voting members of the HSCP Board are appointed through nomination by EDC and NHS GG&C in equal numbers being three nominations from each partner agency. Nomination of the HSCP Board 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) Regulations 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 HSCP 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 HSCP Board does not provide any additional remuneration to the Chair, Vice Chair or any other board members relating to their role on the HSCP Board. The HSCP Board does not reimburse the relevant partner organisations for any voting board member costs borne by the partner. There were no taxable expenses paid by the HSCP Board to the Chair and Vice Chair .

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

Remuneration: Officers of the HSCP Board

The HSCP Board does not directly employ any staff in its own right; however specific post-holding officers are non-voting members of the Board. All staff working within the partnership are employed through either NHS GG&C or EDC and remuneration for senior staff is reported through those bodies. This report contains information on the HSCP Board Chief Officer and the Chief Finance & Resources Officer's remuneration together with details of any taxable expenses relating to HSCP Board voting members claimed in the year.

Chief Officer

Under section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 a Chief Officer for the HSCP Board has to be appointed and the employing partner has to formally second the officer to the HSCP Board. 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 HSCP Board. The Interim Chief Officer, Mrs Sinclair was appointed from the 6th January 2020. Mrs Sinclair is employed by East Dunbartonshire Council and seconded to the HSCP Board.

Other Officers

No other staff are appointed by the HSCP Board under a similar legal regime. Other non-voting board members who meet the criteria for disclosure are included in the disclosures below. The HSCP Board Chief Finance & Resources Officer is employed by NHS GG&C.

The Council and Health Board share the costs of all senior officer remunerations.

Total 2018/19 £	Senior Employees	Salary, Fees & Allowances £	Compensation for Loss of Office £	Total 2018/19 £
0	**C Sinclair** Interim Chief Officer 6th January 2020 to present	23,590	0	23,590
98,071	**S Manion** Chief Officer 12th December 2016 to 5th January 2020	77,938	0	77,938
75,387	**J. Campbell** Chief Finance & Resources Officer 9th May 2016 to present	79,412	0	79,412
173,458	**Total**	**180,940**	**0**	**180,940**

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 HSCP Board balance sheet for the Chief Officer or any other officers.

The HSCP Board 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 HSCP Board. The following table shows the HSCP Board'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 31/03/19	For Year to 31/03/20		Difference from 31/03/19	As at 31/03/20
	£	£		£000	£000
C Sinclair	0	4,600	Pension	0	0 - 5
Interim Chief Officer 6th January 2020 to present			Lump sum	0	0
S. Manion	15,000	16,300	Pension	0 – 2.5	15 - 20
Chief Officer December 2016 to 5th January 2020			Lump sum	0 – 2.5	50 - 55
J. Campbell	11,000	16,600	Pension	0 – 5	5 - 10
Chief Finance & Resources Officer 9th May 2016 to present			Lump sum	0	0
Total	**26,000**	**37,500**	**Pension**	**0 – 7.5**	**20 - 30**
			Lump Sum	**0 – 2.5**	**50 - 55**

The Chief Officer and the Chief Finance & Resources Officer detailed above are members of the NHS Superannuation Scheme (Scotland). The Interim Chief Officer is a member of the Local Government Superannuation Scheme. The pension figures shown relate to the benefits that the person has accrued as a consequence of their current appointment and role within the HSCP Board. The contractual liability for employer's pension contribution rests with NHS GG&C and East Dunbartonshire Council respectively. On this basis there is no pension liability reflected on the HSCP Board balance sheet. There was no exit packages payable during either financial year.

Mrs S Murray 28th September 2020
IJB Chair

Mrs C Sinclair 28th September 2020
Interim Chief Officer

ANNUAL GOVERNANCE STATEMENT

Scope of Responsibility

The HSCP Board is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, that public money and assets are safeguarded and that arrangements are made 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 HSCP Board's policies, aims and objectives. Reliance is placed on the NHS GG&C and EDC 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 HSCP Board.

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

Impact of Coronavirus (COVID-19) pandemic on governance arrangements

<u>Impact on business as usual in the delivery of services</u>

The COVID-19 pandemic has led to significant changes in the ways in which people are living and working, and changes to the focus of health and social care services delivery. The Health & Social Care Partnership continues to provide essential care and protection services, in line with Business Continuity and the Caring for People Plans. There is a clear focus within the Business Continuity Plan on continuing to provide support to our most vulnerable services users and patients, alongside a commitment to supporting staff to work safely and in line with Health Protection

Scotland advice. As such, as many of our staff as possible are now working remotely from home.

Other changes have included a public protection collaborative team consisting of specialists in child and adult protection, and justice services, to ensure our approach is consistent with the changes to legislation that have been brought about through the Coronavirus (Scotland) Bill and to ensure there is clear and regular guidance to staff undertaking these duties.

The HSCP established a local Assessment Centre on 30 March 2020, based at Kirkintilloch Health and Care Centre. This centre provider triage to members of the public who have contacted NHS 111 with concerns about being symptomatic and are in need of medical advice and support.

Funding consequences

The HSCP's response to the COVID-19 pandemic has resulted in additional costs being incurred, including short term costs such as those relating to increased demand for care, staffing and PPE costs. The HSCP, along with all other HSCPs, was required to submit a Mobilisation Plan to Scottish Government, outlining the actions being taken in response to the COVID-19 situation. This is supported by further detail which is submitted on a regular basis through the health board to the Scottish Government, detailing the financial costs associated with these actions. These costs are being separately tracked internally for monitoring and reporting purposes and to help secure additional funding available. For the HSCP this additional funding is necessary, given the lack of available reserves.

Longer term funding impacts are difficult to comment on at this stage, as future funding settlements are subject to a greater degree of uncertainty and the longer term impacts on costs are also highly uncertain. Although it is expected that there will be significant changes in demand pressure patterns as a result of COVID-19, mapping and quantifying these is difficult as there remains much unknown regarding the medium and long term impacts of the pandemic. Demand trends will be closely monitored for any implications for future service delivery.

Governance Implications

Since the end of March 2020, the HSCP Board has adopted temporary arrangements, and authority has been delegated to the Chief Officer; such provisions are normally actioned during the annual summer recess. This delegation is set out in the Scheme of Delegation to Officers and is subject to reporting to the HSCP Board at the first available opportunity. This power is exercised in consultation with the Chairperson or Vice-Chairperson, as appropriate. In addition, the Chief Officer is seeking legal and financial advice prior to making significant decisions and is liaising

throughout with the Chief Executives of both the Council and the Health Board. These temporary arrangements are required to deliver new and existing high priority services in these challenging and unprecedented times and will be reviewed as circumstances evolve.

Assessment of the longer-term disruption and consequences arising from the coronavirus pandemic

The HSCP recognises that the pandemic is a health crisis, social crisis, and economic crisis of unprecedented scale, with profound and permanent implications for our society. The crisis has brought about significant developments in, and embedding of, remote and digital ways of working that will be utilised throughout the pandemic and beyond. The full practical implications of the pandemic on society's expectations of care providers, the HSCP's demand for services, service users and ways of working in the medium and long term are not yet fully apparent but will continue to be assessed as the situation evolves and further government advice becomes available.

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 Partnership's 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 includes an ongoing process, designed to identify and prioritise those risks that may affect 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. However, see further detail provided above on the impact of the COVID-19 pandemic on these arrangements.

Key features of the governance framework in 2019/20 are:

- The HSCP Board comprises six voting members – three non-executive Directors of NHS GG&C and three local Councillors from EDC. The Board is charged with responsibility for the planning of Integrated Services through directing EDC and the NHS GG&C to deliver on the strategic priorities set out in the Strategic Plan. In order to discharge their responsibilities effectively, board members are supported with a development programme. This programme aims to provide 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 HSCP Board.

- HSCP Boards 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 HSCP Board 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 HSCP Board has produced and adopted a Scheme of Administration that defines the powers, relationships and organisational aspects for the HSCP Board. This includes the Integration Scheme, Standing Orders for meetings, Terms of reference and membership of HSCP Board committees, the Scheme of Delegation to Officers and the Financial Regulations.

- The Strategic Plan for 2018-2021 outlines eight key priorities to be delivered over the three year period and describes for each priority what success will look like and the outcome measures to be used to monitor delivery. It sets out the identified strategic priorities for the HSCP and links the HSCP's priorities to National Health and Wellbeing Outcomes. An established Strategic Planning Group (SPG), comprising legislatively determined membership, oversees the delivery of the Strategic Plan. This is supported by a range of planning groups to take forward particular priorities which reports through the SPG and to the HSCP Board.

- Financial regulations have been developed for the HSCP in accordance with the Integrated Resources Advisory Group (IRAG) guidance and in consultation with EDC and NHS GG&C. They set out the respective responsibilities of the Chief Officer and the Chief Finance & Resources Officer in the financial management of the monies delegated to the partnership.

- The Risk Management Policy sets out the process and responsibilities for managing risk in the HSCP. The Corporate Risk Register was revised and approved in November 2019 and is reviewed by the Senior Management Team on an ongoing basis. In light of the recent COVID-19 pandemic, a specific risk register has been complied for the risks associated with this event. Regular reports to IJB members to keep them abreast of ongoing action during this period, much of which will mitigate the risks of this pandemic. Services have internal systems in place to review and prioritise risks relating to service delivery and resources. The Service Risk Registers are updated when required and reviewed on a quarterly basis.

- Performance Reporting – Regular performance reports are presented to the HSCP Board 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. This scrutiny is supplemented through the Performance, Audit and Risk Committee. A performance management framework has been developed and implemented across the HSCP to ensure accountability for performance at all levels in the organisation. This includes regular presentations on team / service performance to the Senior Management team at a more detailed level and informs higher level performance reporting to the partner agency Cheif Executives as part of regular organisation performance reviews (OPRs) and ultimately to the IJB.

- The Performance, Audit & Risk Committee advises the Partnership Board and its Chief Finance & Resources Officer on the effectiveness of the overall internal control environment.

- Clinical and Care Governance arrangements have been developed and led locally by the Clinical Director for the HSCP and through the involvement of the Chief Social Work Officer for EDC.

- 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. The HSCP Board approved this in March 2019, prior to submission to the Keeper of the Records of Scotland. 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.

- The HSCP Board is a formal full partner of the East Dunbartonshire Community Planning Partnership Board (CPPB) and provides regular relevant updates to the CPPB on the work of the HSCP.

Roles and Responsibilities of the Audit Committee and Chief Internal Auditor

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

The Performance, Audit & Risk Committee performs a scrutiny role in relation to the application of CIPFA's Public Sector Internal Audit Standards 2017 (PSIAS) and regularly monitors the performance of the Partnership's internal audit service. The appointed Chief Internal Auditor has responsibility to review independently and report to the Performance, Audit & Risk 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 Performance, Audit and Risk Committee, based on a strategic risk assessment. The appointed Chief Internal Auditor provides an independent opinion on the adequacy and effectiveness of internal control. East Dunbartonshire Council's Audit & Risk Manager is the 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 summary of reports of the internal auditors of NHS GG&C that relate to the partnership.

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. Although no system of internal control can provide absolute assurance, nor can Internal Audit give that assurance, based on 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. A number of recommendations have been made by the internal audit team in order to improve controls further, with action plans developed with management to address the risks identified.

Review of Effectiveness

East Dunbartonshire HSCP Board 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 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.

A range of internal audit assignments has been completed that reviewed the operation of internal controls of relevance to the HSCP Board. These were generally

found to operate as intended, with reasonable assurance provided on the integrity of controls. A number of recommendations have been made for areas for further improvement and action plans developed to address the risks identified. Senior Officers have provided assurances that the issues raised by Internal Audit have been or will be addressed. Auditors will conduct testing following completion of the actions, as part of the 2020/21 audit programme.

There has been specific work undertaken by each partner's audit functions. The Council's internal auditors were able to provide reasonable assurance over the areas reviewed by NHSGCC internal auditors, which includes audits completed by 31 March 2020. Key areas for improvement identified by NHSGCC internal auditors included those in relation to having an agreed Performance Plan and reporting against this, the medicines reconciliation process in hospitals, and IT security in relation to leavers and the development of a roadmap for replacing legacy infrastructure and systems. Management have given assurances that these areas have been or will be addressed.

An area identified for improvement by the HSCP is that of the process for purchasing emergency or short notice commissioned care. The processes for ensuring this, and other existing commissioning, has proper contractual under-pinning requires strengthening. In support of these improvements, an internal audit review of two specific arrangements is currently underway. The outcome of the review will support improvements to be taken forward through the Senior Management Team and in collaboration with NHSGGC and EDC, to ensure controls are improved and proper governance arrangements are operating correctly.

The HSCP Board has various meetings, which have received a wide range of reports to enable effective scrutiny of the partnership's 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 and service visits for members covering topics such as Corporate Parenting, Health & Well Being Survey results and the Framework for Community Health & Social Care Integrated Services.

Governance Improvement Plans

There are a number of areas of improvement identified for 2020/21, which will seek to enhance governance arrangements within the partnership:

- External Reports – the HSCP will take cognisance of external reports and develop action plans that 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 internal audits including a review of the HSCP Financial Outturn and Key Controls, a systems audit of Direct Payments and a review of a Direct Payment Case, which are of interest to the HSCP. These highlighted areas were identified through follow up processes as requiring further improvement and formal action plans have been developed to mitigate the risks identified. Any outstanding audit actions will continue to be monitored for compliance in 2020/21.

Assurance

The system of governance (including the system of internal control) operating in 2019/20 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 to the achievement of the strategic priorities and outcomes have been mitigated. Temporary arrangements have been put in place in response to the COVID-19 pandemic. These arrangements are necessary measures to enable to the HSCP to meet its responsibilities. The HSCP will continue to review its Corporate Governance arrangements and take any additional steps, as required, to enhance these arrangements.

Certification

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

Mrs S Murray

IJB Chair 28th September 2020

Mrs C Sinclair

Interim Chief Officer 28th September 2020

COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT

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

2018/19 Re-Stated				2019/20		
Gross Expenditure £000	Gross Income £000	Net Expenditure £000	Care Group	Gross Expenditure £000	Gross Income £000	Net Expenditure £000
3,510	(305)	3,205	Strategic / Resources	3,633	(746)	2,887
1,360	(0)	1,360	Addictions	1,301	(89)	1,212
37,940	(1,194)	36,746	Older People	40,681	(1,799)	38,882
19,169	(610)	18,559	Learning Disability	20,133	(553)	19,580
4,089	(47)	4,042	Physical Disability	4,687	(620)	4,067
5,519	(415)	5,104	Mental Health	5,652	(618)	5,034
13,527	(13)	13,514	Children & Families	14,356	(79)	14,277
1,366	(1,108)	258	Criminal Justice	1,372	(1,161)	211
946	0	946	Other - Non Social Work	817	0	817
10,509	(790)	9,719	Oral Health	10,916	(1,081)	9,835
27,258	(1,410)	25,848	Family Health Services	29,049	(1,371)	27,678
19,072	0	19,072	Prescribing	19,484	(32)	19,452
27,471	0	27,471	Set Aside for Delegated Services to Acute Services	32,247	0	32,247
246	0	246	HSCP Board Operational Costs	270	0	270
171,982	**(5,892)**	**166,090**	**Cost of Services Managed By East Dunbartonshir**	**184,598**	**(8,149)**	**176,449**
	(164,273)	(164,273)	Taxation & Non Specific grant Income		(176,267)	(176,267)
171,982	**(170,165)**	**1,817**	**(Surplus) or deficit on Provision of Services**	**184,598**	**(184,416)**	**182**
		1,817	**Total Comprehensive Income and Expenditure**			**182**

The 2018/19 expenditure has been re-stated to reflect an amendment to the set aside figures. NHS GG&C are now in a position to report the set aside figures based on actual expenditure which has resulted in the restatement of 18/19 figures which were previously based on a notional budget figure. The notional budgets for set aside were based on NRAC activity and information from the cost book and were very high level. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

Movement in Reserves Statement

This statement shows the movement in the year on the HSCP Board'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 2019/20	General Fund Balance	Ear-Marked Reserves	Total Reserves
	£000	£000	£000
Opening Balance at 31 March 2019	**(41)**	**(1,853)**	**(1,894)**
In Year drawdown of Reserves	0	908	908
Re-designation of earmarked to general	(561)	561	0
Total Comprehensive Income and Expenditure	602	(419)	183
Increase or Decrease in 2019/20	**41**	**1,050**	**1,091**
Closing Balance at 31 March 2020	**(0)**	**(803)**	**(803)**

Movements in Reserves During 2018/19	General Fund Balance	Ear-Marked Reserves	Total Reserves
	£000	£000	£000
Opening Balance at 31 March 2018	**(957)**	**(3,130)**	**(4,087)**
In Year drawdown of Reserves	0	376	376
Re-designation of earmarked to general	(2,114)	2,114	0
Total Comprehensive Income and Expenditure	3,030	(1,213)	1,817
Increase or Decrease in 2018/19	**916**	**1,277**	**2,193**
Closing Balance at 31 March 2019	**(41)**	**(1,853)**	**(1,894)**

BALANCE SHEET

The Balance Sheet shows the value as at the 31st March 2020 of the HSCP Board's assets and liabilities. The net assets of the HSCP Board (assets less liabilities) are matched by the reserves held by the HSCP Board.

31 March 2019 £0		Notes	31 March 2020 £0
1,894	Short term Debtors	9	803
	Current Assets		
1,894	**Net Assets**		**803**
(41)	Usable Reserve: General Fund	11	(0)
(1,853)	Unusable Reserve: Earmarked	11	(803)
(1,894)	**Total Reserves**		**(803)**

The unaudited accounts were issued on 18th June 2020 and the audited accounts were authorised for issue on 28th September 2020.

Ms J Campbell
Chief Finance &
Resources Officer

28th September 2020

NOTES TO THE FINANCIAL STATEMENTS

1. Significant Accounting Policies

General Principles

The Financial Statements summarises the authority's transactions for the 2019/20 financial year and its position at the year-end of 31 March 2020.

The HSCP Board 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 2018/19, 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 HSCP Board 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 HSCP Board.
- Income is recognised when the HSCP Board 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 HSCP Board is primarily funded through contributions from the statutory funding partners, East Dunbartonshire Council and NHS Greater Glasgow & Clyde. Expenditure is incurred as the HSCP Board commissions specified health and social care services from the funding partners for the benefit of service recipients in East Dunbartonshire.

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Cash and Cash Equivalents

The HSCP Board does not operate a bank account or hold cash. Transactions are settled on behalf of the HSCP Board by the funding partners. Consequently the HSCP Board 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 HSCP Board's Balance Sheet.

Employee Benefits

The HSCP Board 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 HSCP Board therefore does not present a Pensions Liability on its Balance Sheet.

The HSCP Board 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 HSCP Board'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 HSCP Board's Balance Sheet, but is disclosed in a note only if it is probable to arise and can be reliably measured.

Reserves

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

The balance of the General Fund as at 31 March 2020 shows the extent of resources which the HSCP Board 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 funding which have been allocated for specific purposes but not spent in year.

Indemnity Insurance

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

Unlike NHS Boards, the HSCP Board does not have any 'shared risk' exposure from participation in CNORIS. The HSCP Board 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 HSCP was £0k, the balance will be payable in Board'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. Prior Year Restatement – Set Aside

There has been a re-statement of the 2018/19 figures for the set aside expenditure and an associated adjustment to the contribution from the GG&C to support this increased expenditure. The net effect to the Comprehensive Income and Expenditure Statement is therefore nil.

The 2018/19 figures were previously based on a notional budget figure. The notional budgets for set aside were based on NRAC activity and information from the cost book and were very high level. There has been considerable work progressed in refining the set aside mechanism with actual figures now based on a much more detailed approach including actual spend on acute services and activity data for each year.

3. Critical Judgements and Estimation Uncertainty

In applying the accounting policies set out above, the HSCP Board has had to make critical judgement relating to services hosted within East Dunbartonshire HSCP for other HSCPs within the NHS GG&C area. In preparing the 2019/20 financial statements the HSCP Board is considered to be acting as 'principal', and the full costs of hosted services are reflected within the financial statements.

A further critical judgement relates to the assumption that all costs associated with the Covid_19 pandemic will be met from government funding. The amounts included for 2019/20 relate to the final weeks in March 2020 when the impact of the pandemic began to be felt, therefore the exposure is not significant (<£0.5m) and these have been accrued appropriately. However, in the event that funding is not available to support the full extent of these costs, this will have an impact during 2020/21.

4. Events After the Reporting Period

The Annual Accounts were authorised for issue by the Chief Finance & Resources Officer on 28th September 2020. 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 2020, the figures in the financial statements and notes have been adjusted in all material respects to reflect the impact of this information.

5. Expenditure and Income Analysis by Nature

2018/19 *Re-stated* £000		2019/20 £000
38,858	Employee Costs	41,598
475	Property Costs	603
4,822	Supplies and Services	5,487
52,683	Contractors	55,151
1,015	Transport and Plant	1,229
194	Administrative Costs	177
27,342	Family Health Service	28,856
19,072	Prescribing	19,484
27,471	Set Aside	32,247
246	HSCP Board Operational Costs	270
(6,088)	Income	(8,653)
166,090	Net Expenditure	176,449
(164,273)	Partners Funding Contributions and Non-Specific	(176,267)
1,817	**(Surplus) or Deficit on the Provision of Services**	**182**

The 2018/19 expenditure has been re-stated to reflect an amendment to the set aside figures. NHS GG&C are now in a position to report the set aside figures based on actual expenditure which has resulted in the restatement of 18/19 figures which were previously based on a notional budget figure. The notional budgets for set aside were based on NRAC activity and information from the cost book and were very high level. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

6. HSCP Board Operational Costs

2018/19 £000		2019/20 £000
221	Staff Costs	243
25	Audit Fees	27
246	**Total Operational Costs**	**270**

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 2019/20 were £9k. The audit fee agreed for 19/20 was £27k, the balance of £18k has been accrued and will be payable in 20/21.
Given the HSCP Board cannot physically pay for invoices; this will be paid through EDC or NHS GG&C and charged as a cost in the HSCP Board Accounts.

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7. Support Services

Support services were not delegated to the HSCP 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: 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 HSCP Board were considered not material to these accounts.

8. Taxation and Non-Specific Grant Income

2018/19 *Re-Stated* £000		2019/20 £000
52,690	Funding Contribution from East Dunbartonshire Council	55,760
111,583	Funding Contribution from NHS Greater Glasgow & Clyde	120,507
164,273	**Taxation and Non-specific Grant Income**	**176,267**

The funding contribution from the NHS GG&C shown above includes £32.2m in respect of 'set aside' resources relating to acute hospital and other resources. These are provided by NHS GG&C which retains responsibility for managing the costs of providing the services. The HSCP Board however has responsibility for the consumption of, and level of demand placed on, these resources.

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.

The 2018/19 expenditure has been re-stated to reflect an amendment to the set aside figures. NHS GG&C are now in a position to report the set aside figures based

on actual expenditure which has resulted in the restatement of 18/19 figures which were previously based on a notional budget figure. The notional budgets for set aside were based on NRAC activity and information from the cost book and were very high level. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

9. Debtors

31 March 2019 £000		31 March 2020 £000
1,775	NHS Greater Glasgow & Clyde	726
119	East Dunbartonshire Council	77
1,894	**Debtors**	**803**

The short term debtor relates to the balance of earmarked reserves to support specific initiatives for which the Scottish Government made this funding available and is money held by the parent bodies as reserves available to the partnership.

10. Usable Reserve: General Fund

The HSCP Board 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 HSCP Board'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.

Balance at 1 April 2018 £000	Transfers Out 2018/19 £000	Transfers In 2018/19 £000	Balance at 31 March 2019 £000		Transfers Out 2019/20 £000	Transfers In 2019/20 £000	Balance at 31 March 2020 £000
(102)	24		(78)	Scottish Govt. Funding - SDS	1		(77)
(36)	36		0	Mental Health project	0		0
-			0	Delayed Discharge – HAT Funding	0		0
(1,665)	1,665		0	Social Care Fund	0		0
(6)	6		0	Keys to Life Funding	0		0
-			0	Autism Funding	0		0
-			0	Police Scotland – CPC Funding	0		0
(523)			(523)	SG - Integrated Care / Delayed	216		(307)
			0	Infant Feeding		(13)	(13)
			0	CHW Henry Programme		(15)	(15)
(198)	159		(39)	SG - Primary Care Cluster funding	39	(39)	(39)
(600)	600	(200)	(200)	Oral Health Funding	200		0
		(632)	(632)	SG - Primary Care Improvement	632	(195)	(195)
		(121)	(121)	SG – Action 15 Mental Health	121	(108)	(108)
		(73)	(73)	SG – Alcohol & Drugs Partnership	73	(38)	(38)
		(11)	(11)	SG – Technology Enabled Care	11	(11)	(11)
		(176)	(176)	Prescribing	176		0
(3,130)	2,490	(1,213)	(1,853)	Total Earmarked	1,469	(419)	(803)
(957)	3,513	(2,597)	(41)	Contingency	1,300	(1,259)	0
(4,087)	**6,003**	**(3,810)**	**(1,894)**	**General Fund**	**2,769**	**(1,678)**	**(803)**

11. Related Party Transactions

The HSCP Board has related party relationships with the NHS GG&C and EDC. In particular the nature of the partnership means that the HSCP Board may influence, and be influenced by, its partners. The following transactions and balances included in the HSCP Board's accounts are presented to provide additional information on the relationships.

Transactions with NHS Greater Glasgow & Clyde

2018/19 *Re-stated* £000		2019/20 £000
(111,583)	Funding Contributions received from the NHS Board	(120,507)
93,174	Expenditure on Services Provided by the NHS Board	101,977
110	Key Management Personnel: Non-Voting Board Members	122
(18,299)	**Net Transactions with the NHS Board**	**(18,408)**

Key Management Personnel: The non-voting Board members employed by the NHS Board and recharged to the HSCP Board include the Chief Officer and the Chief Finance & Resources 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.

The 2018/19 expenditure has been re-stated to reflect an amendment to the set aside figures. NHS GG&C are now in a position to report the set aside figures based on actual expenditure which has resulted in the restatement of 18/19 figures which were previously based on a notional budget figure. The notional budgets for set aside were based on NRAC activity and information from the cost book and were very high level. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

Balances with NHS Greater Glasgow & Clyde

31 March 2019 £000		31 March 2020 £000
1,775	Debtor balances: Amounts due from the NHS Board	726
1,775	**Net Balance with the NHS Board**	**726**

Transactions with East Dunbartonshire Council

2018/19 £000		2019/20 £000
(52,690)	Funding Contributions received from the Council	(55,760)
72,670	Expenditure on Services Provided by the Council	74,202
111	Key Management Personnel: Non-Voting Board Members	121
25	Support Services	27
20,116	**Net Transactions with the Council**	**18,590**

Balances with East Dunbartonshire Council

31 March 2019 £000		31 March 2020 £000
119	Debtor balances: Amounts due from the Council	77
119	**Net Balance with the Council**	**77**

12. Contingent Assets & Liabilities

A contingent asset or liability arises where an event has taken place that gives the HSCP Board 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 HSCP Board. 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.

The HSCP Board is not aware of any material contingent asset or liability as at the 31st March 2020.

13. VAT

The HSCP Board is not a taxable person and does not charge or recover VAT on its functions.

The VAT treatment of expenditure in the HSCP Board's accounts depends on which of the partner organisations is providing the service as these agencies are treated differently for VAT purposes.

The services provided to the HSCP Board by the Chief Officer are outside the scope of VAT as they are undertaken under a special legal regime.

Agenda Item Number: 6

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	25 June 2020
Subject Title	HSCP Quarter 4 (Full Year) Performance Report 2019-20
Report By	Caroline Sinclair, Interim Chief Officer and Chief Social Work Officer
Contact Officer	Alan Cairns, Planning, Performance & Quality Manager Alan.cairns2@ggc.scot.nhs.uk

Purpose of Report	The purpose of this report is to provide an update to the HSCP Board on the preparation of the full statutory HSCP Annual Performance report, which has been delayed due to the Covid-19 emergency response. In the interim, a performance report for the period January to March 2020 (Quarter 4) and for full year 2019-20 is provided, to inform the Board of progress made against an agreed suite of performance targets and measures, relating to the delivery of the HSCP strategic priorities.

Recommendations	It is recommended that the Health & Social Care Partnership Board: • Note the deferment of the full statutory HSCP Annual Performance Report for 2019-20 due to the impact of the Covid-19 emergency and agree to its later publication in the Autumn of 2020; • Note the content of the Quarter 4 and Full Year Performance Report 2019-20 at **Appendix 1**.

Relevance to HSCP Board Strategic Plan	Quarterly and annual performance reports contribute to HSCP Board scrutiny of performance and progress 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 report includes indicators and measures of quality and performance relating to services provided by the Council, under Direction of the HSCP Board.

Implications for NHS Greater Glasgow & Clyde:	The report includes indicators and measures of quality and performance relating to services provided by NHS Greater Glasgow and Clyde, under Direction of the HSCP 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

1.1 In common with other HSCP areas, East Dunbartonshire HSCP has been unable to commence preparation of its formal Annual Performance Report (APR) 2019-20 due to the impact of the Covid-19 pandemic crisis. In normal circumstances, this would be due for publication by the end of July 2020.

1.2 The format and content of the full HSCP Annual Performance Report is prescribed as a minimum in statute, compliance with which involves substantial input by operational leads, Heads of Service and planning. The impact of Covid-19 has been very significant across many aspects of strategic and operational capacity. The Chief Officer has agreed to delay the publication date for the Annual Performance Report until 30 September HSCP, in exercise of the power granted to public authorities under the Coronavirus (Scotland) Act 2020 to do so. The staff who would have been involved in its preparation have been heavily engaged in supporting the Covid-19 pandemic response.

1.3 It is important though, that the HSCP Board, wider partners, stakeholders and the general public have access to performance outturn data for the 2019-20 reporting year without undue delay, despite the deferment of the full Annual Performance Report. For this reason, a report has been prepared at **Appendix 1** that provides this information across the full range of HSCP indicators and measures that are ordinarily reported on a quarterly basis to the HSCP Board. This reporting format has been extended to provide full year performance information across this territory, except in a very small number of measures where full year data are not yet reportable. The HSCP Board is invited to consider progress against the performance targets and measures within this report, which are aligned to the delivery of the HSCP strategic priorities.

1.4 The performance report contains a range of information, most of which is available and complete for the full reporting period. However there are routine delays with the publication of validated data by the Information Services Division (now part of Public Health Scotland), due to incomplete hospital-derived data in Section 3 of the report and the timing of certain waiting times data publications. In order to provide an indication of full year performance in these areas, tables and charts are included that use Greater Glasgow and Clyde Health Board's own activity data for the full year. These are also presented in a way that permits comparison of our performance with other HSCP areas across the Health Board area. The methodology of local Health Board data differs in aspects from national data publications, so is not precisely comparable. However it provides an accurate proxy measure in the absence of full year published national figures. The local data is presented separately in well defined "blue boxes" to ensure clarity of source.

1.5 At the January 2020 HSCP Board meeting, the Board requested that numbers be added to percentages for certain Children's Services indicators, to provide additional contextual scale. This additional information has been added to the accompanying narrative for each of these indicators, where available.

1.6 Work will commence for the preparation of the statutory HSCP Annual Performance Report, for proposed publication in the Autumn, following approval by the HSCP Board. The Scottish Government has intimated that it will provide a data release in September to support this process.

East Dunbartonshire Health & Social Care Partnership

PERFORMANCE REPORT 2019-20 QUARTER 4 (FULL YEAR)

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

NHS
Greater Glasgow and Clyde

SECTION 1
Introduction

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

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

Covid-19 Outbreak:

The Covid-19 outbreak impacts on a number of the performance metrics covering Quarter 4. With the diversion of health and social care resources to support the crisis response, and the impact of social distancing on business-as-usual, service demand and activity reduced significantly during March 2020.

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

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

Section 3 Health & Social Care Delivery Plan
The data for unscheduled acute care reported in this document is provided by National Services Scotland for the Ministerial Steering Group for Health & Social Care (MSG). This section provides the latest available data for those indicators identified as a priority by the MSG.

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

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

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

Section 7 Criminal Justice Performance

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

Section 8 Corporate Performance

Workforce sickness / absence, Personal Development Plans (PDP) & Personal Development Reviews (PDR) are monitored, and reported in this section

SECTION 2
Performance Summary at Q4

- Positive Performance (on target) improving (10 measures)
- Positive Performance (on target) declining (4 measure)
- Negative Performance (below target) improving (8 measures)
- Negative Performance (below target) declining (5 measures)

Positive Performance (on target & maintaining/improving)

4.1	Number of homecare hours per 1,000 population 65+
5.2	% of people waiting<18 weeks for psychological therapies
4.3	% of Service Users 65+ meeting community care assessment to service delivery waiting times target (6 weeks)
5.4	Total number of alcohol brief interventions delivered (cumulative)
5.5	Smoking quits at 12 weeks post quit in the 40% most deprived areas
6.1	Child Care Integrated Assessments (ICAs) submission timescales to Reporters Administration
6.5	% of first Looked After and Acccommodated Children (LAAC) reviews taking place within 4 weeks of accommodation
6.6	% of children receiving 27-30 months assessment
7.1	% of individuals beginning a work placement within 7 days of receiving a Community Payback Order
7.2	% of Criminal Justice Social Work reports submitted to court on time

Positive Performance (on target but declining)

4.2	% of People 65+ with intensive needs receiving care at home
5.3	% of people newly diagnosed with dementia receiving post diagnostic support
6.2	% of initial Child Protection case conferences taking place within 21 days from receipt of referral
7.3	% of court report requests allocated to a social worker within 2 days

Negative Performance (below target but maintaining/improving)

3.1	Number of unplanned acute emergency admissions
3.2	Number of unscheduled hospital bed days
3.4	Number of Accident and Emergency attendances (all ages)
4.4a	No of people 65+ in permanent care homes
4.5	% of Adult Protection cases where timescales are met
5.1	% of people waiting <3 weeks for drug and alcohol treatment
6.4	% of children being Looked After in the community
8.6	% of Council employee Performance Development Reviews recorded on the MIS system

Negative Performance (below target and declining)

3.3	Number of Delayed Discharge Bed Days
5.6	Child and Adolescent Mental Health Services (CAMHS) waiting times
6.3	% of first Child Protection review conferences taking place within 3 months of registration
8.5	% of NHS Knowledge & Skills Framework staff reviews recorded on the MIS system

The following targets relate to unscheduled acute care and focus on areas for which the HSCP has devolved responsibility. They are part of a suite of indicators set by the Scottish Government, and all HSCPs were invited to set out local objectives for each of the indicators. They are reported to and reviewed quarterly by the Scottish Government Ministerial Steering Group for Health & Community Care (MSG) to monitor the impact of integration. Delays can occur with completeness of hospital-based data, so these tables and charts are based upon the most recent reliable data relevant to the reporting period.

Greater Glasgow and Clyde Full Year Data:

As a consequence of delays with the publication of some national unscheduled care data, additional GG&C data charts have been added to this Quarter 4 (full year) report. Local data is calculated slightly differently to the national MSG publications, but provides effective proxy performance information.

The local data charts are identifiable by being presented in blue boxes like this one. Performance has been presented as a rate of the relevant populations across each of the HSCPs in GG&C to give an indication of comparative performance.

3.1 Emergency Admissions

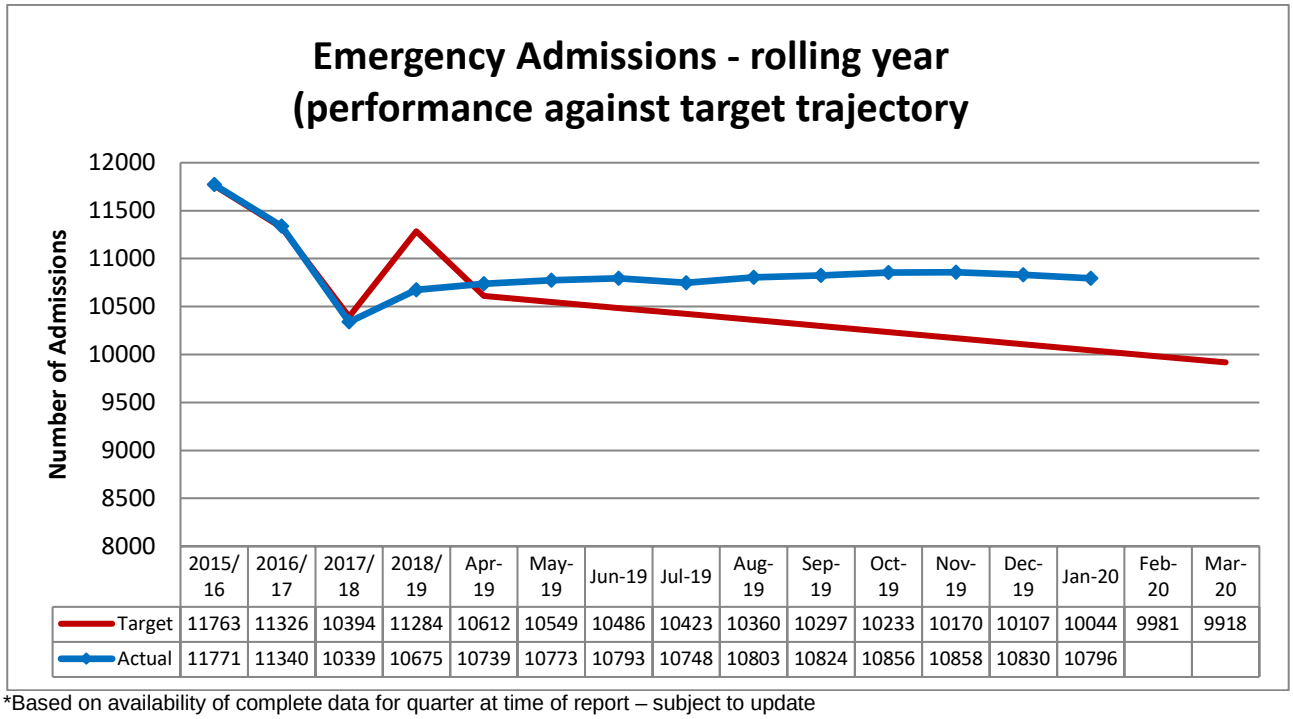
Rationale: Unplanned emergency acute admissions are focussed on reducing inappropriate use of hospital services and shifting the focus from a reliance on hospital care towards proactive support in the community setting. Aim = to minimise.

Table 3.1 Quarterly Number of Unplanned Acute Emergency Admissions

Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Target (quarter)
2,689	2,707	2,662	2,719	n/a*	2,480

*Based on availability of complete data for quarter at time of report – subject to update.

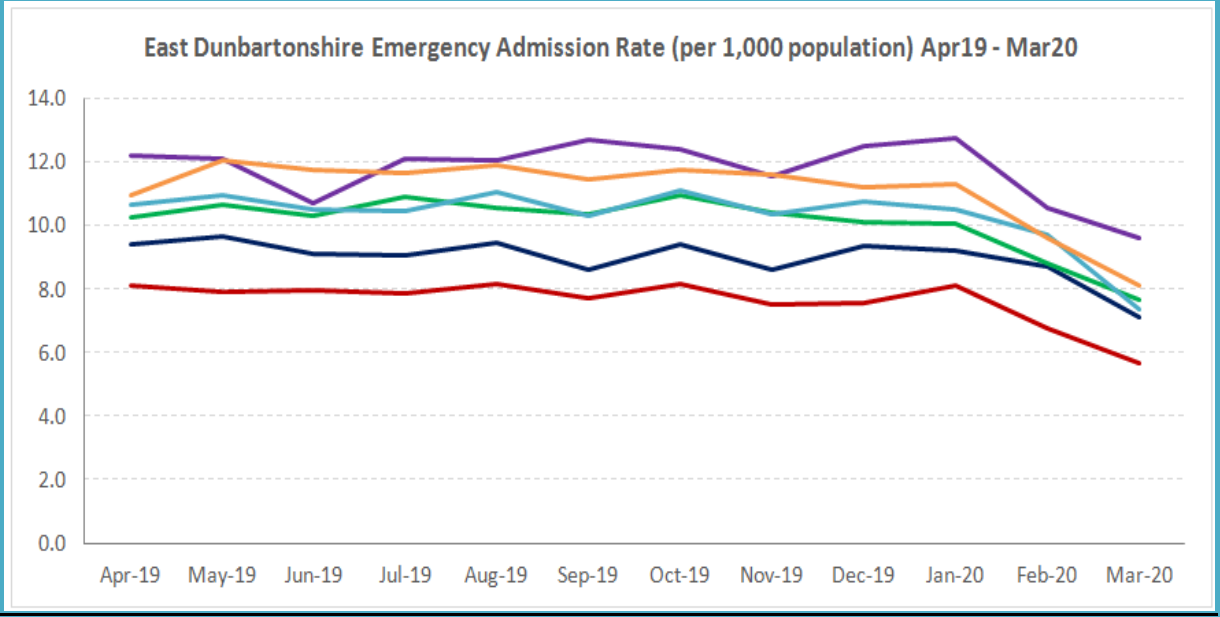
Figure 3.1a Rolling Year Number of Unplanned Emergency Admissions*



	2015/16	2016/17	2017/18	2018/19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Target	11763	11326	10394	11284	10612	10549	10486	10423	10360	10297	10233	10170	10107	10044	9981	9918
Actual	11771	11340	10339	10675	10739	10773	10793	10748	10803	10824	10856	10858	10830	10796		

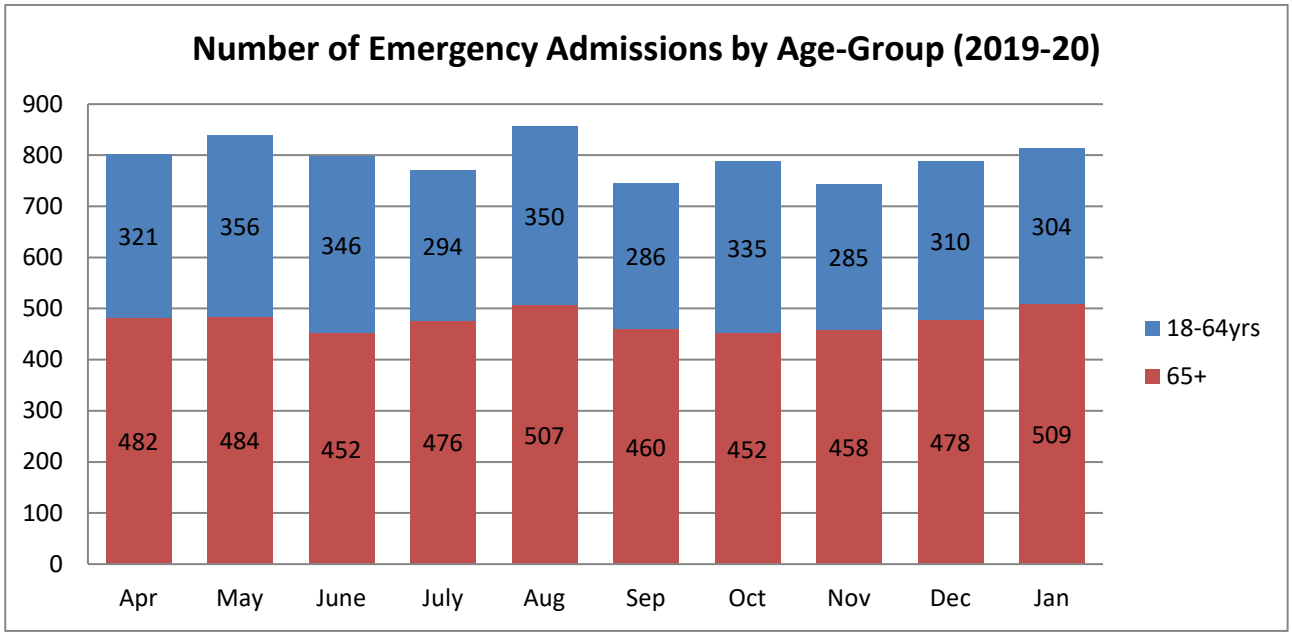
*Based on availability of complete data for quarter at time of report – subject to update

Local GGC Full Year Data:



East Dunbartonshire		Renfrewshire	
East Renfrewshire		Glasgow	
West Dunbartonshire		Inverclyde	

Figure 3.1b Unplanned Emergency Admissions by Age Group



Situational Analysis:
The number of people being admitted unexpectedly to hospital is a key indicator of how well we are doing to maintain people in their own homes, particularly later in life. It is also a proxy indicator of the level of complexity being managed in the community, as secondary care clinicians continue to consider the majority of unplanned admissions of East Dunbartonshire residents as clinically appropriate. National hospital-derived data publications remain incomplete for around three months so the most recent validated data covers to January 2020. However the blue box provides local data which gives comparative performance for the full year. Numbers were relatively stable over the first quarter of the financial year, but pressures during the late summer and autumn are reflected at 3.1(a), with trend moving away from the target trajectory. The blue box demonstrates a significant reduction in admission from January 2020, with a particular downturn associated with the Coronavirus outbreak. This does not include Covid-related admissions. East Dunbartonshire ended the reporting year with the second lowest level of emergency admissions in Greater Glasgow and Clyde.

Improvement Actions:
The Partnership will continue to work with NHSGGC colleagues to impact positively on admissions levels. Improvement activity has included the further development of community based rehabilitation, providing rapid assessment to assist in the prevention of admission. Learning from the Covid-19 experience will also be used to inform improvement going forward in relation to looking collectively to see what arrangements should be retained and what can be explored further, for example: digital consultations, Community Assessment Centre model for emergency attendances etc.

3.2 Unscheduled hospital bed days; acute specialities

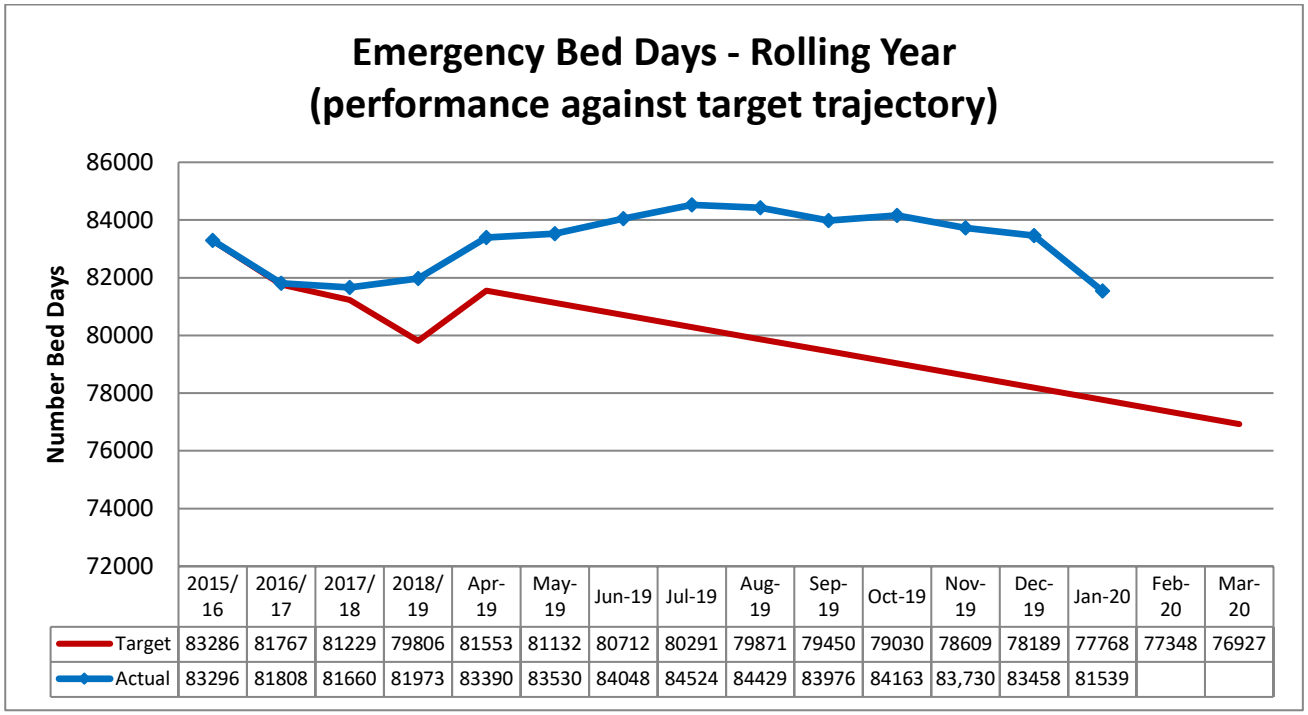
Rationale: Unscheduled hospital bed days are focussed on reducing inappropriate use of hospital services and shifting the focus from a reliance on hospital care towards proactive support in the community setting. Aim = to minimise

Table 3.2 Quarterly number of Unscheduled Hospital Bed Days

Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Target (quarter)
20,955	21,870	19,484	20,438	n/a*	19,232

*Based on availability of complete data for quarter at time of report – subject to update.

Figure 3.2a Rolling year number of Unscheduled Hospital Bed Days



	2015/16	2016/17	2017/18	2018/19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Target	83286	81767	81229	79806	81553	81132	80712	80291	79871	79450	79030	78609	78189	77768	77348	76927
Actual	83296	81808	81660	81973	83390	83530	84048	84524	84429	83976	84163	83,730	83458	81539		

Local GGC Full Year Data:

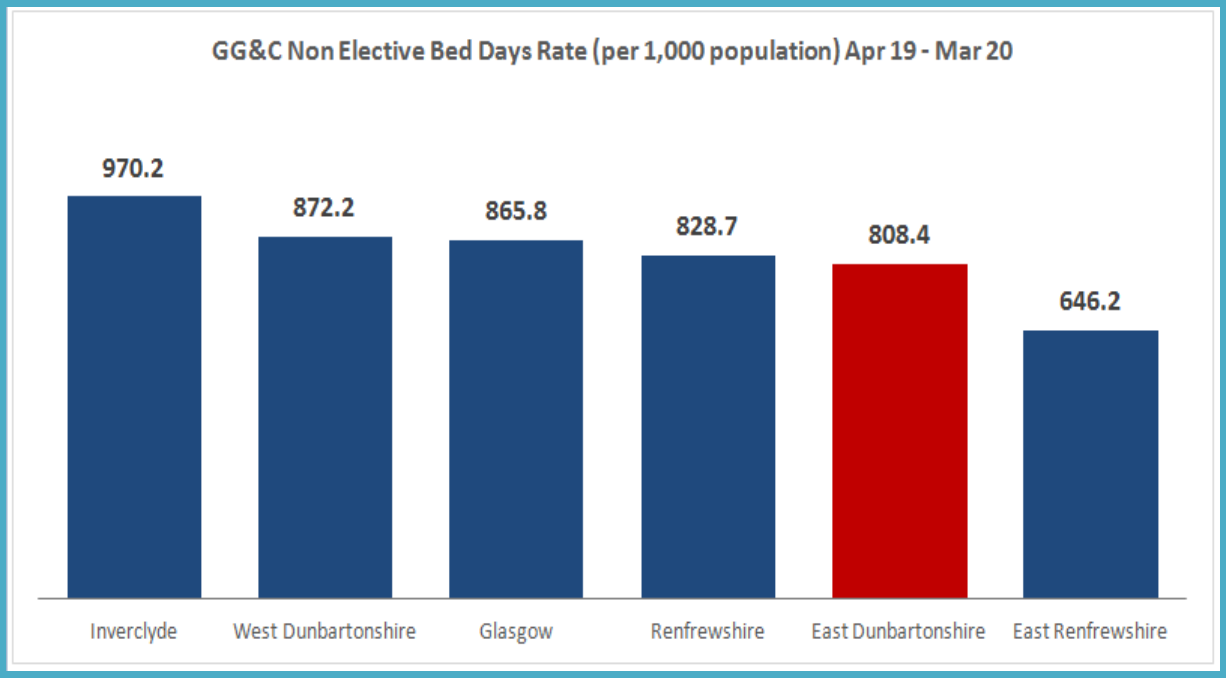
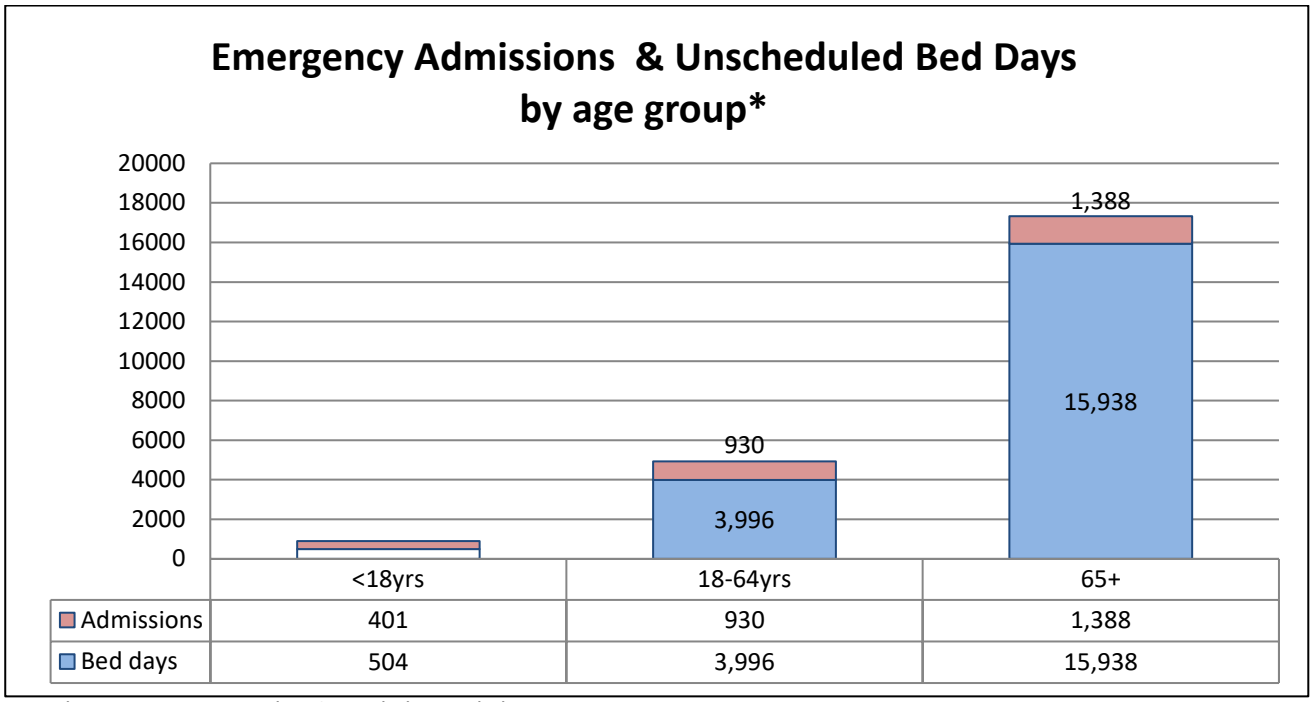


Figure 3.2b Number of Unscheduled Admissions/Hospital Bed Days by Age Group (July – Sept 19)



	<18yrs	18-64yrs	65+
Admissions	401	930	1,388
Bed days	504	3,996	15,938

*Based on most recent complete 3 month data period

Situational Analysis:
This indicator describes the number of bed days in secondary care used by patients who have been admitted unexpectedly. Fig 3.2a shows an initial trend sharply away from the target trajectory, but since then there has been a steadying of emergency bed days and reduction back towards target over the year. The national published data is only available to January 2020, but local data in the blue box shows our comparative performance across the whole year, which places East Dunbartonshire as having the second lowest level of unscheduled bed days in GG&C.

Improvement Actions:
Our primary focus continues to be on prevention of admission, where possible, so that unnecessary accrual of bed days is avoided. Improvement activity has also included daily scrutiny of emergency admissions and proactive work with identified wards to facilitate discharge. The reduction in bed days is a positive indication of progress in this regard.

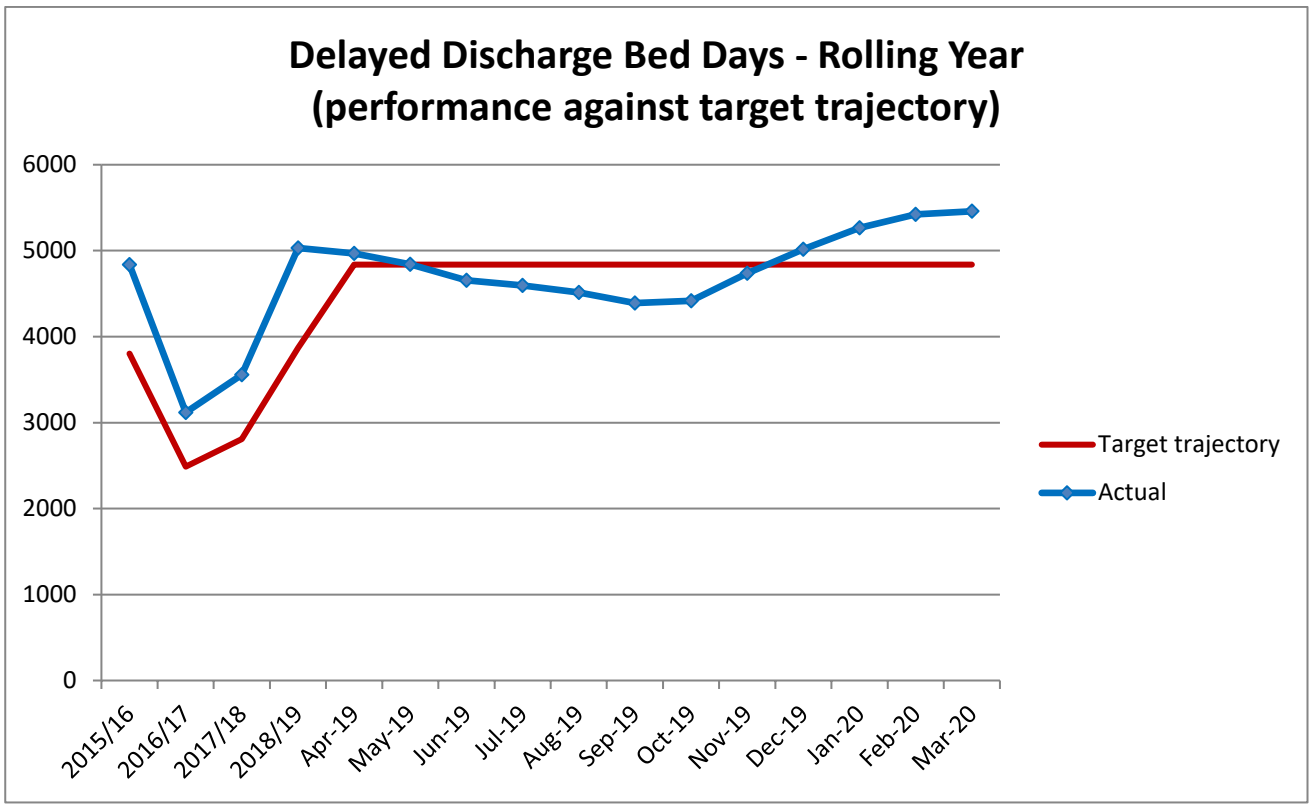
3.3 Delayed Discharges

Rationale: People who are ready for discharge will not remain in hospital unnecessarily. Aim = to minimise

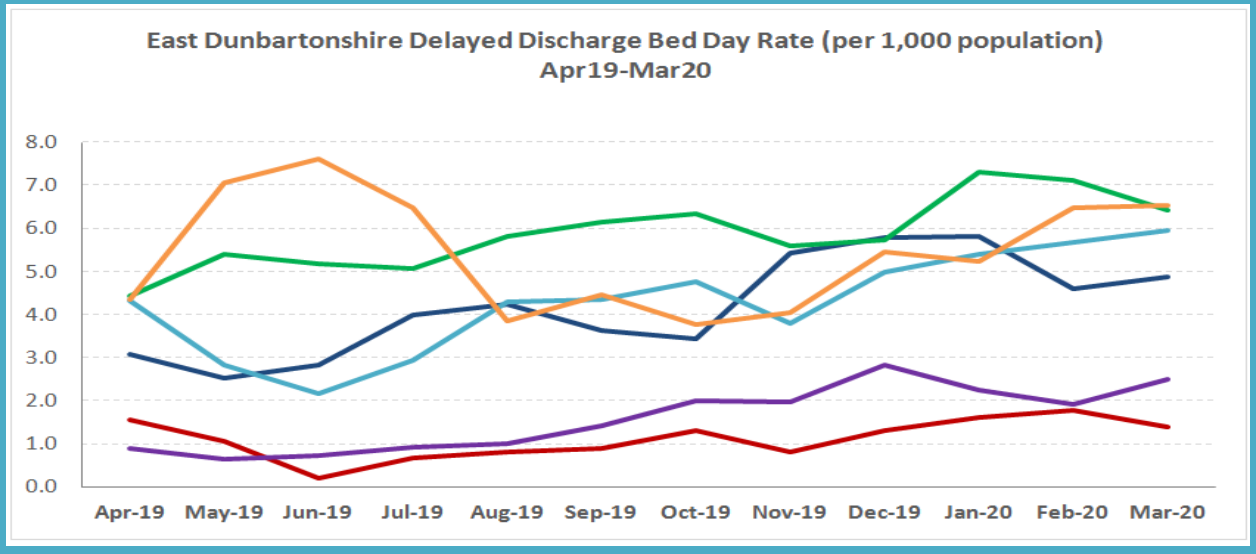
Table 3.3 Quarterly Number of Delayed Discharge Bed Days

	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Target (quarter)
No. Bed Days	**1,222**	**917**	**1,286**	**1,592**	**1,663**	**1,208**

Figure 3.3a Rolling year number of Delayed Discharge Bed Days

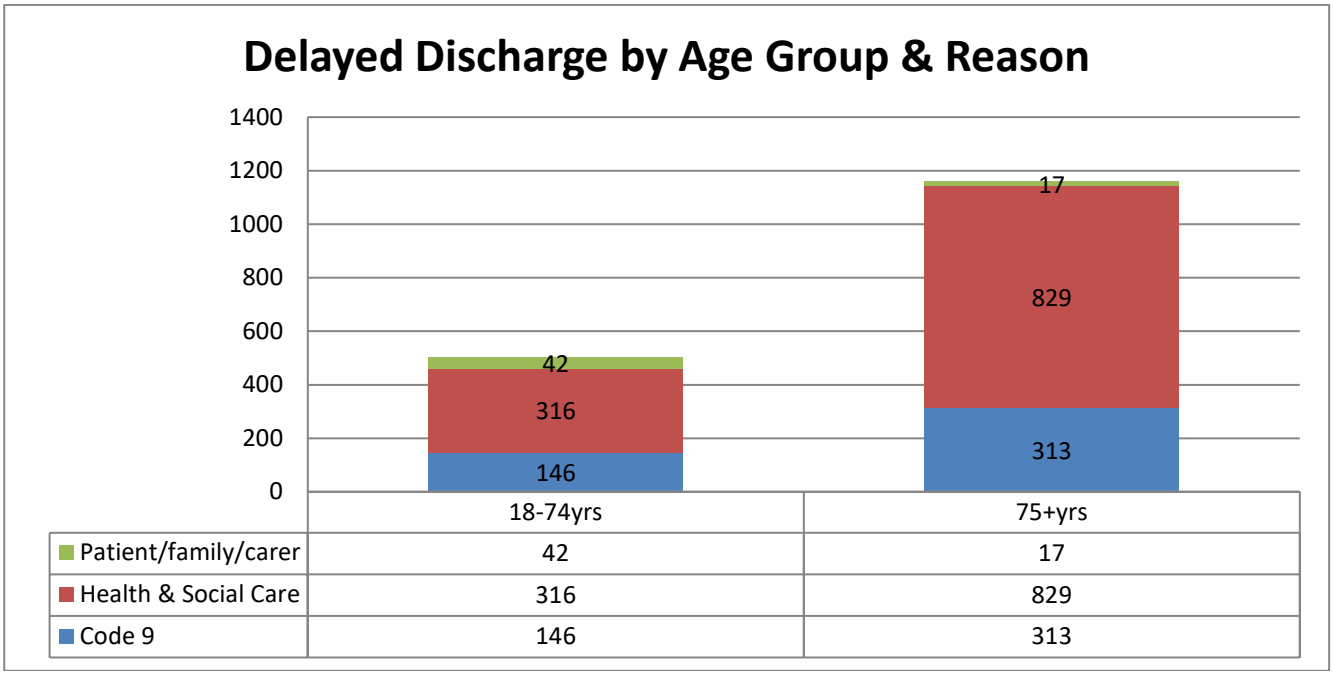


Local GGC Full Year Data:



East Dunbartonshire		Renfrewshire	
East Renfrewshire		Glasgow	
West Dunbartonshire		Inverclyde	

Figure 3.3b Number of Delayed Discharge by Age and Reason (Jan – Mar 20)



Situational Analysis:
Progress in quarters 1 and 2 of this year was very positive, with reductions in both periods. Quarters 3 and 4 were more challenging with the impact of the winter period. Overall, performance is broadly in line with the target for the year. Emerging data for the period following March shows a marked reduction in delayed discharges due to Covid-19 emergency planning.

Improvement Actions:
Use of electronic operational activity "dashboards" now allow us to be better sighted on community patients who have been admitted to hospital so that we can respond more quickly, prior to these patients being deemed fit for discharge. We can also see patients who have been admitted who are not currently known to us, again allowing us to intervene early. In addition, all of the actions described in the previous indicator around prevention of admission are relevant to avoiding delayed discharges. We will continue to work creatively within the legal framework and support patients and their families to make choices timeously for ongoing care. Home for Me is now well established and coordinates our admission avoidance and discharge facilitation work across a range of services.

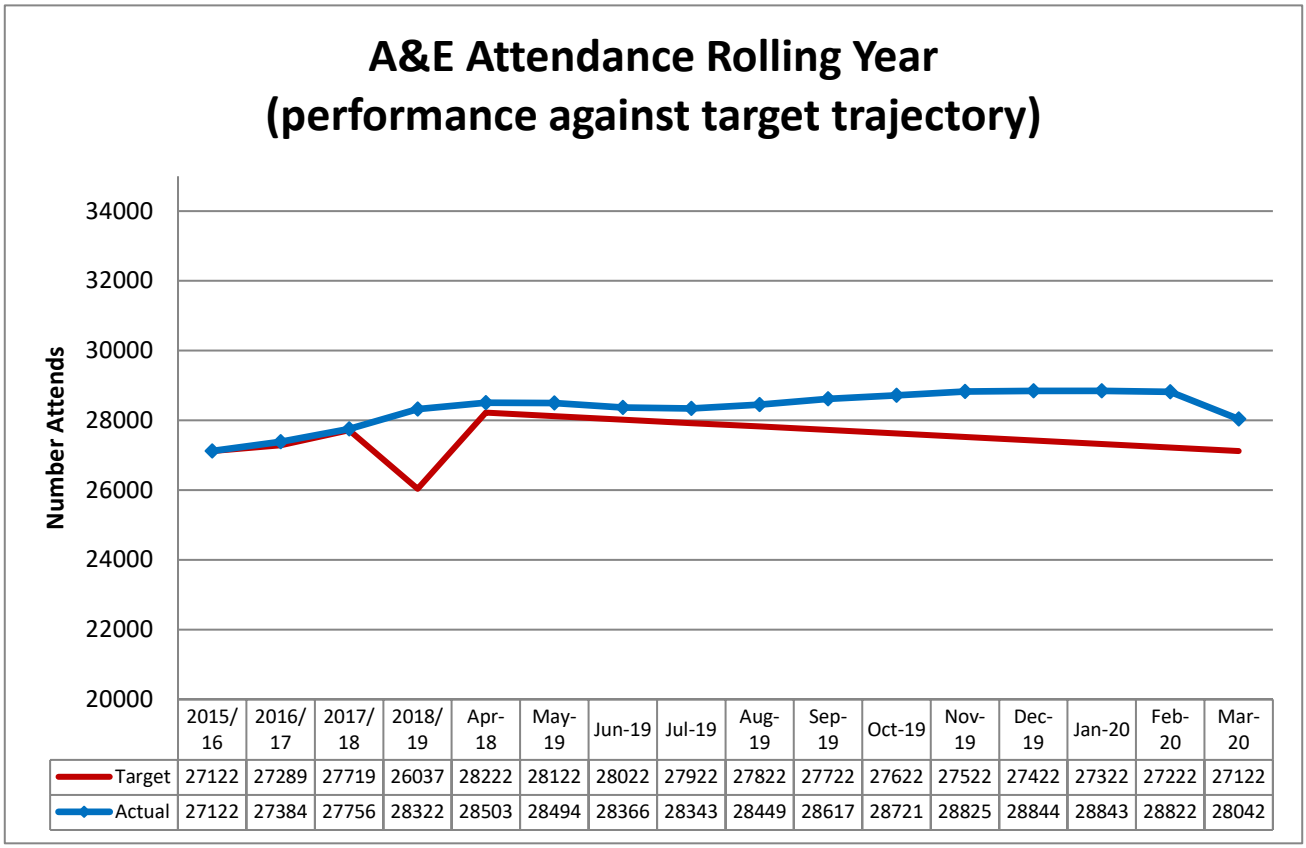
3.4 Accident & Emergency Attendances

Rationale: Accident & Emergency attendance is focussed on reducing inappropriate use of hospital services and changing behaviours away from a reliance on hospital care towards the appropriate available support in the community setting. Aim = to minimise

Table 3.4 Quarterly Number A&E Attendances (all ages)

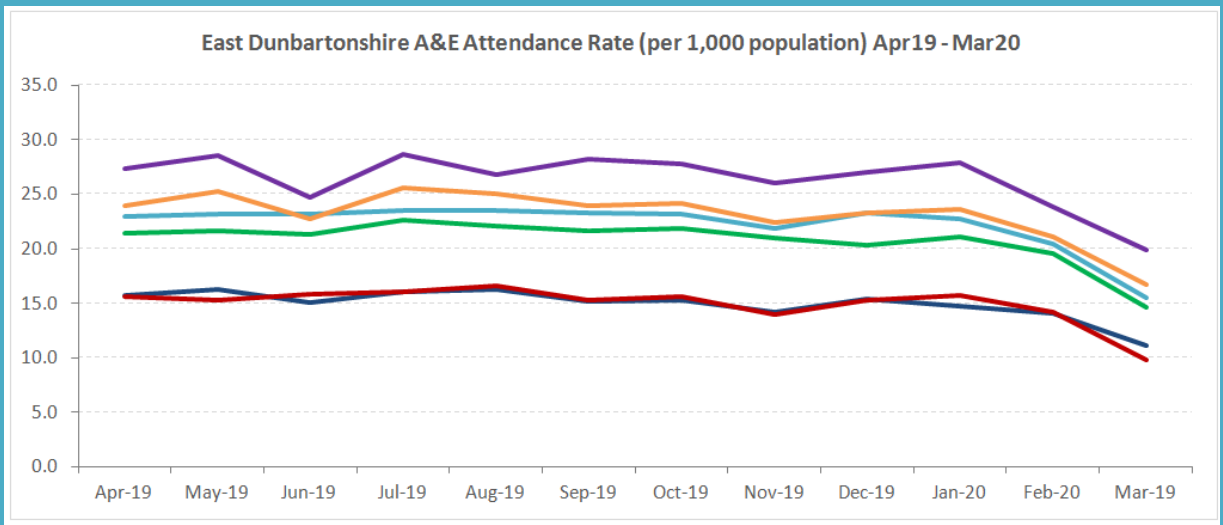
Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Target (quarter)
6,830	7,358	7,451	7,205	6,028	6,780

Figure 3.4a Rolling year number of A&E Attendances



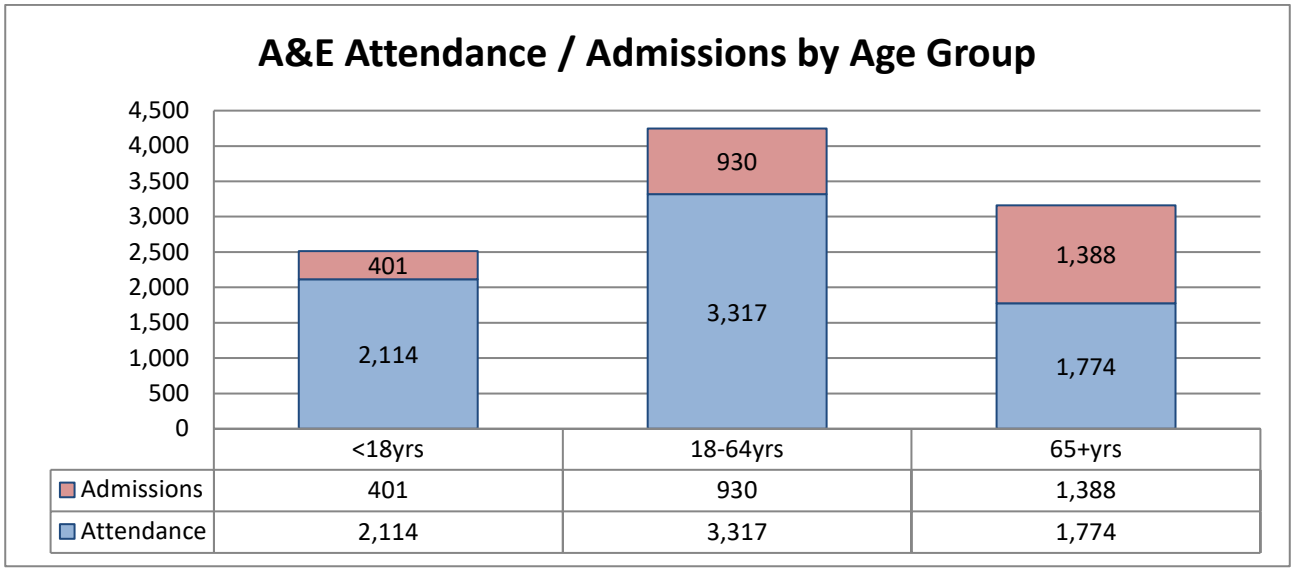
	2015/16	2016/17	2017/18	2018/19	Apr-18	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Target	27122	27289	27719	26037	28222	28122	28022	27922	27822	27722	27622	27522	27422	27322	27222	27122
Actual	27122	27384	27756	28322	28503	28494	28366	28343	28449	28617	28721	28825	28844	28843	28822	28042

Local GGC Full Year Data:



East Dunbartonshire		Renfrewshire	
East Renfrewshire		Glasgow	
West Dunbartonshire		Inverclyde	

Figure 3.4b A&E Attendances Admitted to Hospital by Age Group (Dec - Mar 19)



Situational Analysis:

During 2019-20, after a positive reduction in Q1, performance saw a gradual upward trend until March, when the impact of the Covid-19 emergency response impacted on A&E attendance numbers. It should be noted, however, that some demand which would previously have been included in A&E data will have been streamed to the SATA (Specialist Assessment and Treatment Area) for suspect Covid-19 pathway and counted separately, thus excluding this level of demand for A&E/ED. Despite the trend against target trajectory, East Dunbartonshire has the second lowest level of emergency department attendances across Greater Glasgow and Clyde, as can be seen from local data presented in the blue box. The data in figure 3.4b show the proportion of those who attended A&E who were subsequently discharged, suggesting a significant number of those attending A&E could have had their needs met in the community or via self care. This is a challenge across Scotland which is being considered by Scottish Government and all public sector partners.

Improvement Actions:

From an HSCP perspective we continue our work around the Primary Care Improvement Plan, to recalibrate and sustain GP services. This will enable more flexible responses to patient need in the community although is likely to be significantly impacted in 2020/21 by the Covid-19 experience. We hope that increased focus on self care for people with long term conditions will also mean that people can manage their own health more proactively. We are working closely with secondary care colleagues around their introduction of redirection protocols to ensure that people who do not need to be at A&E are redirected to community services or self care timeously. We are also engaged in national conversations about programmes of public education regarding who service users should turn to for support when they are sick, injured, or in distress. Again, winter planning provided an opportunity to sharpen up our focus on all these areas in order to help mitigate seasonal pressures we routinely see in all services, but the new context during and post Covid-19 will be impactful.

SECTION 4
Social Care Core Indicators

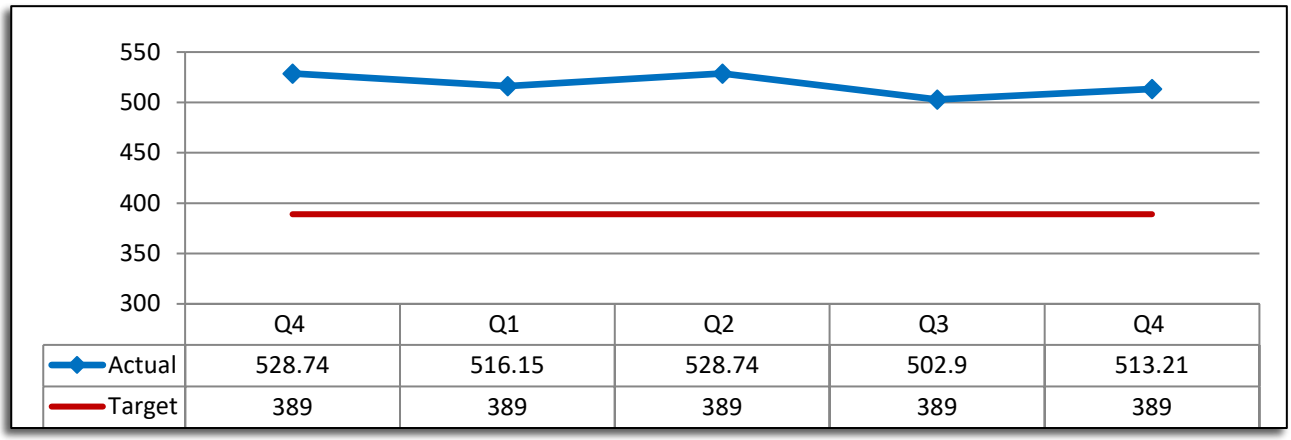
This section provides an updated report of Social Care core dataset and includes data collated by East Dunbartonshire Council Performance & Research Team. Although reported separately from the Health and Social Care data, the following indicators are integral to achieving the targets set out in Health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

4.1 Homecare hours per 1,000 population aged 65+yrs
4.2 People aged 65+yrs with intensive needs receiving care at home
4.3 Community assessment to service delivery timescale
4.4 Care home placements
4.5 Adult Protection inquiry to intervention timescales

4.1 Homecare hours per 1,000 population aged 65+yrs

Rationale: Key indicator required by Scottish Government to assist in the measurement of Balance of Care. Aim = to maximise in comparison to support in institutional settings

Figure 4.1 No. of Homecare Hours per 1,000 population 65+



	Q4	Q1	Q2	Q3	Q4
Actual	528.74	516.15	528.74	502.9	513.21
Target	389	389	389	389	389

Situational Analysis:
This indicator was first established nationally to measure the extent of community-based support, in comparison with institutional care. The number of homecare hours per 1000 population over 65 remains on an upward overall trajectory and well above target. Whilst this demonstrates success in supporting people in the community, the increase is also a result of increased demand overall. Our analysis on the reasons for the increase point to the disproportionate increase in people aged 85+ in East Dunbartonshire, which has been the highest in Scotland over the past 10 years at +5% per year. We are projected to continue to have the fastest growing increase over the next 10 years. People aged 85+ overall have the greatest level need in terms of volume and intensity of older people's service.

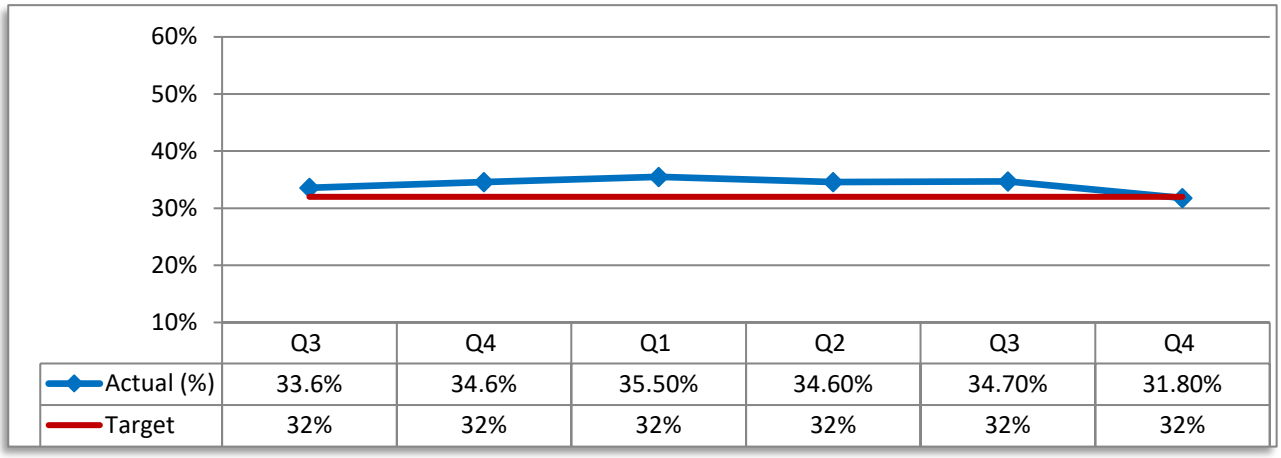
Improvement Action:
Homecare is a cornerstone service in the community health and social care landscape. Performance in relation to maintaining people in their own home, facilitating people to die in their preferred place of care and reducing the number of people living in long term care

are all dependant on homecare. We are progressing well with implementing our homecare review which establishes new organisational and service model arrangements to meet future need in a sustainable way. We are also carrying out a significant service improvement plan in partnership with the Care Inspectorate. A recent in-depth analysis will also help us to consider how to most effectively manage the unprecedented increase in service demand.

4.2 People Aged 65+yrs with Intensive Needs Receiving Care at Home

Rationale: As the population ages, and the number of people with complex care needs increases, the need to provide appropriate care and support becomes even more important. This target assures that home care and support is available for people, particularly those with high levels of care needs. Aim = to maximise.

Figure 4.2 Percentage of People Aged 65+yrs with Intensive Needs Receiving Care at Home



	Q3	Q4	Q1	Q2	Q3	Q4
Actual (%)	33.6%	34.6%	35.50%	34.60%	34.70%	31.80%
Target	32%	32%	32%	32%	32%	32%

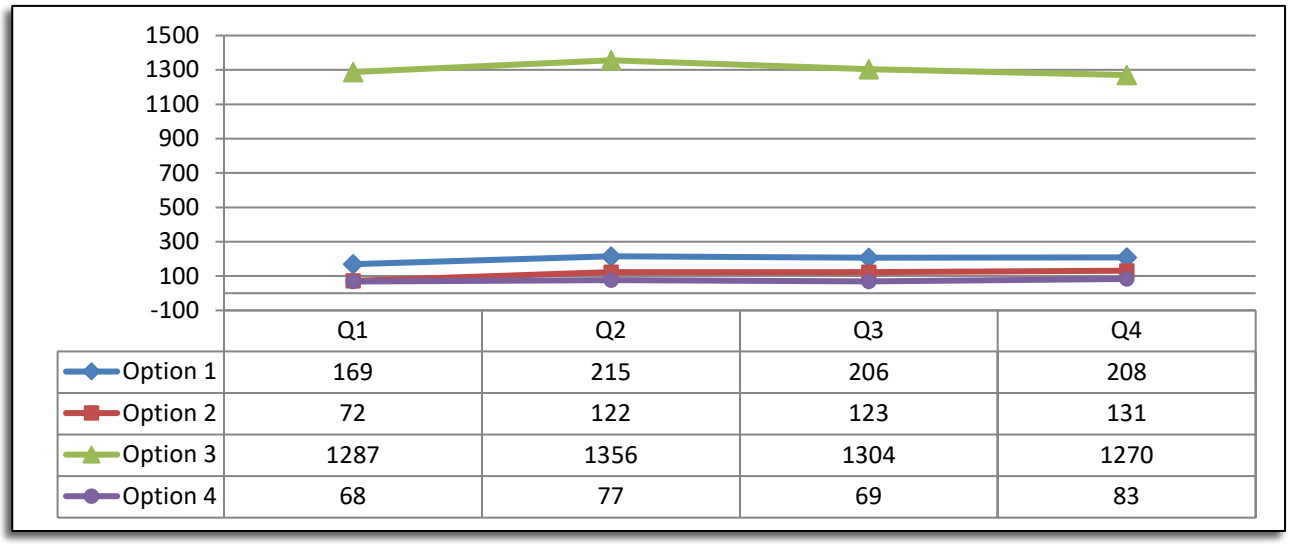
Situational Analysis:
This indicator measures the number of people over 65 receiving 10 hours or more of homecare per week, which is a measure of intensive support. Our policy is to support people with intensive care needs in the community as far as possible, traditionally the aim has been to maximise this value. However we also have to be mindful of the need to maximise independent living using "just enough" support rather than creating over-dependency. We have been consistently above target for this indicator over the past year, with an overall upward trend. Performance for Quarter 3 shows a very slight dip below target, which will be monitored. As with indicator 4.1, this demonstrates the increasing complexity of care needs within our community.

Improvement Action:
Our intention is to maintain good, balanced performance in this area.

4.2b Systems supporting Care at Home

Rationale: The following indicators contribute partly to support the previous indicators. They are important in improving the balance of care and assisting people to remain independent in their own homes, but do not have specific targets.

4.2b(i) Number of people uptaking SDS options

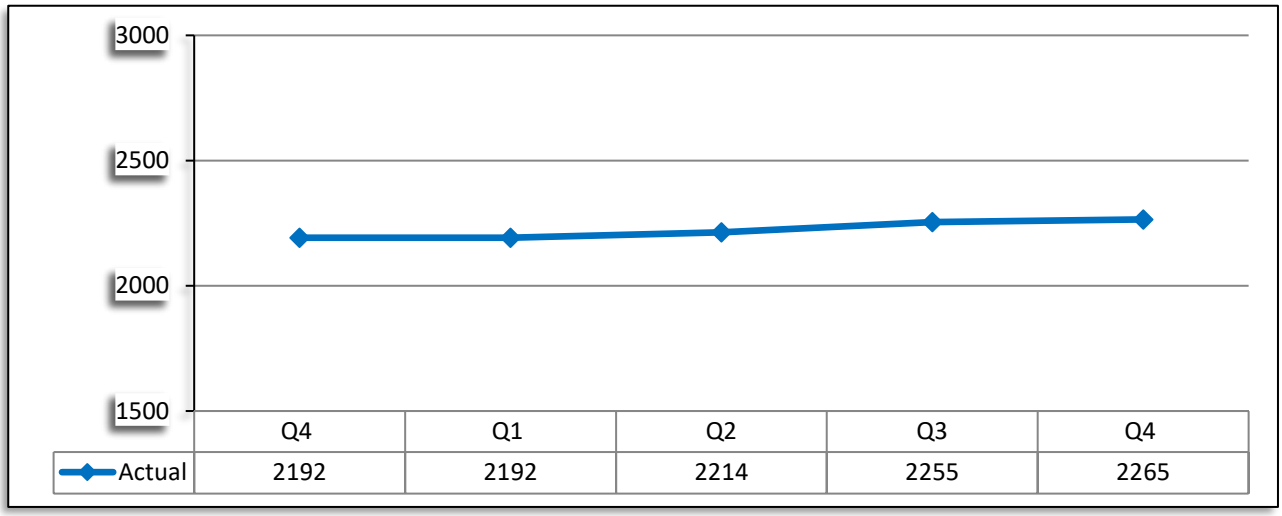


	Q1	Q2	Q3	Q4
Option 1	169	215	206	208
Option 2	72	122	123	131
Option 3	1287	1356	1304	1270
Option 4	68	77	69	83

Situational Analysis:
The indicators measure the number of people choosing Self Directed Support Options to direct their own support package. Their choice will be dependent upon the amount of control and responsibility that the customer or their family wish to take in arranging the delivery of care. None of the options are considered inferior to the other options and the statistics reflect customer choice. Despite some movement, the distribution of SDS choices is remaining broadly stable.

Improvement Action:
We will continue to ensure that we provide Self Directed Support training to Social Work and Health practitioners to instil confidence and knowledge about the options amongst the workforce. We will also continue to work in partnership with the Third Sector to raise awareness about self directed support to local communities, customers and carers to ensure that the benefits associated with each option are fully explained and recognised.

4.2b(ii) People Aged 75+yrs with a Telecare Package



	Q4	Q1	Q2	Q3	Q4
Actual	2192	2192	2214	2255	2265

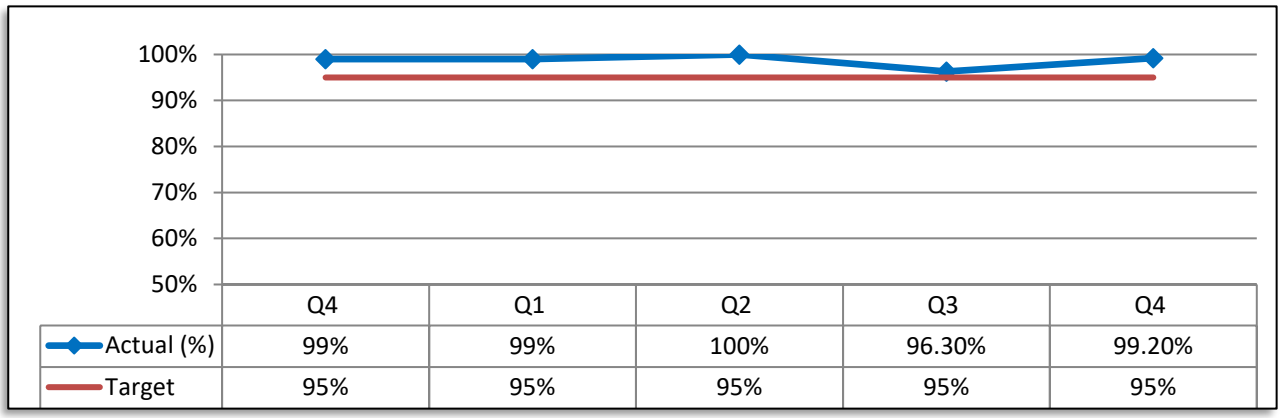
Situational Analysis:
There has been a consistent, gradual increase in the number of people aged 75 and over with a telecare package over the past 12 months. This is in line with expectations, as the population of people in East Dunbartonshire aged 75+ increases and telecare opportunities are maximised.

Improvement Action:
We continue to implement our Assistive Technology Strategy, seeking to link traditional telecare with telehealth monitoring and technology enabled care. A communication plan has been developed for this strategy to support increased workforce awareness of the opportunities technology can bring.

4.3 Community Care Assessment to Service Delivery Timescale

Rationale The HSCP has a duty to undertake community care assessments for those in need, and are responsible for developing packages of care to meet identified need. The national standard is to operate within a six week period from assessment to service delivery, which encourages efficiency and minimises delays for service-users. Aim = to maximise.

Figure 4.3 Percentage of service users (65+yrs) meeting 6wk target



	Q4	Q1	Q2	Q3	Q4
Actual (%)	99%	99%	100%	96.30%	99.20%
Target	95%	95%	95%	95%	95%

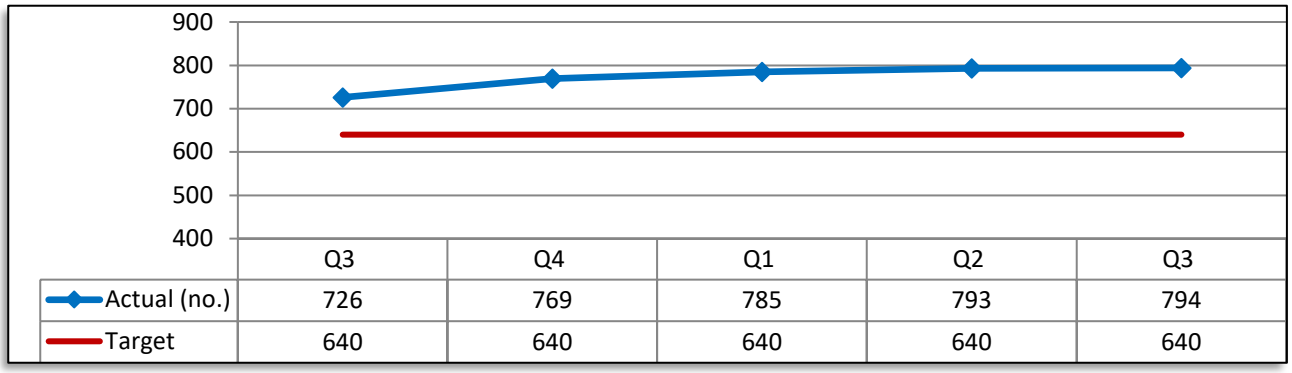
Situational Analysis:
While very many people receive services well within the 6 week target from the completion of their community care assessment, this measure ensures that we can track compliance with this national target timescale. We consistent score very highly with compliance levels of around 100%. The slight reduction in performance in Q3 has been remedied for Q4.

Improvement Action:
The focus is to continue to deliver high levels of performance in this areas.

4.4 Care Home Placements

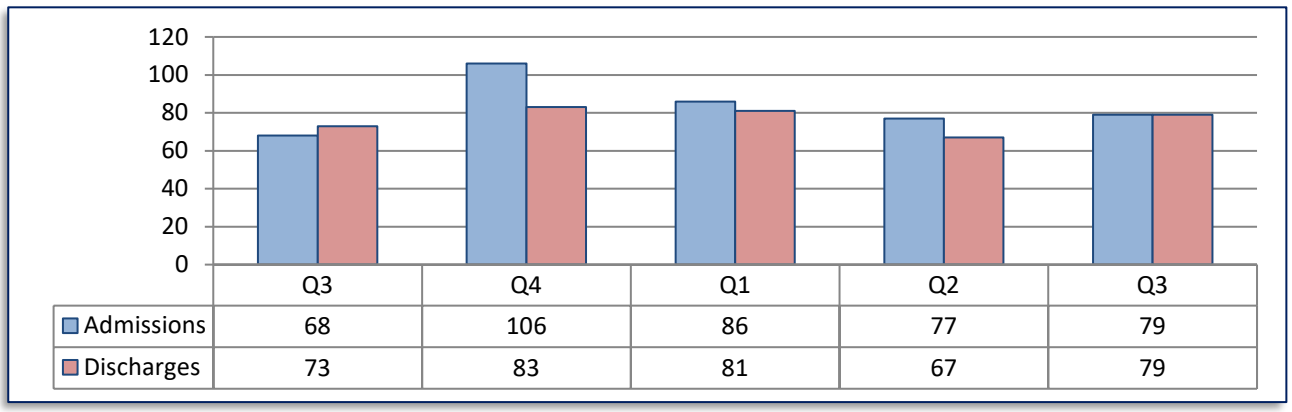
Rationale: Avoiding new permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Aim = to minimise.

Figure 4.4a Number of People Aged 65+yrs in Permanent Care Home Placements (snapshot)



	Q3	Q4	Q1	Q2	Q3
Actual (no.)	726	769	785	793	794
Target	640	640	640	640	640

Figure 4.4b Number of Care Home Admissions and Discharges (including deaths)



	Q3	Q4	Q1	Q2	Q3
Admissions	68	106	86	77	79
Discharges	73	83	81	67	79

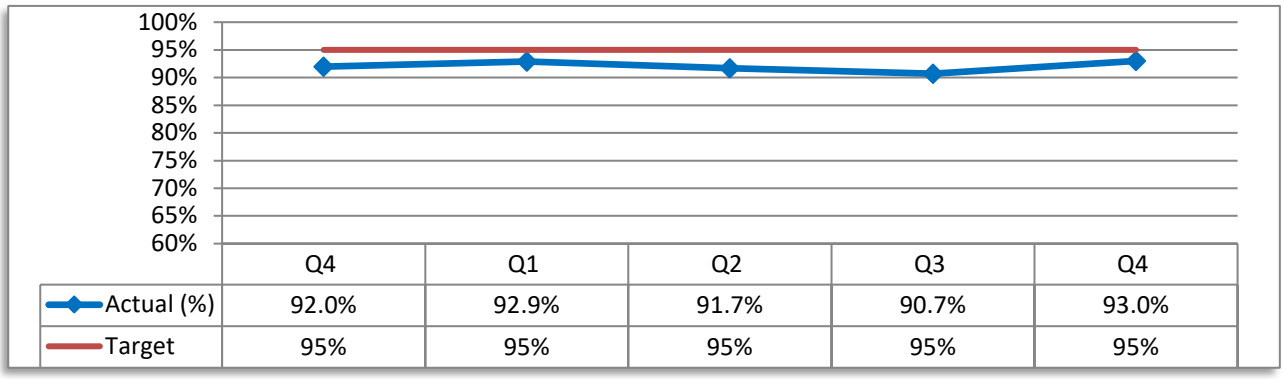
Situational Analysis:
Care home admissions are determined at an individual level, based upon an assessment of support needs and with consideration to the balance of care and cost thresholds. The HSCP policy is to support people in the community for as long as possible, which is generally the preference of the individual concerned. National and local policy is also geared towards carefully balancing the use of care home admissions. Increases in care at home provision to older people demonstrate that this has been successful, but demand pressures continue across all service sectors. Demographic and demand pressures are described more fully at 4.1 above, and apply equally to this measure. Work to balance admissions and discharges has been successful during Q3, which is the most recent data available for this area of service.

Improvement Action:
Work continues to analyse and manage care home admission pressures, taking into account the potential consequences, both personal and organisational, for decision-making.

4.5 Adult Protection Inquiry to Intervention Timescales

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

Figure 4.5 Percentage of Adult Protection cases where timescales were met



	Q4	Q1	Q2	Q3	Q4
Actual (%)	92.0%	92.9%	91.7%	90.7%	93.0%
Target	95%	95%	95%	95%	95%

Situational Analysis:
After a period of lower performance last year due to the impact of industrial action, performance has recovered to levels much closer to the target. However, increasing rates of referrals linked to a Large Scale Investigation undertaken during the year have also added to the overall workload in this area making consistent achievement of targets challenging.

Improvement Action:
Improvement action will continue to pursue achievement of compliance with target timescales. Performance is regularly scrutinised by the Adult Protection Committee to identify improvement opportunities and these are progressed where possible. An updated national performance reporting framework is anticipated during the coming year and reporting will be adjusted to meet this, if required.

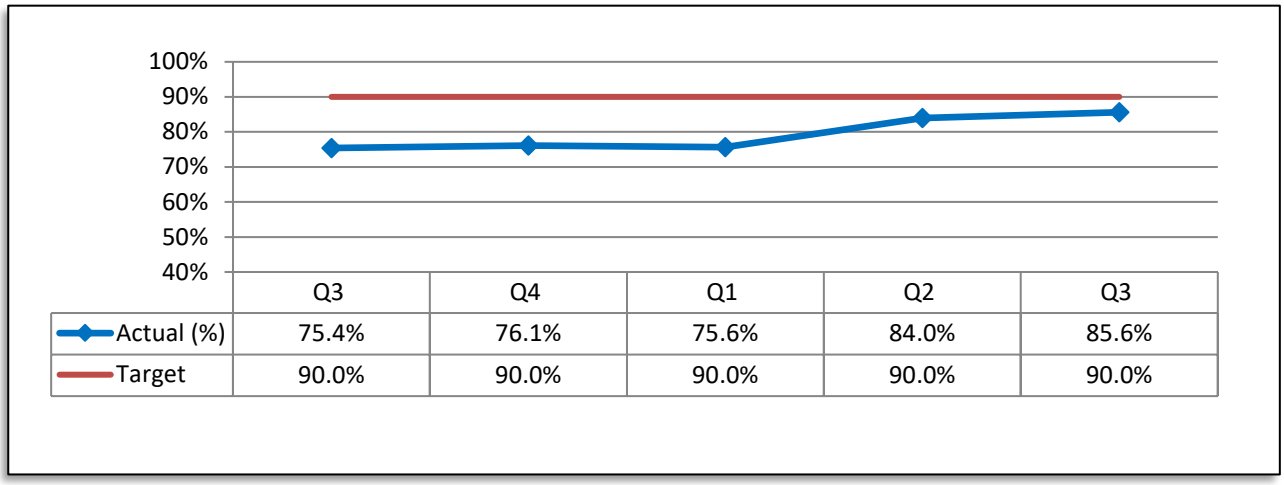
SECTION 5
Local Delivery Plan (Health) Standards

LDP Standards refer to a suit of targets, set by the Scottish Government, which define performance levels that all Health Boards are expected to either sustain or improve. This section reports on the Standards delivered by, or relevant to, the HSCP.

5.1 Drugs & Alcohol Treatment Waiting Times

Rationale: The 3 weeks from referral received to appropriate drug or alcohol treatment target was established to ensure more people recover from drug and alcohol problems so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy. The first stage in supporting people to recover from drug and alcohol problems is to provide a wide range of services and interventions for individuals and their families that are recovery-focused, good quality and that can be accessed when and where they are needed.

Figure 5.1 Percentage of People Waiting <3wks for Drug & Alcohol Treatment



	Q3	Q4	Q1	Q2	Q3
Actual (%)	75.4%	76.1%	75.6%	84.0%	85.6%
Target	90.0%	90.0%	90.0%	90.0%	90.0%

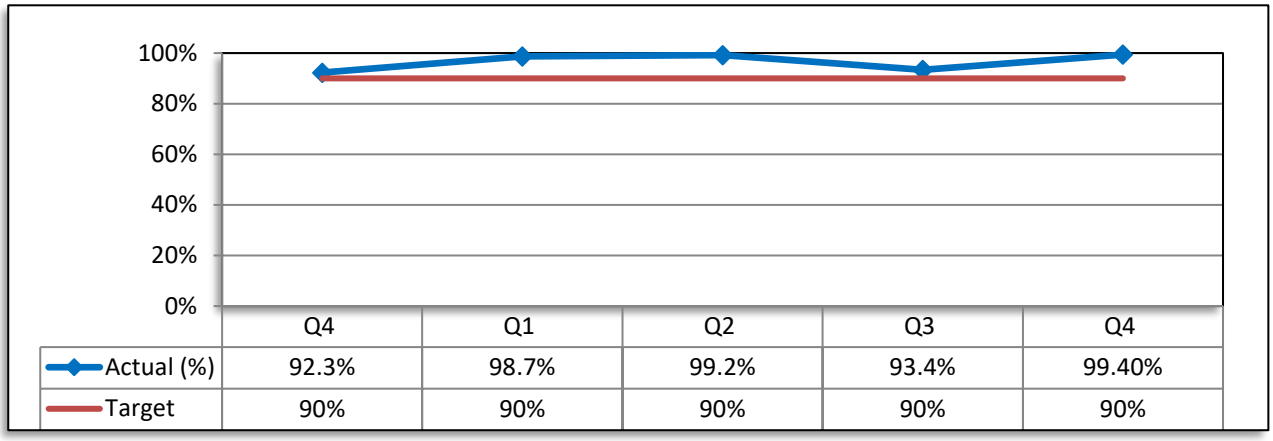
Situational Analysis:
Quarter 4 waiting time performance data had not been published at the time of preparing this report. At Q3, performance was below target but showed continued improvement following progress at Q2. The drug and alcohol team had been significantly impacted by staffing shortages during the last year due to long-term staff absence. Hard work by the team and the successful recruitment to the band 6 alcohol care and treatment nursing post have been instrumental in improving performance in this area.

Improvement Action:
The team will continue to work to maintain and further improve performance in this area to above target levels.

5.2 Psychological Therapies Waiting Times

Rationale: Timely access to healthcare is a key measure of quality and that applies equally in respect of access to mental health services.

Figure 5.2 Percentage of People Waiting <18wks for Psychological Therapies



	Q4	Q1	Q2	Q3	Q4
Actual (%)	92.3%	98.7%	99.2%	93.4%	99.40%
Target	90%	90%	90%	90%	90%

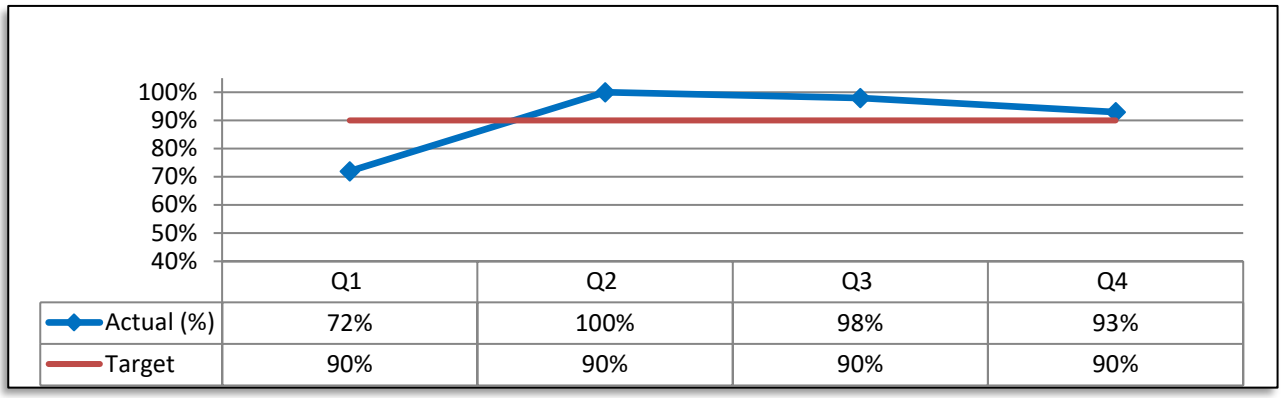
Situational Analysis:
Current performance in the percentage of people seen within 18 weeks from referral to psychological therapy has exceeded target over the past year.

Improvement Action:
The team is taking forward a test of change re-profiling the skill mix of the team to include a dedicated Cognitive Behavioural Therapy practitioner post to enable a more distributed and tiered approach to allocation of work within the team. This should help to maintain positive performance against the target.

5.3 Dementia Post Diagnostic Support (PDS)

Rationale: This Standard supports the improvement of local post-diagnostic services as they work alongside and support people with a new diagnosis of dementia, and their family, in building a holistic and person-centred support plan. People with dementia benefit from an earlier diagnosis and access to the range of post-diagnostic services, which enable the person and their family to understand and adjust to a diagnosis, connect better and navigate through services and plan for future care including anticipatory care planning.

Figure 5.3 Percentage of People Newly Diagnosed with Dementia Accessing PDS



	Q1	Q2	Q3	Q4
Actual (%)	72%	100%	98%	93%
Target	90%	90%	90%	90%

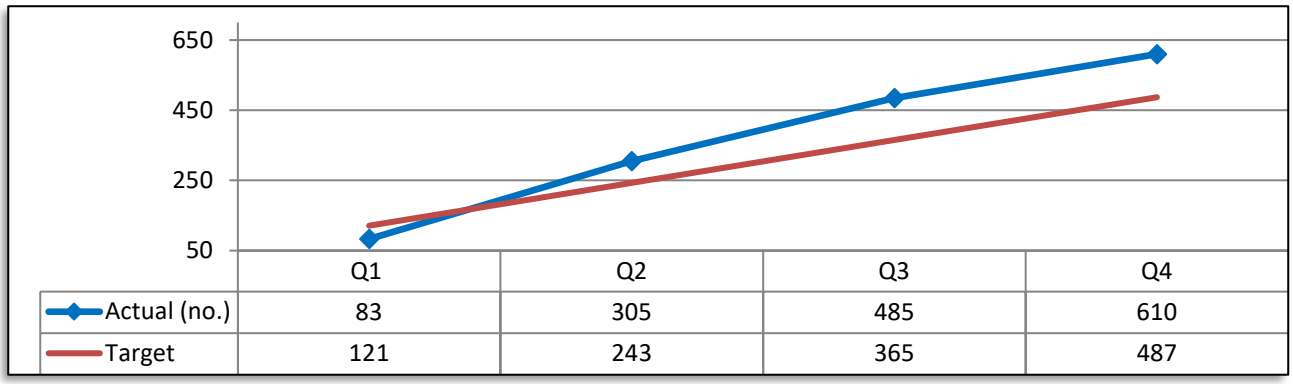
Situational Analysis:
This indicator examines how many patients are accessing PDS within 12 weeks of new diagnosis. Staffing shortages impacted significantly on the service's ability to achieve target levels of performance in Q1, but this has improved over the rest of the year, with performance above target.

Improvement Action:
Work will be ongoing to continue to sustain and improve performance in this area.

5.4 Alcohol Brief Interventions (ABIs)

Rationale: To sustain and embed alcohol brief interventions in the three priority settings of primary care, A&E and antenatal. This standard helps tackle hazardous and harmful drinking, which contributes significantly to Scotland's morbidity, mortality and social harm. Latest data suggests that alcohol-related hospital admissions have quadrupled since the early 1980s and mortality has doubled.

Figure 5.4 Total Number of ABIs delivered (cumulative)



	Q1	Q2	Q3	Q4
Actual (no.)	83	305	485	610
Target	121	243	365	487

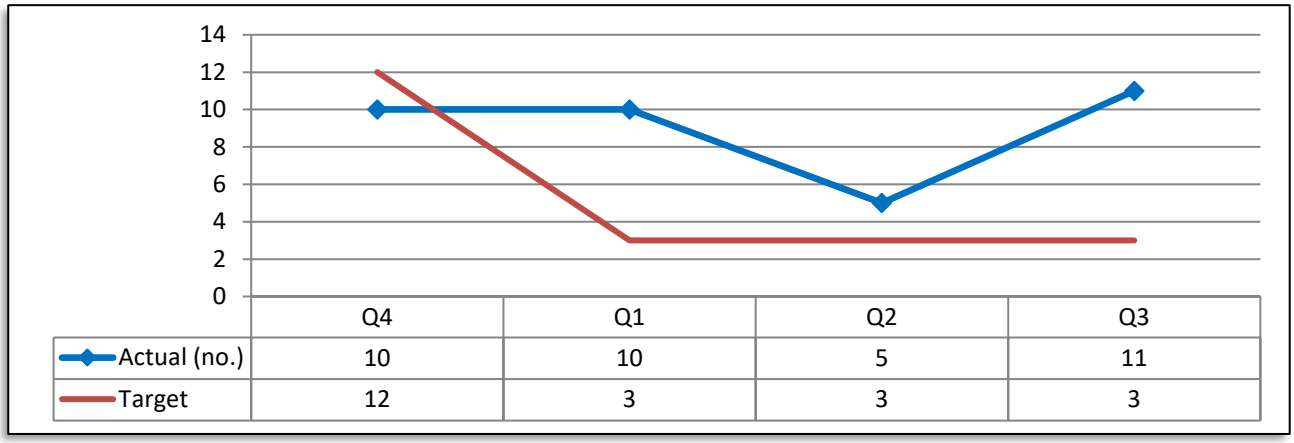
Situational Analysis:
The target of 487 Alcohol Brief Interventions was achieved and exceeded by some margin over 2019-20. Fig 5.4 shows that the target was not achieved in Q1 of this year, but recovered strongly in Q2 and sustained this improvement over the rest of the year.

Improvement Action:
The HSCP aspires to a higher number of Alcohol Brief Interventions being achieved, but uptake within General Practice remains a challenge. The programme of ABI's continues to be developed across East Dunbartonshire. There were some capacity challenges earlier this year that culminated in a temporary reduction in service delivery, which contributed to the below target performance in Q1. To mitigate this, a series of wider Partner training was undertaken. This resulted in an increase in the spread of partners delivering ABIs which has impacted positively on performance since then.

5.5 Smoking Cessation

Rationale: To sustain and embed successful smoking quits at 12 weeks post quit, in the 40 per cent most deprived SIMD areas. This target sets out the key contribution of NHS Scotland to reduce the prevalence of smoking. Smoking has long been recognised as the biggest single cause of preventable ill-health and premature death. It is a key factor in health inequalities and is estimated to be linked to some 13,000 deaths and many more hospital admissions each year.

Figure 5.5 Smoking quits at 12 weeks post quit in the 40% most deprived areas



	Q4	Q1	Q2	Q3
Actual (no.)	10	10	5	11
Target	12	3	3	3

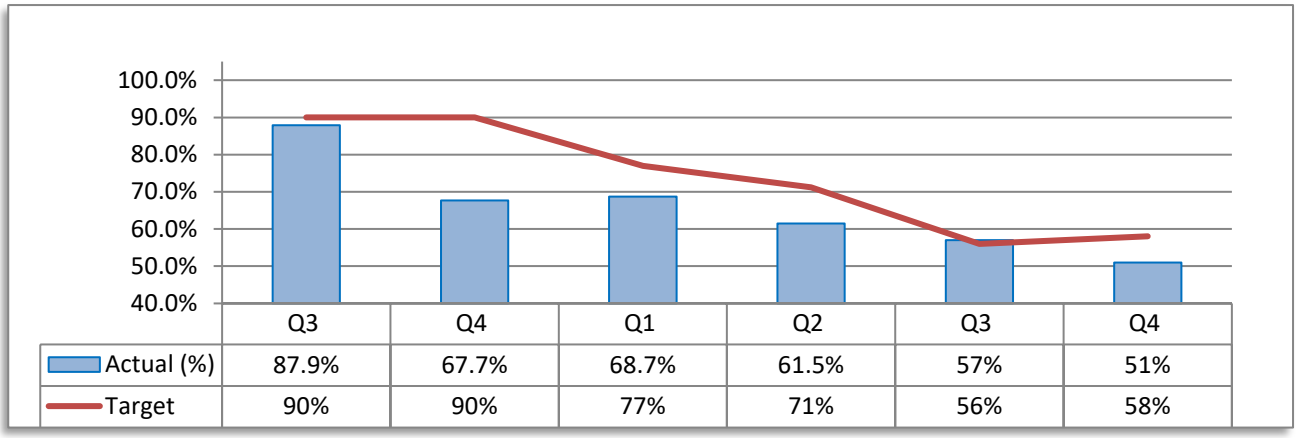
Situational Analysis:
Targets for smoking cessation are set centrally by NHSGGC and have been revised down for 2019-20, to reflect actual smoking rates. Performance with smoking cessation has improved over this period, to exceed the new target. Data only becomes available 12 weeks after the end of each reporting period, so Q3 is the most recent available data.

Improvement Action:
As of the February 2019, a full time HI Practitioner (Smoking Cessation) was recruited on a fixed-term contract (until March 2020) who works primarily within East Dunbartonshire as part of the QYW Community services. The postholder has a focus on raising awareness of the stop smoking services in East Dunbartonshire, delivering service and exploring service development opportunities. One of the objectives of this post is to improve performance against this target. The indications are that this approach impacted very positively upon uptake and success rates.

5.6 Child & Adolescent Mental Health Services (CAMHS) Waiting Times

Rationale: 90% of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral. Timely access to healthcare is a key measure of quality and that applies equally in respect of access to mental health services. Early action is more likely to result in full recovery and in the case of children and young people will also minimise the impact on other aspects of their development such as their education, so improving their wider social development outcomes.

Figure 5.6 Percentage of People Waiting <18wks for CAMHS



	Q3	Q4	Q1	Q2	Q3	Q4
Actual (%)	87.9%	67.7%	68.7%	61.5%	57%	51%
Target	90%	90%	77%	71%	56%	58%

Situational analysis:
NHSGG&C CAMHS aims to prioritise improvement on the Referral to Treatment (RTT) performance in a managed way that acknowledges the considerable task of balancing demand and capacity. Increases in demand over the last two years have had a significant impact on clinical capacity and we are working to resolve this as efficiently and safely as possible.

There are two parts to this performance standard:

1. How long children are waiting who are still waiting at the end of the reporting month. At the end of Q4, the service achieved 56% compliance.
2. How long children waited who started treatment in the reporting month. At the end of Q4, the service achieved 51% compliance. This is shown in the chart above.

Improvement Actions:
The following improvement actions are in progress to address the demands on the service:

- Regular updates with CAMHS management and teams to ensure the most effective use of clinical capacity for the waiting list and open caseload throughout the COVID-19 Pandemic using RAG status to prioritise new referrals and existing waiting list. Those waiting longest are being contacted to validate the referrals.
- Weekly monitoring of CAMHS clinical workforce and capacity available to the service through COVID-19 Pandemic.

- Linking with the Children and Young People's Mental Health Programme Board Performance Team to discuss options and aims of reducing the waiting list backlog.
- Increasing Attend Anywhere and virtual group clinics to increase numbers of children seen and clinical capacity and encourage teams to work efficiently to see children sooner.
- Increase the time available for clinicians to provide help and treatment at first contact. Work with partners and local authorities to support pathways in to and out of CAMHS services utilising tier 2 funding. Develop a Tier 2 information resource to assist clinicians to identify and sign post patients to suitable support.
- Implementation of the revised RTT guidelines to ensure recording of GGC CAMHS waiting lists is in line with the rest of the country (no proxy used). Currently GGC stop the clock at the 2nd appointment, which is not the standard across the country. This will move to a model where the clinician stops the clock when they start treatment, which is anticipated to be at first contact.
- A CAMHS Operational Improvement Group has been established to review the CAMHS delivery model, and identify all options for responding to increasing service demands within the available resource. This group will run throughout 2020.

Agreed Trajectory until December 2020

Please note, that this trajectory is for GGC CAMHS and not specific to East Dunbartonshire. SCS Leadership and CAMHS management are closely monitoring this progress and aim to keep the service on track for a return to achieving the RTT target.

Quarter ending	**Sep 2019**	**Dec 2019**	**Mar 2020**	**Jun 2020**	**Sep 2020**	**Dec 2020**
Performance against the standard (%) – Children Waiting at Month End	71.2%	56%	58%	62%	71%	90%

SECTION 6
Children's Services Performance

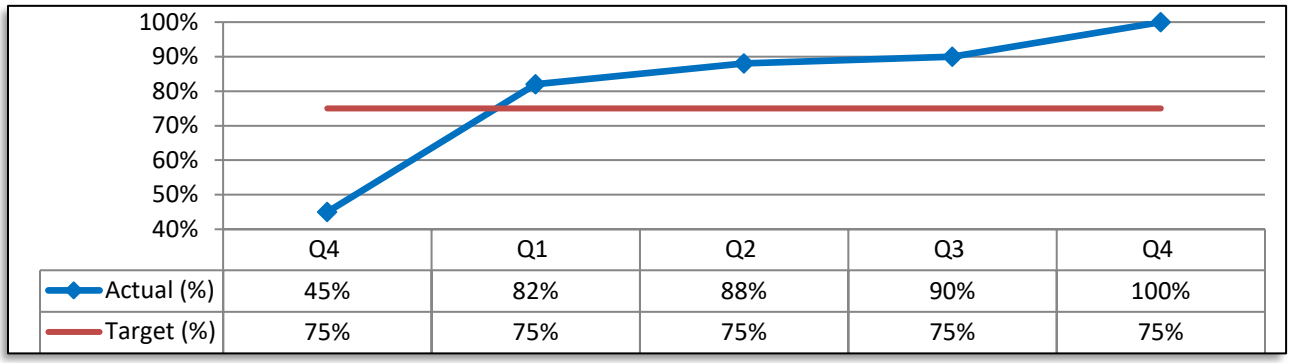
This section provides an updated report performance against key Children and Families indicators. The indicators reported are:

6.1 Child Care Integrated Assessments for Scottish Children Reported Administration timescales
6.2 Initial Child Protection Case Conferences timescales
6.3 First Child Protection review conferences timescales
6.4 Balance of care for Looked After Children
6.5 First Looked After & Accommodated reviews timescales
6.6 Children receiving 27-30 month Assessment

6.1 Child Care Integrated Assessments (ICA) for Scottish Children Reporters Administration (SCRA) Timescales

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

Figure 6.1 Percentage of Child Care Integrated Assessments (ICA) for SCRA completed within 20 days



	Q4	Q1	Q2	Q3	Q4
Actual (%)	45%	82%	88%	90%	100%
Target (%)	75%	75%	75%	75%	75%

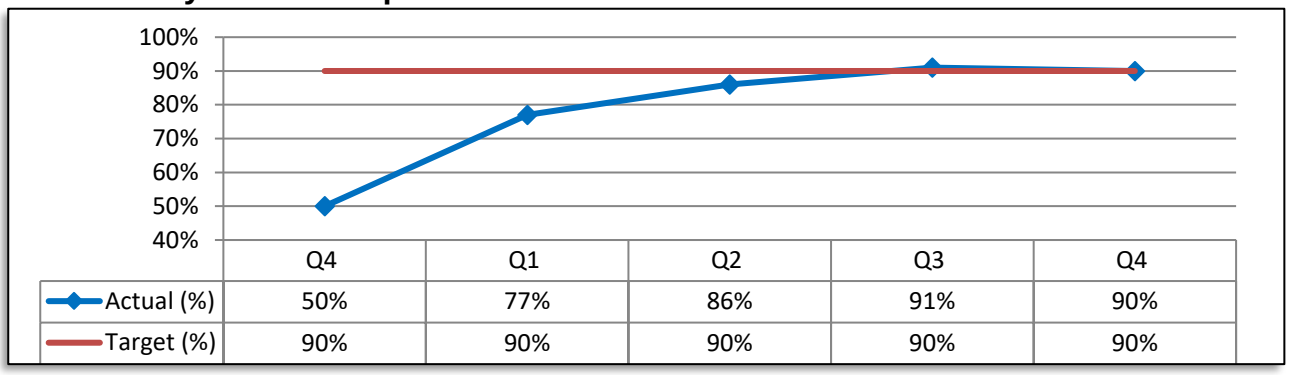
Situational Analysis:
Performance in 2018-19 Q4 was sharply down due to a combination of an unexpected substantial spike in police referrals to SCRA, coupled with seasonal holidays. Performance in 2019-20 has improved markedly and positively exceeded the target for each quarter. 8 ICA reports were submitted to SCRA during Q4, all of which were submitted within target timescale.

Improvement Action:
To maintain good performance.

6.2 Initial Child Protection Case Conferences Timescales

Rationale: Local standard and timescales set by East Dunbartonshire Child Protection Committee. Aim = to maximise

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



	Q4	Q1	Q2	Q3	Q4
Actual (%)	50%	77%	86%	91%	90%
Target (%)	90%	90%	90%	90%	90%

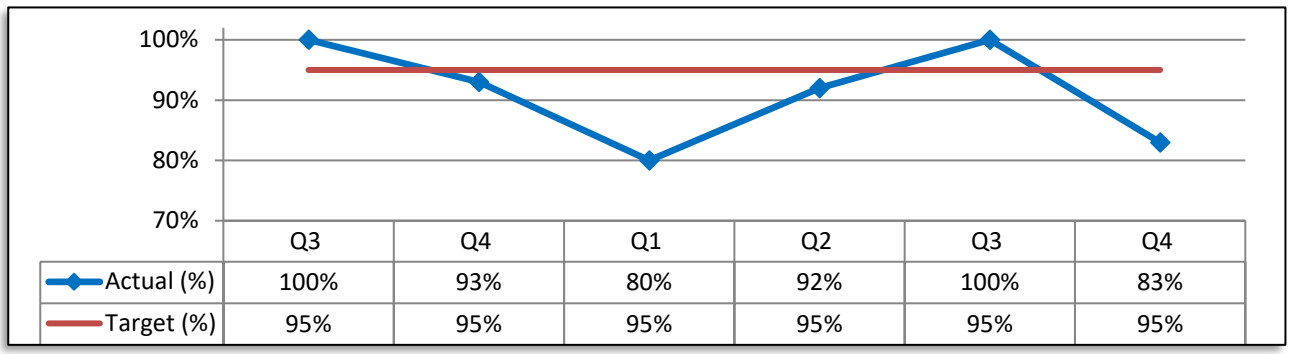
Situational Analysis:
Performance in 2019-20 Q1 and Q2 showed an improvement over a challenging performance result in the final quarter of 2018-19. This trajectory has been sustained, with performance achieving target in Q3 and Q4. These improvements are due to operational support changes that now have the date for Initial Child Protection Case Conferences arranged at the point of a CP investigation starting, to ensure better timescales are achieved. It should be noted that small numbers can impact disproportionately on the figures. 10 Initial Child Protection Case Conferences were held during Quarter 4, of which 9 were within timescale.

Improvement Action:
To continue to embed revised operational procedures in order to sustain above target performance.

6.3 First Child Protection Review Conferences Timescales

Rationale: Local standard and timescales set by East Dunbartonshire Child Protection Committee. Aim = to maximise

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



	Q3	Q4	Q1	Q2	Q3	Q4
Actual (%)	100%	93%	80%	92%	100%	83%
Target (%)	95%	95%	95%	95%	95%	95%

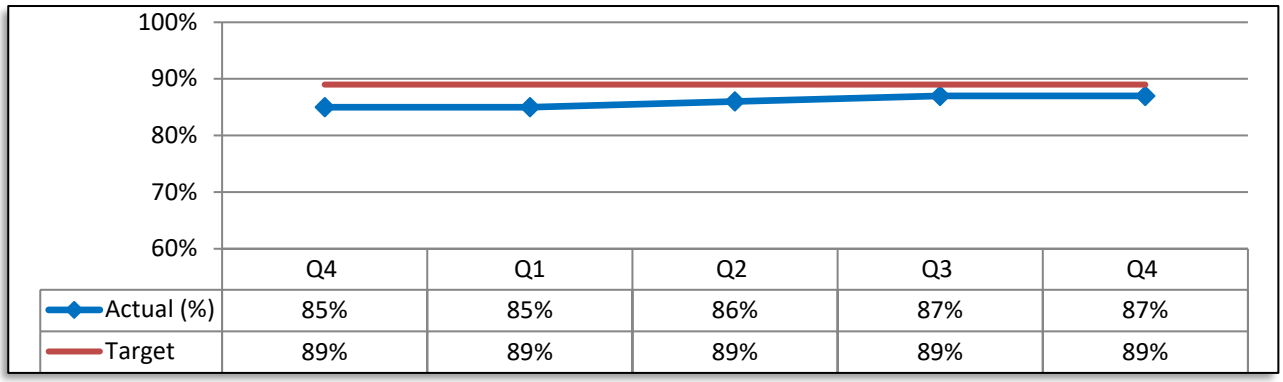
Situational Analysis:
Performance in Q2 reversed the decline in Q1 and performance in Q3 returned above target. Performance in Q4 fell below target but small numbers of cases can have a disproportionate impact overall. 6 first Child Protection Reviews took place during Q4 and 5 of these were within timescale. In one case, legal proceedings meant that the planned date did not go ahead and the rescheduled date was outwith timescale.

Improvement Action:
Team Managers will continue to maximise the achievement of Review Case Conferences timescales.

6.4 Balance of Care for Looked After Children

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

Figure 6.4 Percentage of Children being Looked After in the Community



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

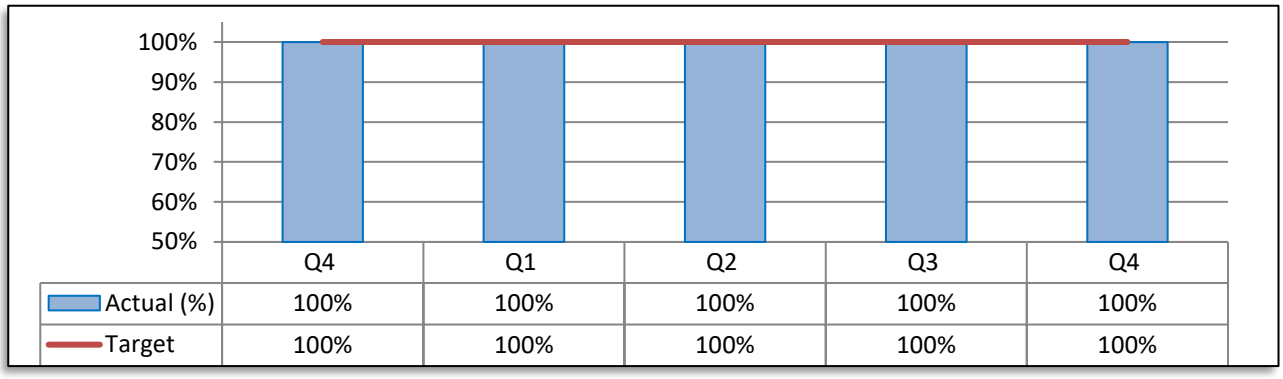
Situational Analysis:
Performance has gradually improved over the year, but still remains below target. Performance at the end of quarter 4 is consistent with the previous quarter. There has been an increase in the number of young people being placed on CSO's at home and in placements with friends/relatives therefore an increase overall in community placements. However, there has also been a slight increase in the number of young people in residential care.

Improvement Action:
Work continues to redress the balance of care by reviewing out of authority placements and continuing the Foster Carer recruitment campaign.

6.5 First Looked After & Accommodated (LAAC) Reviews Timescales

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

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



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

Situational Analysis:
Performance in Quarter 4 maintains 100% compliance with timescales. There was one first LAAC Reviews held during the quarter and it took place within the target timescale.

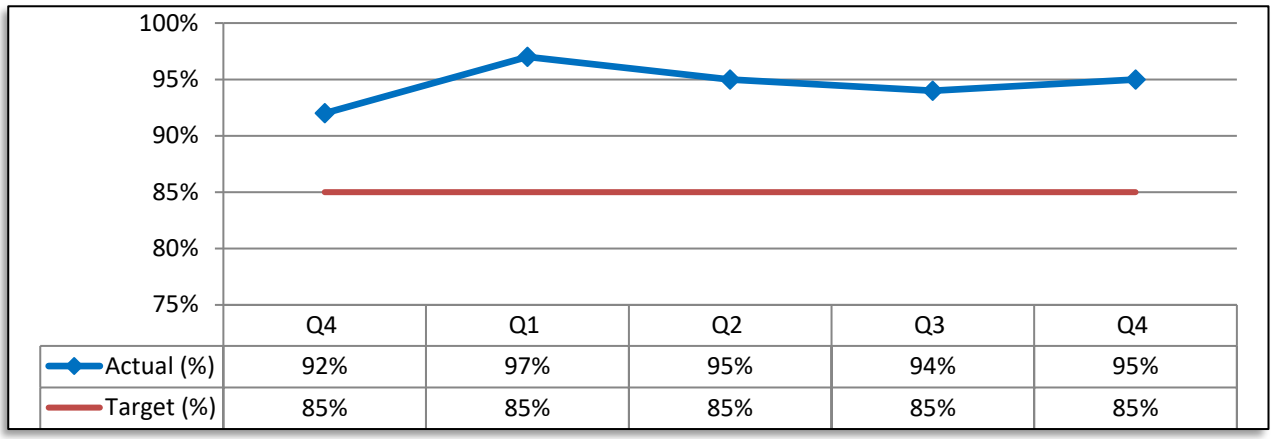
Improvement Action:
To maintain high levels of performance.

6.6 Children receiving 27-30 month Assessment

Rationale: The central purpose of the 27-30 month contact is to seek parental concerns to identify children whose social, emotional and behavioural development puts them at risk of adverse life course outcomes.
Having identified these children, interventions must be put in place to optimise child development in preparation for education. The plan is that wherever possible, children's needs should be met in time for them to benefit from universal nursery provision at age 3.

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

Figure 6.6 Percentage of Children receiving 27-30 month assessment



	Q4	Q1	Q2	Q3	Q4
Actual (%)	92%	97%	95%	94%	95%
Target (%)	85%	85%	85%	85%	85%

Situational Analysis:
This indicator relates to early identification of children within the SIMD quintiles with additional developmental needs. Where additional needs are identified, children are referred to specialist services. Uptake of the 27-30 month assessment across East Dunbartonshire HSCP has been consistently high and above target.

Improvement Action:
Monitor and continue to maximise performance. Data reports are monitored on a monthly basis at team meetings to support early identification of variances and allow improvement plans to be developed where required.

SECTION 7
Criminal Justice Performance

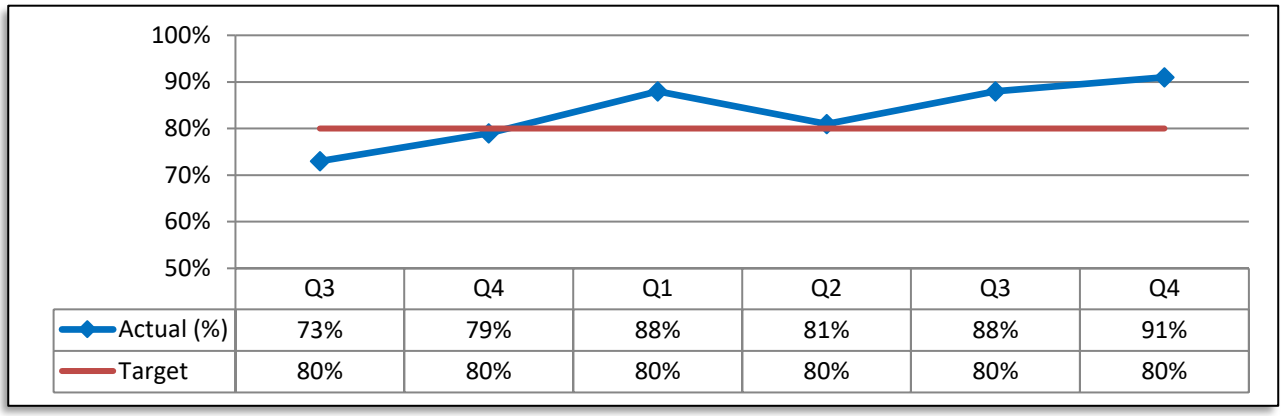
This section provides an updated report performance against key Criminal Justice indicators. The indicators reported are:

7.1 Percentage of individuals beginning a work placement within 7 days of receiving a Community Payback Order
7.2 Percentage of CJSW reports submitted to Court by due date
7.3 Percentage of Court report requests allocated to a Social Worker within 2 Working Days of Receipt

7.1 Percentage of Individuals Beginning a Work Placement Within 7 Days of Receiving a Community Payback Order

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

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



	Q3	Q4	Q1	Q2	Q3	Q4
Actual (%)	73%	79%	88%	81%	88%	91%
Target	80%	80%	80%	80%	80%	80%

Situational Analysis:

A challenge always remains with this performance metric as service users may fail to start their work placement due to a number of issues outwith the control of the service like a further conviction, ill health with GP line, employment contract clashing with immediate start or if subject to an existing order which means the new order cannot commence until the original one is completed. Performance has been consistently above target since Q1.

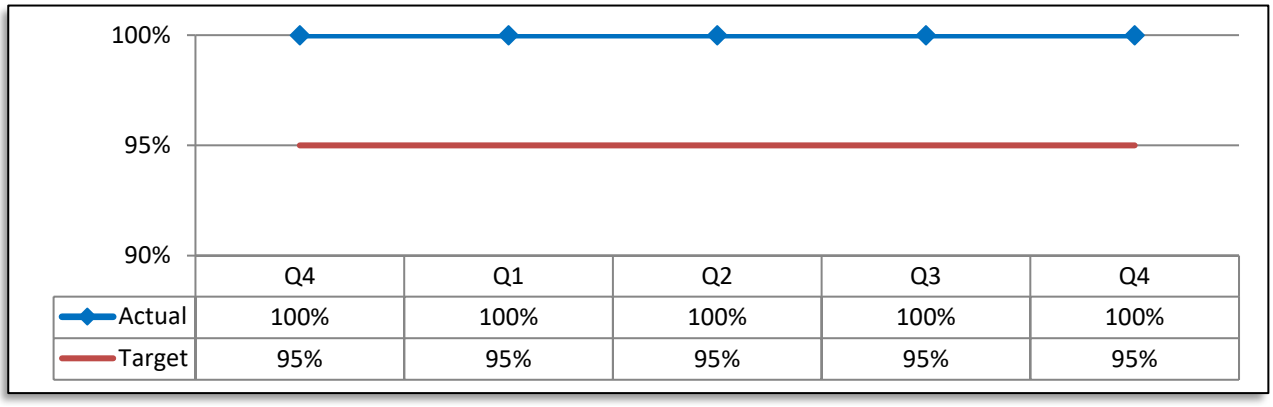
Improvement Action: Continue to monitor and ensure contingencies are enacted swiftly (home visit same day) should the service users fail to attend after court or on day unpaid work placement is due to begin.

7.2 Percentage of CJSW Reports Submitted to Court by Due Date

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

Figure 7.2 Percentage of CJSW reports submitted to Court by due date

Rationale: National Outcomes & Standards (2010) stresses the importance of providing reports to courts by the due date, to facilitate smooth administrative support arrangements.



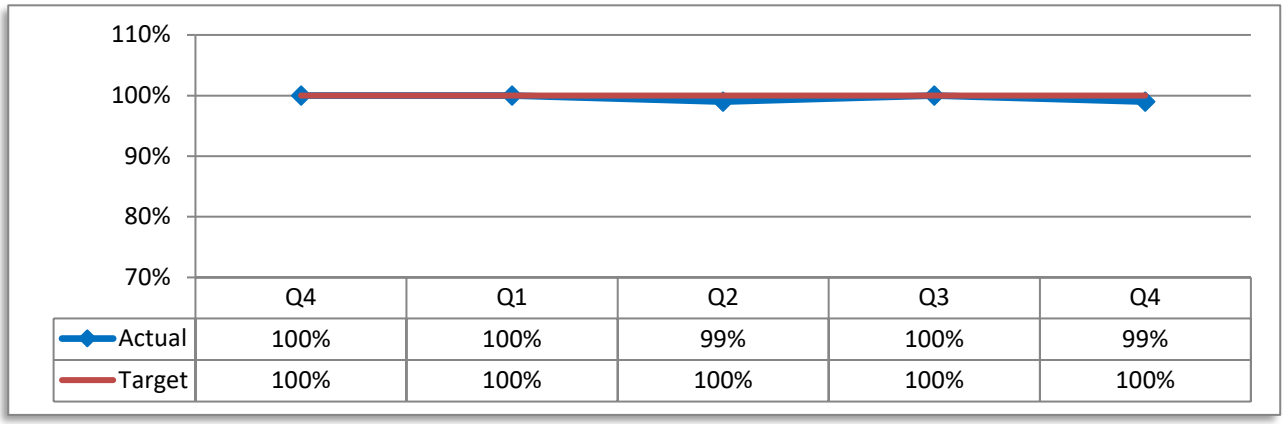
Situational Analysis: On target.

Improvement Action: Monitor and maintain.

7.3 Percentage of Court Report Requests Allocated to a Social Worker within 2 Working Days of Receipt

Rationale: National Outcomes & Standards (2010) places responsibility on Criminal justice service to provide a fast, fair and flexible service ensuring the offenders have an allocated criminal justice worker within 24 hours of the Court imposing the community sentence.

7.3 Percentage of Court report requests allocated to a Social Worker within 2 Working Days of Receipt



Situational Analysis: Performance dipped very slightly below target at 99% in Q4.

Improvement Action: Refocus on ensuring 100% allocation timescales, monitor and maintain.

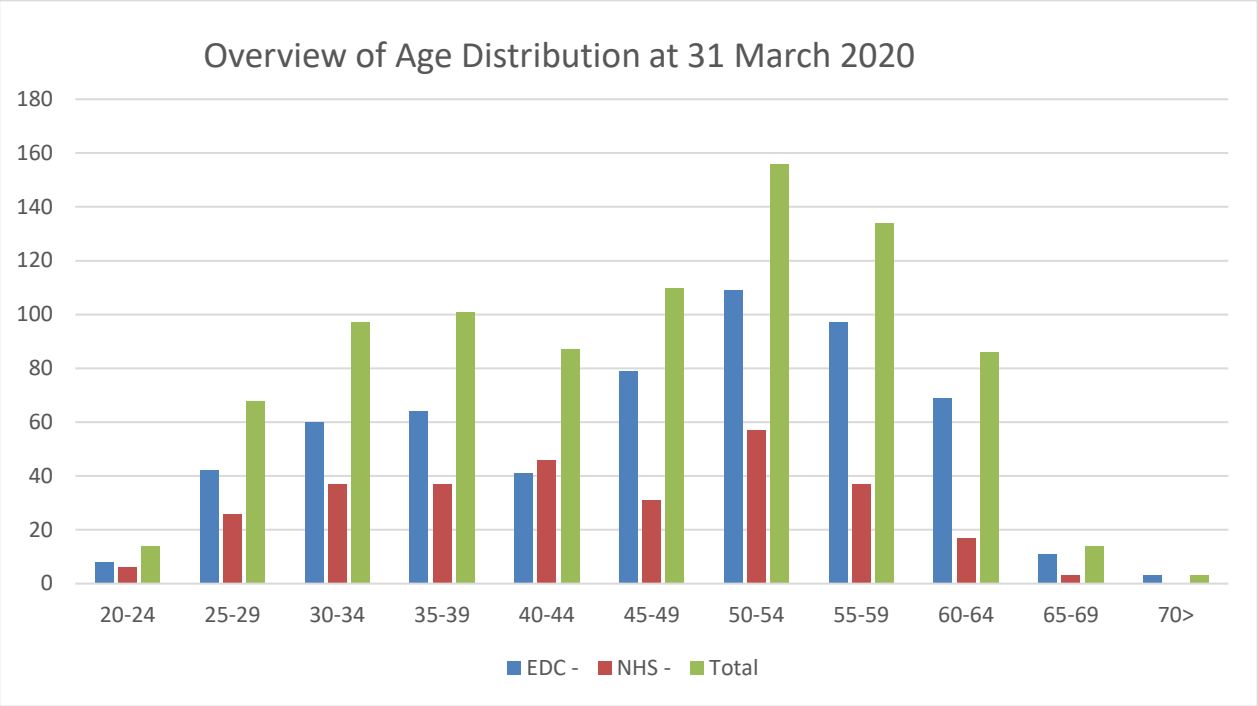
- Workforce Demographics
- Sickness / Absence Health Staff and Social Care Staff
- Knowledge & Skills Framework (KSF) / Personal Development Plan (PDP) / Personal Development Review (PDR)

8.1 Workforce Demographics

Employer	Headcount				WTE			
	June-19	Sept-19	Dec-19	Mar - 20	June - 19	Sept - 19	Dec-19	Mar - 20
NHSGGC	274	283	294	297	227	238	247	250
EDC	579	584	579	583	486	490	485	491
Total	853	867	873	880	713	728	733	741

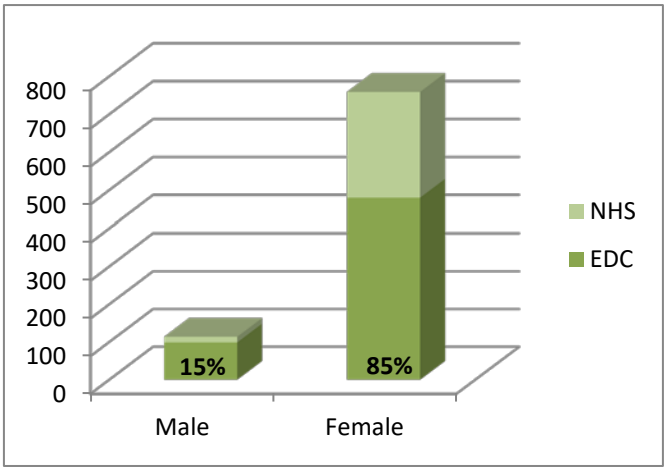
The picture on workforce shows a slight increase overall since December 2019 of 7 with an overall increase of 8.04 wte staffing. This picture shows that the partnership is working hard to accommodate flexible working for staff.

8.2 HSCP Staff by Age profile



The age profile shows that the majority of staff remains aged over 45yrs and that we have a very low number of staff less than 25yrs of age (16). This age range is not unexpected within the services that the HSCP provides, although as identified above, this high percentage of older staff might impact on the number of requests for a more flexible employment option.

8.3 Gender Profile



The gender ratio of female to male employed staff has remained the same for the first 3mths of 2020, with 85% of staff now being female.

Sickness / Absence %		
Month	**EDC**	**NHSGGC**
April 19	8.47	4.96
May 19	7.82	4.38
June 19	7.52	4.28
July 19	8.01	3.3
Aug 19	7.49	2.8
Sept 19	8.53	3.6
Oct 19	8.6	4.71
Nov 19	9.23	5.58
Dec 19	11.31	5.56
Jan 20	9.05	4.64
Feb 20	8.20	4.05
Mar 20	8.24	5
Average	**8.54**	**4.4**

8.4 Sickness / Absence Health and Social Care Staff

Average absence within EDC has reduced in the final quarter of 2019-20. Whilst we have had a number of variations in attendance patterns the overall issues remain one of longer term absence. Overall absence is well managed within the HSCP and as identified the main contributing factor in both Health and Social Care for higher absence is aligned with staff moving from short term to longer term absence due to health conditions. There is a notional absence threshold of 4% across both East Dunbartonshire Council and NHSGGC.

8.5 KSF / PDP / PDR

KSF Activity	Apr 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Actual	**56.6**	**58.4**	**58.4**	**58.6**	**60**	**63.3**	**60.9**	**59.5**	**59**	**54.9**	**50.6**	**44.3**
Target	**80**	**80**	**80**	**80**	**80**	**80**	**80**	**80**	**80**	**80**	**80**	**80**

KSF (Knowledge & Skills Framework) is the NHS staff review process to ensure that staff are competent to undertake the tasks associated with their role and have the appropriate learning and development planned across the year. Whilst we are below the expected target work is progressing to make a positive contribution.

8.6 Performance Development Review (PDR)

PDR		
Quarter	**% recorded**	**Target %**
Q1	30.05	65
Q2	68.27	75
Q3	73.1	80
Q4	82.44	85

PDR (Performance, Development Review) is the Council process for reviewing staff performance and aligning their learning and development to service objectives. We have achieved a recording rate of 82.44% against the target of 85% in this quarter; however it is acknowledged that some scheduled PDRs may not have taken place or uploaded in Q4 due to Covid-19 priorities.

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

Agenda Item Number: 7.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	25 June 2020
Subject Title	Clinical Care Governance Group update
Report By	Val Tierney, Chief Nurse East and West Dunbartonshire Val.Tierney@ggc.scot.nhs.uk Tel:07785762201
Contact Officer	Val Tierney, Chief Nurse East and West Dunbartonshire Val Tierney@ggc.scot.nhs.uk Tel:07785762201

Purpose of Report	To provide the IJB with an update of the work of the clinical and care subgroup

Recommendations	Note for information

Relevance to HSCP Board Strategic Plan	This group support assurance on the clinical land care delivery aspects of the strategic plan

Implications for Health & Social Care Partnership

Human Resources	N/A

Equalities:	N/A

Financial:	N/A

Legal:	N/A

Economic Impact:	N/A

Sustainability:	N/A

Risk Implications:	N/A

Implications for East Dunbartonshire Council:	N/A

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

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

1.0 MAIN REPORT

Summary Report Clinical and Care Governance

- Meetings of Clinical and Care Governance Group were stood down at the beginning of the beginning of HSCP Pandemic response. However robust governance oversight was achieved via alternative routes for a brief period. e.g. Local Response Management Team and Senior Management Team. Regular HSCP Clinical and Care governance meetings were reinstated as of 13.05.20
- The meeting on 13.05.20 provided an opportunity to review governance of our Covid response and related service developments including opening of Covid Assessment Service, Plans for Covid 19 Testing Streams in Care Homes.
- Recognising the unprecedented demand on care homes during the pandemic period the mechanisms to provide additional assurance and support regarding quality of care within care homes were reviewed. An area of good practice is the significant clinical support that has been provided by the HSCP – ANP, District Nurses and GP's and this is reported to have been greatly appreciated by local Care Homes.
- It was noted at the meeting that testing requirements while necessary also introduced key risk relating to staffing complement should large numbers of staff test positive – contingency planning required to be strengthened for this eventuality.
- The HSCP is working effectively in Partnership with Care Home Providers to secure the required enhanced oversight and provide necessary support to assure care quality.
- Robust governance an assurance mechanisms are in place to enable timely identification of issues with clear escalation routes been established to enable prompt response to emerging risks within care homes.
- The HSCP is working to ensure service delivery, albeit sometimes in a different way through the use of technology. There were no significant risks identified from services however

services remain sighted on the impact of the pandemic on services users and emerging risks that threaten person centred safe and effective care.

- It was agreed that SCI /Datix Incidents and Complaints would be added to the SMT agenda to provide enhanced and more frequent oversight of these matters.

2.0 Draft Minutes of the previous Clinical and Care Governance Group on 13th May 2020 are attached for information

Agenda Item 7a.

Minutes of
East Dunbartonshire Health & Social Care Partnership Clinical & Care Governance Sub Group
Wednesday 13th May 2020, 2pm
Microsoft Teams Meeting

Members Present

Name	**Designation**
Val Tierney	Chief Nurse / Interim Chair
Caroline Sinclair	Interim Chief Officer
Derrick Pearce	Head of Community Health & Care Services
David Aitken	Interim Head of Adult Services
Paul Treon	Interim Clinical Director
Claire Carthy	Interim Head of Children's Services & Criminal Justice
Michael McGrady	Consultant in Dental Public Health
Lorraine Currie	Operations Manager, Mental Health
Carolyn Fitzpatrick	Lead for Clinical Pharmacy and Prescribing

In Attendance

Name	**Designation**
Dianne Rice	Clinical & Care Governance Support Officer
Fraser Sloan	Clinical Risk Analyst

Apologies

Name	**Designation**
Karen Lamb	Head of Specialist Children's Services

No.	Topic	Action by
1.	**Welcome and Apologies**	
	Apologies are noted on page 1	
2.	**Minutes of Previous Meeting**	
	With the exception of one amendment, it was noted that the previous minutes were an accurate reflection of the meeting. Amendment: Add Derrick Pearce, Head of Community Health & Care Services to the attendee list.	**DR**
3.	**Rolling Action List**	
	The group reviewed and commented on the rolling action list. Dianne Rice will update the list for the next meeting.	**DR**
4.	**Matters Arising**	
	The members agreed that all matters arising were covered within the agenda.	
5.	**New Service Development – COVID related**	
	Community Assessment Centre There were 2 papers circulated with the agenda in relation to the Community Assessment Centre (CAC). One paper showed the model / reporting structure for the CAC. The other paper was a risk register. Paul Treon spoke to both papers and advised that he was seeking formal approval from the members. Paper 1 - CAC Model Val Tierney asked if this was the same model that has been used for CACs throughout Greater Glasgow & Clyde. Model and Risk register for agreement. Paul Treon confirmed that this is the same model used within Greater Glasgow & Clyde. The members agreed the model. Paper 2 – EDCAC Risk Register The members reviewed the Risk Register. Caroline Sinclair noted that the risk register had been devised when the CAC was established and that some of the risks may now be lowered to reflect current position, rather than initial risk. Paul advised he was happy to downgrade the “IT Failure” risk from High to Medium. Val Tierney highlighted that the Senior Nurse, Adult Nursing is involved in both CAC and now testing response and asked if there was sufficient community nursing staffing resource to support these additional service developments. PT DP advised that at present there is currently no concerns around staffing resource impact on existing services being closely monitored.	

Care Homes

Covid Testing

PT advised that a letter had been received from the Chief Nursing Officer 16.04.19 outlining expectations around testing and the testing of symptomatic residents within Care Homes. Paul noted that there are four testing streams.

- Surveillance testing within Community Assessment Centre
- A-Symptomatic
- Enhanced Symptomatic in Care Home
- Symptomatic where the GP refers thinks it is relative

The monitoring of this will be through Care Home Oversight Group which has an established governance structure. The group feeds into the LRMT and Boardwide Tactical Group.

There have been two Care Home pathways developed. One for care homes to follow for GP medication and enhanced clinical support and one for HSCP Support & Testing.

Paul Treon advised that the role out of the a-symptomatic stream has the potential to identify a cohort of staff that will not be able to work which could cause staffing issues, however, this will be closely monitored by the HSCP, care homes had their own business continuity plans in place and planning underway to develop additional pathways of support via HSCP/NHSGGC.

Confirmation of Death – There has been new guidance circulated and subsequently and online training module was introduced on the 1st May. This means that Nurse can now confirm a death. The guidance has been circulation to District Nursing Teams, Nurses who have got previous experience with verifying death, Nursing Homes and Care Home Nurses.

PPE Hub – MoU

The new MoU expands the role of the Hub. With the expanded role, NSS require to make sure that they are supporting social care, independent and third sector with appropriate supplies should their business as usual route be compromised. It was confirmed that PPE supplies via both NSS Hub and NHS GGC route were currently reliable and sufficient stock was readily available. Ongoing monitoring planning is in place to anticipate future demand requirements.

Derrick Pearce added that although the Hub is in a relatively good position the HSCP will continue to monitor.

Care Home Oversight Group

DP advised that a care home oversight group has been established to enhance oversight of any risks to performance or quality of care within this sector recognizing the particular challenge posed by Covid 19 pandemic.
The governance and reporting structure were attached for review by the group. The clear line for and escalation for any issues identified was noted as were established links to requisite board reporting structures. A multidisciplinary oversight group meets daily to review data gathered from the homes and to consider risks and mitigation of these. Local pathways developed to provide enhanced clinical support for residents were noted to be working well.
The group were informed that although most Care Homes within the area have no difficulty accessing PPE, some have reported delays in obtaining stock in a timely manner via business as usual routes. The HSCP PPE Covid Hub has been able to assist as required in these instances.

6.	**COVID Related Policy / Guidance**	
	National Guidance for Community Health and Care Staff (GGC Community Nursing, CH&F, FNP, SCS) The guidance was circulated with the agenda for information. Val informed that this paper will be discussed at the SEG on Friday 15th May and she will bring the outcome of the discussion to the next meeting. NMC – COVID Stakeholder Pack The paper was attached to the agenda for information. Val informed the group that included within the papers was Information to help when checking NMC registrations. COVID Risk Register The risk register was included within the agenda for information. Val advised that the register was discussed and monitored at other forums, however, welcomed members to provide comment or request anything they think should be escalation / de-escalated. Staff Wellbeing Val advised that Linda Tindall, OD Advisor was leading on a workstream to scope what's required for moving forward. This will include views from staff on lessons learned throughout the pandemic crisis. Once the outcomes have been analysed, the results will be brought to a future Clinical & Care Governance meeting.	**VT**
7.	**Governance Leads Update / Report**	
(a)	Core Audit Reports Val advised that these have currently been suspended. The group agreed to suspend updates until picked up again on a Boardwide basis.	

(b)	Adult Services LD David Aitken advised that one completed suicide had occurred. This incident will be taken through the Mental health Clinical Governance Group. During this period there had also been one drug related death. David informed that during the pandemic situation, it had been expected that there would be an increase in drug deaths, however, this has not occurred. Mental Health Lorraine Currie has asked staff to gather feedback from service users on their consultations via attend anywhere. Lorraine noted that referral numbers have decreased across the teams but it has been noted that service users are becoming more unwell and psychotic leading to crisis point. The team have reduced their face to face consultation significantly, however, still have contact for certain interventions including crisis, depo etc.	

(b)	Adult Services contd. Adult Social Work David advised that the service continues to be provided following assessment and referral process. There has been a slight increase in the Adult Intake and other teams in referrals. David noted that there is a universal strain across service and carers and that the HSCP may have to intervene more often. Mental Health Officer work 2003 Act David advised the group that following an expected increase after lockdown, detentions are now stable and not significantly higher than what would normally be expected. Adult Nursing Pressure Ulcer SCI Learning – It was agreed that this item would be carried to the next meeting. End of Life Survey Results – It was agreed that this item would be carried to the next meeting.	

(c)	Older Peoples Service OPMH The group were informed that although some services had been reduced, there were no risks to report in terms of performance. OPSW There was no relevant update to note. CRT The group were informed that a session would take place at the end of May in relation to the GGC OO Plan and findings from this. It was noted that throughout the crisis situation, all teams had undertaken significant work to expedite discharges. The average current position for the HSCP is: 3-4 delays 1-2 AWI delays	

(d)	Children's Services C&F SW Claire Carthy advised that Child & Adult Services across the HSCP have established a virtual Public Protection Team meeting. This group provides assurance of activity throughout Adult Protection, Child Protection and MAPPA cases are monitored and carried out correctly. Data monitoring reports have also been established and Claire advised that she would be happy to circulate to the members for information. The service have carried out 2 single agency reviews over the past few months. Two cases were reviewed. From the first review recommendation and actions were identified which will be completed and added to the HSCP Training Calendar. The second review was highlighted through the Child Protection Quality Assurance process. Caroline Sinclair, Chief Officer has asked the process be reviewed to highlight gaps and provide recommendations. C&F Health SBAR Universal Pathway The SBAR paper featured at a previous Clinical & Care Governance Group. The paper was a proposal for a reduction in caseload. Following a paper provided by GG&C some anomalies had been highlighted for East Dunbartonshire and East Renfrewshire. Claire advised that this was submitted to the Chief Officer group for discussion and decision prior to the pandemic crisis. This will be picked up when normal service resumes and the outcome will be shared with the members. There was one completed SCI which is still to go through Quality Assurance. Once this is complete, Claire will bring the outcome to a future meeting. Specialist Children's Services There was not relevant report provided for the meeting.	CC/LH CC

(e)	Oral Health Update Michael McGrady informed the members that all dental treatment is being provided by Urgent Dental Care Service and Glasgow Dental Hospital. Patients are triaged by their own General Dental Practitioner and if deemed urgent will be referred. Michael noted that they have seen an increasing number of patients requiring interventions. As per Scottish Government request, OHD are currently looking at their recovery plan for GDS. Antibiotic Prescribing – Michael advised that he is currently liaising with Carolyn Fitzpatrick, Lead Pharmacist on how to get prescriptions to the Chemists quickly and that they are also trying to establish the same process for Care Homes etc. In order to reduce waiting times, OHD are looking to obtain theatre lists at weekends, however, only have access to urgent slots at the moment for children on GA waiting list and unfortunately this has been picked up by the media. Paul Treon highlighted that Barr Street Community Assessment Centre are looking to use some Dentists as clinical leads and asked if the governance around this was appropriate. Michael advised that here was an initial request for staff to volunteer and that his understanding was that because GPs had supported NHS24 that the offer for GDPs to assist was still available.	
(f)	Criminal Justice Update Claire advised that due to the pandemic business changed radically at the beginning which included stopping unpaid work. CJS and the government are currently looking at this issue as this stops individuals finishing their sentence. The minister announced early release from prisons. It is stated that anyone with 3 months or less left on their sentence will be released. We have only one individual in East Dunbartonshire matching this criteria, however, a multi-agency group has been established to monitor and support this function. The service is also continuing to monitor high risk MAPPA meetings which are taking place virtually at the moment to monitor high risk offenders.	
(g)	Primary Care & Community Partnerships Governance Group – 30th January 2020 The minutes of the above meeting were circulated with the agenda for information.	
(h)	Board Clinical Governance Forum Update Val advised that the forum is not operational at the moment and that the HSCP currently do not have a rep on this forum. Val will speak to Derrick Pearce regarding representation at this meeting.	VT/DP
(i)	Service Inspections There were no service inspections to note.	
(j)	Recruitment & Retention of Staff – GP Contract Due to pandemic situation, the implementation of the GP contract is on hold.	

6.	**Risk Management**	
(a)	Care Home Update The members were advised that Large Scale Investigations into care home discussed prior to COVID had been completed, however, the criminal proceedings were still ongoing.	
(b)	Large Scale Investigations Police investigation under LSi is now concluded.	
(c)	Clinical Risk Update The report covering the period January 2020 – March 2020 was circulated previously with the agenda for information. Fraser Sloan highlighted that 3 SCIs were commissioned across East Dunbartonshire HSCP between January and March 2020. Two SCIs were reported by the Community Mental Health Team (CMHT); the first relates to a patient's suicide whilst the other relates to an unexpected patient death. The final SCI commissioned during this time relates to a child protection concern. Fraser informed that Clinical Risk have been advised that this incident is no longer an SCI and a significant case review will be carried out however an updated severity 4/5 screening tool is required to be attached to the incident. During this time 4 SCIs were closed. Within the report it was noted that a total of 19 4/5 incidents did not have screening tools completed. Val asked that each Head of Service present take note of the ID numbers to progress with their respective teams to complete. All members were asked to review all outstanding incidents and actions with a view to complete. It was agreed that all SCI/ Datix and complaints reports would be include in SMT agenda meetings to provide more frequent assurance and scrutiny during pandemic period.	VT VT HoS All VT
(d)	HSCP Incident Report The members agreed that the incident report will now be reviewed at the SMT.	
(e)	OHD Incident Report Although there was no report to note, Michael McGrady advised that there was no concerns at present.	
(f)	SCS Incident Report There was no report to note.	
(g)	SCI Actions	
	As noted in item 6b, all members are asked to review and complete any outstanding SCI actions.	All

(h)	Datix Update - February 2020 The February Datix bulletin was circulated previously with the agenda for information. This edition provided information on recording Falls Incidents, guidance for checking correct information for contacts to allow feedback of incidents and actions and information on the new sub category of "Haemodialysis Circuit Blood Loss" under the "Medical Devices / Equipment" category.	
(i)	Complaints Report	
	Health Complaints During the reporting period the HSCP received a total of 4 complaints. All 4 complaints were treated as a Stage 2 Complaint under the NHS Greater Glasgow & Clyde Complaint Process. At the time of reporting 3 of the complaints had been investigated and closed with a "Not Upheld" outcome. One complaint is still under investigation. All three completed complaints achieved the 20 working day timescale and the outstanding complaint currently under investigation is on target to achieve this timescale. Social Care A Social Care complaints report will be included within the next meeting.	
(j)	Risks or Issues requiring escalation to Strategic Executive Group (SEG)	
	Val invited members to highlight anything they wished to escalate to SEG. There were no items to note.	
8.	**Reducing Harm from Medicines**	
	Public Health Reports / Prescribing Updates There were no public health reports to note. Yellow Card reporting site for healthcare products used in Coronavirus (COVID-19) The Medicines and Healthcare products Regulatory Agency (MHRA) has launched a dedicated Yellow Card reporting site for healthcare products that are used in Coronavirus (COVID-19) treatment to be easily reported:. Healthcare professionals, patients and carers are asked to report all suspected side effects to medicines or medical device adverse incidents related to COVID-19 treatment. This also includes medicines that patients and healthcare professionals are using off-label to treat COVID-19. Reporting for clinical trials should be in line with the trial protocols. This reporting will enable the MHRA to rapidly identify new and emerging side effects and medical device issues which may not have been previously known about, including diagnostic tests for COVID-19. This includes any medicines taken by patients to manage long-term, or pre-existing conditions that may influence the disease or have any potential interactions. The MHRA is closely monitoring any new or emerging safety signals in relation to medicines and medical devices used in patients with COVID-19.	

	Any healthcare product used in the treatment of COVID-19 can be reported, this includes medical devices such as ventilators and respiratory support devices, testing kits, certain protective personal equipment that are classified as medical devices, as well as medicines that are being used in COVID-19 treatment. During the pandemic, Yellow Card reporting for suspected side effects has decreased, especially from healthcare professionals. The Yellow Card scheme continues to operate as usual and safety concerns should still be reported to the MHRA.	
9.	**Clinical Effectiveness / Quality Improvement**	
	The members agreed that this would be carried over to a future meeting.	
10.	**Scottish Patient Safety Programme**	
(a)	Partnership Patient Safety Bulletin There was no report to note as this meeting fell out with the reporting period.	
(b)	SPSO Update – February 2020 The February SPSO update was circulated previously with the agenda for information.	
11.	**Child Protection**	
(a)	Child Protection Register Discussion took place around what should be reported to the Clinical & Care Governance group under Child Protection. It was agreed that Val and Claire Carthy would discuss this outwith this meeting. For the purposes of this meeting Claire advised that they had seen a decrease in the number of referrals they had received which has caused some concern within the team. Claire advised that this would be related to the school closures. It was noted that Schools and Health Visitors provide the majority of referrals. Claire noted that in transition to resuming normal service they are expecting an increase in referrals.	**VT/CC**
(b)	**Child Protection Stats & Update** As per previous action, this will be discussed with Val and Claire to determine reporting at Clinical & Care Governance Group.	
(c)	**Looked After & Accommodated Children**	
	As per previous action, this will be discussed with Val and Claire to establish appropriate and relevant reporting to Clinical & Care Governance Group.	
13.	**Adult Protection**	
	Adult Protection Stats & Updates David Aitken advised that the Public Protection Group are looking at live adult protection referrals. They have noted a slight increase in referrals. It was noted that due to the lockdown situation some concerns may be less evident, however, an increase is expected when normal service resumes.	
14.	**Infection Control Minutes**	
	There was no minutes to note.	

	General Business	
15.	Clinical & Care Governance Annual Report Val reminded members to submit their service updates for the Clinical & Care Governance Annual Report 2019.	**All**
16.	AOCB There was no other competent business to report	
17.	Schedule of meetings 2020 To be reviewed and set for every 8 weeks.	
18.	Date and time of next meeting To be confirmed	

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

Agenda Item Number: 8

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	25 June 2020
Subject Title	Minutes of Staff Partnership Forum -
Report By	Tom Quinn, Head of People & Change Tom.Quinn@ggc.scot.nhs.uk Tel :07801302947
Contact Officer	Tom Quinn, Head of People & Change Tom.Quinn@ggc.scot.nhs.uk Tel :07801302947

Purpose of Report	To provide the re-assurance that Staff Side engagement continues during the period of pandemic within the government guidance for social distancing. In addition the minutes of the last forum meeting before lockdown are also attached. Key topics covered within the minute include: 1) Caroline Sinclair gave a brief overview of the CSWO Annual Report for 2018-19, which was well received 2) Val Tierney gave an update on the Quality Improvement Framework which was again well received and the work undertaken by Alan Cairns was acknowledged 3) Meeting was updated on the work currently on-going to review staff on pay protection, concern was raised by staff side colleagues about time parameters to conclude the work

Recommendations	Note for information

Relevance to HSCP Board Strategic Plan	

Implications for Health & Social Care Partnership

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

Equalities:	N/A

Financial:	N/A

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

Economic Impact:	N/A

Sustainability:	N/A

Risk Implications:	N/A

Implications for East Dunbartonshire Council:	N/A

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

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

1.0 MAIN REPORT

1.1 The Health & Care Partnership has increased its engagement with our staff side partners during the COVID-19 pandemic.

1.2 The staff side Joint Chairs are invited to attend the weekly Local Response Management Team (LMRT)

1.3 We have increased the frequency of the staff forum from 8weekly to 2 weekly by Microsoft Teams to ensure opportunity to engage in transition planning

1.4 Staff side colleagues have also been asked to provide nominations to work on a staff well-being strategy, which will focus on local solutions and process as well as connecting to the national frameworks

2.0 Minutes of the previous staff forum on 13 February 2020 are attached for information

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

Minutes of East Dunbartonshire HSCP Staff Forum Meeting
Thursday 13th February 2020 at 2pm in F33A&B, Kirkintilloch Health & Care Centre

PRESENT

Andrew McCready (AMcC)	Unite Oral Health (Co Chair) Chairing
Lyndsay Ovenstone (LO)	British Dental Association Area Representative
Claire Carthy (CC)	Interim Head of Children & Criminal Justice Services
Caroline Smith (CSm)	HR Business Partner
Lorna Hood (LH)	Children and Families Senior Nurse
Leanne Connell (LC)	Community Nursing Senior Nurse
Derrick Pearce (DP)	Head of Primary Care and Community Services
Allan Robertson (AR)	Unison Steward
Diana McCrone (DMcC)	Unison NHS
David Radford (DR)	Health Improvement Team Manager
Brian McGinty (BMcG)	Unite Convenor EDC
Margaret McCarthy (MMcC)	Unison Divisional Convenor
Margaret Hopkirk (MH)	Human Resources Manager
Tom Quinn (TQ)	Head of Human Resources
Susan Frew (SF)	Clinical Service Manager Dental Health
Marie Low (ML)	RCN Rep
Craig Bell (CB)	Unison EDC Convenor
Janice Campbell	Unison
Sharon Mackie (SMacK)	Unison EDC Rep
Karen Gillespie (KG)	HSCP Administrator – Minute Taker
Sarah Hogg (SH)	Clerical Officer (Shadow Minute Taker)

ITEM	SUBJECT	ACTION
1.	**Welcome & Apologies.** AMcC opened the meeting by welcoming everyone present. Apologies were submitted on behalf of Caroline Sinclair, Lisa Johnston, Jean Campbell, Anne McDaid and Jenny Russell.	
2.	**Minutes of previous meeting.** Minutes of meeting held on Tuesday 3rd December 2019 were agreed as an accurate reflection of discussions.	
3.	**Matters Arising.** **Noticeboards** TQ advised once the refurbishments have been completed the noticeboard will be provided. MMcC enquired if noticeboards will be provided for each floor. TQ advised this would be space dependant.	

	Social Work Supervision Policy SMacK enquired if the policy will now go through EDC Procedures. CSm advised this was not a new policy and only an update.	
4.	**Management Update** TQ advised the staff forum Susan Manion has now been seconded to the GP Out of Hours Services. Temporary management adjustments have been made and will be reviewed in line with Susan Manion's secondment. Caroline Sinclair has been appointed as Interim Chief Officer, David Aitken has been appointed as Interim Head of Adult Services. Line management responsibility for Health Improvement Services sits under Derrick Pearce as Head of Primary Care and Community Services.	
5.	**Finance Update** DP gave a brief update to those present in the absence of Jean Campbell. The finance paper had previously been submitted to the HSCP board in November 2019. DP advised the projected overspend is not related to unregulated overspend, but rather increased service demand over the winter months. The paper also outlines the financial position of the HSCP for the coming 2020/2021 year.	
6.	**Refurbishment of KHCC and Southbank House.** DP provided an update to those present on the current refurbishment of KHCC and Southbank House. DP advised KHCC is currently in phase 5 of 10 with no issues identified. Structural issues had been identified in Southbank House with work going on to rectify these; this may impact on timescales for return. DP advised work is ongoing in two of the three car parks at KHCC, however completion has been delayed due to technique difficulties. Car Parking Group had previously met, this group included Management, Operations Managers and Staff Side Representation. Wording of the Car Parking Guidance Document was tweaked at the meeting and it was agreed that there would be a two strike rule i.e if staff abuse the content of the guidance document their fob would be taken from them. CB advised of his concerns that all EDC employees should be afforded the same treatment and exception would be taken if a member of staff within KHCC was treated differently to a colleague based on a different EDC Site with regard to car parking guidance and consequences. MMcC informed that she could not agree to the car parking guidance being implemented until she has had the opportunity to discuss it fully with her staff side colleagues and they are clear on what they are agreeing to. CB advised the EDC Joint Negotiation Group (JNG) had not had the opportunity to view or comment on the guidance. CSm advised she will arrange for documents to be taken to next JNG meeting.	

	TQ asked if any comments on the guidance document could be submitted to Gillian Notman by the end of February 2020. TQ spoke about the importance of information flowing between the JNG and the Staff Partnership Forum.	
7.	**HR Update** MH gave an overview of the absence report highlighting the activity until December 2019. MH advised that TQ job title had changed to Head of Human Resources and her own would be Human Resources Manager. MH advised NHS Scotland will release six policies on 1st March 2020 with training available locally for managers, staff side representatives are invited to attend the awareness sessions being delivered within the partnership. DMcC enquired if training will be available for staff. MH advised all guidance is included in the policies.	
8.	**EDC HR Policy Update** CSm advised a number of changes to East Dunbartonshire Council policies have been made, CM noted the policies will be available from 1st March 2020. An awareness session has been booked for the 24th February 2020 at KHCC in F33A&B from 9.00am – 12.00noon.	
9.	**Once for Scotland – NHS Policy Update.** TQ Provided a verbal update to those present. Sessions have been booked for 21st February and 24th February in KHCC in F33A&B. Training has also been arranged at Stobhill and the Dental Hospital to ensure staff have every opportunity to attend. TQ advised all policies are available on HR connect. Further sessions throughout NHS GGC are also running in different locations. AMcC noted HR Connect can now be accessed on any device including mobile phones etc.	
10.	**iMatter Update** TQ advised the first stage has been completed ensuring staff and managers are correctly aligned. TQ advised the iMatter survey goes live for Oral Health on the 2nd March 2020, with the rest of the HSCP going live on the 23rd March 2020. The iMatter survey results are due in May 2020. TQ advised the previous iMatter survey had 85 spoiled questionnaires. Staff being given paper copies will also be offered the opportunity to have the survey sent to their mobile phones. CSm noted the most recent surveys results are due to be shared with the management team and staff side prior to being rolled out to all services.	

11.	**Protection Payments** TQ updated those present and advised the grievance in the system is on hold. There are eight staff within the HSCP affected with this change but nothing will happen until the grievance has been resolved. A further update will be brought to the next Staff Partnership Forum.	
12.	**PDS Update** SF advised the clinical leadership structure had been agreed and staff engagement events had been arranged. LO asked if the comments on the PDS paper are available for review. TQ advised the page will include all groups and will be updated regularly. SF advised first meeting of the programme board had taken place, terms of reference and membership had been agreed and work streams discussed. MMcC advised Unison will have a staff side rep attending the meeting.	
13.	**Celebrating the service we deliver** TQ advised the NHS Scotland event is booked for June 2020. The event is open to all staff. The event celebrates good practice across NHS Scotland, all HSCPs, Local Authorities and the Voluntary Sector. TQ encouraged staff to participate.	
14.	**Staff Governance Group** TQ advised work within the group is ongoing and requested nominations from both EDC and NHS to participate.	
15.	**Workforce Planning – Scottish Government Guidance** TQ advised those present nominations are being sought for the coming 2020/2021 year. An email will be sent to staff. TQ noted the paper attached does not take effect until 2021, this is synchronised with the strategic plan for the HSCP as both papers work together. The Workforce planning paper covers all areas and services. The Workforce reference group will be set up and invites to staff for attendance will follow, the group will return a plan in April 2021. TQ encourage staff to join the workforce meeting.	
16.	**APF Update** • Management Update • Finance Position • Refurbishment of KHCC and Southbank House There was some confusion around who receives the feedback from the APF, this should be a two way process. TQ and AMcC will clarify and update at next meeting.	

21.	**A.O.C.B** TQ acknowledged Susan Manions contributions to the HSCP and wished her well with her work at GP Out of Hours Service.	
	Date & Time of Next Meeting 9th April 2020, 2pm in F33A&B KHCC. Staff side from 1pm	

Agenda Item Number: 9.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	25th June 2020
Subject Title	East Dunbartonshire Draft Performance, Audit & Risk Committee Minutes of the 17th March 2020
Report By	Jean Campbell, Chief Finance & Resources Officer Jean.Campbell2@ggc.scot.nhs.uk Tel: 0141 232 8216
Contact Officer	Jean Campbell, Chief Finance & Resources Officer

Purpose of Report	To provide the Board with an update on the business of the Performance, Audit & Risk Committee held on the 17th March 2020.

Recommendations	The Integration Joint Board is asked to: a. Note the contents of the minute Performance, Audit & Risk Committee held on the 17Th March 2020.

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

Implications for Health & Social Care Partnership

Human Resources	None
Equalities:	N/A
Financial:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Risk Implications:	N/A

Implications for East Dunbartonshire Council:	N/A

Implications for NHS Greater Glasgow & Clyde:	N/A

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

Minutes of
East Dunbartonshire HSCP Performance, Audit & Risk Committee Meeting
Date: Tuesday 17th March 2020
Location: S1, Kirkintilloch Health & Care Centre

Present:	**Jacqueline Forbes (Chair)**	**(JF)**	**Ian Ritchie**	**(IR)**
	Susan Murray	**(SM)**	**Jean Campbell**	**(JC)**
	Caroline Sinclair	**(CS)**	**Peter Lindsay**	**(PL)**
	David Aitken	**(DA)**		
	Gillian McConnachie	**(GM)**		
In attendance:	**Kirsty Gilliland (Minutes)**		**(KG)**	
	Siobhan McGinley (Shadow Minutes)		**(SMc)**	

No.	Topic	Action by
1.	**Welcome and Apologies**	
	Chair welcomed everyone and acknowledged apologies from Derrick Pearce, Mags Maguire, Alan Moir and Sheila Mechan.	
2.	**Minutes of previous meeting – 18th December 2019**	
	The minute of the meeting held on 18th December 2019 was approved as accurate, no items raised.	
3.	**Audit Scotland – Annual Audit Plan 2019/20**	
	PL gave an overview of the Annual Audit Plan for 2019/20 and highlighted areas of relevance to the Committee. JF asked what business continuity measures had been put in place in relation to Covid19, given face to face meetings are being discouraged during this time. PL advised that they would be using video conferencing where possible and were in the process of sending an email to all audit bodies to inform them what the process would be. Some discussion took place regarding the risks identified which included the section on financial statements within Exhibit 1, page 4. Following this there were discussions around the Audit Fee, page 8 and concern raised by JC regarding the increase of the standard fees to IJBs which is being raised via CFO network nationally. JC advised that they are currently waiting for feedback from Audit Scotland in relation to the audit fee. JC will feed this back to the Committee. PL explained the materiality aspect of the audit process for the Committee. The Committee noted the report.	

4.	**Internal Audit Progress Update to December 2019**	
	GM provided an update to the Committee of the progress against the agreed 2019/20 audit and risk plan with nine outputs completed in the months of October to December. She made particular reference to points 1.10 – review of HSCP Financial Outturn and Key Controls and 1.13 – HSCP Outturn Variance. JF queried two statements under point 1.11 which referred to: HSCP management being required to provide more than oversight of those budgets delegated to them; and the point noted that over £3.5m of HSCP payments were made in 2018/19 on the basis of information held in Excel spreadsheets and databases, out with the primary system, Carefirst. In response, GM advised that there is always an element of risk with two organisations being involved, however, there are clear guidelines and the HSCP are clear on their roles and responsibilities. In respect of payments outwith carrfirst, JC advised there is now a strategic Carefirst group looking at the development of a new system which can include the full range of payments and expenditure within the one system and the Heads of Service from the HSCP are part of this group. A clearer picture will emerge as this progresses which will include timescales. GM informed the Committee that the HSCP have accepted the risk for the payments made outwith carefirst as these relate in the main to Children's service where payments are more static, and in terms of scale, easier to monitor. However, the introduction of the new system in the near future should now capture all of this information. It is hoped over the coming months that a business case could be put forward to look at other systems using a joint, shared approach with other HSCPs, perhaps Glasgow. The Committee noted the report.	
5.	**Interim Follow Up Report 2019/20**	
	GM provided a summary of outstanding audit issues, focusing on 7 outstanding high risk areas: Business Continuity; Payroll; Carefirst Testing; Home Care Review; Social Work Contract Monitoring and Procurement Practices. Questions were invited from the rest of the Committee, no questions or issues raised. The Committee noted the update.	
6.	**HSCP Transformational Plan 2019/20 Update**	

JC updated the Committee on the delivery of the Annual Business Development Plan for the HSCP for 2019/20.

The plan includes a financial framework for each area there are a number of projects reliant on the review of ongoing care packages where there is expected to be efficiencies delivered.

At present there are 54 priorities.

- Delivered – 17
- On track – 16
- Some risk – 11
- Significant risk – 10

The plan indicates a shortfall of £2.074m

JF enquired if it would be possible to have an additional column for 2021 for the next meeting, JC confirmed that this could be developed.

IR asked if the £2.074m was cumulative resulting in a £5.074m shortfall next year. JC confirmed that this would be the case, although some of this will be mitigated through identifying other options and recovery measures for 2020/21. Also by working with the Council to identify and progress further transformation activity through robust budget challenge will help identify what level of services are discretionary, what areas are being looked at to try to identify what can be stopped as a matter of urgency?

Discussion took place regarding which services were statutory and discretionary as well as options to reduce service delivery. CS discussed the interdependencies and impact of cutting discretionary services as these tend to be preventative in nature.
SM suggested having a development session around this. JF highlighted that it might be helpful to outline these in a paper.

SM asked about priority 43 where it refers to utilisation of set aside budgets as there is no background to this. Is there an opportunity with set aside budget to pay for services within the community?
JC advised that set aside remains a notional allocation at this stage with work continuing to develop a mechanism for quantifying activity to actual expenditure. Based on work to date East Dun is slightly above where we need to be in terms of performance for unscheduled care which would create a cost pressure – other areas may see some financial benefit to this given reduction in activity in this area.

JF queried whether this is in relation to our demographic. JC advised that although there are a high number of older people, other groups such as Mental Health and EDADS also contribute to this activity.
CS concluded that there is a vast amount of spend within older peoples services as they require direct care, however, we are looking to maximize best use of equipment, maximize staff visits etc.

JC confirmed that Homecare is not an area that they plan to make any savings in 2020/21.
We have developed a recovery plan to manage expenditure within the allowed budget, however this would require to be considered by the IJB as part of the budget setting process for 2020/21.

SM asked if savings could be identified when the budget is set out formally to ensure transparency.

The Committee noted the report.

7.	**Audit Scotland Report – Local Government in Scotland: Financial Overview 2018/19**	
	JC gave an overview of the publication of the Audit Scotland report on Local Government in Scotland, highlighting the HSCP position in line with the recommendations and concerns of the IJB. IR highlighted that there was a need to be diligent going forward as there was not much comfort from appendix 2 given that we had failed to agree a budget with our partners in previous years. The Committee noted the update.	
8.	**Community Support Team: Care Inspectorate Report**	
	CS gave an overview of the outcome of the recent inspection of the Community Support Team. From the inspection 2 of the 3 areas were graded as very good (Quality of care and support) and excellent (Quality of management and leadership). It was agreed that this is a very good example of continued improvement. The Committee acknowledged and appreciated the efforts of staff and management paying tribute to their ability to achieve good results. The Committee noted the report.	
9.	**Adult Residential Services Inspection Reports**	
	DA informed the Committee that the Care Inspectorates unannounced inspections in both of East Dunbartonshire Council / HSCP residential services for adults with learning disabilities within John Street (December 2019) and Meiklehill / Pineview (January 2020) had been very positive. The Grade 5 (very good) grades have been maintained across the service since the last inspection in 2018. CS confirmed that it is more difficult than in previous years to achieve a Grade 5 or 6 since they changed the standards. The Committee noted the report.	
10.	**Best Value framework Assessment**	
	JC updated the Committee on the delivery of the action plan developed in response to the Audit Scotland Annual Audit report for 2018/19. The report sets out a number of areas for improvement across the HSCP financial landscape. ED HSCP has adopted a best value framework which has been developed by the Scottish Government. SM queried whether reports were too consolidated which may result in voting members not getting enough information in order to make a voting decision. JF suggested that timing of information coming through should also be considered along with the right level of information in order for members to be assured. The Committee noted the report.	
11.	**Future Agenda Items**	

	Overall budget GP Prescribing 3 year Financial Plan Transformational Plan 2021	
12.	**A.O.C.B.**	
	The Committee agreed that future dates should be set out in advance. Discussion took place regarding when the meetings should be set in relation to the Board meeting and the final year accounts, 2/3 weeks prior to Board meeting?	
13.	**Date of Next Meeting**	
	18 June 2020, 11.30 – 13.30 via MS Teams.	

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

Agenda Item: 10

East Dunbartonshire HSCP Board Agenda Planner
Meetings – March 2020 to January 2021

Updated 12/06/2020

Standing items (every meeting)
Declaration of Interests
Minutes of last meeting (CS)
Chief Officers Report (CS)
HSCP Board Agenda Items – 25 June 2020
As per papers
HSCP Board Development Session – end July 2020 (date to be confirmed)
Our experiences of working through COVID-19
HSCP Board development Session – mid to late August 2020 (date to be confirmed)
Unscheduled care
Prescribing
Primary Care Improvement Plan
HSCP Board Agenda Items – 17 September 2020
Seminar Topic – Autism Strategy (Richard Murphy)
Sexual Health Service Review Implementation Plan (agreed at Board meeting January)
Workforce Update
Performance Reports
Financial Reports
Transition/Recovery Planning
Chief Social Work Officers Annual Report
Clinical and Care Governance Annual Report

HSCP Strategic Plan 2021 – 2023 Development and Consultation Process
HSCP Board development Session – November 2020
Transformation Plan
HSCP Strategic Plan 2021 – 2023 Priorities
HSCP Board Agenda Items – 12 November 2020
Records Management Plan
Performance Reports
Financial Reports
Transition/Recovery Planning
Corporate Risk Register
HSCP Board Agenda Items – 21 January 2021
Performance Reports
Financial Reports
Transition/Recovery Planning
HSCP Strategic Plan 2021 – 2023 Draft
HSCP Board development Session – February 2021
HSCP Strategic Plan 2021 – 2023 Development of Final Version

ED HSCP Board distribution list at Jan 2020

ED HSCP BOARD MEMBERS - VOTING		
Name	**Designation**	
Susan Murray	Chair -EDC Elected member	1
Margaret McGuire	NHS non-executive Board Member	1
Jacqueline Forbes	Vice Chair - NHS non-executive Board Member	1
Sheila Mechan	EDC Elected member	1
Alan Moir	EDC Elected member	1
Ian Ritchie	NHS non-executive Board Member	1
ED HSCP BOARD MEMBERS - NON VOTING		
Caroline Sinclair	Interim Chief Officer	1
Jean Campbell	Chief Finance & Resources Officer	1
Alex Meikle / Gordon Thomson	Voluntary Sector Representative	1
Martin Brickley	Service User Representative	1
Jenny Proctor	Carers Representative	1
Andrew McCready	Trades Union Representative	1
Thomas Robertson	Trades Union Representative	1
Vacant	Clinical Director	1
Adam Bowman	Acute Services Representative	1
Val Tierney	Chief Nurse	1
EDC & HSCP SUPPORT OFFICERS - FOR INFORMATION		
Linda Tindall	Organisational Development Lead	**e-copy only**
Claire Carthy	Interim Head of Children, Families & Criminal Justice	1
Derrick Pearce	Head of Adult and Primary Care Services	1
Gillian McConnachie	Chief Internal Auditor HSCP	**e-copy only**
Karen Donnelly	EDC Chief Solicitor and Monitoring Officer	**e-copy only**
Martin Cunnigham	EDC Corporate Governance Manager	3
Jennifer Haynes	Interim Corporate Services Manager	**e-copy only**
L. Johnston	Interim General Manager – Oral Health Directorate	**Paper copy / e-copy**
Tom Quinn	Head of Human Resources	**e-copy only**
Caroline Smith	Human Resources	**e-copy only**
Elaine Van Hagen	Head of NHS Board Administration	**e-copy only**
For information only (Substitutes)		
Councillor Mohrag Fischer	EDC Elected member	**e-copy only**
Councillor Graeme McGinnigle	EDC Elected member	**e-copy only**
Councillor Rosie O'Neil	EDC Elected member	**e-copy only**
S. McGlennan Briggs	Carers Representative	**1 copy**
Mary Kennedy	Service User Representative	**1 copy**