For meeting on

28 JUNE 2018

Agenda 2018

East Dunbartonshire Health & Social Care Partnership Board

NHS Greater Glasgow and Clyde

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

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, 28th June 2018** at **9.30 am** to consider the undernoted business.

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

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

A G E N D A

Sederunt and apologies

Any other business - Chair decides if urgent

Signature of minute of meeting HSCP Board held on; 10th May 2018

Item	Contact officer	Description	Page
STANDING ITEMS			
1.	Ian Fraser	Expressions of Interest	
2.	Martin Cunningham	Minute of HSCP Board held on 10th May 2018	**To Follow**
3.	Susan Manion	Chief Officers Report	**Verbal**
GOVERNANCE ITEMS			
4.	Jean Campbell	Financial Performance - Budget Outturn 2017/18	**13-22**
5.	Jean Campbell	Financial Plan 2018/19 update	***To Follow***
6a.	Lisa Johnston	Oral Health Performance Report - East Dunbartonshire Health & Social Care Partnership.	**23-50**
6b.	Lisa Johnston	Oral Health Performance Report - Greater Glasgow & Clyde	**51-78**

7.	Fiona McCulloch	Draft Annual Performance Report 2017-18	**79-118**
8.	Fiona McCulloch	Quarter 4 Performance Report 2017-18	**119-154**
9.	Martin Brickley/Jenny Proctor	Public, Service User & Carer Representative Support Group	**155-164**
10.	Lisa Williams	East Dunbartonshire HSCP Clinical & Care Governance Sub Group minutes of 28th March 2018	**165-170**
11.	Tom Quinn	East Dunbartonshire HSCP Staff Partnership Forum minutes of 21st May 2018 (draft)	**171-178**
STRATEGIC ITEMS			
12.	Derrick Pearce	East Dunbartonshire Primary Care Improvement Plan	***To Follow***
13.	Caroline Sinclair	Transformational Change Programme - Sexual Health Services	**179-206**
14.	Susan Manion	What is Integration? Audit Scotland Report April 2018	**207-222**
ITEMS FOR INFORMATION / NOTING			
15.	Caroline Sinclair	Equal, Expert and Valued, Enhancing Carer Representative involvement on Integration Joint Boards, Second Edition, February 2018	**223-238**
16.	Caroline Sinclair	NHS Health Scotland new resource - The Role of Health and Social Care Partnerships in Reducing Health Inequalities	**239-264**
FUTURE HSCP BOARD AGENDA ITEMS			
17.	Susan Manion	HSCP Schedule of Topics/Business Plan	**265-266**
		Date (s) of next meeting Thursday 6th September at 9am for a development session. Board meeting start time 09.30am Tom Johnston Chambers, Southbank Marina Future dates; 15th November 2018	

Agenda Item Number: 4

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	15th March 2018
Subject Title	Financial Performance – Budget Out turn 2017/18
Report By	Jean Campbell, Chief Finance & Resources Officer Tel: 0300 1234510 Ext 3221
Contact Officer	Jean Campbell, Chief Finance & Resources Officer Tel: 0300 1234510 Ext 3221

Purpose of Report	To update the Board on the financial performance of the partnership as at period 10 of 2017/18.

Recommendations	The Integration Joint Board is asked to: a. Note the final Out turn position is reporting an overspend of £1.1m for the period 1st April 2017 to 31st March 2018. b. Note the updated reserves position for the partnership as detailed in 1.27. c. Note the risks associated with the delivery of a balanced budget as detailed in 2.0.

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

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

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

Legal:	None.

Economic Impact:	None

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

Risk Implications:	There are a number of financial risks moving into futures years giving the rising demand in the context of reducing budgets which will require effective financial planning as we move forward and in particular the cessation of the risk sharing arrangement for GP prescribing.

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

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

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

MAIN REPORT

1.1 The underlying financial position for the partnership for the year 1st April 2017 to 31st March 2018 was that of an over spend of £1.1m. This is an improvement on the projection of £800k from that previously reported at period 10, which projected a £1.9m over spend on budget.

1.2 The position as at the 31st March 2018 is outlined in the table below:-

Partnership Expenditure	Annual Budget £000	YTD Budget £000	YTD Actual £000	Projected Out-turn Variance £000
NHS Community Budgets	22,049	22,049	21,631	418
ED Social Care Fund (£250m +£100m)	6,000	6,000	6,000	0
Oral Health	10,094	10,094	9,632	462
FHS & Prescribing	44,197	44,197	44,197	0
Adult Social Care	39,383	39,383	40,731	(1,348)
Children & CJ Services	11,297	11,297	11,971	(674)
Care of Gardens	84	84	90	(6)
Adaptations (PSHG)	450	450	271	179
Care and Repair	244	244	244	0
Fleet	452	452	593	(141)
SUB-TOTAL	**134,250**	**134,250**	**135,360**	**(1,110)**
Acute Set Aside	17,381	17,381	17,381	0
TOTAL	**151,631**	**151,631**	**152,741**	**(1,110)**
Application of Reserves				2,056
Final Outturn 2017/18				**946**
To General Reserve				(252)
To Earmarked reserve				(694)

HSCP Budget Outturn

1.3 The final position for the year to 31st March 2018, following the application of reserves to manage the in year pressures, provides an overall surplus on budget of £946k with £694k being taken to earmarked reserves and £252k to supplement the general reserve position.

1.4 The pressures for the partnership, throughout the year, relate to Children's Social Work services (£674k negative), primarily in relation to residential and fostering placements for Children. This is due to a combination of additional demands and restrictions on places within our in-house residential provision being held during the year in the expectation that a number of Asylum Seeking children will be placed within East Dunbartonshire. This required the purchase of additional external placements to support children requiring residential care. This has been offset to some extent through vacancy management within Children's SW Services. This represented an improvement on that previously reported of £300k due, largely, to the cost of care placements being less than expected.

1.5 In addition overspends were experienced on Adult Social work budgets (£1.348m negative) as a result of demand pressures from children transitioning into adult learning disability and mental health services and challenging savings targets for these areas as part of the budget process for 2017/18. There was also some pressure in relation to care at home services for older people as the demands from this care group continue to rise. This represented an improvement on that previously reported of £400k due to the level of uplifts on spend to reflect the increases to the living wage being not as high as expected and in estimating the backlog in processing care packages payments, assumptions were made on the worst case scenario where the outcome of the financial assessment provided a better position than predicted for care placements.

1.6 The demand pressures in relation to Social Work Services required the application of general reserves of £2.056m to achieve a balanced budget for the year and this is the position reflected within the Annual Accounts for 2017/18.

1.7 There were some variances on the other budgets allocated from East Dunbartonshire Council (£32k positive) in relation to pressures for care of garden services and recharges for the use of fleet vehicles to support service delivery offset by an under spend in private sector housing grants. This positive variation on budget will supplement the general reserves position for the partnership.

1.8 There continued to be a small under spend position in relation to NHS Community budgets (£220k positive) as a result of residual capacity within delayed discharge funding, additional savings identified to mitigate pressure on prescribing which look unlikely to be required in year. There were some pressures on payroll budgets in relation to challenging turnover savings applied at the time of setting the budgets in the areas of alcohol and drug services, adult community services including district nursing and elderly mental health service which will require to be monitored into future years in terms of achievability.

1.9 In addition there were monies allocated late in the year to support GP Clusters (£198k positive) as part of the Primary Care Transformation Fund which will be earmarked within reserves with planned expenditure during 2018/19.

1.10 The positive variation in relation to the Oral Health Directorate (£462k) will be taken to earmarked reserves to be allocated in future years to a planned equipment replacement programme with primary care oral health services. This surplus arose as a result of staff turnover and vacancies across the service and repre4sents a slightly improved position on that previously reported of £62k.

1.11 **Appendix 1** provides a detailed breakdown of the partnership Social Work budget performance for the year to the 31st March 2018.

1.12 **Appendix 2** provides a detailed breakdown of the partnership NHS budget performance for the year to the 31st March 2018.

1.13 The Draft Annual Accounts for 2017/18 have been considered by the Audit Committee on the 27th June 2018 with the Final Accounts to be presented to the Audit Committee on the 21st September 2018 and thereafter to the IJB.

1.14 Partnership Reserves

Public Bodies (Joint Working) Scotland Act 2014 (section 13) empowers the Integrated Joint Board to hold reserves and recommends the development of a reserves policy and reserves strategy.

1.15 A Reserves policy was approved by the ED HSCP Audit Committee on the 20th June 2016. This provides for a minimum of 2% of net expenditure (£150.631m) to be held in reserves which equates to approximately £3.033m for the partnership. The level of general reserves expected to be carried forward to 2018/19 will be nil depending on agreement to use the balance of general reserves to balance the budget for 2018/19. In addition a level of reserves was earmarked for specific Scottish Government initiatives and to support transformation activity and service redesign in line with the strategic priorities set out in the Strategic Plan totalling £3.1m, of which a further £1.1m is expected to be used to balance the budget for 2018/19.

1.16 The position, as at the 31st March 2018, with regard to partnership reserves is set out below:-

2016/17 Balance at 31 March 2017		Transfers Out 2017/18	Transfers In 2017/18	**2017/18** Balance at 31 March 2018
£000		£000	£000	£000
(106)	Scottish Govt. Funding - SDS	4		(102)
(36)	Mental Health project			(36)
(29)	Delayed Discharge	29		-
0	Communications Post			0
(1,704)	Service Redesign / Transformation	72	(34)	(1,666)
(11)	Keys to Life Funding	5		(6)
(19)	Autism Funding	19		-
(5)	Police Scotland – CPC Funding	5		-
(523)	Integrated Care / Delayed Discharge Funding			(523)
-	Primary Care Cluster funding		(198)	(198)
(138)	Oral Health Funding		(462)	(600)
(2,571)	**Total Earmarked**	**134**	**(694)**	**(3,131)**
(2,660)	Contingency – General Reserve	1,922	(252)	(991)
(5,231)	**General Fund**	**2,056**	**(946)**	**(4,121)**

The 2016/17 expenditure has been re-stated to reflect a late adjustment of £48k to Adult services expenditure in relation to payroll costs associated with job evaluation.

2.0 Financial Risks

The most significant risks that will require to be managed during 2018/19 are:

- Prescribing Expenditure - Prescribing cost volatility represents the most significant risk within the NHS element of the partnership's budget. For 2017/18 this is mitigated through the risk sharing arrangement in place across GG&C, however this will terminate from the 1st April 2018. The pressure in relation to the short supply of certain drugs has presented a significant risk to this budget.
- Achievement of Savings Targets – there are challenging savings targets to deliver efficiency and transformational change to achieve a balanced budget position for 2018/19. There are significant dependencies and complexities to be considered in order to effectively deliver on these.
- Demographic Pressures - Increasing numbers of older people is placing additional demand on a range of services including Home Care. In addition, achieving the required reductions in delayed discharges and hospital bed usage is creating increased demand on older people services and resulting in increased levels of self-directed support payments. These factors increase the risk that overspends will arise and that the partnership Board will not achieve a balanced year end position.
- Children's Services - managing risk and vulnerability within Children's Services is placing significant demand pressures on residential placements which will increase the risk of overspend which will impact on achieving a balanced year end position.
- Financial Systems – the ability to effectively monitor and manage the budgets for the partnership are based on information contained within the financial systems of both partner agencies. This information needs to be robust and current as reliance is placed on these systems for reporting budget performance to the Board and decisions on allocation of resources throughout the financial year..
- The implementation of the Carers Act from the 1st April 2018 could result in significant increase in demand from carers for services to enable them to continue in their caring role.
- The extension of the entitlement to free personal care for those aged under 65 will present significant additional demands, potentially from a population who are previously not known to Social Work services.
- Independent / Private Providers – the sustainability of independent and private providers to effectively support the provision of a range of social care services presents risks to the delivery of services for the partnership. There are a range of contracts that are due for renewal over the short term where there is an expectation of increases in the rates paid for services to align with neighbouring local authority areas.

APPENDIX 1

GENERAL FUND REVENUE MONITORING 2017/18

SUMMARY FINANCIAL POSITION

As at : 31 March 2018 Accounting Period 12	BUDGET Annual Budget	BUDGET Budget Period 12	ACTUAL Expenditure Period 12	ACTUAL Projected Annual	VARIANCE At Period 12	VARIANCE Projected Period 12
	£000	£000	£000	£000	£000	£000
Integrated Health & Social Care Partnership						
Adult Social Care	39,383	39,383	40,731	40,731	1,348	1,348
Children's Health, Children's Social Work & Criminal Justice	11,297	11,297	11,971	11,971	674	674
HSCP Overspend Position for Discussions at HSCP Board					(2,022)	(2,022)
Total	**50,680**	**50,680**	**52,702**	**52,702**	**0**	**0**

GENERAL FUND REVENUE MONITORING 2017/18	Annual	Budget	Expenditure	Projected	Variation	Projected Year
DETAILED FINANCIAL POSITION as at Period 12: 31 March 2018	Budget	Period 12	Period 12	Annual	Period 12	End Variation
	£000	£000	£000	£000	£000	£000
INTEGRATED HEALTH AND SOCIAL CARE						
ADULT SOCIAL CARE						
1 **Employee Costs**	14,365	14,365	14,709	14,709	344	344
Detailed analysis of payroll costs have been continually reviewed throughout the financial year. This involved comparison of actual posts to budgeted and liaison with service managers in order to ascertain when vacancies would be filled. There is an overspend as a result of bringing the Pineview service in house which is being offset with reserves in the current year, a number of posts in older people services supported through NHS income. Overtime within homecare was monitored as an area of recurring pressure, however the filling of vacancies in this area has alleviated pressure in year.						
2 **Property Costs**	108	108	212	212	104	104
Unbudgeted rates charges in respect of Pineview and Milan have been partly offset by those for Sheltered Housing. There was also unbudgeted security and furniture costs for the KHCC which resulted in a further variance against Property costs.						
3 **Supplies and Services**	944	944	810	810	-134	-134
Spend on equipment and adaptations is tightly controlled within budget limits with critical and substantial criteria continuing to be applied in this area. This was monitored through the Equipu contract. The final figures show an underspend in this area. This is also the first year of recording stock of employee protective clothing expenditure so a reduction has resulted.						
4 **Agencies and Other Bodies**	42,009	42,009	43,420	43,420	1,411	1,411
The final outturn has seen increased commitment against Daycare, Homecare, Supported Accommodation and Supported Living. There was pressure in learning disability services as a consequence of challenging savings targets and the impact of children transitioning into Adult Services from Childcare. This, however, has partly been offset by a lower than anticipated cost of Residential Care homes. This also includes costs associated with previous financial years. This is volatile area for the partnership as any changes in caseload or packages can have a significant impact on commitments.						
5 **Budget Savings**	-502	-502	0	0	502	502
The gap in the savings programme to be addressed through total resourcing and other transformational savings was taken as a one off in year recharge with plans for recurring delivery to be identified going forward into future years.						
6 **Transport and Plant**	416	416	439	439	23	23
Additional transport costs have resulted in a final variance of £0.023m						
7 **Admin and Other Costs**	134	134	102	102	-32	-32
Additional expenditure for the recovery café can now be reported, however administrative expenditure was monitored and in year savings were identified in stationery, independent living fund, conferences and courses and other admin.						
8 **Health Board Resource Transfer Income**	-10,795	-10,795	-10,795	-10,795	0	0
Health Board Resource Transfer Income						
9 **Other Income**	-7,296	-7,296	-8,166	-8,166	-870	-870
Social Care Funding is included within the final figures. There was an under recovery in service user and other local authority recharges for homecare, Kelvinbank and older peoples services. This, however is partly offset by additional income receipts for telecare. The figures include income relating to the implmentation of the carers Act which has been carried forward with planned expenditure in 2018/19 to support this delivery.						
Total - Adult Social Care	39,383	39,383	40,731	40,731	1,348	1,348
CHILDREN'S SOCIAL WORK & CRIMINAL JUSTICE						
1 **Employee Costs**	5,587	5,587	5,391	5,391	-196	-196

GENERAL FUND REVENUE MONITORING 2017/18 DETAILED FINANCIAL POSITION as at Period 12: 31 March 2018	Annual Budget £000	Budget Period 12 £000	Expenditure Period 12 £000	Projected Annual £000	Variation Period 12 £000	Projected Year End Variation £000
There was a significant number of vacancies during 2017/18. Detailed analysis of costs involved both a comparison of actual posts to budgeted and liaison with service managers to ascertain when timescales for vacancies being filled. Savings realised through vacancies have partly offset overspends within agencies and other bodies.						
2 Property Costs	**92**	**92**	**60**	**60**	**-32**	**-32**
A reduction in assumed rates charges for Ferndale, furniture and other property costs have materialised this financial year.						
3 Supplies and Services	**116**	**116**	**158**	**158**	**42**	**42**
A review of costs identified in year savings in other supplies & services and furniture and fittings.						
4 Agencies and Other Bodies	**6,222**	**6,222**	**7,233**	**7,233**	**1,011**	**1,011**
There has been pressure on Voluntary Organisations payments, Homecare and Kinship, Adoption and Foster Carers' Allowances. A review of projections previously also identified pressures within flexible support and supported living.						
0	**0**	**0**	**0**	**0**	**0**	**0**
Additional costs (fully funded) were anticipated within Criminal Justice. This was for Women's Services, however, the start for this has slipped to 18/19						
This budget included £0.137m funding for the delivery of a new service which would provide additional flats for young people. This project will no longer go ahead.						
5 Transport and Plant	**84**	**84**	**103**	**103**	**19**	**19**
To date there has been pressure on transport costs for children. This has resulted in an overspend within 17/18.						
6 Admin and Other Costs	**135**	**135**	**100**	**100**	**-35**	**-35**
Previously reported higher than anticipated spend in relation to pathways payments (leaving care) and membership fees and subscriptions did not materialise. Savings in legal fees and hospitality were achieved.						
7 Income	**-939**	**-939**	**-1,074**	**-1,074**	**-135**	**-135**
Increased income in respect of Scottish Government grant funding for Criminal Justice (though not for the women's services element) and also recharges to Strathclyde University for an external secondment over recovered within 17/18.						
Total - Children's Social Work & Criminal Justice	**11,297**	**11,297**	**11,971**	**11,971**	**674**	**674**
Total Integrated Health and Social Care Variances	**-50,680**	**-50,680**	**-52,702**	**-52,702**	**-2,022**	**-2,022**

NHSGG&C - East Dunbartonshire HSCP - Financial Year Ending 31st March 2018

APPENDIX 2

Care Group	Annual Budget £'000	IJB Final Actual Expenditure	Revised IJB Variance £'000
Alcohol + Drugs - Community	690.1	717.7	(27.6)
Adult Community Services	4,318.8	4,347.6	(28.8)
Integrated Care Fund	684.2	560.2	124.0
Child Services - Community	1,439.6	1,410.1	29.5
Fhs - Prescribing	19,472.7	19,473.0	(0.3)
Fhs - Gms	13,040.5	13,040.5	0.0
Fhs - Other	12,968.7	12,968.6	0.1
Learn Dis - Community	611.8	496.5	115.3
Men Health - Adult Community	1,366.7	1,380.1	(13.4)
Men Health - Elderly Services	986.2	1,018.4	(32.2)
Oral Health	10,882.1	10,420.0	462.1
Other Services	2,807.2	2,548.0	259.2
Planning & Health Improvement	733.6	752.5	(18.9)
Resource Transfer - Local Auth	15,384.4	15,373.8	10.6
Expenditure	85,386.6	84,507.0	879.6
Adult Community Services	(0.2)	(0.2)	0.0
Fhs - Other	(1,285.4)	(1,285.4)	0.0
Men Health - Adult Community	(229.4)	(229.4)	0.0
Men Health - Elderly Services	(137.7)	(137.7)	0.0
Oral Health	(787.7)	(787.7)	0.0
Other Services	(219.0)	(219.0)	0.0
Planning & Health Improvement	(42.5)	(42.5)	0.0
Resource Transfer - Local Auth	(345.6)	(345.6)	0.0
Income	(3,047.5)	(3,047.5)	0.0
East Dunbartonshire Hscp	**82,339.1**	**81,459.5**	**879.6**

Agenda Item Number: 6a

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	28th June 2018
Subject Title	Oral Health Performance Report – East Dunbartonshire HSCP
Report By	Frances McLinden – General Manager Oral Health
Contact Officer	Frances McLinden – General Manager Oral Health

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

Recommendations	To note the content.

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

Implications for Health & Social Care Partnership

Human Resources	None.

Equalities:	None.

Financial:	None.

Legal:	None.

Economic Impact:	None.

Sustainability:	None.

Risk Implications:	None.

Implications for East Dunbartonshire Council:	None.

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

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

1.0	**MAIN REPORT**
1.1	This report provides an overview of the oral health services provided throughout East Dunbartonshire HSCP.
1.2	This report provides performance data in relation to oral health programmes and monitoring of oral health activities in East Dunbartonshire.

NHS GG&C
Oral Health Directorate
Performance Report
(June 2018)

East Dunbartonshire HSCP

Foreword

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

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

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

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

The Scottish Government has set challenging targets for child dental health: by 2022, there needs to be a 10% increase in Primary 1 and Primary 7 children who have “no obvious decay” as reported through the NDIP programme for each Health Board area. East Dunbartonshire HSCP will contribute to meeting these targets and we have provided trajectories of where we expect NDIP outcomes to be leading up to 2022.

The launch this year of the Oral Health Improvement Plan for Scotland has provided a road map to how dental services will evolve in Scotland. There will be a greater focus on prevention and shared working to meet the needs of an ageing population, with complex dental needs. To meet these challenges, oral health targets will require continued partnership working and community development with our colleagues in East Dunbartonshire HSCP and elsewhere.

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

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

Table of Contents

GENERAL DENTAL SERVICES

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

Registration with NHS Dental Services

Data available from Information Services Division (ISD) (September 2017) shows the proportion of patients registered in East Dunbartonshire are:

- 90.3% Children (compared to 93.8% Scotland; 95.8% GG&C)
- 93.6% Adults (compared to 92.2% Scotland: 96.1% GG&C)

The registration data for children in East Dunbartonshire are lower than the data for GG&C and for Scotland. The proportion for registered adult patients in East Dunbartonshire is also lower than the average for GG&C, but slightly higher than for Scotland. Encouragingly, the proportion of children and adults registered with an NHS dentist in East Dunbartonshire has increased in the last year. The previous data for child and adult registrations were 89.3% and 91.8% respectively.

A number of patients (particularly adults) may be registered with non-NHS dentists, or may travel outside of East Dunbartonshire for dental treatment. As these statistics are not collected for non-NHS dental practices, it is not possible to determine numbers of patients seeking treatment outside of the NHS. This explanation will not hold as robustly for children, as dentists may hold list numbers with NHS GG&C to provide NHS dental registration and treatment for children, whilst providing non-NHS treatment for parents.

More detailed data on dental registrations from ISD[1] highlights a continuing issue relating to the registration of very young children (aged 0-2 years). In East Dunbartonshire the proportion of children aged 0-2 years who are registered with a dentist is 50.0%. This compares to 47.6% for Scotland and 52.2% for NHS GG&C. For children aged 0 to 11 months, the proportion of children registered is extremely low, with fewer than 15% registered with an NHS dentist in East Dunbartonshire. A pilot scheme engaging with the Registrar and Health Visiting Teams is underway in East Dunbartonshire to target very young children who are not yet registered with an NHS Dentist.

[1] **Dental Statistics - NHS Registration and Participation Statistics as at 30 September 2017**
http://www.isdscotland.org/Health-Topics/Dental-Care/Publications/data-tables2017.asp?id=1843#1843

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

It is probable the proportion of patients with routine or regular dental attendance is lower than the proportion of patients registered with an NHS dentist.

GDS Administration

The Oral Health Directorate performs an administrative function in relation to clinical and financial governance in all NHS practices within East Dunbartonshire. This is to ensure that General Dental Services are delivered to an expected professional standard and includes carrying out Combined Practice Inspections and Sedation Practice Inspections on a minimum three year basis in line with General Dental Service Regulations.

We also work with Practitioner Services Division and National Services Scotland in relation to financial oversight/activity and regulatory functions in relation to Primary Care Dental Services.

Emergency and Out of Hours Attendances

The Oral Health Directorate provides emergency daytime and Out of Hours (OOH) cover for the population of GG&C. The Emergency Dental Treatment Centre (EDTC) service is located on Floor 1 of Glasgow Dental Hospital and is operated by the Public Dental Service. OOHs appointments are provided via NHS 24. The daytime service provides emergency cover for unregistered patients and patients from outwith the area who are unable to attend their own dentist. The evening and weekend Out of Hours service provides emergency cover for patients registered in GG&C on behalf of GDPs as well as unregistered patients.

The following table details the number of patients residing in East Dunbartonshire who attended these services during the year 2016/17.

Age Group	Daytime Service (pop^n rate/1000)		Out of Hours (pop^n rate/1000)	
0 to 4	2	0.37	6	1.1
5 to 9	1	0.16	21	3.46
10 to 15	2	0.27	22	3.02
16 to 29	65	3.96	146	8.89
30 to 44	52	3.07	146	8.61
45 to 64	46	1.50	106	3.45
65+	21	0.85	44	1.78
Total	**189**		**491**	

Table of East Dunbartonshire Residents Attending the Emergency Dental Treatment Centre during 2016/17

The data from the table suggests the age range of patients in relation to population size who most frequently attend the EDTC is 16 to 45. This age range is predominantly the working population and those in higher education. These age groups are also the least likely to maintain regular participation with their own dentist. It is possible a number of the attendances at the Out of Hours service are registered patients who for a variety of reasons are unable to arrange appointments at their own dentist during the daytime, examples of these could be work commitments, distance from place of work to dentist.

It is clear from the data available there are opportunities to explore how more people in this age range can be encouraged to attend their own dentist for routine care regularly and review educational campaigns and opportunities to encourage resolution of care with their own GDP. We will work with local General Dental Practitioner's and the Health Improvement teams in East Dunbartonshire to seek ways to widely advertise dental services and seek greater participation in routine care.

East Dunbartonshire Health & Social Care Partnership

NHS Greater Glasgow and Clyde 70 YEARS #nhsscot70

Details for NHS Dental Practices at 31st May 2018

Practice_Name	Address1	Address2	Postcode	Date of Combined PI	Date of Sedation PI	Orthodontic Practice	Sedation Practice	Childsmile activity (Y/N)	Age 0-2	Age 3-5	Age 6-12	Age 13-17	Age 18-64	Age 65+	Grand Total
Kessington Dental Practice	53 Milngavie Road		G61 2DW	03/10/17				Y	71	362	3,483	187	497	1,053	**5,653**
Boclair Dental Care	91 Milngavie Road	Bearsden	G61 2EN	08/02/18				Y	96	144	1,933	148	336	656	**3,313**
Dental FX	84 Drymen Road	Bearsden	G61 2RH	14/12/16				Y	17	99	1,036	41	141	222	**1,556**
Park Cottage Dental Practice	8a Roman Road	Bearsden	G61 2SW	29/07/17				Y	78	276	1,698	130	369	388	**2,939**
Chartwell Dental Care	148-150 Drymen Road	Bearsden	G61 3RE	11/07/17				Y	31	276	944	77	269	50	**1,647**
Bearsden Dental Care	8 - 12 Ledi Drive	Bearsden	G61 4JJ	15/09/17	14/09/17		Y	Y	154	501	4,427	290	723	1,746	**7,841**
Milngavie Orthodontics	Suite 1, 13 Main Street	Milngavie	G62 6BJ	10/02/16		Y		N	-	-	-	-	-	-	-
Milngavie Dental Care	Suite 6, Douglas House	42 Main Street, Milngavie	G62 6BU	08/09/17				N	9	66	295	15	73	178	**636**
Allander Dental Care	7 Stewart Street	Milngavie	G62 6BW	16/12/14				Y	86	532	6,353	245	628	2,673	**10,517**
Jennings Dental Care	4 Station Road	Milngavie	G62 8AB	10/12/14				N	62	267	2,777	133	356	1,417	**5,012**
Woodhill Dental Care	176 Woodhill Road	Bishopbriggs	G64 1DH	21/08/17				Y	58	280	1,415	105	318	222	**2,398**
One Eighty Dental	180 Woodhill Road	Bishopbriggs	G64 1DH	18/08/15				Y	49	190	2,121	93	327	438	**3,218**
Bishopbriggs Dental Care	17 Arnold Avenue	Bishopbriggs	G64 1PE	07/05/15				Y	77	281	3,220	171	427	1,115	**5,291**
Dental Care By Claire Tierney Bds Mfds	Unit 1	122 Kirkintilloch Road	G64 2AB	01/08/17				Y	42	166	1,400	86	224	346	**2,264**
Dental Professionals Bishopbriggs	171 Kirkintilloch Road	Bishopbriggs	G64 2LS	01/11/17				Y	71	289	3,863	121	348	1,228	**5,920**
F J Murphy	4 Morar Crescent	Bishopbriggs	G64 3DQ	16/08/17				Y	39	153	1,612	83	208	668	**2,763**

Torrance Dental Practice	22-24a Main Street	Torrance	G64 4EL	13/09/17				Y	26	124	1,154	53	144	333	**1,834**
Kirkintilloch Orthodontic Clinic	22 West High Street	Kirkintilloch	G66 1AA	23/10/17		Y		N	-	-	-	-	-	-	**-**
Cowgate Dental Surgery	11 Cowgate	Kirkintilloch	G66 1HW	13/03/18				Y	71	201	2,926	130	372	828	**4,528**
Oak Tree Dental Kirkintilloch	14-16 Townhead	Kirkintilloch	G66 1NL	04/02/16				Y	87	228	2,825	170	388	678	**4,376**
Hazel Hiram Dental Care	26 Townhead		G66 1NL	09/05/17				Y	43	118	1,483	66	164	530	**2,404**
MacKenzie Dental	69 Townhead	Kirkintilloch	G66 1NN	20/09/17	12/03/18		Y	Y	58	321	3,661	99	400	1,178	**5,717**
Marina Dental Care	Southbank Marina, 8 Strathkelvin Place	Kirkintilloch	G66 1XQ	27/10/15				Y	132	461	5,499	329	729	1,916	**9,066**
Richard Skillen Dental Care	95 Hillhead Road	Kirkintilloch	G66 2JD	07/11/17				Y	17	145	959	38	130	403	**1,692**
Millersneuk Dental Practice	112 Kirkintilloch Road	Lenzie	G66 4LQ	18/07/17	13/11/15		Y	Y	120	310	1,380	194	473	213	**2,690**
Campsie Dental Practice	127 Main Street	Lennoxtown	G66 7DB	31/08/16				Y	46	168	2,030	107	268	590	**3,209**

PUBLIC DENTAL SERVICE

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

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

Location and services delivered by the PDS

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

There is 1 surgery on this site, 10 sessions available, due to insufficient demand we are unable to utilise this to its maximum capacity.

PRISON DENTAL SERVICE

HMP Low Moss is a modern facility opened in 2012. It houses approximately 800 male inmates on remand, serving short and long term sentences, life offenders and extended sentence offenders.

The PDS Prison dental service clinical offer has been largely defined by Scottish Government and set out in guidance[1]. This guidance rationalises the type of treatment an inmate could expect according to the nature of confinement whether classified as remand, short-term or long-term sentence. There is a clinical dental service in HMP Low Moss on 4 sessions per week. This is a combination of hygienist and dentist care. Glasgow City HSCP manages the prison dental service on behalf of GG&C as they have overall responsibility for all SPS healthcare provision.

Oral Health Improvement in Prisons

Currently there is 1 WTE (DHSW) to support Oral Health Improvement activities across the three prisons in NHS GGC. This support worker delivers both group and one to one sessions to assist prisoners with their oral health needs. OHD staff also support health events across the three prisons by providing stalls with information and free resources. This year we have also planned to supply free toothpaste and toothbrushes on at least one occasion to all prisoners.

Low Moss prison has also recently employed an early year's worker. The early year's worker offers toothbrushing to all children who visit their fathers in the family centre following support and training by an Oral Health Educator (OHE).

Successful peer mentor and health coaching schemes have been developed in prisons in Scotland. The Training Officers from the OHD have supported a peer mentor programme in Low Moss prison but now aim to build on this to encourage additional peer mentors and explore the possibility of introducing the prison based health coaching schemes and subsequent qualifications that have been piloted in HMP Perth. This scheme has led to all participants receiving a health coaching certification and qualifications from the Royal Society of Public Health, accredited by the International Coaching Federation. Prisoners have spoke about the life skills developed during this training which they feel will assist them on liberation to develop more positive lifestyles and relationships which may prevent them from re-offending.

The work of the DHSW at Low Moss in relation to Oral Health Improvement events where prisoners were invited to participate in the oral health group intervention was noted as a practice worthy of sharing in the HM Inspectorate of Prisons for Scotland report on Low Moss 29 May – 9 June 2017.[2]

[1] Oral Health Improvement and Dental Services in Scottish Prisons.
http://www.gov.scot/Resource/0048/00481744.pdf
[2] Report on HMP Low Moss - Full Inspection - 29 May–8 June 2017
https://www.prisonsinspectoratescotland.gov.uk/publications/report-hmp-low-moss-29-may-9-june-2017

DENTAL PUBLIC HEALTH

The oral health of children in NHS GG&C has improved significantly over the last 20 years. A major contributing factor in this has been the implementation of the Childsmile Programme. Children in East Dunbartonshire have generally demonstrated better levels of oral health than the average for GG&C and Scotland, supported by data from the National Dental Inspection Programme (NDIP). The national report for NDIP is published during autumn each year. The most recent report is dated October 2017 and was reported on in full in the last Oral Health Directorate report. New data is not available until the end of October/beginning of November 2018. The headline data is listed below.

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

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

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

NDIP Data for Primary 7 (Detailed Inspections 2015/17)

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

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

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

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

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

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

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

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

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

Basic NDIP P1 Schools 2015/6 – 2016/7

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

Basic NDIP Data P7 Schools 2014-2016

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

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

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

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

NDIP Trajectories for East Dunbartonshire

A major driver for oral health improvement is the need to meet Scottish Government targets for NHS Boards and NDIP outcomes by 2022. There is an expectation there will be 10% improvement in the proportion of caries-free children based upon 2014 data.

For NHS GG&C this equates to:

An improvement in the proportion of caries-free P1 children from 65.3% (2014) to 71.8% (2022)

An improvement in the proportion of caries-free P7 children from 67.8% (2013) to 74.6% (2021)[3]

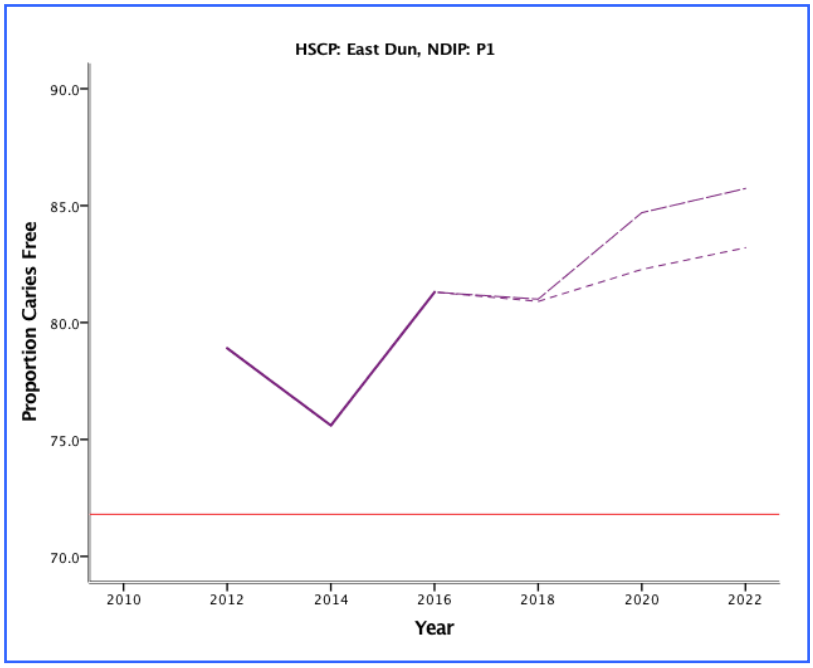
The data from NDIP provides an indication of how effective oral health improvement initiatives have been in a population. There is an obvious delay or lag between an intervention and its effect on a population, as determined by NDIP. In simple terms, the NDIP outcomes for Primary 1 will be influenced mostly by health behaviours established from birth and any contact with dental professionals and oral health improvement interventions. This is the rationale behind encouraging very you children to register with an NHS dentist in the HSCP area.

Childsmile activity in nurseries would have less of an impact on Primary 1 outcomes than oral health behaviours in early year however it maintains the oral health message in the pre-school years. This also holds true for NDIP outcomes for Primary 1. This early engagement with a GDP is essential in starting the journey to good oral health.

The Scottish Government targets for NDIP lie at a Board level. However, each HSCP has a contribution to make to meet these targets. Historically, child oral health and the NDIP outcomes in East Dunbartonshire have been largely favourable and significantly better than the average for GG&C. A 10% improvement on outcomes in East Dunbartonshire would be an unachievable target to set, based upon the high baseline, but a drive for continued improvement would benefit the population of East Dunbartonshire.

Trajectories for P1 and P7 for East Dunbartonshire are illustrated overleaf, demonstrating historical performance at NDIP and providing an indication of what desirable future NDIP outcomes would look like.

[3] Scottish Government targets based on 2014 P1 data. Nearest available P7 data is 2013.

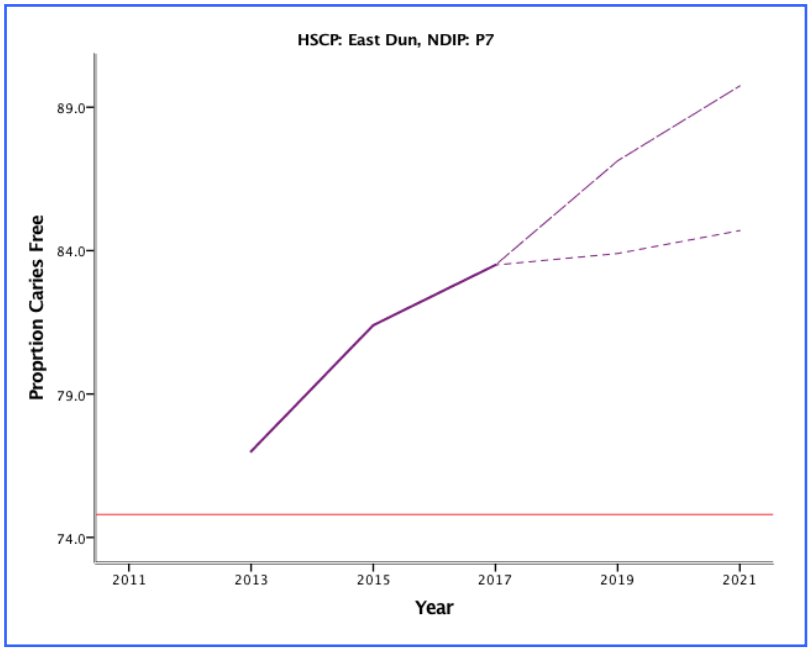


P1 NDIP Trajectory for East Dunbartonshire HSCP

The chart above illustrates the proportion of P1 children in East Dunbartonshire free from “obvious” decay for each year of NDIP. The horizontal red line is the overall NHS GG&C target for 2022. The solid purple line demonstrates the NDIP outcomes from previous year’s data. The data shows East Dunbartonshire already performs significantly better than the 2022 Board target. A decrease in the proportion of decay free children in 2014 was followed by improvement in 2016.

The data has been modelled to estimate future NDIP outcomes. The dotted lines are estimates of what NDIP might look like from 2016 up to 2022. The lower dotted line is an estimate of what the NDIP outcomes might be if there was a 10% improvement on the NDIP data from 2014. The upper dotted line is an estimate of the NDIP might look like if progress continues at the same rate as previous years.

What the data suggests is East Dunbartonshire should remain well above the expected target for the Board. Both estimates suggest there should be continued improvement in P1 NDIP outcomes in East Dunbartonshire. This would be considered a successful outcome and a positive contribution towards continued improvements in child oral health in East Dunbartonshire.



P7 NDIP Trajectory for East Dunbartonshire HSCP

The corresponding chart for outcomes for Primary 7 NDIP in East Dunbartonshire provides a similar picture to that of Primary 1. The outcomes in East Dunbartonshire have demonstrated steady improvement year on year and are already significantly above the Board target for 2022.

If current progress is continued through to 2022, this would be considered a successful outcome for East Dunbartonshire.

The progress of NDIP up to 2022 will be monitored against these trajectories and adjusted, if required.

Dental Extraction under General Anaesthetic

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

Postcode	2013	2014	2015	2016	2017	Total	Popⁿ Rate (per 1000) in 2015
G61 1	2	7	4	3	4	20	
G61 2	3	2	5	4	3	17	
G61 4	10	3	5	5	3	26	
G62 7	5	4	7	4	12	32	
G64 1	**9**	**17**	**15**	**13**	**25**	**79**	
G64 2	3	2	9	1	5	20	
G65 9	4	11	3	5	3	26	
G66 1	9	1	4	3	3	20	
G66 2	**13**	**13**	**20**	**22**	**23**	**91**	
G66 3	5	7	10	10	9	41	
G66 4	1	7	5	2	6	21	
G66 7	5	9	12	10	10	46	
G66 8	2	6	7	6	4	25	
Total East Dun	**71**	**89**	**106**	**88**	**110**	**464**	**5**
Cumulative total GG&C 2013/2017	**2339**	**2340**	**2413**	**2007**	**1900**	**10,999**	**9**

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

As with data for dental caries, the numbers of referrals for extractions under general anaesthetic are lower in East Dunbartonshire than for other localities in GG&C. It should be noted the data rows in the table above are raw data and not weighted by population. Nevertheless, the data illustrates there was been a slight reduction in the number of GA episodes in East Dunbartonshire between 2015 and 2016. However, there has been an increase in 2017. Although the reason for this may be multifactoral this may in fact be the benefit of reaching more children for dental care and thereafter those hardest to reach groups. The numbers of episodes remain higher in certain localities, highlighted in bold text above. The population rate in 2015 for East Dunbartonshire for episodes for extraction under general anaesthetic is 5/1000, compared to 9/1000 for GG&C. This demonstrates the better oral health of children in East Dunbartonshire compared with GG&C as a whole.

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

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

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

It is therefore expected that in partnership we will identify further strategies and workstreams to improve and support the oral health of children in East Dunbartonshire HSCP.

It would be folly to believe that there are children in more affluent areas not observed to have significant dental decay and the Oral Health Directorate and the Oral Health Improvement Teams will seek to determine if there is a risk that more affluent children are being overlooked in oral health improvement programmes which are targeting more vulnerable, or deprived children.

ORAL HEALTH IMPROVEMENT

Childsmile

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

Childsmile Practice

The Childsmile Practice programme is designed to improve the oral health of children in Scotland from birth by working closely with dental practices. It is being developed to provide a universally accessible child-centred NHS dental service.

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

Children Successfully Contacted and Not Contacted by DHSW, and Families Who Refused Childsmile 2015/16 - 2016/17

SIMD	Children with (at least one) kept DHSW appointment		Children whose families refused Childsmile		'Family could not be contacted'		Family Appts with outcome 'FTA / Not at home' (Further contact required)	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
1	12	7	0	0	1	0	3	1
2	56	23	0	0	1	0	12	6
3	14	1	0	0	0	0	2	0
4	40	19	0	1	0	0	8	4
5	117	34	1	0	1	0	15	2
Total	239	84	1	1	3	0	40	13

Data taken from HIC

The number of children with (at least one) kept DHSW appointment has fallen in 2016/2017 when compared to 2015/2016. This has been influenced by redistribution of health improvement resources in East Dunbartonshire. The DHSWs involved in home visits now has a greater commitment to delivering the toothbrushing programmes. This has resulted in a reduced capacity for home visits.
Dialogue between partners in the oral health directorate and East Dunbartonshire will be required to discuss options to address this situation.

The most recent quarterly data available for Childsmile Practices activity demonstrates 2 practices with no activity.

The OHD will monitor this to ensure continued compliance of independent dentists with this programme and take action with practices to address if required.

Childsmile Core

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

The 2 non-participating schools are contacted on a regular basis to review interest in participation and offered support to implement Childsmile.

The partnership may wish to raise non-participation with educational links to support participation.

East Dunbartonshire Establishments Participating in Toothbrushing 2015/16 - 2016/17

SIMD	Nurseries		Primary Schools		Total		ASN Schools	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
1	1	1	0	0	1	1		0
2	4	5	4	5	8	10	1	1
3	8	8	6	6	14	14	0	0
4	10	10	4	4	14	14	1	1
5	24	25	14	18	38	43	0	0
Total	47	49	28	33	75	82	2	2

Data taken from HIC

100% of nurseries and Additional Support Needs schools are participating in toothbrushing, this has remained stable. The number of schools brushing has increased with 5 additional schools participating in toothbrushing during 2016/2017 when compared to 2015/2016.

Oral Health Educators Activity

The OHE linked to the East Dunbartonshire HSCP attends health events in primary schools, delivers oral health advice related to toothbrushing, diet and dental attendance. The OHEs work with school staff to provide support to families who have received a category A NDIP letter. The support offered includes 1-1 advice to parents to address their individual needs and encourage registration with a dentist. Support is also offered to children who have a fear around going to the dentist by offering acclimatisation sessions before their dental appointment. OHEs have also followed up all families who contacted NHS 24 for out-of hour's dental care. This commenced in November 2016.

The OHE offers Toothbrushing training to all establishments, this training re-enforces the national toothbrushing standards.

The OHE monitor all toothbrushing establishments every term and record data onto HIC (Health Informatics Centre) system hosted by Dundee University. Several parents workshops and one to one oral health advice have been delivered to parents e.g. parents evenings, induction days, providing dentists list to encourage dental registration.

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

Summary of OHE Activity 2015/16 - 2016/2017

East Dunbartonshire HSCP	Health Days	OH Session/ Monitoring	Induction Days	ED HSCP Events	School Nurse Referral/ School	NSM Talk/ Event	Training
2016/17	10	91	9	1	1	7	14
2015/16	10	81	7	1	0	5	14

Overall OHE activity increased during 2016/17 with a higher number of OH sessions and National Smile Month (NSM) talks/events delivered in this period.

Fluoride Varnish

Currently there is no fluoride varnish provision within East Dunbartonshire delivered by the Oral Health Directorate as this is a targeted intervention that is delivered in areas of highest deprivation with high caries levels.

It should be noted that fluoride varnish can be accessed through the children's GDP so children can receive this treatment twice yearly at their own dentist. The Oral Health Improvement Team engages with local NHS practices to encourage and advise on delivery of fluoride varnish as part of Childsmile Practice.

National Smile Month 2018

National Smile Month is the UK's largest and longest-running oral health campaign. It is organised by the oral health charity, the British Dental Health Foundation and the campaign hopes to raise awareness of important health issues, and make a positive difference to the oral health of millions of people throughout the UK.

This year National Smile Month campaign runs from the 14th May and goes to the 14th June. To celebrate National Smile Month 2018, the Oral Health Improvement team have invited all schools to participate. The theme of this years' local campaign is to highlight the importance of dental attendance and positive dental experiences. Primary 5 children have been asked to produce a Dental Visit Poster for the NSM competition. There will be a certificate for the winning poster in each HSCP then the overall winner will be picked by the 6 finalists.

The winning school will receive the 'Sparkling Smile Trophy'. 7 East Dunbartonshire Schools have participated in the National Smile Month poster campaign. The primary 5 children have drawn positive and amusing posters around visiting the dentist.

Caring for Smiles

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

The Caring for Smiles Programme has been active within East Dunbartonshire since early 2013.

One establishment in East Dunbartonshire does not engage in CfS monitoring. This issue has been raised with the HSCPs to address with the care home.

The table below provides data on the number of Care Homes involved in the Caring for Smiles programme in East Dunbartonshire within 2015/16 - 2016/17.

East Dunbartonshire HSCP	Number of Care Homes	Number participating in CFS Training	Number participating in CFS Monitoring	Total number of Residents	Number registered & seen by a dentist within last 12 months	% of residents seen & registered with a dentist within last 12 months
2016/17	13	13	12	496	384	68%
2015/16	13	13	12	276	163	59%

The local NHS GG&C standard for training asks that 30% of care home staff have been trained in the Caring for Smiles dental programme. All care homes in East Dunbartonshire continue to deliver the Caring for Smiles programme, the total number of residents seen by a dentist in the last 12 months has increased from 163 to 384. The percentage of residents seen and registered with a dentist in the last twelve months has increased from 59% to 68%.

Ten care home staff attended for SCQF (Foundation) training - 6 completed. A date for SCQF Intermediate training has been offered to those who passed Foundation level.

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

The number of care homes in East Dunbartonshire was stable during 2015/2016 and 2016/2017 remaining at 13. However there has been a significant increase in the number of residents within these establishments.

Care Home	Total Number of staff	Number of WTE	Number of WTE trained	% of WTE trained	Cumulative Number of staff trained
Canniesburn Care Home	101	69.0	26.9	38.29%	30
Abbotsford House	20	15.0	7.5	50.2%	10
Buchanan House	80	70.0	10.5	15.1%	13
Buchanan Lodge	30	26.6	22.2	90.8%	36
Mavis Bank	45	35.2	26.6	75.6%	32
Campsie View	125	90.0	31.8	35.3%	47
Campsie House	17	14.0	13.6	96.8%	17
Whitefield Lodge	41	36.0	17.1	47.6%	19
Lillyburn	80	42.3	17.7	41.7%	21
Westerton Care Home	77	66.0	28.79	43.8%	33
Antonine Care Home	70	65.0	42.3	65.1%	51
Whitehill Court Care Home (respite)	8	6.0	5.4	90.6%	11
Mugdock House	54	44.0	24.3	55.1%	28

Key Findings and Recommendations

- There needs to be dialogue with East Dunbartonshire HSCP and the Oral Health Directorate to ensure resource is in place for the delivery of appropriate oral health improvement activity.

- The registration of very young children in East Dunbartonshire remains very low and must improve. The pilot programme with the Registrar will inform progress on improvement.

- There needs to be a focus on improving childsmile activity reported for Childsmile Practice.

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

- The Oral Health Improvement team will aim to improve links with NHS dental practice and provide support & training for Childsmile, particularly fluoride varnish application in areas where fluoride varnish programmes are not a focus to the board

- The Oral Health Improvement team will continue to work with partners in HSCP and education to improve the uptake and delivery of Childsmile programme, particularly in challenging areas where there is low uptake or sustainability of school toothbrushing

- The Oral Health team will work with the Children and Family's team in the HSCP to ensure our continued focus is on improving registration and outcome for NDIP national inspection.

- The Oral Health Team will work with the HSCP to look for innovative ways to improve the oral health of their population and use HSCP intelligence to drive new methods of working

- The Oral Health Team will work with the HSCP and partners to implement the recommendations of the Scottish Oral Health Improvement Plan.

- The Oral Health Team will work the Care Home Liaison teams to increase dental registration amongst the residents to ensure appropriate dental intervention when required.

Agenda Item Number: 6b

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	28th June 2018
Subject Title	Oral Health Performance Report - Greater Glasgow and Clyde
Report By	Frances McLinden – General Manager Oral Health
Contact Officer	Frances McLinden – General Manager Oral Health

Purpose of Report	To provide an overview of the activities carried out by the Oral Health Directorate across NHS GG&C.

Recommendations	To note the content.

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

Implications for Health & Social Care Partnership

Human Resources	None.

Equalities:	None.

Financial:	None.

Legal:	None.

Economic Impact:	None.

Sustainability:	None.

Risk Implications:	None.

Implications for East Dunbartonshire Council:	None.

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

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

1.0	MAIN REPORT
1.1	This report provides an overview of the oral health services provided throughout NHS GG&C.
1.2	This report provides performance data in relation to oral health programmes and monitoring of oral health activities across GG&C.

NHS GG&C
Oral Health Directorate
Performance Report
(June 2018)

Foreword

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

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

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

Registration of adults and children is at the highest level we have ever seen in Greater Glasgow and Clyde and better than the average for Scotland. Registration of 0-2 year old children is higher than the Scottish average and continues to rise, but still remains low at 52.2%.

The Scottish Government has set challenging targets for child dental health. The board is required by 2022, to demonstrate a 10% increase in both P1 and P7 children who have “no obvious decay”.

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

The launch this year of the Oral Health Improvement Plan for Scotland has provided a road map to how dental services will evolve in Scotland. There will be a greater focus on prevention and shared working to meet the needs of an ageing population, with complex dental needs. To meet these challenges, oral health targets will require continued partnership working and community development with our colleagues in each HSCP in Greater Glasgow and Clyde.

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

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

Table of Contents

GENERAL DENTAL SERVICES

There are 824 dentists working in 272 independent contractor practices providing NHS dentistry in NHS GG&C. These practices provide General Dental Services (GDS) and in addition 68 practices provide sedation services. NHS GG&C has 11 practices that provide only orthodontic services meaning no patients are registered with them for GDS.

HSCP	No. Dentists	No. Practices	No. Ortho Practices	No. Sedation Practices
West Dunbartonshire	49	16	0	4
Renfrewshire	106	34	1	12
Inverclyde	41	12	1	4
Glasgow South	172	58	1	18
Glasgow North West	161	64	3	13
Glasgow North East	137	40	1	12
East Renfrewshire	72	22	2	2
East Dunbartonshire	86	26	2	3

Registration with NHS Dental Services

Data available from Information Services Division (ISD) (September 2017) shows the proportion of patients registered in NHS GG&C are:

- 95.8% Children (compared to 93.8% Scotland)
- 96.1% Adults (compared to 92.2% Scotland)

The registration data for children in GG&C are higher than the data for Scotland. There are possible explanations for the data, relating to activities in addressing inequalities. A number of patients (particularly adults) may be registered with non-NHS dentists, or may travel outside of their HSCP area for dental treatment. As data is not collected for non-NHS dental practices, it is not possible to determine numbers of patients seeking treatment outside of the NHS. This explanation may not hold as robustly for children, as dentists may hold list numbers with NHS GG&C to provide NHS dental registration and treatment for children, whilst providing non-NHS treatment for parents. Registration rates in GG&C for children and adults have improved on the previous years figures, which were 95.0% and 94.8%, respectively.

The Oral Health Improvement Team will also seek to determine if there is a risk that more affluent children are being overlooked in oral health improvement programmes which are targeting more vulnerable, or deprived children. As we still see a number of children in SIMD4/5 areas experience dental extractions for decay.

More detailed data on dental registrations from ISD[1] highlights an issue relating to the registration of very young children (aged 0-2 years).

[11] **Dental Statistics - NHS Registration and ParticipationStatistics as at 30 September 2017**
http://www.isdscotland.org/Health-Topics/Dental-Care/Publications/data-tables2017.asp?id=1843#1843

In GG&C the proportion of children aged 0-2 years who are registered with a dentist is 52.2%. This compares to 47.6% for Scotland. This represents a continued improvement on the previous figure for the Board, which was 50.9%.

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

GDS Administration

The oral health directorate performs an administrative function in relation to clinical and financial governance in all NHS practices across NHS GG&C. This is to ensure that General Dental Services are delivered to an expected professional standard and includes carrying out Combined Practice Inspections and Sedation Practice Inspections on a minimum three year basis in line with General Dental Service Regulations.

We also work with Practitioner Services Division and National Services Scotland in relation to financial oversight/activity and regulatory functions in relation to Primary Care Dental Services.

Emergency and Out of Hours Attendances

The Oral Health Directorate provides emergency daytime and Out of Hours (OOH) cover for the population of GG&C. The Emergency Dental Treatment Centre (EDTC) service is located on Floor 1 of Glasgow Dental Hospital and is operated by the Public Dental Service. OOHs appointments are provided via NHS 24. The daytime service provides emergency cover for unregistered patients and patients from outwith the area who are unable to attend their own dentist. The evening and weekend Out of Hours service provides emergency cover for patients registered in GG&C on behalf of GDPs as well as unregistered patients residing in GG&C.

The following table details the number of patients residing in GG&C who attended these services during the year 2016/17.

Age Group	Daytime Service (pop^{n} rate/1000)		Out of Hours (pop^{n} rate/1000)	
0 to 4	14	0.22	96	1.51
5 to 9	24	0.38	278	4.45
10 to 15	42	0.61	171	2.5
16 to 29	1735	7.31	2345	9.87
30 to 44	1120	4.90	1914	8.37
45 to 64	718	2.40	1249	4.18
65+	185	0.92	284	1.41
Total	**3838**		**6337**	

Table of GG&C Residents Attending the Emergency Dental Treatment Centre during 2016/17

The data from the table suggests the highest participation age range of patients in relation to population size who most frequently attend the EDTC is 16 to 45. This age range is predominantly the working population and those in higher education. These age groups are also the least likely to maintain regular participation with their own dentist, it is probable a number of the attendances at the Out of Hours service are registered patients who for a variety of reasons are unable to arrange appointments at their own dentist during the daytime, examples of these could be home/work commitments or distance from place of work to dentist.

It is clear from the data available there are opportunities to explore how more people in this age range can be encouraged to attend their own dentist for routine care regularly and review educational campaigns and opportunities to encourage resolution of care with their own GDP. We will work with local General Dental Practitioner's and the Health Improvement teams across GG&C to seek ways to widely advertise dental services and seek greater participation in routine care.

PUBLIC DENTAL SERVICE

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

We are in the process of conducting a review of the Public Dental Service the outcome of which will be available in June 2018. As part of this review we are looking to produce a dental premises strategy for the Board. This should include not just PDS sites but also locations of GDP practices within each HSCP area and overall within the Board. As part of this process we will be engaging with HSCP colleagues regarding the possible closure and amalgamation of some sites to provide a comprehensive adult and child service.

Location and services delivered by the PDS

Locations/Services	Paediatric Dentistry	Special Care Dentistry	Adult Special Care – General Anaesthetic Assessment	Adult Special Care – General Anaesthetic	Adult Special Care – Sedation Services	General Dental Services	Oral Hygiene Services	Domiciliary Care
East Dunbartonshire								
Kirkintilloch Health Centre	√						√	√
Low Moss Prison						√		
Inverclyde								
Greenock Health Centre	√	√	√		√		√	√
Inverclyde Royal Hospital							√	
Greenock Prison						√	√	
Renfrewshire								
Royal Alexandra Hospital	√	√	√	√	√	√	√	√
West Dunbartonshire								
Vale Centre for Health & Care	√	√			√		√	√
Golden Jubilee National Hospital		√				√		√

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

*Including outreach

PRISON DENTAL SERVICE

The PDS provide dental care for inmates and prisoners on remand in the three main prisons within the NHS GG&C boundaries. Healthcare provision within the Scottish Prison Service (SPS) was transferred to the NHS in 2011. The main driver for this was to reduce inequalities in healthcare provision for people with convictions by providing a service in line with the wider society. The aims were to:

- To tackle ongoing health inequalities within the prisoner population
- To meet international standards on prison health and treatment
- To provide continuity of care to prisoners on leaving prison; and
- To provide sustainability of services with the support of community based services

A Memorandum of Understanding (MOU) was developed to provide a frame work for service delivery with responsibilities set out for the Board and Scottish Prison Service[2].

The separate and joint roles of each partner were described as:

NHS Boards are responsible for:

- The smooth day to day running of the prison health centre
- Contracted dental services delivering care to prisoners
- Information management, technology and governance
- Maintenance and replacement of all clinical fixed and non-fixed assets
- Clinical dental service-related complaints
- Clinical performance management and monitoring

In relation to dental services the SPS are responsible for:

- Ensuring an environment within prisons that promotes oral health
- Security and good order within dental surgeries
- Structural maintenance, facilities management and cleaning services of the dental surgeries; including all fixed and non- fixed non clinical assets
- Escorting functions to facilitate attendance at dental appointments
- Non-clinical dental service related complaints

NHS Board and SPS joint responsibilities

- Development of a prison oral health strategy and delivery plan
- The management, training and support of the dental team
- Good governance and effective monitoring of the service
- Introduction of a networked dental clinical IT system
- Reporting and investigation of critical and adverse incidents
- Business continuity planning
- Effective and appropriate sharing of management and necessary clinically-related information

[2] National Memorandum of Understanding. http://www.parliament.scot/S4_JusticeCommittee/Inquiries/20130226__FINAL_revised_MOU_Prison_Healthcare_HIS_December_2012.pdf

NHS GG&C deliver healthcare services from three prisons: HMP Barlinnie, HMP Greenock and HMP Low Moss.

HMP Barlinnie is the oldest and largest prison. It houses approximately 1,400 inmates ranging from prisoners on remand, prisoners awaiting transfer to another prison, those transferred awaiting liberation and long-term inmates. This maximum number of inmates is often exceeded. The long-term inmates include high risk and high security inmates and segregation.

Barlinnie Prison has a large and transient population. This is owing to the high numbers of inmates who are on remand awaiting trial, inmates awaiting transfer to another prison and those awaiting liberation.

HMP Greenock houses approximately 250 inmates. There is a wide variation within the inmate population at HMP Greenock, with remand, short-term and long-term inmates for males and females.

HMP Low Moss is a modern facility opened in 2012. It houses approximately 800 male inmates on remand, serving short and long term sentences, life offenders and extended sentence offenders.

The PDS Prison dental service clinical offer has been largely defined by Scottish Government and set out in guidance[3]. This guidance rationalises the type of treatment an inmate could expect according to the nature of confinement whether classified as remand, short-term or long-term sentence.

The current level of clinical dental resource across prisons in GG&C is 10 weekly clinical sessions.

The clinical sessions are divided across the prison sites accordingly:

- Barlinnie 5 sessions per week
- Greenock 2 sessions per week
- Low Moss 3 session per week

In general, prisoners tend to have high dental treatment need. This is often as a result of social deprivation and associated with a history of prolonged substance misuse (drugs, tobacco and alcohol). Dental attendance outside of the prison is often infrequent. Part of the rehabilitation process is to raise awareness of health issues and participation in detoxification programmes. The Oral Health Improvement team play an active part in this process in delivering Mouth Matters[4]. The national programme dedicated to prison dental care.

The high numbers of inmates, with high treatment need results in a significant demand for dental care and can often lead to longer waiting times.

[3] Oral Health Improvement and Dental Services in Scottish Prisons. http://www.gov.scot/Resource/0048/00481744.pdf
[4] Scottish Oral Health Improvement Prison Programme: SOHIPP http://dentistry.dundee.ac.uk/scottish-oral-health-improvement-prison-programme-sohipp

The Oral Health Directorate are working closely with Glasgow City HSCP to ensure we work collaboratively to deliver services. Discussion around dental resource is part of this process.

Oral Health Improvement in Prisons

Scottish Government Guidance provides direction for the oral health improvement activities that should be carried out in Scottish prisons. The OHD has developed a plan which details the progress made towards implementing the recommendations from this guidance. A significant contribution to delivering the recommendations from Scottish Governments guidance is made by the Dental Health Support Worker (DHSW) employed by Glasgow City HSCP.

Currently there is 1 WTE (DHSW) to support Oral Health Improvement activities across the three prisons in NHS GG&C. This support worker delivers both group and one to one sessions to assist prisoners with their oral health needs. We also support health events across the three prisons by providing stalls with information and free resources. This year we have also planned to supply free toothpaste and toothbrushes on at least one occasion to all prisoners.

Low Moss prison has also recently employed an early years worker. The early year's worker offers toothbrushing to all children who visit their fathers in the family centre following support and training by an Oral Health Educator (OHE). The aim is to replicate this model in Barlinnie and Greenock prisons once the scheme is validated and reviewed.

Successful peer mentor and health coaching schemes have been developed in prisons in Scotland. The Training Officers from the OHD have supported a peer mentor programme in Low Moss prison but now aim to build on this to encourage additional peer mentors and explore the possibility of introducing the prison based health coaching schemes and subsequent qualifications that have been piloted in HMP Perth. This scheme has led to all participants receiving a health coaching certification and qualifications from the Royal Society of Public Health, accredited by the International Coaching Federation. Prisoners have spoken about the life skills developed during this training which they feel will assist them on liberation to develop more positive lifestyles and relationships which may prevent them from re-offending.

DENTAL PUBLIC HEALTH

Child Dental Health

The oral health of children in GG&C has improved significantly over the last 20 years. A major contributing factor in this has been the implementation of the Childsmile Programme. Children in GG&C are now demonstrating child oral health levels comparable to the average for Scotland, supported by data from the National Dental Inspection Programme (NDIP). However, there remain wide variations within GG&C. The NDIP report is published in autumn each year. The most recent report was October 2017 and new data will not be available until end of October/beginning of November 2018. The following are summary data from NDIP.

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

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

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

NDIP Data for Primary 7 (Detailed Inspections 2015/17)

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

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

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

Comparison of data between 2015 and 2017 suggests a steady improvement in oral health at a local and national level.

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

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

Data for P1 and P7 Basic NDIP for Scotland (2016/17) is illustrated below.

Summary of Basic P1 NDIP Programme 2016/17

NHS Board	Estimated Total no. of P1-age children in Scotland	Total no. of P1 children inspected	Percentage (%) of P1 children inspected	Percentage (%) of A letters issued	Percentage (%) of B letters issued	Percentage (%) of C letters issued
Ayrshire & Arran	3,879	3,623	93.4	4.3	25.2	70.5
Borders	1,129	1,048	92.8	4.5	23.6	71.9
Dumfries & Galloway	1,539	1,314	85.4	4.9	23.7	71.3
Fife	4,265	2,571	60.3	4.7	26.6	68.7
Forth Valley	3,353	2,992	89.2	6.8	20.2	73.1
Grampian	6,734	5,697	84.6	7.1	17.9	75.0
Greater Glasgow & Clyde	12,314	11,638	94.5	10.3	23.2	66.5
Highland	3,284	2,886	87.9	6.8	19.5	73.7
Lanarkshire	7,436	7,063	95.0	7.8	21.8	70.4
Lothian	9,545	8,504	89.1	6.0	20.8	73.2
Orkney	224	198	88.4	2.0	14.1	83.8
Shetland	276	239	86.6	2.5	14.2	83.3
Tayside	4,255	3,896	91.6	8.9	21.7	69.5
Western Isles	264	230	87.1	4.3	20.4	75.2
Scotland	**58,497**	**51,899**	**88.7**	**7.3**	**21.8**	**70.9**

Summary of Basic P7 NDIP Programme 2016/17

NHS Board	Estimated Total no. of P7-age children in Scotland	Total no. of P7 children inspected	Percentage (%) of P7 children inspected	Percentage (%) of A letters issued	Percentage (%) of B letters issued	Percentage (%) of C letters issued
Ayrshire & Arran	3,866	3,341	86.4	1.6	26.3	72.1
Borders	1,228	1,065	86.7	1.8	30.0	68.2
Dumfries & Galloway	1,480	1,342	90.7	2.8	26.0	71.2
Fife	3,884	3,366	86.7	1.1	34.4	64.6
Forth Valley	3,342	2,918	87.3	4.9	28.3	66.7
Grampian	5,696	4,876	85.6	1.8	25.9	72.3
Greater Glasgow & Clyde	11,282	10,472	92.8	2.5	32.3	65.2
Highland	3,420	2,738	80.1	1.5	21.0	77.5
Lanarkshire	7,409	6,635	89.6	2.3	31.8	65.8
Lothian	8,346	7,060	84.6	1.3	25.2	73.5
Orkney	211	201	95.3	0.5	10.4	89.1
Shetland	249	230	92.4	2.2	14.3	83.5
Tayside	4,148	3,593	86.6	1.7	27.3	71.0
Western Isles	303	237	78.2	1.3	20.7	78.1
Scotland	**54,864**	**48,074**	**87.6**	**2.1**	**28.6**	**69.4**

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

NDIP Trajectories for NHS GG&C

A major driver for oral health improvement is the need to meet Scottish Government targets for NHS Boards and NDIP outcomes by 2022. There is an expectation there will be 10% improvement in the proportion of caries-free children based upon 2014 results for each board area.

For NHS GG&C this equates to:

An improvement in the proportion of caries-free P1 children from 65.3% (2014) to 71.8% (2022)

An improvement in the proportion of caries-free P7 children from 67.8% (2013) to 74.6% (2021)[5]

[5] Scottish Government targets based on 2014 P1 data. Nearest available P7 data is 2013.

The data from NDIP provides an indication of how effective oral health improvement initiatives have been in the child population. There is an obvious delay or lag between an intervention and its effect on a population, as determined by the NDIP results for a board area.

In simple terms, the NDIP outcomes for Primary 1 will be influenced mostly by health behaviours established from birth and any contact with dental professionals and oral health improvement interventions. Hence, the value of partners driving early contact and registration of very young children with an NHS dentist.

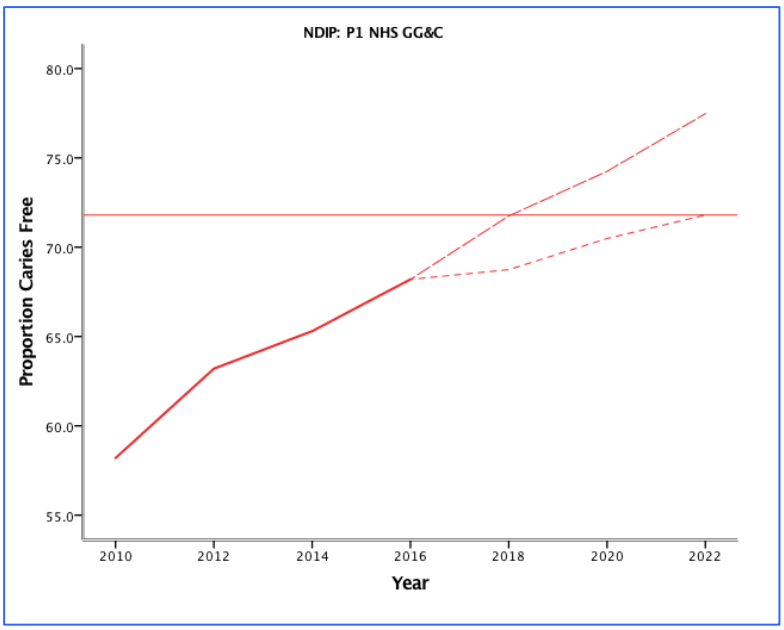
Childsmile activity in nurseries would have less of an impact on Primary 1 outcomes than oral health behaviours in early years but it continues across a spectrum of children the importance of good oral health habits. NDIP outcomes for Primary 1 can also be influenced by, the effective delivery of Childsmile Core activity.

It would be advantageous to HSCPs to be able to monitor progress through the NDIP and this is one of the only measures we are able to gain data on.

It is possible for the board to make estimates of future NDIP outcomes based upon existing data and the Scottish Government targets for 2022.

The Scottish Government targets for NDIP lie at a Board level. However, each HSCP has a contribution to make to meet these targets. Owing to the disproportionately larger population resident in Glasgow City relative to other HSCPs, much of the burden for improvement will lie in Glasgow City.

Trajectories for P1 and P7 for GG&C are illustrated overleaf, demonstrating historical performance at NDIP and providing an indication of what desirable future NDIP outcomes would look like.

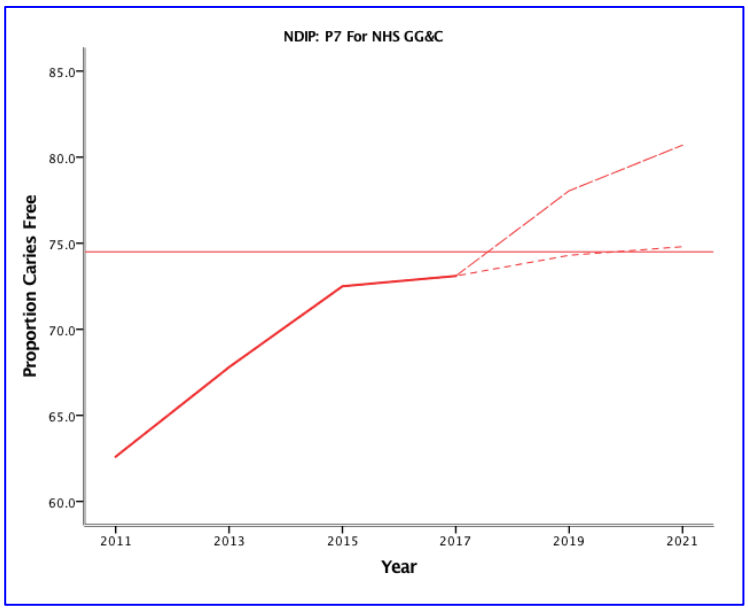


P1 NDIP Trajectory for NHS GG&C

The chart above illustrates the proportion of P1 children in GG&C free from “obvious” decay for each year of NDIP. The horizontal red line is the overall NHS GG&C target for 2022. The solid red line demonstrates the NDIP outcomes from previous years data. The data shows GG&C is improving towards the 2022 Board target

The data has been modelled to estimate future NDIP outcomes. The dotted lines are estimates of what NDIP might look like from 2016 up to 2022. The lower dotted line is an estimate of what the NDIP outcomes might be if there was a 10% improvement on the NDIP data from 2014. The upper dotted line is an estimate of the NDIP might look like if progress continues at the same rate as previous years.

What the data suggests is the Board faces a significant challenge to meet the Scottish Government target. The above estimates suggest there should be continued improvement in P1 NDIP outcomes in GG&C. If the actual outcomes for future NDIP lie above the lower dotted line, this should be considered a successful outcome.



P7 NDIP Trajectory for NHS GG&C

The corresponding chart for outcomes for Primary 7 NDIP in GG&C provide a similar picture to that of Primary 1. The outcomes in GG&C have demonstrated steady improvement year on year but are beginning to plateau. This represents a challenge to meet the desired target.

Once again, if the actual delivery against NDIP lies above the lower dotted line, this would be considered a successful outcome for the Board.

The progress of NDIP up to 2022 will be monitored against these trajectories and adjusted, if required.

Dental Extraction under General Anaesthetic

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

Postcode	2013	2014	2015	2016	2017	Total	Pop^{n} Rate (per 1000) in 2015
Total GG&C	2339	2340	2413	2007	1900	10,999	9

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

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

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

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

ORAL HEALTH IMPROVEMENT

Childsmile

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

Childsmile Practice

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

Children Successfully Contacted and Not Contacted by DHSW, and Families Who Refused Childsmile 2015/16 - 2016/17 (Apr-March)

SIMD	Children with (at least one) kept DHSW appointment		Children whose families refused Childsmile		'Family could not be contacted'		Family Appts with outcome 'FTA / Not at home' (Further contact required)	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
1	3134	3778	87	89	19	11	613	641
2	1196	1352	52	44	5	1	198	173
3	787	848	31	36	3	1	115	111
4	667	863	41	36	0	0	74	60
5	826	806	61	46	2	0	73	67
Total	6749	7849	276	254	30	13	1103	1075
unknown	139	202	4	3	1	0	30	23

Data taken from HIC

Overall levels of activity have increased across Childsmile Core and GG&C has consistently performed well when compared in the national Childsmile report to all other boards in Scotland.

A total of 7849 home visits were made across GG&C during 2016/2017. There were 1075 family contacts where families were not at home at the time of the visits. Repeated attempts are made to visit these families. In most areas DHSW will refer back to HV's if they are unsuccessful in completing a family visit.

The data recorded on the HIC (Health Informatics Centre) system hosted by Dundee University and illustrated in the table relates to the contacts with families.

What is not clearly recorded or available from the data are the numbers of families where all attempts to engage have failed and the family have been referred back to the Health Visitor.

The Oral Health Improvement team need to engage with HSCPs and HIC to develop a more robust means of identifying families where contact has been unsuccessful.

Childsmile Core

100% of nurseries and additional support needs schools (ASN) are participating in toothbrushing. A total of 264 out of 299 primary schools were observed as brushing during 2016/2017. A school is considered as a toothbrushing if it has been observed on at least one occasion as toothbrushing in line with the National Toothbrushing standards.

Oral Health Educator's (OHEs) have established effective partnership working with HSCP colleagues to support this work.

The non-participating schools are contacted on a regular basis to review interest in participation and offered support to implement Childsmile.

The partnerships may wish to raise non-participation with educational links to support participation.

NHS GG&C Establishments Participating in Toothbrushing 2015/16 - 2016/17

SIMD	Nurseries		Primary Schools		Total		ASN Schools	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
1	102	104	63	62	165	166	6	5
2	100	109	78	75	178	184	10	10
3	91	95	58	55	149	150	3	2
4	76	76	35	37	111	113	1	1
5	66	67	28	33	94	100	2	2
Unknown	1	3	1	2	2	5	0	0
Total	436	454	263	264	699	718	22	20

Data taken from HIC

The number of nurseries participating in the toothbrushing programmes remains very high with almost 100% of nurseries participating each year. Gaining agreement from all Schools to brush on a daily basis is an ongoing challenge, particularly in the most deprived areas of GG&C. However, the total number of establishments has increased from 699 in (2015/2016) to 718 in (2016/2017). The number of ASN schools would appear to have fallen but this is due to the merger of establishments in the board area.

There needs to be improved engagement with Oral Health and the HSCPs to influence positive change with partners in education to improve the uptake and sustainability of tootbrushing schemes, particularly in establishments with high levels of deprivation, lower compliance and higher risk to developing dental disease.

Childsmile Fluoride Varnish Programme

The Oral Health Improvement Team work with HSCP partners to deliver the Childsmile Fluoride Varnish programme in nurseries and schools within GG&C. A total of **43562** applications of varnishes were made by the FV team during 2016/2017. The aim is to apply varnish to children's teeth twice annually.

It should be noted that fluoride varnish can be accessed through the children's GDP so children can receive this treatment twice yearly at their own dentist.

The health board focuses targeted fluoride varnish on SIMD 1 and 2 schools and nurseries.

Childsmile Nursery and School: Fluoride Varnish activity 2016/17

CLASS TYPE	Targeted Children	Children with validated consents		Children receiving at least one FVA			Children receiving two or more FVAs		
	T	V	% of T	n	% of T	% of V	n	% of T	% of V
nursery	14032	7772	55.4%	6211	44.3%	79.9%	3222	23.0%	41.5%
p1	6330	4971	78.5%	4757	75.2%	95.7%	3723	58.8%	74.9%
p2	5779	5128	88.7%	4814	83.3%	93.9%	4132	71.5%	80.6%
p3	5537	4972	89.8%	4678	84.5%	94.1%	3912	70.7%	78.7%
p4	5292	4794	90.6%	4483	84.7%	93.5%	3614	68.3%	75.4%
p5	381	13	3.4%	10	2.6%	76.9%	6	1.6%	46.2%

Data taken from HIC

Childsmile Nursery and School: Fluoride Varnish activity 2015/16

CLASS TYPE	Targeted Children	Children with validated consents		Children receiving at least one FVA			Children receiving two or more FVAs		
	T	V	% of T	n	% of T	% of V	n	% of T	% of V
nursery	8893	7517	84.5%	6533	73.5%	86.9%	4078	45.9%	54.3%
p1	5824	5047	86.7%	4823	82.8%	95.6%	3695	63.4%	73.2%
p2	5645	5045	89.4%	4735	83.9%	93.9%	4147	73.5%	82.2%
p3	5324	4843	91.0%	4605	86.5%	95.1%	4136	77.7%	85.4%
p4	5190	4689	90.3%	4427	85.3%	94.4%	3992	76.9%	85.1%
p5	95	6	6.3%	2	2.1%	33.3%	1	1.1%	16.7%

Data taken from HIC

There are a number of points for discussion from the fluoride varnish data. During 2016/17, a larger number of nursery children were targeted compared to the previous year. This data from the HIC system resulted in a large number of children on the class lists being listed more than once. This would account for the reduction in compliance in the overall fluoride varnish activity falling from the previous year. Changes to the quality assurance processes in place for the fluoride varnish visits will be revisited to provide a more robust programme for results. The fluoride varnish programme will be monitored to identify ways to improve efficiency and increase uptake of fluoride varnish.

Summary of Oral Health Educators Activity

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

In addition OHE's are involved in targeted programme including; Fluoride Varnish sessions, providing support to families who have received an A NDIP letter, providing support to families who have contacted NHS24, providing oral health promotion to parents/carers at Glasgow Dental Hospital General Anaesthetic sessions.

This support offered includes 1-1 advice to parents to address their individual needs and encourage registration with a dentist. Support is also offered to children who have a fear around going to the dentist by offering acclimatisation sessions before their dental appointment.

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

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

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

Targeted OHE Sessions

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

Social Media

In order to reach as many people as possible the OHE's have engaged the community via twitter by advertising events, showcasing oral health promotion activities, and promoting key oral health messages throughout the community. In the coming year OHD will consider its own twitter feed to cascade good oral health and dental access messages.

National Smile Month 2018

National Smile Month is the UK's largest and longest-running oral health campaign. It is organised by the oral health charity, the British Dental Health Foundation and the campaign hopes to raise awareness of important health issues, and make a positive difference to the oral health of millions of people throughout the UK.

This year National Smile Month (NSM) campaign runs from the 14th May to the 14th June. To celebrate National Smile Month 2018, the Oral Health Improvement team have invited all schools to participate in an art competition. The theme of this years' local campaign is to highlight the importance of dental attendance and positive dental experiences. Primary 5 children have been asked to produce a Dental Visit Poster for the NSM competition; the winning school will receive the 'Sparkling Smile Trophy'. A total of 34 schools participated in the campaign with almost all primary 5 children involved in drawing a poster.

Caring for Smiles

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

The Care Inspectorate are currently considering the inclusion of this work in the national care home inspection.

Summary of Caring for Smiles Training

CARING FOR SMILE IN CARE HOMES			
No of care homes for older people in board area	146	No. of care staff in board area:	7424
SCQF-ACCREDITED TRAINING NUMBERS			
		2017-18	To date
Number of care homes participating (minimum of one staff member passing)		17	55
Number of care staff with pass at Foundation level		11	70
Number of care staff with pass at Intermediate level		0	21
NON-ACCREDITED TRAINING ATTENDANCE NUMBERS			
Number of care homes participating (minimum of one staff member trained) 224 excludes other disciplines & those trained twice (235)		40	167
Number of care staff attending a session		226	4677

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

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

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

All establishments are visited by an OHE on a monthly basis to carry out a baseline audit and update the dental registration figures which are reported back to the Oral Health Directorate. One establishment in East Dunbartonshire and one establishment in Renfrewshire do not engage in CfS monitoring. This issue has been raised with the HSCPs locally.

Additional Caring for Smiles Activity

Adaptations of the Caring for Smiles programme are also delivered to other members of staff these include:

- All new HCSW staff receive training (acute setting)
- Care at Home i.e. Share Scotland
- Adult care homes for residents who have a learning disability
- Respite Care Homes
- OHE to relatives and residents
- Visits to Older People groups
- Oral Health Education to adult day care centres
- Care Home Liaison Teams (our DHSW for CFS are employed and based with this team)
- Care Home Education Facilitators
- Care home nutrition group
- SALT Teams on request

A total of 526 staff have been trained. This training is provided routinely for some groups whilst for other this is on an ad hoc request basis.

The team react positively to any opportunity to influence the oral health of the population of GG&C and will continue to seek every opportunity to support and improve the oral health of the community and citizens of GG&C.

Key Findings and Recommendations

- Child oral health continues to improve in GG&C overall, but is still lower than the Scottish average

- Registration with an NHS dentist continues to rise in GG&C, but participation rates for young and middle aged adults could be improved

- The proportion of very young children registered with an NHS dentist remains unacceptably low

- Wide inequalities in oral health persist across the population and HSCP area in GG&C

- Innovative methods of spreading good oral health habits are bearing fruit in prison settings and with the Roma community

- Dental extraction under GA continues to reduce across the board area

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

- The Oral Health Improvement team will aim to improve links with NHS dental practice and provide support & training for Childsmile, particularly fluoride varnish application in areas where fluoride varnish programmes are not a focus to their HSCP area

- The Oral Health Improvement team will continue to work with partners in HSCP and education to improve the uptake and delivery of Childsmile programme, particularly in challenging areas where deprivation is high and there is low uptake or sustainability of school toothbrushing

- The Oral Health team will work with Children and Family's teams in HSCPs to ensure our continued focus is on improving registration to support outcomes for NDIP national inspection

- The Oral Health Team will work with the HSCP and partners to implement the recommendations of the Scottish Oral Health Improvement Plan

- The Oral Health Team will work with the HSCP to look for innovative ways to improve the oral health of their population and use HSCP intelligence to drive new methods of working

- The Oral Health Team will work the Care Home Liaison teams to increase dental registration amongst the residents to ensure appropriate dental intervention when required

- The Oral Health Team will strive to raise the profile of oral health across the board area to improve the oral health of the population in GG&C

Agenda Item Number: 7

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	28th June 2018
Subject Title	Draft Annual Performance Report 2017-18
Report By	Susan Manion Chief Officer
Contact Officer	Fiona McCulloch, Planning, Performance & Quality Manager

Purpose of Report	The purpose of this report is to detail the HSCP's achievements and progress made during 2017/18 against the priorities set out in the 2015-18 Strategic Plan.

Recommendations	It is recommended that the Board: a) note the content of the Draft Annual Performance Report b) approve the content of the draft report as presented

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

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

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

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

Economic Impact:	None.

Sustainability:	None.

Risk Implications:	None

Implications for East Dunbartonshire Council:	None.

Implications for NHS Greater Glasgow & Clyde:	None.

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

1.0 MAIN REPORT

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

1.2 The Public Bodies (Joint Working) (Scotland) Act 2014, Section 42 obliges all Health and Social Care Partnerships (HSCPs) to prepare and publish a Performance Report setting out an assessment of performance in planning and carrying out the integration function for which they are responsible. The required content of the Annual Performance Report is set out in The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014, laying out the minimum expectations on the content under the following headings:

- Assessing Performance in Relation to the National Health and Wellbeing Outcomes
- Reporting on Localities
- Financial Performance and Best Value

1.4 Under these headings, this report provides detailed descriptions on what has been achieved during 2017-18 towards achieving the priorities set out in the Strategic plan 2015-18.

1.5 The Strategic Plan focussed on adult services only as Children's Social Work Service and Criminal Justice Social Work Services were not delegated functions to the HSCP until August 2016. However, as these services are now integral to the delivery of the HSCP services, the progress against their specific outcomes is also included in this Report.

1.6 Annual Performance Reports are required to be published by the end of July each year.

East Dunbartonshire
Health & Social Care
Partnership

DRAFT

ANNUAL PERFORMANCE REPORT

2017- 2018

CONTENTS

PART 1. INTRODUCTION

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

This document represents the third Annual Performance Report produced by East Dunbartonshire Health and Social Care Partnership (HSCP), and relates to the key priorities for adult health and social care set out in the Strategic Plan (2015-2018). This report provides detailed descriptions on what has been achieved against these priorities during 2017-18. A range of reporting methods are used including qualitative information, statistical information, case studies, service user/carer feedback, and examples of good practice.

Children's Health and Social Work Services and the Criminal Justice Social Work Service became delegated functions to the HSCP in August 2016. As a consequence these services were not reflected in the Strategic Plan 2015-2018. However, as these services are now integral to the delivery of the HSCP services, the progress against their specific outcomes is also included in this Report.

The 'at a glance' overview in Section 2 provides the HSCP's progress achieved during 2017/18 in relation to:

- National Health & Wellbeing Outcome
- National Outcomes for Children
- National Outcomes for Justice
- National Core Indicators
- Scottish Government Ministerial Steering Group Data

Looking forward, the HSCP has agreed the Strategic Plan for 2018-21. Staff, partners, third sector, service users and carers were all involved in developing our future priorities. The Patient, Service User and Carer Group is now well established and integrated within the strategic decision making groups to help inform efficient and effective service delivery within East Dunbartonshire.

Chief Officer
East Dunbartonshire
HSCP

PART 2a PLAN AT A GLANCE

Each of the National Outcomes below has been assigned a RAG status to indicate the HSCP's assessment of overall performance during 2017/18. This has been based on the available data in the core indicators, and the achievements described within the Report.

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

NATIONAL OUTCOMES FOR CHILDREN	POSITIVE IMPACT EVIDENCED
Our children have the best possible start in life	✅
Our young people are successful learners, confident individuals, effective contributors and responsible citizens	✅
We have improved the life chances for children, young people and families at risk	✅

NATIONAL OUTCOMES FOR JUSTICE	POSITIVE IMPACT EVIDENCED
Community safety and public protection	✅
Reduction of offending	✅
Social inclusion to support desistance from offending	✅

RAG KEY

✅	Positive performance improved
⟷	Performance maintained (within 2% change)
❌	Negative performance

PART 2b PERFORMANCE AT A GLANCE

This section provides the data and RAG status of HSCP's performance against the national core indicators. The final column indicates the HSCP's Benchmarking Rank in relation to the 32 HSCPs across Scotland, with 1 being the best performing HSCP.

NATIONAL CORE INDICATORS - Outcome Indicators		Related National Outcome	2015/16	2017/18	RAG Status	Benchmark Rank
1	Percentage of adults able to look after their health very well or quite well	1	95%	96%		1
2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	2	88%	84%		8
3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	2, 3	84%	86%		1
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	3, 9	75%	84%		3
5	Total percentage of adults receiving any care or support who rated it as excellent or good	3	84%	84%		6
6	Percentage of people with positive experience of the care provided by their GP practice	3	91%	90%		2
7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	4	86%	83%		7
8	Total combined % carers who feel supported to continue in their caring role	6	45%	41%		6
9	Percentage of adults supported at home who agreed they felt safe	7	86%	87%		5

NATIONAL CORE INDICATORS - Data Indicators		Related National Outcome	2016/17	2017/18	RAG Status	
11	Premature mortality rate per 100,000 persons	1, 5	345	N/A		6
12	Emergency admission rate (per 100,000 population)	1, 2, 4, 5	12,330	10,787		12
13	Emergency bed day rate (per 100,000 population)	2, 4, 7	125,189	109,384		14
14	Readmission to hospital within 28 days (per 1,000 population)	2, 4, 7, 9	82	73		3
15	Proportion of last 6 months of life spent at home or in a community setting	2, 3, 9	87%	89%		18
16	Falls rate per 1,000 population aged 65+	2, 4, 7, 9	21	22		18
17	Proportion of care services graded ‘good’ (4) or better in Care Inspectorate inspections	3, 4, 7	86%	82%		27
18	Percentage of adults with intensive care needs receiving care at home	2	67%	67%		9
19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	2, 3, 4, 9	186	231		4
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	2, 4, 7, 9	23%	21%		7

MINISTERIAL STEERING GROUP PERFORMANCE DATA	Related National Outcome	2015/16	2016/17	2017/18	RAG Status
Unplanned admissions	**1, 2, 4, 5**	11,737	11,308	10,259*	
Unplanned bed days	**2, 4, 7**	83,115	83,151	76,320*	
A&E attendances	**1, 2, 9**	27,122	27,289	27,791	
Delayed discharge bed days	**2, 3, 4, 9**	4,838	3,119	3,553	
Last 6 months of life	**2, 3, 9**	85.5%	87.1%	N/A	
Balance of Care (% of population in community or institutional settings)	**2, 4, 9**	2.3%	2.3%	N/A	

Detailed data and charts regarding the HSCP performance during 2017/18 can be found in the Quarter Performance Reports published with the HSCP Board papers on our website:
https://www.eastdunbarton.gov.uk/health-and-social-care/health-and-social-care-services/east-dunbartonshire-health-and-social-care

PART 3. DELIVERING THE NATIONAL OUTCOMES

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

WHAT WERE OUR 2017/18 STRATEGIC PRIORITIES FOR THIS OUTCOME

- Supporting the population to adopt healthy lifestyles
- Deliver the national Detect Cancer Early programme, both universally and targeted
- Strengthen and further develop co-productive approaches to enhance people's roles
- Improve access to primary care services

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- A series of Cookery and Skills Development courses has been established for adults with learning disabilities to equip people with cookery, budgeting and shopping skills in preparedness for living a more independent life.
- Developed an enhanced monitoring and weight management programme for adults with learning disabilities who are wheelchair users to monitor and support weight management and nutritional status. This service has supported **25** attendees since being established, removing barriers that prevent health equality for adults with learning disabilites. The service also provided an opportuniy to identify other health issues and take preventative measures.
- **633** Alcohol Brief Interventions were carried out over the year, providing opportunity to highlight to people that their alcohol consumption was above recommended safe levels, and advise on reducing their alcohol intake.
- **287** local people attended a range of organised discussions and activities, with an emphasis on engaging with hard to reach groups, aimed at improving the public's awareness and confidence to encourage an increase in uptake of cancer screeing.
- A 'smear test amnesty day' project in partnership with Auchinairn Medical Practice encouraged **78** women to attend for a smear test with some being invited back for further consultations. The women appreciated the more relaxed welcoming atmosphere and the opportunity to ask questions. **90%** of women asked said that they would share their experience and encourage other women to attend
- The Diabetes Nursing service continue to provide monthly group education for up to 10 newly diagnosed type 2 diabetes as well as the provision of ongoing self

management. A text and email support and advice is offered to people who are unable to attend clinics. This increased support has encouraged **59.6%** of clients to completed the '9 processes of care' annual screeing and monitoring programme (GG&C =44.7%).

- Developed a community safety checklist to support early identification of falls risk and management.

Case Study

Jen was more than 15 years overdue for her smear test. She was so nervous that she hadn't slept the previous night. She was tearful in the waiting area and felt calmer after tea and chat with us. After her test she came back to the waiting room feeling so relieved, really happy and determined not to miss future tests. She said it was totally fine and couldn't believe she had worried so much.

Staff presenting 'Stress & Distress' Poster at National NHS Conference, June 2017

Outcome 2

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

WHAT WERE OUR 2017/18 STRATEGIC PRIORITIES FOR THIS OUTCOME

- Strengthening community services for older people to avoid unplanned hospital admissions and to support people to remain in an appropriate setting
- Develop long term solutions in the community for adults with learning disability and physical disabilities.
- Develop and consolidate augmented system of care for people with mental health, alcohol and drug problems
- People with dementia have support and access to services
- Test and promote models of self management for people with long term conditions
- Work with the care home sector to develop an enhanced model
- Develop condition specific strategies for people with:
    - → physical disability
    - → sensory impairment
    - → autism.
- Expand availability of a range of aids, adaptations and equipment in homes to support independent living

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- **89** people were discharged from hospital into the HSCP Intermediate Care Unit during 2017/18, of which **17%** returned to their own homes following a period of rehabilitation; **75%** transferred to a suitable Care Home; **6%** were readmitted to hospital and **2%** died
- During 2017/18, Homecare received **2,449** referrals and undertook **1,121,503** visits to support vulnerable people to remain as independent as they were able in their own homes.
- Rapid Response Service has established a pathway between A&E and the Community Rehabilitation Team to provide next day response. During 2017/18, the service prevented approximately **33%** of referrals being admitted to hospital.
- Establishing pathways across primary care, social work, health improvement, Home Care & Third Sector organisations to ensure those at risk are identified at an early stage and have access where required to a multi-factorial assessment and determine what actions are required to prevent and /or manage future falls.
- Rolled out an agreed pathway between the Scottish Ambulance Service and Community Rehabilitation for referral of non injured fallers to prevent unnecessary

conveyance to hospital.

- Introduction of 'Take the Balance Challenge' across the HSCP. This tool allows participants to evaluate their own balance and strength. If participants identify any issues in their balance the challenge recommends 'The Super Six'. These are exercises designed to build and sustain strength and balance going into later life.
- Piloted a Young Onset Dementia Womens' Group as it was identified that there was a higher proportion of young women with diagnosis of Young Onset Dementia. The group improved cognigition and level of function, social connections and quality of life outcomes for these women. It also helped carers to find supports and delivered Psycho-education to improve resilience.
- Post Diagnostic Support services continue to be developed utilising a mixed model with a team comprised of NHS and Alzheimer Scotland Link Workers.
- District Nursing service undertook **52,582** visits to people with disablities, long term conditions, or who are frail, over the last year. They also set up a local Bladder Health group to reduce unplanned catherter changes for people with disablities, and initial data suggest a **25%** reduction in unplanned changes.
- A robust pathway has been developed between primary and secondary care to improve pathways for people affected by cancer, and for people with cancer to have improved access to community support services. Futher to the pathway **55** people were offered a full Holistic Needs Assesment as a component of there ongoing Cancer review programme.

Case Study

Mrs A who had previously experienced two failed discharges after sustaining a head injury and several falls, was readmitted to hospital. Following a further readmission, the hospital staff referred her to social work with concerns regarding her being able to return home. Also, her husband was feeling very stressed as the sole carer and was not receiving support from social care services. Mrs A was transferred to the intermediate care unit where an assessment identified that she would benefit from an environmental visit and physiotherapy review at home, including a review of equipment in the home that had previously been provided.

Mrs A was discharged home from the intermediate care unit with a comprehensive care package including homecare provision, physiotherapy aid and a respite package for her husband. She and her husband felt well supported by the intermediate care staff and were very grateful for the interventions from the whole team, and Mrs A has continued to remain at home seven months after discharge.

Relative's Comment

"Our experience of the Intermediate Care Unit was very positive. It afforded us the opportunity to establish the care needs of my grandmother following her stay in hospital. We could investigate, in a safe environment, whether my grandmother could cope with moving from the nursing care provided in the hospital to the residential care offered in the Intermediate Care Unit and ultimately establish

whether she could cope at home with support".

Case Study

Mrs B had stopped socialising and was going to cancel a planned holiday with family because of a chronic wound. The District Nursing Service were visiting daily to provide wound management, and to support Mrs B to self manage her wound. Mrs B's wound improved with self management and the District Nurses reduced their visits to fortnightly. As a result, Mrs B was able to go on holiday with her family and resume social activities.

Members of the Homecare Team

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

WHAT WERE OUR 2017/18 STRATEGIC PRIORITIES FOR THIS OUTCOME

- Promote SDS as a positive option to develop creative solutions to support independence
- Embed systems that effectively capture service user experience and views to inform service improvement
- Develop an effective and empowered service user and carer group

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- In 2017/18 there were **1,918** service users actively utilising SDS. During 2017/18, there was a 20.7% rise in people choosing option 3 (local authority arranged services), and a 14% rise in people choosing option 4, utilising a mixture of direct payment and local authority arranged services. The percentage of service users choosing to utilise a single option of direct payment (option 1), or individual service fund (option 2), reduced by 1.5% and 8% respectively during the year.
- People with palliative and end of life care needs have been supported to die in their preferred place of care and support them to remain in a homely setting. There were 220 deaths of patients on the Palliative Care register during 2017-18 of which **89%** had their preferred place of care achieved. (74% at home or homely setting, 13% died in hospital, 13% in hospice).
- District Nursing "How are we doing?" survey had **100%** of respondents report that they agreed/strongly agreed the service gave them the care they needed, when they needed it and how they needed it. Also **100%** of carers of patients known to the service for end of life care agreed/strongly agreed that they got the help that was needed, when it was needed and how it was wanted. Qualiatitive data demonstrates high levels of carer satisfaction.
- Home Care provided satisfaction surveys to all service users receiving re-ablement, complex and private provision, and received a 51% response rate. **100%** of respondents stated they were 'satisfied' or 'very satisfied' with the quality of service. A freepost envelope is now being provided, to increase level of response rates.
- Community Mental Health introduced improved assessment clinics for non discipline specific referrals, resulting in quicker access and treatment for service users.
- Provided training for care home staff across East Dunbartonshire in the use of

the Scottish Palliative Action Register.(SPAR). Care Home Liaison service delivering ongoing support to care home staff around the early identification and the prevention of hospital admission for patients approaching end of life.

Clients' Comments

"We were very impressed with the level of care from the homecare team. They made my mum's recovery a lot easier (and peace of mind for me!) A big thank you all round."

"The help my husband received from your reablement carers after being discharged from Gartnavel Royal was, without doubt, the reason he improved so rapidly."

"I am writing to express our thanks to all the care team for the excellent care given to our mum over the last few months. The carer's kindness, care, good humour and professionalism all made mum's time back home a lot easier and was also greatly appreciated by all the family."

Stakeholder and Public Engagement Event

A local Self Directed Support conference 'My Own Story in East Dunbartonshire' was held in March 2018, bringing together service users, carers, elected members, social work, health practitioners, senior managers, social care providers and voluntary organisations. Conference attendees learned about:

- The principles, values and Self Directed Support options;
- The support available for our third sector partners;
- Personal accounts from service users and carers who have experienced taking choice and control over how their social care support is delivered;
- The positive impact, barriers and challenges that people experienced, and dispelling the SDS myths.

Outcome 4

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

WHAT WERE OUR 2017/18 STRATEGIC PRIORITIES FOR THIS OUTCOME

- Build community capacity and develop volunteering opportunities to enhance peoples' role in their community
- Develop and implement programmes to improve quality of life for people impacted by long term conditions
- Implement a single point of access into the Third sector to meet the wider holistic needs of the population
- Implement *Keys to Life* recommendations

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- Continued to embed the successful '*Stress and Distress in Dementia'* approach to improve the management of client distress within care homes and reduce unscheduled care admissions. Training has now been given to a second cohort of Consultant Psychiatrists, Care Home Managers, GPs, Social Work Hospital Assessment and Older People Social Workers.
- Built local evidence to the benefits of social prescribing for patients and health professionsals
- Re-engaged patients back into their community through increased partcipation in community activities and involvement in local services, groups and organisations.
- Continued to support OPAL which provides single point of contact for people requiring advice or support from within their local community regarding, for example, long-term health conditions, support for carers, financial advice, or local groups. During 2017/18, OPAL received **397** calls which led to people being signposted to an average **2.5** local support services.
- Commenced review and redesign of Learning Disability services to create a service for service users that is modernised, sustainable and flexible, taking forward the recommendations in the Keys to Life.
- Working to embed recovery outcomes focussed care planning within adult CMHT service delivery.
- Development of the Supported Living Services Framework to improve recovery outcomes focus and consistency of approach across HSCP.
- Re-launched and restructured the Mental Health Recovery Inclusion Group
- Introduced formulation driven care plans, within Older People's Mental Health, that are shared with all care givers and also acute services when there is an unscheduled admission, to provide person centred information and improve care.

- East Dunbartonshire HSCP Local Area Coordination(LAC) service provides advice and direct support to adults affected by autism and they have a range of community based projects, often co-produced with the aim of being self sustaining in the future They have also developed a number of new intititives in 2017/18.
- Care Home quality support meetings have been established to improve sharing of information between Adult and Mental Health Care Home Liaison Nurses, ED contract monitoring team and the Care Inspectorate.
- Developed a pathway between Scottish Fire & Rescue and Scottish Ambulance Service to refer people they identify as vulnerable to the Community Reabilitation Team.
- Initiated local client access to a Consultant Psychiartist for those with addictions who would previously have been required to travel to Glasgow hospitals. The Consultatnt is also available to support complex case reviews and multi agency meetings as well as one to one support.
- Development of Specilaist post for Alcohol Care & Treatment Nurse who can offer home based detox which was previously a service gap in local services.

Case Study

An older man with significant long standing alcohol problems and possible alcohol related brain damage was refusing to engage with support services and had previoulsy defaulted on all appointments provided outwith East Dunbartonshire. His wife was experiencing considerable carer stress which was affecting her physical and mental wellbeing. With the introduction of local enhanced medical support, the Consultant was able to engage directly with this gentleman in East Dunbartonshire and this resulted in Mr D agreeing to required inpatient treatment. Local medical support also ensured that Mr D accessed his treatment timeously, and that a range of supports for both Mr D and his wife were coordinated through the Drug and Alcohol service to enhance a positive outcome.

Consultant Psychiartist Feedback on the 'Formulation' Care Plan

"I met Mrs E following an unscheduled admission to the ward from her Care Home, and due to the excellent work in her Stress and Distress formulation I actually felt like I knew her and was way ahead of the curve in her care and management. Mrs E has expressive and receptive dysphasia and to get a formulation like this and the background info is tremendous. When I spoke with her son and summarised what I understood of Mrs E, he was amazed that I could know her so well. I explained this was due to the detailed information you he added to Mrs E's story. Thank you for the work you are doing and know that it greatly benefits both clients and colleagues".

Outcome 5 **Health and social care services contribute to reducing health inequalities.**

WHAT WERE OUR 2017/18 STRATEGIC PRIORITIES FOR THIS OUTCOME

- Reflect health and social care priorities in the PLACE programme
- Develop targeted low intensity peer led programmes and services that improve health
- Develop a trauma informed practice approach with people experiencing drug, alcohol and/or mental health problems
- Ameliorate the impact of welfare reform and poverty
- Support people experiencing drug, alcohol and/or mental health problems into employment as part of a recovery orientated system of care
- Potential disadvantage to particular individuals and communities are identified and actioned
- Implement the duties set out in the Equality Act 2010 with regard to the personal characteristics that are protected

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- East Dunbartonshire Recovery Week in September 2017, led by the Alcohol and Drug Partnership with support from third sector partners and local groups, was community focussed and aimed to raise awareness, and reduce stigma and discrimination with regards to people who have experienced alcohol and drug issues. There were an extensive range of inclusive events and activities such as a recovery football tournament; communitiy recovery cafes; coffee morning; community allotment; family events, and a Recovery Walk led by the Scottish Recovery Consortium. The event seeks to break down barriers and explore experiences of stigma experienced by those who have expereinced issues with alcohol or drugs and is an opportunity to identify challenges, share successes and draw upon lived-experience to set out a collective vision of how we will can work together to change stigma to respect.
- Through a process of of shared responsibilities through establishing a referral pathway for HSCP teams, and partnership working the Income Maximisation Programme, the Health Improvement team have established a best practice model for addressing the issues assiociated with low income and poverty for service users with young children and/or with a disability and for our older service users.A total **270** referrals were made to the programme,resulting in a combined income gain of **£758,000** (an average £2,806 per referral).
- Began process of refreshing the PLACE plans to take account of Health & Social Care priorities and to specifically focus on tackling inequalities.

Empowering People

As part of Recovery Month an East Dunbartonshire resident spoke at a national event which was supported by the Scottish Government and Scottish Recovery Consortium, '*Recovering Connections – Challenging Stigma to Respect*'. Their speech was a very powerful insight into the experiences and the supports they had received within East Dunbartonshire which had supported their recovery journey

Empowering Communities

The East Dunbartonshire HSCP Local Area Coordination(LAC) service provides advice and support to adults affected by autism through a range of community based projects. One of the initiatives established in 2017/18 was the development of a community band, weekly songwriting sessions and group rehearsals, involving up to 20 adults. Initially set up by the LACs, in partnership with Drake Music Scotland as an opportunity for people with autism to develop their music skills, the Band is now a self-supporting group with its own funds and committee structure. The Band has also produced a CD of original material, and was the opening act at last year's Big Helix Picnic in Falkirk.

Sharing Information at Staff Awards Event

Outcome 6

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

WHAT WERE OUR 2017/18 STRATEGIC PRIORITIES FOR THIS OUTCOME

- Update and implement the East Dunbartonshire Strategy for Carers and supporting action plan, reflecting the priorities emerging in the Carers (Scotland) Bill
- Ensure carer involvement and contribution at all relevant strategic levels of planning and delivery of services

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- Planned and prepared for the introduction of the Carers (Scotland) Act 2016 in partnership with the third sector and carers, including, the consultation and publication of the Eligibility Criteria for Carers, development of adult support plans and young carers statements, and staff awareness and development sessions
- **46** carer wellbeing reviews have been completed through the East Dunbartonshire Wellbeing Programme that supports carers and people with Long Term Conditions to improve their overall health and wellbeing through reducing isolation, enabling them to fulfil their caring role and to supporting them to live well in their own community.
- Established an Autism Parents' & Carers' Forum that meets six times a year, and is primarily concerned with promoting mutual support and the exchange of experiences between families. A particular focus is establishing links between parents of newly-diagnosed children with those already receiving services and are aware of services and supports available.
- Supported Carers through the Pubic, Service User and Carer Group to actively participate in HSCP Board, Startegic Planning, and Locality Planning groups as well as consultations startegic plans and service developments

Case Study

Mrs L attended for a wellbeing review at Carers Link and it was identified that she was struggling with caring for her husband and the issues that surround the complexity of his long term condition. As a result, she was not eating or drinking regularly, and was lonely because she could not get out and about. Her stress was causing her to feel frustrated with her husband.

Carers Link liaised with social services on behalf of Mrs L which resulted in her receiving support with personal care and food preparation for her husband, and arranged support from the Befriending Service to enable Mrs L to be out and about. Mrs L is now feeling supported, calm and less lonely.

Outcome 7

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

WHAT WERE OUR 2017/18 STRATEGIC PRIORITIES FOR THIS OUTCOME

- People receive high quality care and are safe from harm
- Implement an outcome focussed person centred approach to safe guarding adults
- A public protection governance structure in place that supports front line service delivery

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- Five Care Homes in East Dunbartonshire HSCP, along with 4 other Health Boards, participated in a Health Improvement Scotland (HIS) pilot project to reduce the incidence of pressure ulcers in Care Homes. The Scottish Patient Safety Programme (SPSP) in partnership with the Care Inspectorate and Scottish Care supported the teams to use a Quality Improvement approach to develop and test a range of tools to improve prevention, risk assessment, accurate identification and record keeping. One Care Home in East Dunbartonshire was selected for a case study as part of the evaluation of the project and the findings demonstrated clearly the benefits of the project. The Care Home staff embraced and led the changes that were implemented which has led to better outcomes for the residents.
- Tissue viability meetings have been established with a tissue viablity link nurse representative from each care home to increase knowledge and support for carehome staff.
- The risk for people with urinary catheters aquiring Catheter Associated Urinary Tract Infection has been reduced they have received insertion and maintenance care bundles. Compliance is **100%** for the insertion bundle and **99%** for the maintenance bundle.
- East Dunbartonshire HSCP, colleagues from Health Improvement Scotland and Living Well in Communities piloted the national tool for prevention of falls and fractures within 4 care homes in East Dunbartonshire. Evaluation from the pilot shows that falls were reduced by between 50 & 62%.
- There have been a number of actions and initiatives during 2017-18 to support vulnerable adults:
    - A Public Protection conference was held to explore improved joint working to better to protect people affected by sexual and gender-based violence across the lifespan.
    - Worked with Empowered Violence Against Women multi-agency partnership

to implement multi-agency risk assessment arrangements and reduce the risk of domestic abuse for women and children in East Dunbartonshire.

  - Developed a multi-agency process to support and protect young adults at risk of harm and exploitation, which was a recommendation of the 2017 multi-agency case file audit.
  - Began to develop a policy for residential care staff that will support adults with learning disabilities to use social media safely
  - 13 HSCP staff have been trained to act as Appropriate Adults to improve access to justice for adults with learning disabilities or mental health conditions where they have been a victim or witness to a crime.
  - Continued to embed the thresholds framework locally, with a seminar for care at home providers
  - Collaborated with NHSGGC to monitor and improve recording and reporting of incidents involving East Dunbartonshire residents who are receiving in-patient services from Glasgow City HSCP.

- Established a Blood Bourne Virus (BBV) Clinic within East Dunbartonshire Alcohol and Drug Service in response to the increasing numbers of adults contracting a BBV. A local clinic enables a holistic harm reduction approach with a public protection focus in terms of education and the reduction of community transmission rates of BBV. It also provides a more seamless support service to treating and removing HepC, Opiate Repalcement Therapy clincs, Recovery services and local support services.
- Training package developed for ED Homecarers to increase the recognition and understand the risks associated with malnutrition.
- The Care Inspectorate inspected, **8** services in East Dunbartonshire during 2017/18, and the majority of findings were extremely positive, indicating the quality of services delivered. Plans are in progress for areas identified as requiring some improvement. The full inspection reports can be found on the Care Inspectorate web page: http://www.careinspectorate.com/index.php/type-of-care

Outcome 8

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

WHAT WERE OUR 2017/18 STRATEGIC PRIORITIES FOR THIS OUTCOME

- Securing visibility of clinical and professional leadership in governance arrangements
- Equip staff to have the knowledge and skills to continuously improve their practice and influence service development
- Create a confident, competent integrated workforce

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- Home care have established a Quality Circle within their team to meaningfully involve all homecare staff in workplace and service improvement. Staff have embraced the opportunity to influence practice, and being able to participate in the problem solving process that leads to improvement in the quality of service they provide.
- Continuously improved our approach to Clinical & Care Governance in 2017/18 and reviewed the membership of the group to ensure visible clinical and professional leadership.
- The iMatter survey collected of staff views on their experience of working for the HSCP. The response rate for participation was considerably higher than previous staff surveys with an overall return of **67%**. The HSCP achieved over 67% for all but one question, *Monitor to Further Improve*, which scored 60%, suggesting that staff do not feel as involved as they would like in decision that affect them. The Employee Engagement Index (EEI), that rated how staff experience across the HSCP, was **78%** which was above the Scottish average.
- Workforce learning and development has continued to be a priority. During 2017/18 there was an 89% uptake of Personal Development Reviews (PDR) for social care staff and 66% uptake Knoweldge Skills Framework (KSF) reviews for health staff.

Outcome 9

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

WHAT WERE OUR 2017/18 STRATEGIC PRIORITIES FOR THIS OUTCOME

- Develop a commissioning strategy that drives a delivery model that reflects best value and agreed strategic priorities
- Develop a shared system of care and support
- Agree described outcomes and link investment to them

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- The District Nurses have achieved an **86%** compliance with the wound care formulary, (the GG&C average is 78%).
- Completed a profile of the Localities with the Local Information Support Team to inform effective service delivery.
- Significant improvments have been made with access to Clinical Portal for both Health & Social Care staff, to provide access to client information and improve shared care and support.
- Care Home quality support meetings have been established to improve sharing of information between Adult and Mental Health Care Home Liaison Nurses, East Dunbartonshire contract monitoring team and the Care Inspectorate.
- Staff sickness and absence has remained an issue, and managers have been focussed on providing appropriate supports to staff in order to improve and maximise attendance.
- Appropriate skill mixing has been considered when suitable opportunities have arisen to maximise efficient use of staff and resources.

Outcome for Children (1)

Our children have the best possible start in life

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- The East Dunbartonshire Delivering for Children and Young People's Partnership (DCYPP) directed the strategic planning, development and delivery of young people's services, and set priorities the in Integrated Children's Services Plan 2017-2020 which would be delivered during 2017/18. Those for which the HSCP has responsibility follow below.
    - Improving child health through supporting breastfeeding, promoting oral health and dental registration and parenting programmes
    - Evaluations for Pre 5 Immunisation geographical clinic implemented in Kirkintilloch from March 2018 reports above **90%** service user satisfaction. Transformation programme will be fully implemented across the HSCP by December 2018.
    - The UNICEF re-accrediatation result was 'excellent' for the 20 standards relating to staff knowledge, none fell below the 80% threshold and a number of staff reached 100%. Service user evaluation for breast feeding support was reported as 'extremely positive'. The Children & Families team participated in the UNICEF Achieving Sustainability Gold Award process and are awaiting the outcome.
    - There was a **98%** uptake of the 27- 30 month assessment achieved in 2017-18, well above the **85%** target.
    - Interventions that improve healthy development were targeted at children living in the most deprived communities of East Dunbartonshire, including Healthier Wealthier Children, Healthy Start, Oral Health initiatives, and second hand smoke reduction.

Client Feedback

"I am writing to express my thanks and appreciation to your health visiting team following the birth of my first child. I was struggling with breast feeding but the level of care I received was of the highest quality. I would also like to highlight the support I received at the breast feeding support group which allowed me to make new friends and gain invaluable advice from like-minded parents. Please accept my gratitude for the support and care over the past 16 months. As a result of your team's skill and professionalism, I look back on my experience positively and owe that primarily to your team".

Outcome for Children (2)

Our young people are successful learners, confident individuals, effective contributors and responsible citizens

- East Dunbartonshire Education services have the overarching responsibility for delivering on this outcome. The HSCP support Education to ensure the delivery of Outcome 3 in the Local Outcome Improvement Plan to ensure children and young people are safe healthy and ready to learn, through our contribution to the implementation of the Integrated Children's Services Plan

Outcome for Children (3)

We have improved the life chances for children, young people and families at risk

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- Significant improvement in relation to the number of Child Protection Case Conferences being held within 21 days of the Child Protection Investigation. The target is 90% and in the last quarter he Children and Families Social Work Team reported **100%**.
- Designed and implemented a multi-agency Child Protection training programme which was positively evaluated by staff.
- Following the Care Inspectorate's inspection of the Fostering and Adoption Service, an action plan was agreed to ensure improvements in service delivery were maintained. The action plan included strategy for the safe recruitment and retention of Foster Carers and Adopters, as well as a training plan and mechanisms for quality assurance.
- Continued to analyse the balance of care and ensure vulnerable LAAC children have their needs met in appropriate placements which promote their wellbeing.
- The Corporate Parenting Steering Group worked to implement an action plan that ensured Corporate Parenting responsibilities were realised. Funding has been secured to develop a mentoring programme for Young People who have been previously Looked After.

Example of Good Practice

A Child Protection Case Conference can be a very difficult and emotional experience for some parents as their parenting skills are under scrutiny and their circumstances are being analysed. At every Case Conference the parent is asked to complete a short exit survey. Despite some very challenging meetings the following feedback indicates that the staff involved are extremely skilled in the Child Protection task:

- All parents and carers felt they were given the opportunity to express their views at the meeting. There were no comments.
- All parents/carers felt that the decisions of the meeting were explained to them. There were no comments.
- All parents/carers indicated that they were treated respectfully during the process.

Children & Families Team representatives receiving a 2017 NHS Chairman's Award

Outcome for Justice (1)

Community safety and public protection

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- Letter of recognition from Deputy Director, Community Justice, Scottish Government acknowledging that EDC had one of the highest rates successful community payback completions in Scotland (2016/7). Visit from Scottish Government representative to observe Criminal Justice Service and share our approach to this work.
- Continue to provide service to the Parole Board for Scotland to assist members to compile Licence Conditions and make defensible decisions in relation to the release of the most serious offenders who are due to be considered for Parole or release at their earliest date of liberation. During 2017/18 **252** reports were submitted.
- Continue to prioritise high risk offenders through partnership working with a range of agencies which contribute to the public protection agenda and work towards the community being a safer place to live and work.

Outcome for Justice (2)

Reduction of offending

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- Continue to support the Courts in relation to the provision of Criminal Justice Social Work Reports with an average of **99%** within timescale. This assists Sheriffs and Judges as an aid to sentencing and implementing community payback orders aimed at reducing reoffending.
- To enhance public protection, Criminal Justice staff have been trained to deliver the Moving Forward Making Changes specialist Programme. This programme aligns with national best practice and is tailored to address the risks and needs of Registered Sex Offenders in an effort to reduce reoffending and create safer communities.
- Within the year 2017/18, the total number of unpaid work hours completed by service users subject supervised work in East Dunbartonshire is **20,643** hours of unpaid work. This equates to just under **£161,634** of unpaid work paid back for the benefit the ED community (based on National Minimum Wage).

Outcome for Justice (3)

Social inclusion to support desistance from offending

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- Re-established and reinvigorated the Community Justice Partnership to meet the objectives in the Community Justice Outcome Improvement plan to create safer and stronger communities. The move towards Community Justice promotes local accountability, inclusion and safer communities.
- Engaged in a national study pilot with regards to Adverse Childhood Experiences (ACES) and the impact this had in supporting therapeutic change and compliance with service users subject to community payback orders. This ties in with the Community Justice agenda and is sponsored by Community Justice Scotland.

Example of Good Practice

Criminal justice Unpaid Work has provided ground maintenance support at Kelvinbank Resource Centre for many years. This has included building a sensory garden for those accessing the service. Gardening is a highly therapeutic activity for service users of the Centre and during 2017/18 the Unpaid Work team have cleaned up and restored a greenhouse for service users to use to grow plants, and they are currently undertaking a garden clean-up to allow for the creation of a Garden Club for the service users. Other work has included painting rooms in the Resource Centre to make them more presentable for the service users.

Within a criminal justice focus group, service users subject to Unpaid Work have stated that they are willing and motivated to undertake this type of work as they can really see the difference they are making in terms of the progress and the benefit to people with disabilities.

PART 4. LOCALITY PLANNING

The Public Bodies (Joint Working) (Scotland) Act 2014 specifies that Health and Social Care Partnerships set up two or more localities to enable service planning at a locally relevant level. Localities aren't hard lines on a map, rather they represent natural communities within the partnership area. The East Dunbartonshire Health and Social Care Partnership has agreed an East and a West locality. Each locality has a Locality Planning Group with a wide range of participation. The Locality Planning Groups inform the work of the Strategic Planning Group which in turn informs the work of the Health and Social Care Partnership Board.

ACHIEVEMENTS IN RELATION TO 2017/18 PRIORITIES

- Recently secured accomodation and established a Men's Shed project in Bearsden of which over **40** men have become members The Men's Shed provides opportunities to reduce social isolation for men living in the community and replicats the well established East Locality Men's Shed. Our localities are sharing information and ideas and learning from each other
- Improved the wellbeing of service users through supporting them to access non-clinical sources of support within the community. This led to a reduction of inappropriate GP consultations. The development of this project came as a result of the locality group identifying that there was a significant amount of GP consultation time spent with people whose support needs were not best met by seeing a GP. These people are now enabled to access different and more appropriate forms of support by 'wellbeing workers'. The outcomes for these people are better than they were before and GP time is freed up for other patients.
- Supported the further development of Dementia Friendly Communities
- Established links with local cancer prevention group to improved coordinated services
- Contributed to the consultations on the Learning Disability Strategy, and Eligibility Criteria for Carers, and contributed to the setting of priorities for the HSCP Strategic Plan 2018-21.

- Discussions informed the redesign of day care services from a traditional model towards a model focused on linking individuals into local services.
- Developed effective links with the Community Planning Partnership and the work they are doing around place plans for specific areas. This work will develop further in the coming year.
- Both locality planning groups began a review of their effectiveness and agreed to develop a revised terms of reference

GP Feedback on Wellbeing Reviews

"I have literally just finished speaking to one of your clients who was saying how life changing your involvement has been.....I can say universally that every patient you have seen has needed little or no contact time with me since as a result of your support"

Engaging in prioirity setting with Locality Group members

PART 5. FINANCE

HSCP BOARD'S POSITION AT 31 MARCH 2018

The activities of the Health and Social Care Partnership are funded through an arrangement whereby the Council and Health Board agree their respective contributions and it is for the partnership thereafter to deliver on the priorities set out in the Strategic Plan. The scope of budgets agreed for inclusion within the HSCP for 2017/18 from each of the partnership bodies were:-

HSCP Board Budgets 2017/18 (from the 1st April 2017 to the 31st March 2018)

HSCP Board Health Budget	£82,340,000
HSCP Board Social Work Budget Adult Services	£39,383,000
HSCP Board Social Work Budget Children & Criminal Justice Services	£11,297,000
HSCP Board Social Work Budget Other	£ 1,230,000
Set Aside – Share of Prescribed Acute functions	£17,381,000
TOTAL	**£151,631,000**

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

The Health Budget includes an element relating to Oral Health Services (£10.1m) which is a service hosted by East Dunbartonshire HSCP and delivered across the other five partnership areas within Greater Glasgow & Clyde (GG&C).

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

The extent to which these services (incl Oral Health) are consumed by the population of East Dunbartonshire is reflected below:-

2016/17 £000		2017/18 £000
524	MSK Physio	356
61	Retinal Screening	66
506	Podiatry	535
408	Primary Care Support	317
379	Continence	342
656	Sexual Health	631
91	Learning Disability	0
1,546	Mental Health Services	1,135
	Oral Health	831
948	Addiction	939
153	Prison Healthcare	161
176	Healthcare in Police Custody	189
2,374	General Psychiatry	2,339
4,610	Old Age Psychiatry	1,927
12,432	**Total Cost of Services consumed within East Dunbartonshire**	**9,768**

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

Work has progressed over the year to develop a more accurate costing framework for unscheduled care services to make this allocation more real reflective of usage of these services and facilitates the resource shift required to deliver sustainable services within the community as opposed to a hospital setting. An allocation has been determined by the Greater Glasgow & Clyde Health Board for East Dunbartonshire of £17.4m.

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

KEY RISKS AND UNCERTAINTIES

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

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

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.

Additional funding of £107m (ED Share - £1.8m) has been provided to Health and Social Care Partnerships during 2017/18 to support providers to pay the living wage to care workers and has provided some capacity to address social care pressures.

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

- The increased demand for services alongside reducing resources. In particular, the demographic increases predicted within East Dunbartonshire is significant with the numbers of older people aged 65+ is set to increase by 54% over the period 2012-2037 (an average increase of 11% every 5 years).

  In addition, more significantly older people aged 85+ is set to increase by 201.4% over the period 2012-2037 (an average increase of 40% every 5 years).

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

- The cost and demand volatility across the prescribing budget which has been significant during 17/18 as a result of a number of drugs continuing to be on short supply resulting in significant increase in prices. This will be particularly relevant for the partnership into 2018/19 with the cessation of the risk sharing arrangement across GG&C where the risks and cost pressures will have to be managed within the partnership.

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

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

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

FINANCIAL PERFORMANCE 2017/18

The partnership's performance is presented in the Annual Accounts 2017/18 and shows a surplus on budget of £947k on the partnership funding available for 2017/18 due largely to monies allocated throughout the year for specific purposes.

This has been the subject of regular reporting throughout the financial year and relates to a favourable position for primary care services within the Oral Health Directorate due, largely, to staff turnover and vacancies across the service. There were also additional monies allocated late in the year to support the development of GP Clusters as part of the Primary Care Transformation Fund which have been earmarked within reserves with planned expenditure during 2018/19.

There was a small under spend position in relation to NHS Community budgets as a result of some residual capacity within delayed discharge funding and planned savings generated from staff turnover to mitigate pressures on prescribing which were not required in year. There were some pressures in respect of these challenging turnover savings in some areas such as alcohol & drug services, adult community services and elderly mental health services which has offset the year end position.

In terms of the functions delegated in respect of Social Work Services - there was significant pressure in relation to Adult and Children's Social Work services of £2.1m during the year which required the application of general reserves to deliver a breakeven position for the year.

These arose as a result of continued pressures on residential and fostering placements for children due to a combination of additional demands and restrictions on placements within our in-house residential provision with places held in the expectation that a number of Asylum Seeking children will be placed within East Dunbartonshire. This was offset to some extent through vacancy management within Children's SW Services.

In addition, pressures continue on Adult Social work budgets as a result of demand from children transitioning into adult learning disability and mental health services, challenging savings targets for these areas in anticipation of the outcome of a review of learning disability and mental health services and continued pressure on care at home services for older people.

The overall surplus generated during 2017/18 will further the Partnership's earmarked reserves for specific initiatives, service re-design and transformation in furtherance of the priorities set out in the Strategic Plan and the need to maximise efficiencies across the partnership to manage these pressures going forward. The general reserves position, which has previously provided some resilience for financial pressures and any slippage in savings targets, is expected to be eradicated in achieving a balanced budget for 2018/19. The level of partnership reserves is now £4.1m.

The HSCP continues to face significant financial pressures from demographic growth particularly amongst the elderly population placing demand on care at home and residential services, pressures in relation to increasing numbers of children transitioning into adult services generating demand and increased cost pressures across a range of adult social care services. This will be compounded during 2018/19 due to the cessation of the risk sharing arrangement across GG&C for prescribing, the anticipated demand from carers with the implementation of the Carers Act and the extension in entitlement to free personal care for those aged under 65 years old.

Both partner organisations continue to face significant financial challenge.

The NHS Greater Glasgow & Clyde Health Board has savings of +£70m to secure during 2018/19, largely within Acute Services, with a number of initiatives underway to deliver on this challenge. This assumes a breakeven position for HSCP's across GG&C. The settlement for 2018/19 provided uplift in funding of 1.5% in respect of payroll and contractual inflationary pressures with additional monies expected as a

consequence of the Barnett formula whereby increased investment to support pay increases nationally for health services in England has a consequential impact for grant funding to Scotland. The significant area of risk moving forward will be in relation to ongoing prescribing pressures arising from certain drugs on short supply pushing up the cost per drug and increasing demand within community services.

East Dunbartonshire Council is also facing significant challenges with £13.6m to close the funding gap during 2018/19 (of which pressures for Social Work account for £5.6m of this gap). This will predominantly be delivered through the Council's transformation and budget reduction programme with the aim of protecting the provision of frontline service delivery. The financial settlement to the partnership is particularly challenging with a further £4.6m of savings to be delivered during 2018/19. This will require a level of bridging through the use of partnership reserves to balance the budget for 2018/19 in the expectation that further efficiencies will be identified to address the gap in future years. This will present a level of risk to the partnership as there will be no resilience to meet in year pressures and this will require close monitoring and early engagement with the constituent bodies throughout 2018/19.

In total the level of savings on Partnership budgets to be delivered is £5m for 2018/19 and it is expected that this position will continue for future years given the challenging financial settlements expected to both the Local Authority and NHSGGC.

There is some recurring funding available to Health & Social Care Partnerships from the Scottish Government in 2018/19 in the form of Integration Funding (ED - £0.7m), Delayed Discharge Funding (ED - £510k) and Social Care Funding (ED - £7.4m, an increase of £1.3m from 2017/18). The latter is aimed at increasing the living wage across the care home, care at home and housing support sectors, supporting implementation of the Cares Act and the extension of entitlement to free personal care to those under the age of 65.

Agenda Item Number: 8

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	28th June 2018
Subject Title	Quarter 4 Performance Report 2017-18
Report By	Jean Campbell Chief Finance and Resources Officer
Contact Officer	Fiona McCulloch, Planning, Performance & Quality Manager

Purpose of Report	The purpose of this report is 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, for the period January - March 2018 (Quarter 4).

Recommendations	It is recommended that the Health & Social Care Partnership Board: Notes the content of the Quarter 4 Performance Report

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

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

Financial:	None

Legal:	None

Economic Impact:	None

Sustainability:	None

Risk Implications:	None

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

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

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

East Dunbartonshire Health & Social Care Partnership

QUARTER 4 2017/18 PERFORMANCE REPORT

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

NHS
Greater Glasgow and Clyde

SECTION 1
Introduction

1.1 Introduction

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

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

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

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

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

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

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

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

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

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

SECTION 2
Performance Summary

- Positive Performance (on target) improving (11 measures)
- Positive Performance (on target) declining (3 measures)
- Negative Performance (below target) improving (5 measures)
- Negative Performance (below target) declining (5 measures)

Positive Performance (on target & improving)

Ref.	
3.1	Number of Emergency Admissions
3.2	Number of unscheduled hospital bed days; acute specialities
4.1	The number of homecare hours per 1,000 population aged 65+
4.4	Number of People 75+ with a telecare package
5.2	Percentage of patients who started Psychological Therapies treatent within 18 weeks of referral
5.4	Number of alcohol brief interventions delivered
6.1	Percentage of Child Care Integrated Assessments (ICA) for Scottish Children Reported Administration (SCRA) completed within target timescales (20 days)
6.2	Percentage of Initial Child Protection Case Conferences taking place within 21 days from receipt of referral
6.3	Percentage of first Child Protection review conferences taking place within 3 months of registration
6.5	Percentage of first Looked After & Accommodated (LAAC) reviews taking place within 4 weeks of the child being accommodated
7.2	Percentage of CJSW submitted to Court by due date

Positive Performance (on target but declining) is reported in

Ref.	
4.2	Percentage of people 65 or over with intensive needs receiving care at home
4.3	Percentage of service users 65+ meeting the target of 6 weeks from completion of community care assessment to service delivery
6.6	Percentage of Children receiving 27/30 month assessment

Negative Performance (below target but maintaining/improving)

Ref.	
4.5	Number of new permanent admissions to care homes for 65+
4.7	Percentage of Adult Protection cases where the required timescales have been met
5.5	Sustain and embed smoking quits, at 12 weeks post quit, in the 40% SIMD areas
6.4	Balance of care for Looked After Children: Percentage of children being looked after in the community
7.1	Percentage of individuals beginning a work placement within 7 days of receiving a Community Payback Order

Negative Performance (below target and declining)

Ref.	
3.3	Delayed Discharge bed days
4.6	Number of people aged 65+ in permanent care home placements
5.1	Percentage of clients waiting no longer than 3 weeks from referral to drug or alcohol treatment
5.3	Percentage of people newly diagnosed with dementia accessing a minimum of one year's post-diagnostic support
5.6	18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services

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

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

3.1 Number of Emergency Admissions

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

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

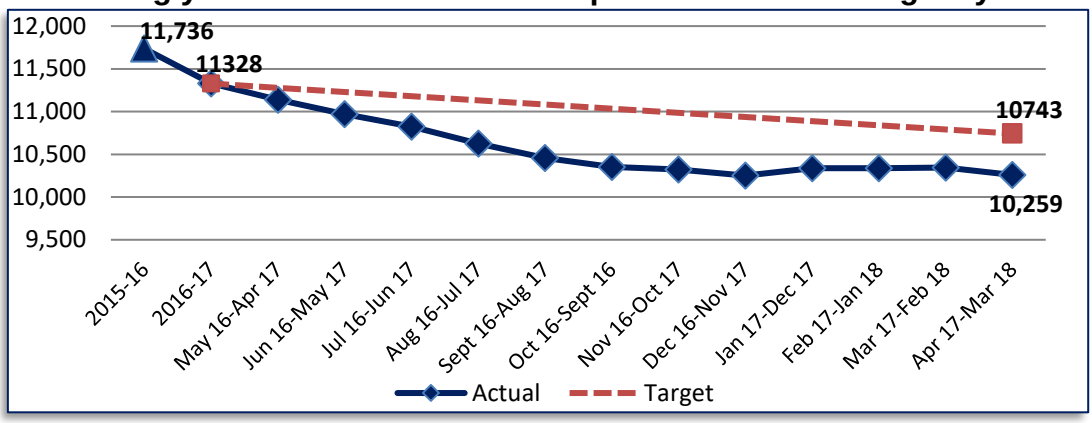


Table 3.1 Quarterly number of Unplanned Acute Emergency Admissions

Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Target (quarter)
2,533	2,530	2,726	2,470*	2,698

*Data correct at time of reporting, may be subject to change

Situational Analysis: The number of people being admitted unexpectedly to hospital is a key indicator of how we are doing to maintain people in their own homes. It is also, however, an indicator of the complexity of cases being managed in the community as evidence suggests the vast majority of unplanned admissions for East Dunbartonshire residents are clinically necessary. There has been a slight decrease in Unplanned Emergency Admissions in Q4. Performance remains below target level for the rolling year and for this quarter demonstrating a significant sustained improvement on last year.

Improvement Actions: We continue to deliver the full suite of community services designed to support people to live independently in their community, particularly those who have a disability or long term condition. Programmes to support people to self manage conditions such as diabetes and COPD will continue to be expanded. We will increase our focus on ensuring people have Anticipatory Care Plans which can be communicated to secondary care services via the Emergency Care Summary so that necessary information to avoid admission and facilitate a speedy return home is readily available.

3.2 Number of unscheduled hospital bed days; acute specialities

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

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

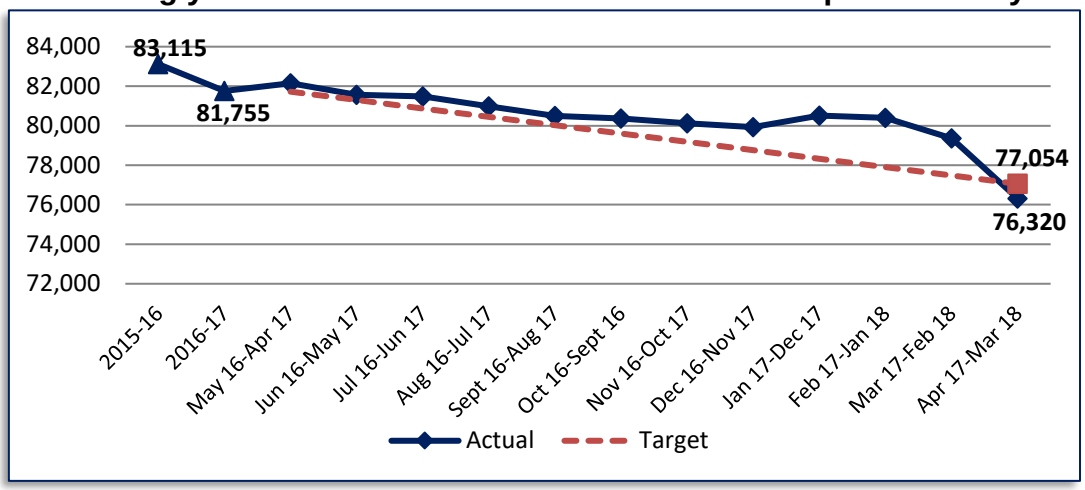


Table 3.2 Quarterly number of Unscheduled Hospital Bed Days

Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Target (quarter)
20,378	19,303	19,980	16,659*	18,586

*Data correct at time of reporting, may be subject to change

Situational Analysis: This indicator describes the number of bed days in secondary care used by patients who have been admitted unexpectedly. There was a significant drop in bed days occupied by East Dunbartonshire residents at the reported quarter, well below our target level. This is largely due to the speed in which patients have been treated by secondary care, but also due to how rapidly community services have been able to respond with input to enable the patient to return home. This indicator relates to patients of all ages, however, so some will have returned home with no service input from the HSCP.

Improvement Actions: Our focus will remain on preventing admissions where possible so that any unnecessary accrual of bed days is avoided. Where patients are admitted unexpectedly, we will continue to support speedy discharge, whenever possible, via the delivery of robust community responses. We have processes in place to rapidly assess patent needs at home and ensure services are put in place or packages of care re-started promptly.

3.3 Delayed Discharge bed days

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

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

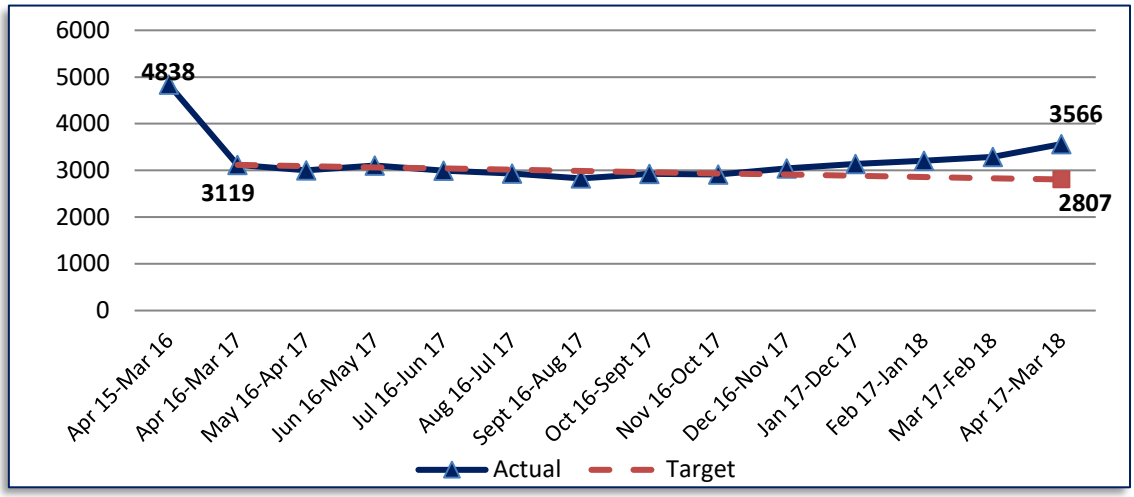


Table 3.3 Quarterly number of Delayed Discharge Bed Days

Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Target (quarter)
690	653	1,039	1,175	702

Situational Analysis: In the last reported quarter and in the rolling year our level of delayed discharges has once again increased and is above our target level. This is not a desirable position. We, in common with the whole system, have experienced a prolonged and challenging period of increased activity due to poor weather and seasonal illness. This has significantly impacted on our ability to move patients through the system as quickly as desired. In addition, a number of patients have presented with complex situations which take longer to resolve, such as incapacity and end of life care need, which require to be met in an inpatient or residential setting for which there has been limited availability.

Improvement Actions: Efforts continue to ensure early referral of patients who are nearing fitness for discharge to our Hospital Assessment Team so that the process of discharge can start promptly. We are working with neighbouring partnerships to ensure fair and equitable use of continuation care bed provision. We are reviewing our use of intermediate care beds, particularly in relation to how patients move through that provision, and scoping the potential for intermediate care at home.

SECTION 4
Social Care Core Indicators

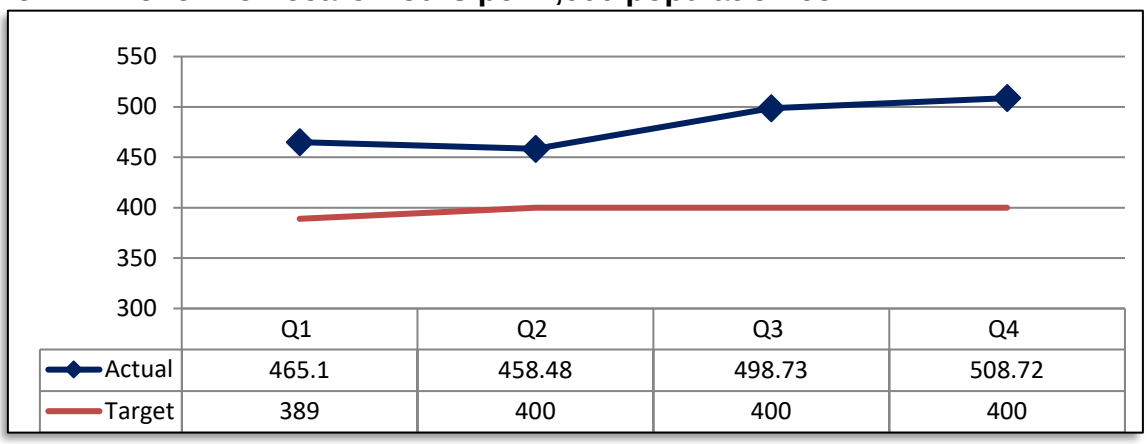
This section provides an updated report of Social Care core dataset and includes data collated by East Dunbartonshire Council Performance & Research Team. Although reported separately from the Health and Social Care data, the following indicators are integral to achieving the targets set out in Health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

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

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

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

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



	Q1	Q2	Q3	Q4
Actual	465.1	458.48	498.73	508.72
Target	389	400	400	400

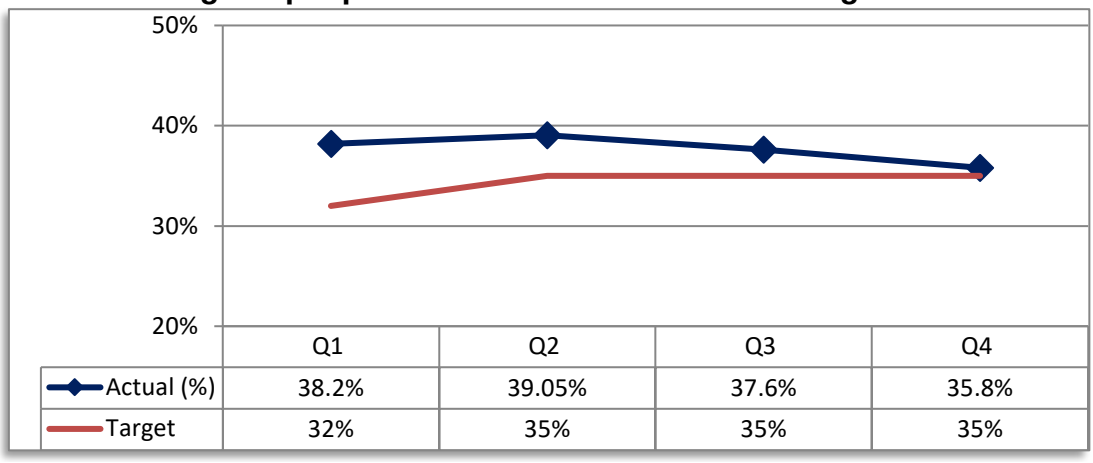
Situational Analysis: The number of homecare hours per 1000 population over 65 have increased again in Q4 to the highest level this year, following a dip in Q2. The hours include hours from internal homecare services or those commissioned from external providers by the homecare service. It also includes hours of care at home supplied through supported living services. It does not include homecare services supplied through SDS option 1 direct payments following the guidance of the annual Social Care return.

Improvement Actions: Performance has shown to be continuing in a positive trend through this quarter and has risen above the target again. We will continue to keep a focus on homecare as cornerstone service enabling people to remain safely living in their own homes and communities, and avoiding hospital or long term care admissions.

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

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

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



	Q1	Q2	Q3	Q4
Actual (%)	38.2%	39.05%	37.6%	35.8%
Target	32%	35%	35%	35%

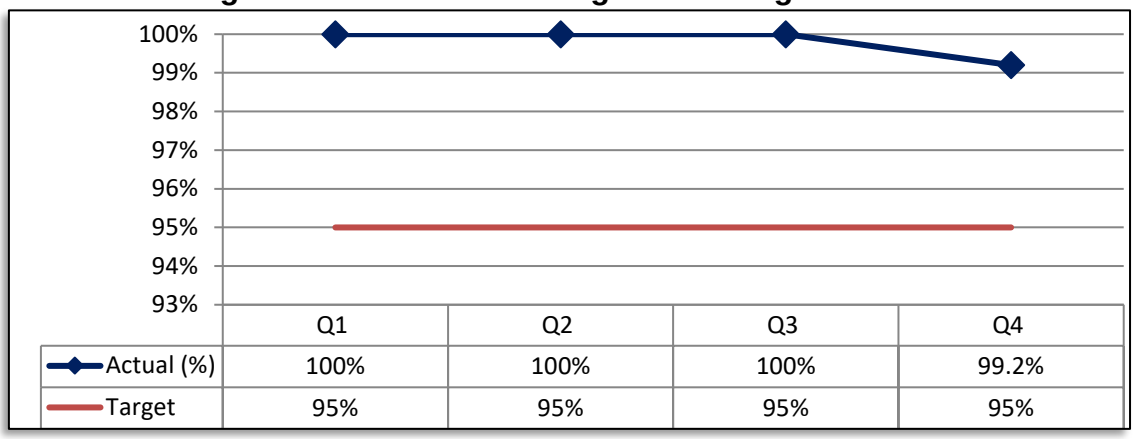
Situational Analysis: The indicator measures service users receiving 10 or more hours of homecare input per week. Our current homecare policy of reablement aims to reduce the number of hours that a user requires. The data presented for this indicator refers to mainstream homecare and does not include hours of homecare from supported living services. There has been another slight dip in this quarter in the performance but it continues to be above target.

Improvement Actions: We will continue to maximise intensive packages to support people at home. We will assess and monitor the impact on homecare service following changes in relation to service provision in the area of complex and continuing care, which is likely to result in increased demand for homecare particularly in respect of complexity following hospital discharge.

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

Rationale Local authorities have a duty to undertake community care assessments for those in need, and are responsible for developing packages of care to meet identified need. Operating within target timescales encourages efficiency and minimises delays for service-users.

Figure 4.3 Percentage of service 65+ meeting 6 week target



	Q1	Q2	Q3	Q4
Actual (%)	100%	100%	100%	99.2%
Target	95%	95%	95%	95%

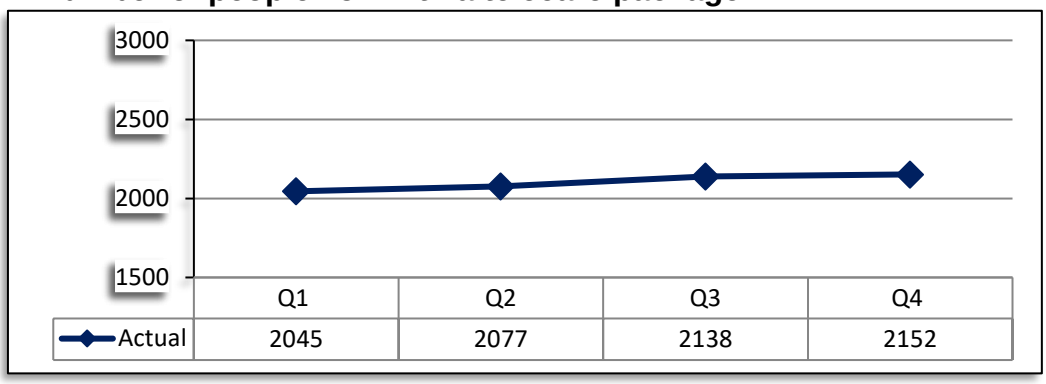
Situational Analysis: This indicator is reported to the Scottish Government for one quarter each year. The data depict our performance in relation to the Government target of 6 weeks from identification of need for service to delivery of first personal care service. The majority of this activity is delivered through homecare services. Performance continues to be strong in this area with a very minor, and tolerable dip in performance in Q4. East Dunbartonshire HSCP Homecare Services provide a 2 hour service response from hospital setting.

Improvement Action: Manage performance to return it to target.

4.4 Number of people 75+ with a telecare package

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

Figure 4.4 Number of people 75+ with a telecare package



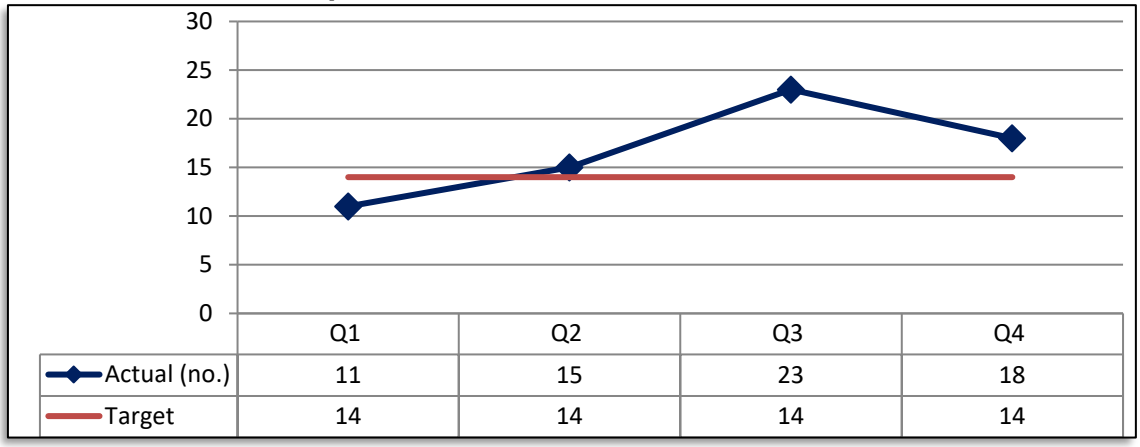
Situational Analysis: There has been an invigoration within the workforce and stakeholders in relation to Assistive Technology over the last 2 quarters resulting in improved performance. Our Assistive Technology Strategy 2018 -2023 was approved by the HSCP Board on 10th May 2018 and performance has increased again in Q4. We have increased our utilisation of the Assisted Living Show Flat to enhance service users and their families knowledge of technology that is available.

Improvement Actions: We will continue to support practitioners to consider the use of available technology to help service users achieve their personal outcomes. We will increase training and awareness sessions for all stakeholders, and develop a comprehensive Communication Strategy to facilitate increased awareness.

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

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

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



	Q1	Q2	Q3	Q4
Actual (no.)	11	15	23	18
Target	14	14	14	14

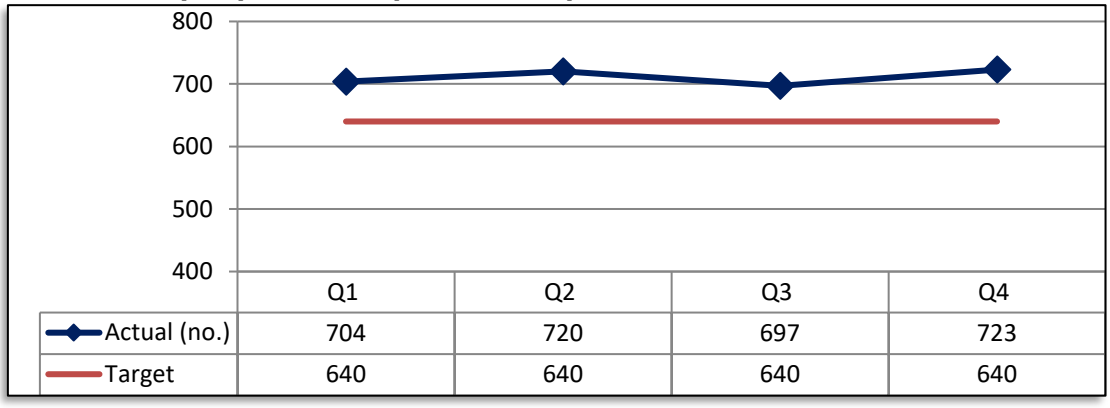
Situational Analysis:
The data reported shows a decrease in admissions to care homes for people over 65 in Q4. We continue to review and improve our data capture in relation to this indicator.

Improvement Actions:
Ongoing improvement and development plan in place to improve the processing of paperwork and recording to ensure that system provided data are robust, thus ensuring good forward planning and real-time measure of activity at operational and strategic level.

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

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

Figure 4.6 No. of people 65+ in permanent placements



	Q1	Q2	Q3	Q4
Actual (no.)	704	720	697	723
Target	640	640	640	640

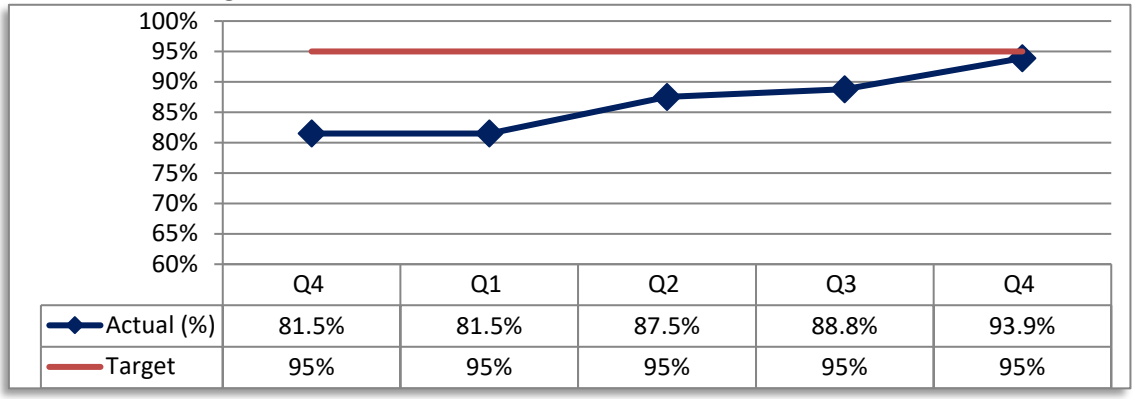
Situational Analysis:
This indicator shows the total number of care home places occupied by East Dunbartonshire people. The ongoing, yet improving issues with data capture and reporting noted in respect of 4.5 also apply to this indicator. Q4 figures show an increase in the numbers of permanent placements, which is at odds with service level intelligence. We continue to see an increase in the building of care homes in our area, suggesting an increase in net migration amongst older people as new homes are occupied by people who have moved here from elsewhere. Should these people require funded care in the future East Dunbartonshire becomes liable for this which poses a challenge for the partnership going forward.

Improvement Actions:
We will continue to reduce care home placement where this is avoidable and undertake analysis on the net migration and qualify the impact. We will also continue to progress our improvement and development plan to address the processing of paperwork.

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

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

Figure 4.7 Percentage of Adult Protection cases where timescales were met



	Q4	Q1	Q2	Q3	Q4
Actual (%)	81.5%	81.5%	87.5%	88.8%	93.9%
Target	95%	95%	95%	95%	95%

Situational Analysis:
The total number of Adult Support and Protection referrals processed by social work this quarter was 134. This continues to reflect the increased volume of referrals made to the social work service over the past two years, being 28% higher than the norm of 105 referrals per quarter reported in 2013-2016.
Q4's performance figure shows a substantial improvement in performance compared to the average achieved in 2016-17. An internal review of referral handling processes was undertaken in Q3, resulting in a new receiving system for police referrals and the piloting of amended recording standards for specific inquiry types. The improvement in performance for Q4 can be directly linked to these initiatives.

Improvement Actions:
Despite the improvement in Q4, performance remains below the 95% target which the social work service was meeting in the 2013-16 period. In light of the findings of the recent Adult Support and Protection inspection, work is planned with Police Scotland to review current inter-agency referral processes and identify any potential process improvements which can be achieved.

SECTION 5
NHS Local Delivery Plan Indicators

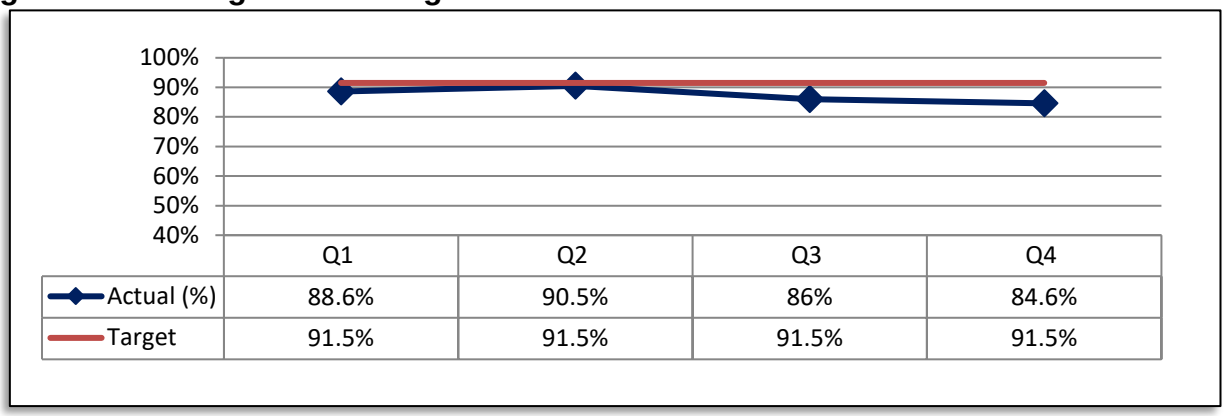
LDP Standards refer to a suit of targets which are set annually by the Scottish Government, and which define performance levels which all Health Boards are expected to either sustain or improve. The HSCP has devolved responsibility for a number of the LDP Standards, namely:

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

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

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

Figure 5.1 Waiting times - Drug & Alcohol Treatment



	Q1	Q2	Q3	Q4
Actual (%)	88.6%	90.5%	86%	84.6%
Target	91.5%	91.5%	91.5%	91.5%

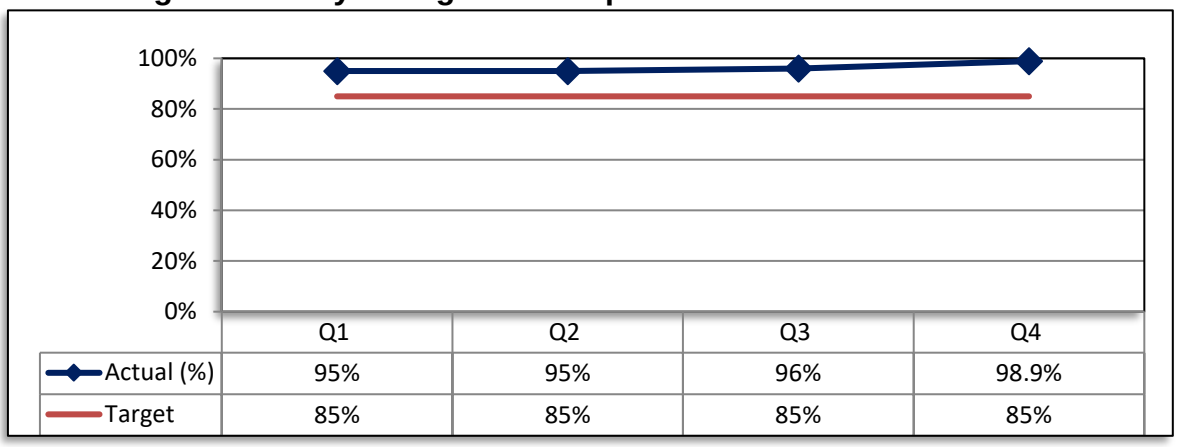
Situational Analysis:
The decrease in performance mainly relates to staffing shortages arising from a combination of staff turnover and long-term sickness absence.

Improvement Actions:
Issues of long-term sickness absence have been addressed with HR support, and approval to recruit to vacant nursing posts within the alcohol and drug team has been secured. Waiting times continue to be robustly monitored within joint allocation meetings and, wherever possible, appropriate action is taken to ensure improving performance in this regard.

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

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

Figure 5.2 Waiting times - Psychological Therapies



	Q1	Q2	Q3	Q4
Actual (%)	95%	95%	96%	98.9%
Target	85%	85%	85%	85%

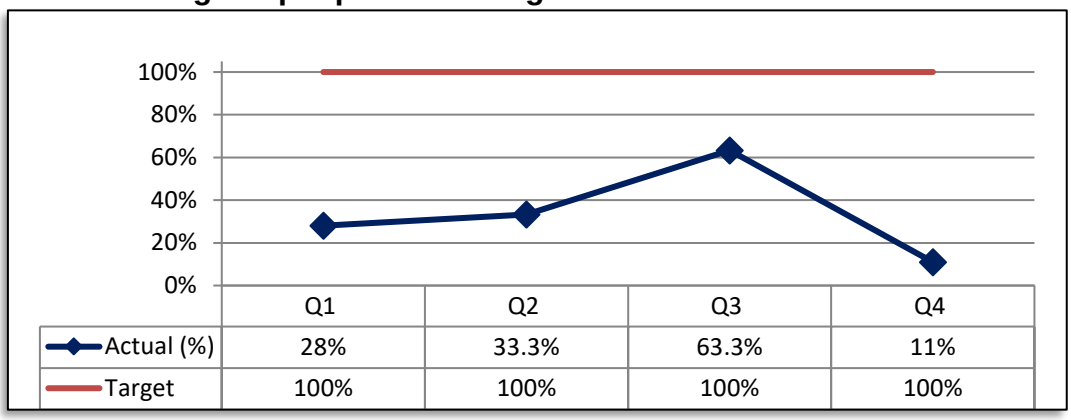
Situational Analysis:
The target continues to be met in regards to waiting times for psychological therapies, and performance has improved from the Q2 and Q3 level, achieving 98.9% compliance with targets for psychological treatments.

Improvement Action:
Continue to maintain the high performance standard in this regard.

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

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

Figure 5.3 Percentage of people accessing PDS



	Q1	Q2	Q3	Q4
Actual (%)	28%	33.3%	63.3%	11%
Target	100%	100%	100%	100%

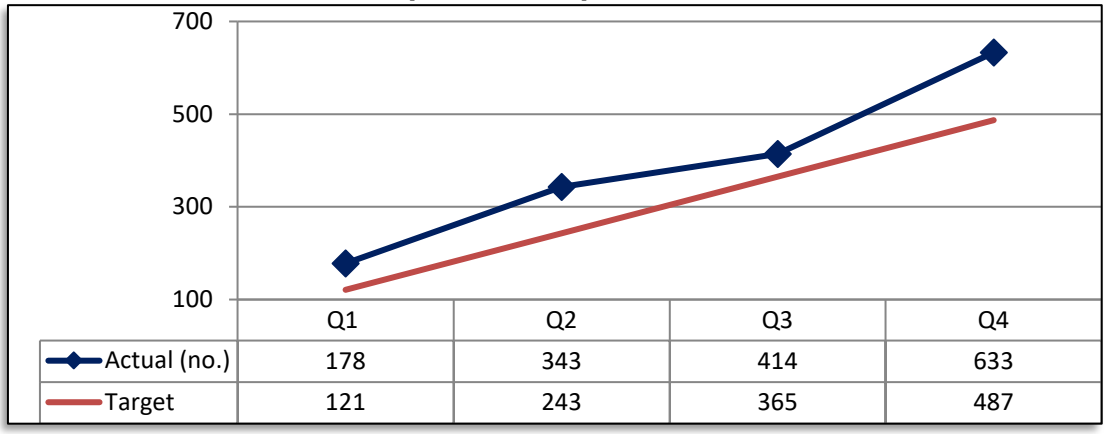
Situational Analysis:
Of all referrals (45) received in Q4, 5 patients (11%) were seen in this quarter, with the remainder all being seen in Q1 of 2018/19. There was therefore a significant reduction in performance in Q4 for a number of operational reasons, including patient preference for a later appointment.

Improvement Action:
We will continue to improve our operating model and take action to mitigate against staffing challenges that are impacting on our performance.

5.4 Number of alcohol brief interventions delivered

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

Figure 5.4 No. of ABIs delivered (cumulative)



	Q1	Q2	Q3	Q4
Actual (no.)	178	343	414	633
Target	121	243	365	487

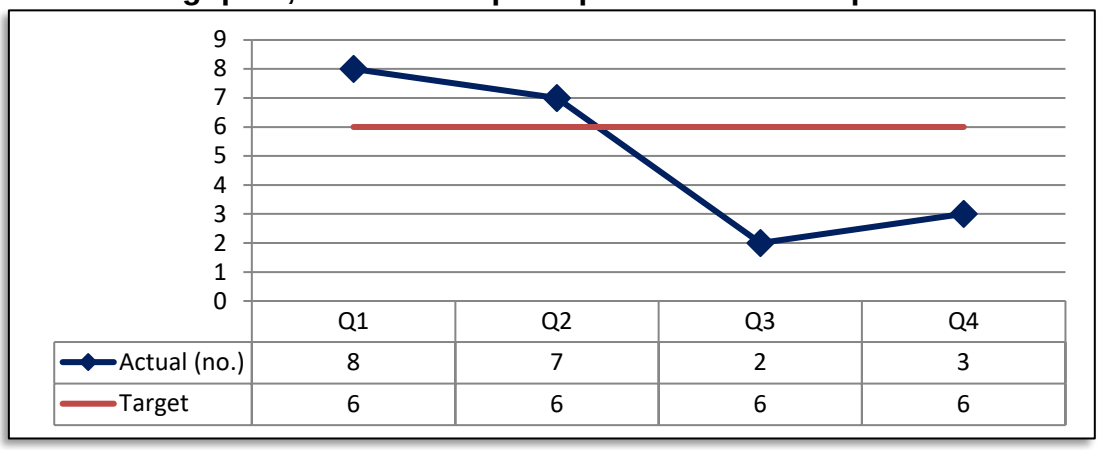
Situational Analysis:
There have been changes to the delivery of ABI's as a consequence of staffing challenges this year. Despite this, the target was achieved and surpassed with increased activity noted during Q4

Improvement Action:
Through a planned revision of the management arrangements for Alcohol and Drug Awareness and Interventions, there will be a wider Partnership approach towards increasing the reach of ABI delivery within Primary Care and across the wider community settings during 2018/19.

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

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

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



	Q1	Q2	Q3	Q4
Actual (no.)	8	7	2	3
Target	6	6	6	6

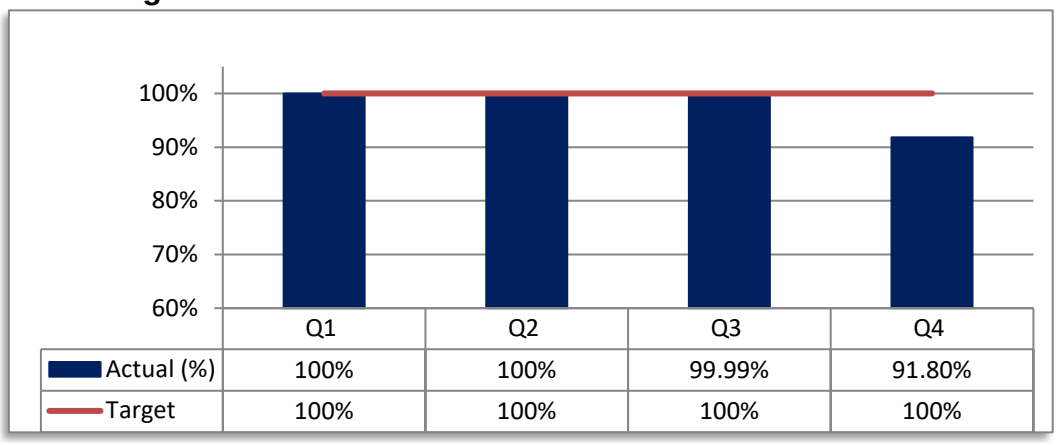
Situational Analysis:
The Smoking Cessation Service has been under review for the past 9 months, and future management arrangements for the Smoking Cessation Service are to be delivered by NHS Greater Glasgow and Clyde. In line with the review, there has been a hiatus on promotion or targeted marketing approaches at a time, when traditionally, the service would see uplift in its engagement with people who wished to quit smoking. In addition, the Smoking Cessation Coordinator post was vacated and, as a consequence of the Service review, the post currently remains vacant.

Improvement Action:
The target number of quits for 2018/19 will be subject to negotiation and agreement between the GGC and the HSCP to outline the arrangements for a revised service delivery model, taking cognisance of the new service model and associated targets.

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

Rationale: Deliver faster access to mental health services by delivering 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services.

Figure 5.6 Waiting times - CAMHS



	Q1	Q2	Q3	Q4
Actual (%)	100%	100%	99.99%	91.80%
Target	100%	100%	100%	100%

Situational Analysis:
The decrease in performance is mainly due to significant recruitment problems, coupled with an inflated staff absence rate that is being dealt with, with HR support. A reduction in capacity has caused GGC to move towards the RTT HEAT target threshold of 90%. Development work in underway to improve this level of performance.

Improvement Actions:
The decrease in performance is mainly due to significant recruitment problems, coupled with a temporarily inflated staff absence rate that is being dealt with, supported by HR. Work is underway to identify particular problem areas, with a view to utilising the CAPA methodology in an appropriate way to maximise efficiencies and quality and reduce waits for treatment. Demand and capacity data will identify where CAPA could be better applied and where available resource would be best placed.

SECTION 6
Children's Service Performance

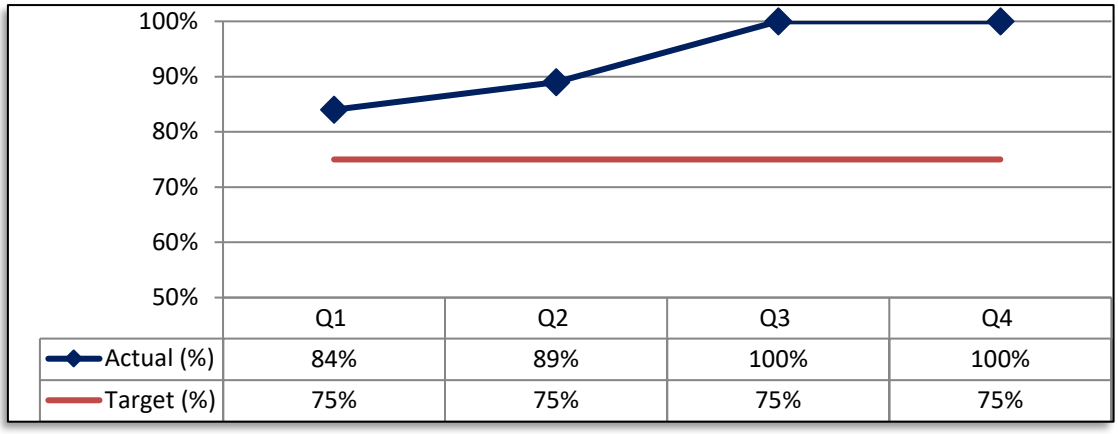
This section provides an updated report performance against key Children and Families indicators. The indicators reported are:

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

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

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

Figure 6.1 Percentage of Child Care ICA for SCRA Completed



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

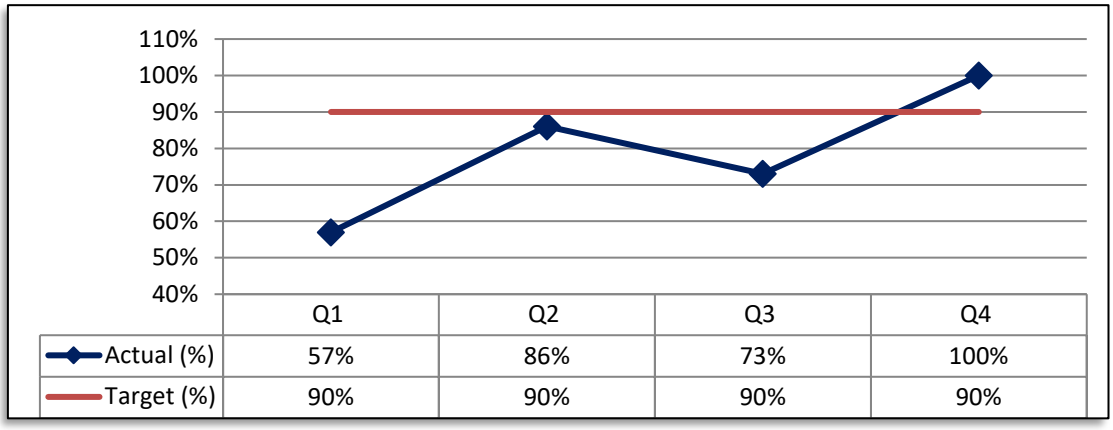
Situational Analysis:
The Children and Families Team continues to perform at a standard which surpasses the identified target.

Improvement Action:
Continue to perform at this standard.

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

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

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



	Q1	Q2	Q3	Q4
Actual (%)	57%	86%	73%	100%
Target (%)	90%	90%	90%	90%

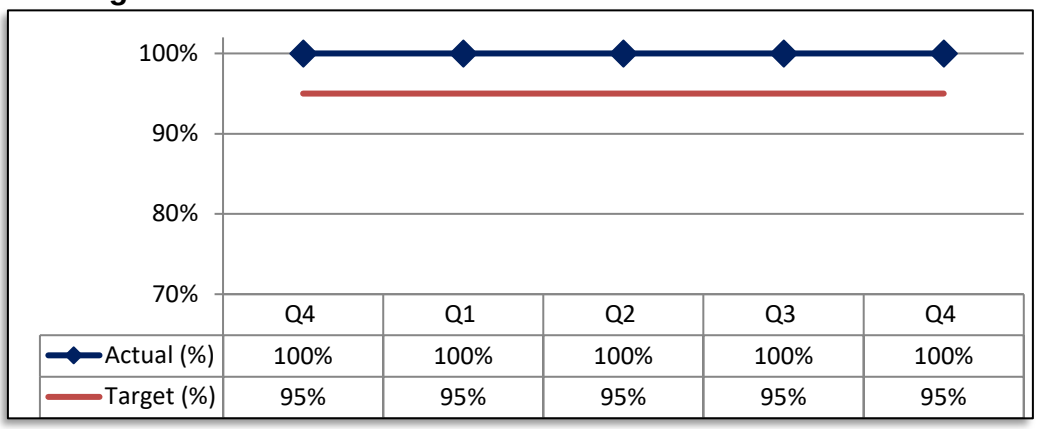
Situational Analysis:
There has been significant improvement from the last quarter and the Children and Families Service has met the target in every Child Protection Investigation.

Improvement Action:
Continue to perform at this standard.

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

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

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



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

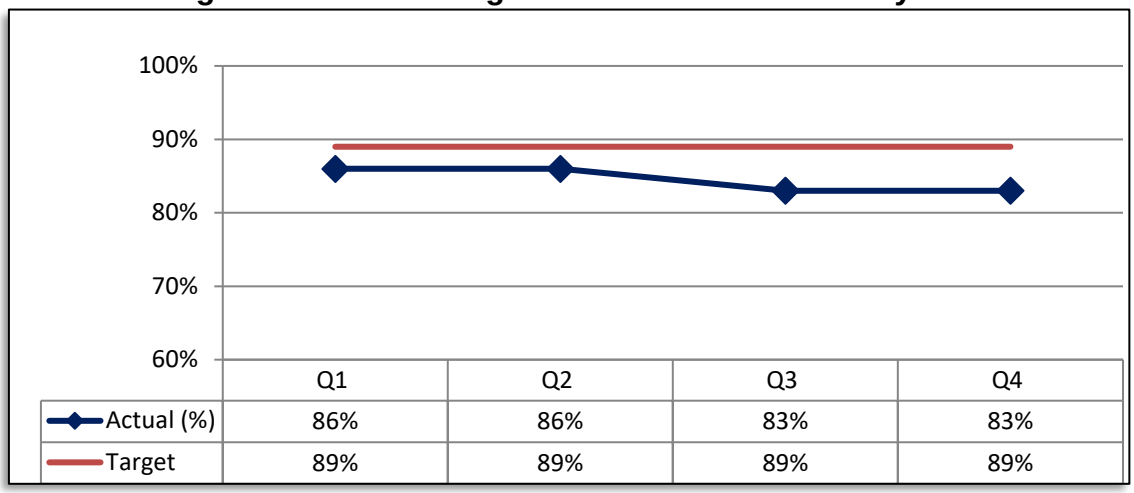
Situational Analysis:
High standards of performance have been maintained in relation to the number of Review Child Protection Case Conferences taking place within 3 months of registration. 100% has been achieved throughout the last year.

Improvement Action:
Maintain the high standard of performance.

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

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

Figure 6.4 Percentage of Children being looked after in community



	Q1	Q2	Q3	Q4
Actual (%)	86%	86%	83%	83%
Target	89%	89%	89%	89%

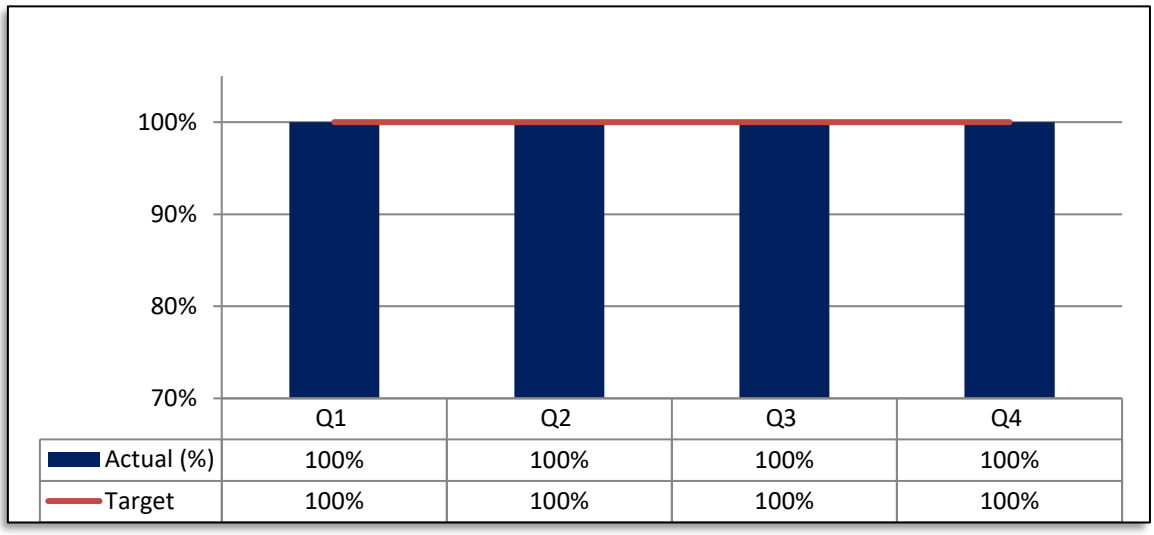
Situational Analysis:
83% of our Looked After Children are Looked After in the Community. The target is 89%.

Improvement Actions:
This has been identified as an area requiring development and improvement. The Children and Families Service is currently working on issues related to the balance of care and this is also directly linked to the development work being undertaken by the Adoption and Fostering Team.

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

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

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



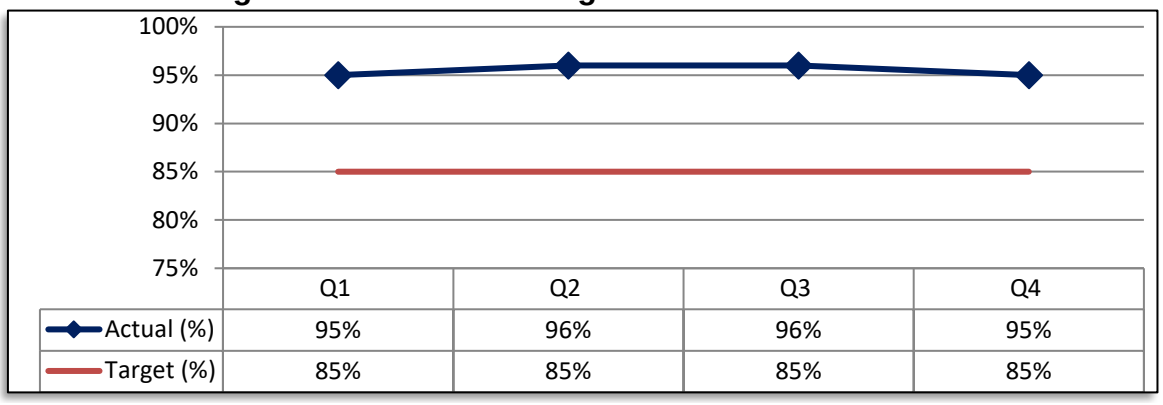
Situational Analysis:
The target of 100% continues to be met in regards of the percentage of Looked After and Accommodated Child reviews taking place within 4 weeks of the child being accommodated.

Improvement Actions:
Continue to meet the target of 100%.

6.6 Percentage of Children receiving 27/30 month Assessment

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

Figure 6.6 Percentage of Children receiving 27/30 month assessment



	Q1	Q2	Q3	Q4
Actual (%)	95%	96%	96%	95%
Target (%)	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 onto specialist services. During Q4, 2% children were identified as requiring onward referral to specialist services.

Improvement Action:
Data reports are monitored on a monthly basis at team meetings to support early identification of variances and allow improvement plans to be developed if required.

SECTION 7
Community Justice Performance

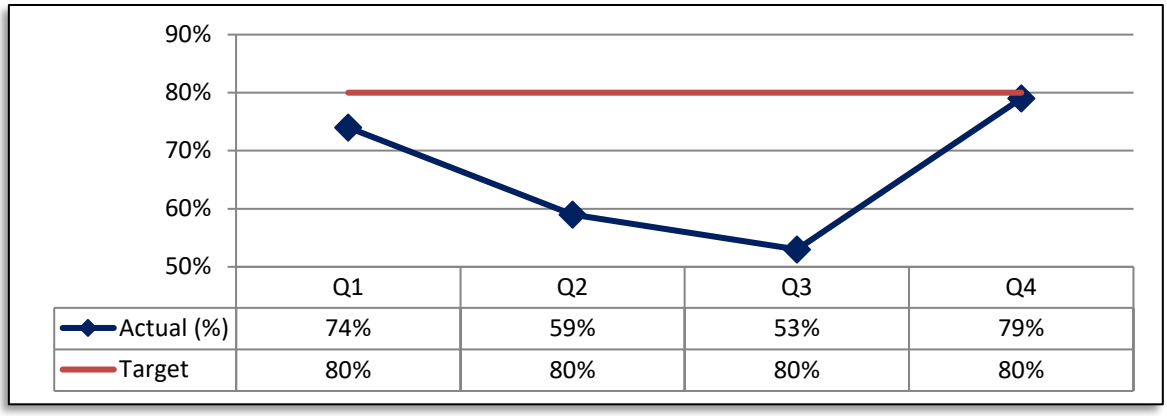
This section provides an updated report performance against key Criminal Justice indicators. The indicators reported are:

7.1 Percentage of individuals beginning a work placement within 7 days of receiving a Community Payback Order
7.2 Percentage of CJSW submitted to Court by due date

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

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

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



	Q1	Q2	Q3	Q4
Actual (%)	74%	59%	53%	79%
Target	80%	80%	80%	80%

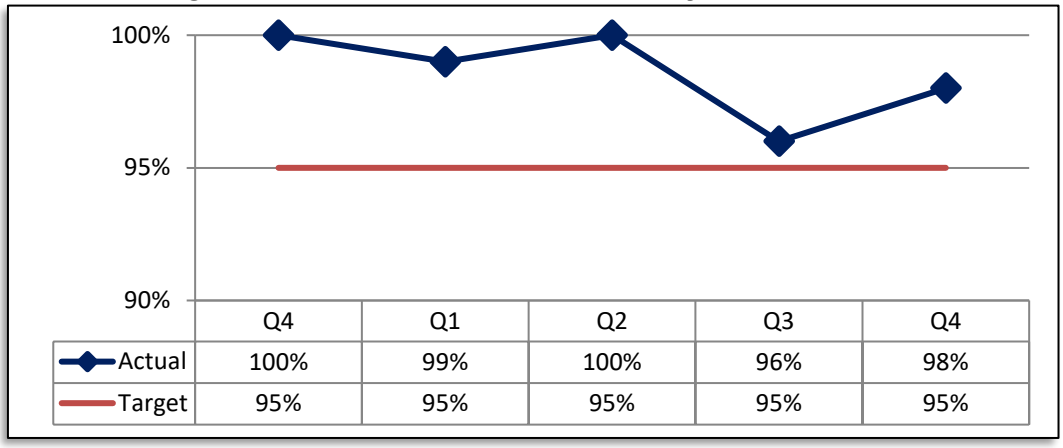
Situational Analysis:
There has been a significant improvement since the last reporting quarter in relation to the percentage of individuals beginning a work placement within 7 days. Last quarter 53% was reported and this has risen to 79%.

Improvement Action:
Continue to implement improvements in order to reach the target of 80%.

7.2 Percentage of CJSW submitted to Court by due date

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

Figure 7.2 Percentage of CJSW submitted to Court by due date



	Q4	Q1	Q2	Q3	Q4
Actual	100%	99%	100%	96%	98%
Target	95%	95%	95%	95%	95%

Situational Analysis:
Whilst there has been some fluctuation in regards the percentage of CJSW submitted to Court by the due date, the Service continues to surpass the target of 95%, this quarter 98% was achieved.

Improvement Action:
Maintain the high performance standard.

SECTION 8
Corporate Performance

The following data focus on corporate performance indicators, namely:

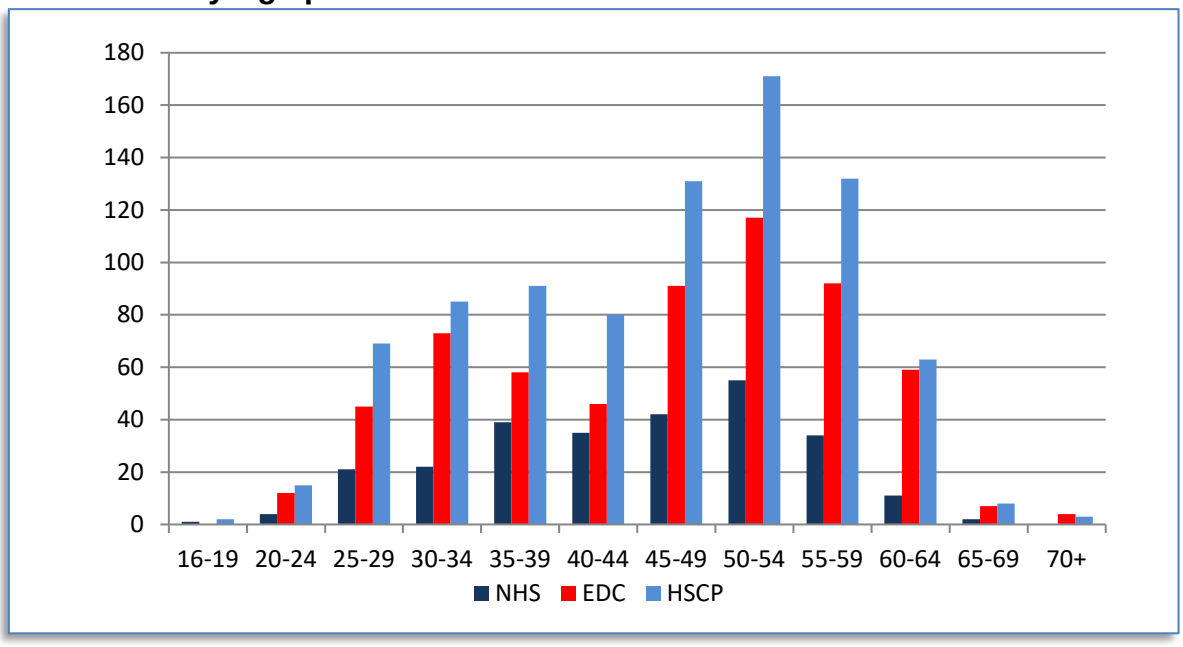
- Workforce Demographics
- Sickness / Absence Health Staff and Social Care Staff
- Knowledge & Skills Framework (KSF) / Personal Development Plan (PDP) / Personal Development Review (PDR)

8.1 Workforce Demographics

Employer	Headcount				WTE			
	Jun-17	Sep-17	Dec-17	Mar-18	Jun-17	Sep-17	Dec-17	Mar-18
NHSGGC	265	261	265	266	225	221.03	227.76	223.34
EDC	553	570	585	604	468	478.9	491.66	492.49
Total	813	831	850	870	693	699.93	719.42	715.83

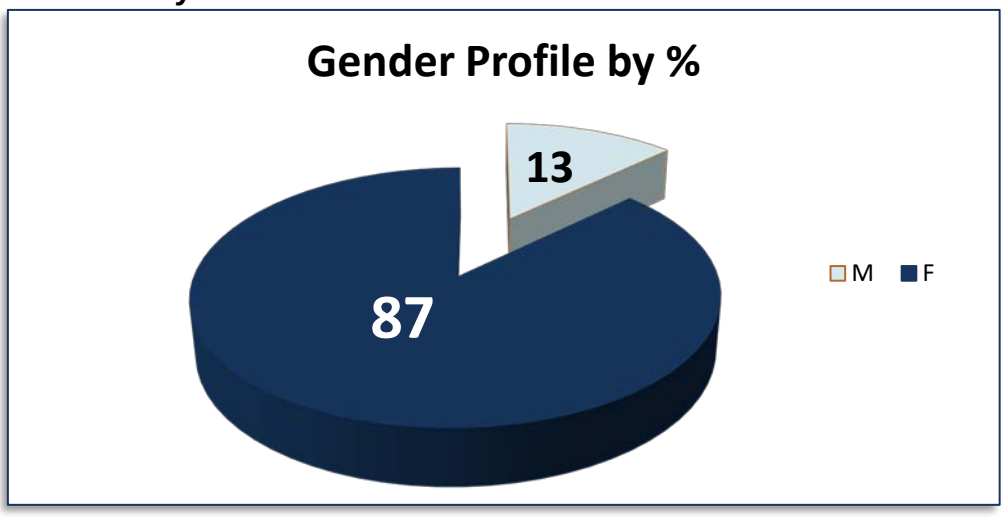
The picture on workforce is ever changing. Whilst we have increased our overall head count, our WTE has dropped by 3.59 in the last quarter of the year. This decrease shows a marked increase in staff looking to have more of a work life balance and might be directly related to the age profile for staff below.

8.2 HSCP Staff by Age profile



The age profile shows that the majority of staff are aged over 45yrs and that we have a very low number of staff under 25yrs of age. 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 by %



The gender ratio of female to male employed staff has remained constant over the last 12mths, with 87% of staff being female.

8.4 Sickness / Absence Health and Social Care Staff

Month	EDC	NHS HSCP
May-17	7.16	4.86
Jun-17	5.95	6.10
Jul-17	5.76	4.16
Aug-17	5.76	4.16
Sep-17	6.85	3.92
Oct-17	7.13	4.62
Nov-17	7.32	5.93
Dec-17	8.17	5.88
Jan-18	9.75	6.00
Feb-18	8.70	5.19
Mar-18	8.33	5.63
Average	**7.35**	**5.13**

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

8.5 KSF / PDP / PDR

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
KSF %	65	65	64	65	54	57	55	56	63
PDP %	68	67	69	67	53	57	53	56	61
Trajectory %	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. Due to a change in the recording

platform, we have been unable to access verifiable data for the last quarter period. It is expected that the new TURAS platform which went live on 2 April 2018 will provide updated information from July 2018

8.6 Performance Development Review (PDR)

PDR	
Quarter	**% Complete on system**
Q1	36.15
Q 2	63.19
Q3	85
Q4	89

PDR (Performance, Development Review) is the Council process for reviewing staff performance and aligning their learning and development to service objectives and deliver requirements. We have achieved a recording rate of 89% at year end, which is a high end figure.

Agenda Item Number: 9

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	28th June 2018
Subject Title	Public, Service User & Carer Representative Support Group
Report By	Martin Brickley (Service User Representative) / Jenny Proctor (Carers Representative)
Contact Officer	David Radford Health Improvement & Inequalities Manager David.radford@ggc.scot.nhs.uk 0141 355 2391

Purpose of Report	The report describes the processes and actions undertaken in the development of the Public, Service User & Carer Representatives Support Group (PSUCRSG)

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

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

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

Financial:	None

Legal:	None

Economic Impact:	None

Sustainability:	None

Risk Implications:	None

Implications for East Dunbartonshire Council:	None

Implications for NHS Greater Glasgow & Clyde:	None

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

1.0	**Main Report**
1.1	The attached report details the actions and progress of the PSUCRSG, highlighting their progress as detailed in **Appendix 1**.
2.0	**SUMMARY**
2.1	The most recent PSUC meeting was on 14 May 2018, where members received a presentation from Derrick Pearce, Head of Community Health and Care Services.
2.2	The group have recently advertised, interviewed and appointed several new members to fill recent membership vacancies.
2.3	The new members have also been aligned to the HSCP committees and will be supported in their roles by a HSCP support officer.
2.4	The PSUC members agreed and signed off on the content of a 6 page leaflet (aide memoire), explaining the role and function of the HSCP. They will share this with their wider groups, local contacts and to the wider public of East Dunbartonshire at their service user and carer engagements.(**Appendix 2**)
2.5	The members received a copy their own 'working agreement' for comment and will be discussed further at the next PSUC meeting.
2.6	Members have approved the report on Hospital Discharge Experiences, which will now be forwarded to the HSCP senior managers.
2.7	Members have developed a checklist for hospital patients preparing for discharge, as an output from the Hospital Discharge Experiences report.
2.8	The Hospital Discharge checklist leaflet is available to all East Dun residents in a

	hospital setting. (**Appendix 3**)
2.9	The PSUC have nominated a member to represent the group onto the East Dunbartonshire Transformational Board.
2.10	Members have been advised to the financial challenges being considered by the HSCP Board.
2.11	Members support the Boards in its efforts to resolve the financial challenges and seek to be informed of progress, timeously.
3.1	It is recommended that the HSCP Board: ▪ Note the progress of the Public, Service User & Carer Representatives Support Group.

Appendix 1

Public Service User and Carer Support Group – 14 May, 2018 – Room F33a, KHCC.

Attending; Gordon Cox, Avril Jamieson, Jenny Proctor, Isobel Twaddle, Karen Albrow, Linda Jolly, Fiona McManus, David Bain and Sandra Docherty

Apologies; Susan Manion, Martin Brickley, Anthony Craig

HSCP Staff in attendance; David Radford, Derrick Pearce

Action points agreed at meeting;

- The Chair wishes the action note to record the member's thanks and best wishes to Marion Menzies who recently resigned from her role with PSUC.

Action	By who	When	G	A	R
The PSUC report / paper collating hospital discharge experiences, was approved by the group. The paper is now to be forwarded to the HSCP SMT, for noting.	D Radford	15/05/18			
The members have agreed and asked that the Carers Link, discharge report be included within the appendix of the PSUC's own paper collating hospital discharge experiences.	AC	15/05/18			
The Hospital Discharge paper – Appendix (the patient / relative/carer checklist). The group wish to have this as a separate document that they can share with the wider East Dun public.	AC	By next meeting 06/08/18			
PSUC group will collate case studies / stories of service users experiences who have attended Woodlands, in conjunction with the hospital discharge with the HSCP SMT	PSUC members	By next meeting 06/08/18			
All PSUC members to receive 20 x copies of the new 'aide memoire'	AC	By next meeting 06/08/18			
Arrange an induction meeting between Fiona	AC	15/05/18			

McManus & Jean Campbell re the role and remit for the Transformational Group					
Members requested a reminder of the cycle of meetings and the updated reps for each group	AC	By next meeting 06/08/18			
The members requested that the latest Carers Eligibility Criteria to be placed on the HSCP website	Fiona McCulloch	By next meeting 06/08/18			
The group wish 3 dates to be identified for a Group visit to the East Dun SMART house	A/C	By next meeting 06/08/18			
Invite to be extended to Caroline Sinclair of the HSCP to attend next meeting	AC	25/05/18			

Decision making groups.

East Dunbartonshire HSCP have Service User and Carer representatives on a number of committees and groups, including:

- HSCP Board
- HSCP Strategic Planning Group, and
- East and West Locality Planning Groups

"I feel valued and you use your own experiences to bring about improvements in health and social care services"

Mr B, Bearsden, East Dunbartonshire, (Member of the Public, Service User and Carer representatives group)

Where is the HSCP based?

The HSCPs main base is in the Kirkintilloch Health and Care Centre (KHCC) on Saramago street, with a satellite clinic in Milngavie.

The KHCC offers a range of services from various teams including district nursing, community midwifery, podiatry, physiotherapy, the community older people's team, family planning, occupational therapy, home care services and the public health improvement team.

To get involved, please contact;
Anthony Craig
East Dunbartonshire HSCP
10 Saramago Street,
Kirkintilloch,
East Dunbartonshire,
G66 3BF - 0141 578 8658
Anthony.Craig@ggc.scot.nhs.uk

East Dunbartonshire Health & Social Care Partnership

East Dunbartonshire Health and Social Care Partnership (HSCP)

Your Guide to East Dunbartonshire HSCP and Volunteering Opportunities

What is Integration?

It is the Scottish Governments programme which strives to improve the health and social care services that the public receive, making sure people are listened to, involved and take an active part in decisions about their care and how it is delivered.

What is a Health and Social Care Partnership?

HSCPs are the organisations formed in 2014 as part of the integration of services provided by Health Boards and Councils in Scotland.

The East Dunbartonshire HSCP is jointly run by NHS Greater Glasgow and Clyde and East Dunbartonshire Council.

What services does the HSCP provide?

East Dunbartonshire HSCP provides **all** adult community health, social care and home care services.

It also provides NHS community children's services, children's social work services and criminal justice social work services and brings closer partnership working between local health, social care and NHS hospital-based services.

Public, Service User and Carer Involvement.

Gives you the chance to:

- Help bring about improvements to the way health and social care is provided.
- Have a say in the way services are commissioned and run.
- Influence how health and social care treatment is delivered.

Who can be involved?

Any East Dunbartonshire resident who has an interest in local health and social care services is welcome to get involved. We are particularly looking for those in a caring role.

Why should you be involved?

- To assist in creating an improved service and the overall experience people receive.
- To assist the HSCP in developing new services which meet the needs of the local population.
- To assist the HSCP in developing and promoting better communication techniques to inform and engage local residents.

How you can be involved.

Join our Public, Service User and Carer (PSUC) representatives 'Group' as a:

- Representative or depute, or;
- Join the local involvement and participation 'Network'...

Find out 'How?' by calling Anthony, on:
0141 578 8658

5

Do I have a follow-up Hospital / Doctors appointment?

Please Tick √

☐ **Yes** ☐ **No**

Date...../...../2018.....

Time:.....Venue:.....

Other:.....

6

Do I know/been shown how to use any equipment, aids or adaptations I need?

Please Tick √

☐ **Yes** ☐ **No**

Further Info.....

.....

7

Do I have contact names and numbers for East Dunbartonshire Health and Social Care Partnership's Social Care / Home Care service?

Please Tick √

☐ **Yes** ☐ **No**

HSCP Homecare: 0141 578 2101, or

call out of hours: 0141 578 2181

Other numbers:.....

8

If you are unsure of the meaning of any of the questions, or you and your carer simply want more information then please ask the member of staff at discharge.

Notes:

East Dunbartonshire Health & Social Care Partnership

East Dunbartonshire Health and Social Care Partnership (HSCP)

A Checklist for Hospital Patients Who are Preparing for Discharge

Created in association with the East Dunbartonshire Public, Service User and Carer Representatives Group (PSUC)

sustainable thriving achieving East Dunbartonshire Council www.eastdunbarton.gov.uk
NHS Greater Glasgow and Clyde 70 YEARS #nhsscot70
East Dunbartonshire Health & Social Care Partnership
sustainable thriving achieving East Dunbartonshire Council www.eastdunbarton.gov.uk
NHS Greater Glasgow and Clyde 70 YEARS #nhsscot70

A checklist can be an important source of information for patients / carers / family members to ensure there are no unanswered questions when leaving the hospital.

If you need help to complete, please ask your carer / family member to assist you.

In this leaflet we will cover:

- **Do you have all your belongings**
- **Your transport home**
- **Your hospital discharge letter**
- **Your medications**
- **Your follow up appointments**
- **Your aids and adaptions**
- **Your contacts and other important numbers - Homecare etc.**

1

Do I have clothes to go home in, my belongings, including any cash or valuables / my door keys?

Please Tick √

☐ **Yes** ☐ **No**

Further Info.....

.....

2

Do I know how I am getting home?

Please Tick √

☐ **Yes** ☐ **No**

Further Info.....

.....

3

Do I have a copy of my hospital discharge letter?

Please Tick √

☐ **Yes** ☐ **No**

When will it be sent to my GP? .....

Further Info.....

.....

4

Do I have all the medication I need?

Do I understand what my medication is for, how to take it, and any associated side effects?

Please Tick √

☐ **Yes** ☐ **No**

Further Info.....

.....

sustainable thriving achieving East Dunbartonshire Council www.eastdunbarton.gov.uk
NHS Greater Glasgow and Clyde 70 YEARS #nhsscot70
East Dunbartonshire Health & Social Care Partnership
sustainable thriving achieving East Dunbartonshire Council www.eastdunbarton.gov.uk
NHS Greater Glasgow and Clyde 70 YEARS #nhsscot70

Clinical & Care Governance Sub Group
28th March 2018, 2.30pm
F33A, Kirkintilloch Health & Care Centre

Members Present

Name	Designation
Lisa Williams	Clinical Director
Leanne Connell	Senior Nurse, Adult Nursing
Susan Manion	Chief Officer
Michael McGrady	Consultant in Dental Public Health Clinical Effectiveness Co-ordinator
Lorna Hood	Senior Nurse, Children & Families
Raymond Carruthers	Operational Service Manager, Oral Health
Andrew Millar	Clinical Effectiveness Co-ordinator
Lorraine Currie	Operations Manager, Mental Health
Fiona Munro	Manager, Rehab & Older Peoples Services

In Attendance

Name	Designation
Dianne Rice	Clinical Governance Support Officer

Apologies

Name	Designation
Wilma Hepburn	Professional Nurse Advisor
Claire Carthy	Fieldwork Manager
Fraser Sloan	Clinical Risk Analysis
Carolyn Fitzpatrick	Lead for Clinical Pharmacy and Prescribing
Derrick Pearce	Inverclyde HSCP
Paolo Mazzoncini	Head of Children's Services / Chief Social Work Officer
David Aitken	Joint Adult Services Manager
Alex O'Donnell	Criminal Justice Service Manager
Gillian Notman	Change & Redesign Manager

No.	Topic	Action
1.	**Apologies and attendance**	
	Apologies and attendance are detailed on page 1 Lisa Williams welcomed all attendees to the group. Lisa stated that there were a large number of apologies noted for today's meeting and that all members agreed the Terms of Reference and membership for the group which states that if a member is unable to attend, then a representative should attend in their place. If a representative is not available, a written report / update should be submitted prior to the meeting.	
2.	**Minutes of Previous Meeting – 7th February 2018**	
	The minutes of the 7th February 2018 were agreed as correct.	
3.	**Matters Arising**	
	Adult Support & Protection Review The group were advised that following the above review the HSCP have received a verbal update which was largely positive but did make some recommendations. Once finalised the group will receive a copy of the full report to review and consider.	
	Governance Leads Update / Reports	
4(a)	Core Audit Reports Core Adult reports were submitted for CMHT, PCMHT, Woodlands Resource Centre & District Nursing. With the exception of District Nursing, all core audits were 100% compliant. District Nursing received 97% compliance in relation to Record Keeping and 94% compliance in relation to medication. Action plans have been compiled and are being implemented. Leanne advised that the Safety Cross report is no longer completed and stated that this only showed a small percentage of compliance problems. Leanne informed the group that she will now submit their CQI report which shows overall compliance in relation to Pressure Ulcers.	
(b)	LD Governance No update available.- no one in attendance to provide update and no verbal or written report submitted.	
(c)	Mental Health Governance Lorraine Currie advised that group had not met since the previous Clinical & Care Governance meeting.	
(d)	Primary Care & Community Partnerships Governance Group update (PCCPG) No update available - Lisa Williams advised that the group had not met since the previous Clinical & Care Governance meeting.	

(e)	Board Clinical Governance Forum update No update available. Lisa Williams advised that group had met since the previous Clinical & Care Governance meeting, but she had not received any update at this time.	
	Risk Management	
5(a)	Care Home Update Leanne Connell advised that at present both District Nursing and Older People's Mental Health Team are awaiting approval of Care Home Liaison post(s). Susan Manion asked that this proposal be highlighted at the Senior Management Team meeting for approval. Lisa advised that following an inspection by the Care Commission, there have been concerns around the level of care provided to residents at Clachan of Campsie Care Home in Lennoxtown. Regent Gardens Medical Practice initially provided GP support via a LES agreement, however, as of March 2018 they have withdrawn from the LES and now provide only standard GMS for the residents in their care. Negotiations are ongoing between the Care Home Management Team and the HSCP with regard to support for the home and the best way to provide GP support to residents. Leanne highlighted that the Care Home experiences a high turnover in staff which leads to inconsistencies and that perhaps one way the HSCP could help is to support the Care Home in securing permanent members of staff. The situation will continue to be monitored closely to ensure adequate care is provided to the residents. Derrick Pearce is currently reviewing the difficulties. Lisa informed the group that another Care Homes has opened recently in Milngavie, and is being managed under standard GMS provision by the 2 local GP practices. Plans are in place for another 2 homes, one within Bishopbriggs and the other in Canniesburn. Michael McGrady stated that oral health for Care Homes are managed in the community through GDPs and also the Caring for Smiles Team. This is covered within the Oral Health Improvement Plan. Michael will send this to Dianne for inclusion in the May meeting. Raymond Carruthers explained that safety reporting is similar to the previous year reports. It was noted that there were issues around categorisation within the system; however, analysis of this is currently underway which should provide a clear picture of issues once complete. Michael noted that there is a desire to improve learning within OHD through quality improvement and that this may give the opportunity to share learning.	**MMcG/ DR**
(b)	Clinical Risk Update This meeting falls outwith the reporting timeframe of the Clinical Risk Update.	
(c)	Incident Report – 01/02/18-12/03/18 The group reviewed the incident report. Lisa noted that she has concerns around the amount of incidents reporting threats of physical violence and that in some disciplines tolerance levels will be higher, however, this does not mean that this behaviour is acceptable. NHSGG&C have a zero tolerance policy again violent &	

	aggressive behaviours but it was noted that if the behaviours persists staff are maybe unsure of next steps. Leanne advised that all pressure ulcer incidents reported during this period were all unavoidable. Dianne will now include Oral Health Incidents within the report. This will be provided by the Oral Health Team.	**RC/DR**
	Public Health Reports / Prescribing Updates	
6	There were no reports to note however, it was noted that there are issues around risk sharing arrangements with regard to the overspend on the Prescribing budget. This has been caused by a range of issues, and applies across all of GGC. This will be discussed at the next GP Forum.	
	Clinical Effectiveness / Quality Improvement	
7	Quality Improvement Workplan Andrew Millar updated the group on the new projects, progress against current pilots and completed projects made within the QI Workplan.	
	Scottish Patient Safety Programme	
8(a)	Scottish Patient Safety Programme (SPSP) Lisa advised there was no current update at this time.	
(b)	Clinical Governance Related Guidance Newsletter This meeting took place outwith the reporting period for the newsletter.	
(c)	SPSO Update – February 2018 For noting	
	Enabled to Deliver Person Centred Care	
9(a)	Complaints Report – 01/02/18 – 12/03/18 There were no Health complaints to note. It was noted that during this period Social Work received a total of 5 complaints. Two complaints were partially upheld, 1 was upheld, 1 was not upheld and 1 was still to be completed.	
(b)	GP Complaints Report The report was reviewed by Lisa who advised the group that there were no concerns to note.	
(d)	Pharmacy Complaints Report Complaint reports for Pharmacy are now available on an annual basis but will remain on the agenda.	
(e)	Optometry Complaints Report No report was available for the time of this meeting.	

10	Mental Health SCI Update This paper was circulated previously with the agenda. Lorraine Currie gave a brief overview of the documents embedded and progress to date. Lorraine advised that one of the actions detailed within the action plan was in relation to GPs advising services of deaths. Lorraine will take this to the next GP Forum. Lisa noted that GPs may not be aware of other services involved in the patients care if they have self referred.	
11.	**Vulnerable Children and Adults**	
(a)	Child Protection There was no update was available for this meeting.	
(b)	Child Protection Case Conference Attendance – Q3 An update Q3 was presented to the group for information. It was noted that GP attendance remains low. Lisa expressed concern at the lack of GP reports noted. Dianne had met with the Child Protection coordinator to express concern around the number of reports not being noted. Dianne and Lisa will discuss process and highlight this at the next GP Forum.	**DR/LW**
(c)	Looked After & Accommodated Children There was no update was available for this meeting.	
(d)	Child protection Forum Minutes – 01/08/17 The minutes were unavailable at the time of this meeting.	
(e)	Adult Protection This item was covered previously under matters arising.	
12	**Infection Control Minutes – 18th January 2018**	
	The minutes were circulated previously with the agenda for noting.	
	General Business	
13	AOCB Clinical & Care Governance Annual Report Lisa urged the members of the group to send Dianne updates for inclusion with the Clinical & Care Governance Annual Report 2016. Dianne will recirculation the template. Lisa suggested that Oral Health should appear as a standing item on the agenda under Governance Updates.	**DR**
14	Schedule of meetings 2018 The schedule is for noting.	
15	**Date and time of next meeting** **Wednesday 30th May, 2pm, F26, KHCC**	

Agenda Item Number: 11

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	28th June 2018
Subject Title	East Dunbartonshire HSCP Staff Partnership Forum - Minutes of 21 May 2018 (Draft)
Report By	Tom Quinn
Contact Officer	Tom Quinn

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

Recommendations	The Health and Social Care Partnership Board is asked to:- a. note the draft minutes of the meeting held on the 21st May 2018.

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 Minute of meeting of 21 May 2018 attached.

Item 12

Minutes of East Dunbartonshire Staff Forum Meeting
Monday 21 May 2018 at 2pm in F33A&B, Kirkintilloch Health & Care Centre

PRESENT

Susan Manion	Chief Officer (Co-chair)
Andrew McCready (AMc)	Unite Rep (Co Chair)
Linda Tindall (LT)	Senior Organisational Development Advisor
Caroline Sinclair (CS)	Head of Community Mental Health, Learning Disability & Addictions
Margaret Hopkirk (MK)	People & Change Manager
Frances McAlinden (FMc)	General Manager Oral Health (from item 7 only)
Sharon Bradshaw (SB)	HR Business Partner
Paolo Mazzoncini (PM)	Chief Social Worker & Head of Children & Criminal Justice Services (until point 4)
Tom Quinn (TQ)	Head of People & Change
Anne McDaid (AMcD)	RCN Representative
Craig Bell (CB)	EDC Unison Chair
Billy McLeod (BM)	EDC Homecare Steward
David Radford (DR)	Health Improvement Manager
Stephen McLeod	Head of Children's Services
Karen Gillespie (KG)	HSCP Administrator – Minute Taker
Sarah Hogg (SH)	Clerical Officer (shadowing KG)

No	Topic	Action by
1.	**WELCOME AND APOLOGIES** SM opened meeting by welcoming everyone present and requesting roundtable introductions for the benefit of CS attending for the first time. Apologies were recorded for Jean Campbell, Derrick Pearce, Lyndsay Ovenstone, Louise Martin, Marie Law, Margaret McCarthy and Esther O'Hara.	
2.	**MINUTES OF PREVIOUS MEETING** Minutes of meeting held on 26th March 2018 were agreed as correct with the following amendments noted • Point 11 on page 2. PM Advised a minor amendment of his shadowing experience with Staff Nurses undertaking Immunisation Programme not School Nurses as recorded.	

3.	**MATTERS ARISING** **Statutory & Mandatory Learning NHSGGC** TQ spoke to the paper which detailed the statutory./mandatory Learnpro modules all staff are required to undertake and the completion rate of the training modules to date.	
4.	**Management Update** SM expressed a warm welcome to Caroline Sinclair who has commenced her role as Head of Community Mental Health, Learning Disability, Addictions and Health Improvement.	
5.	**Finance Update** SM spoke to the finance paper that was submitted to the IJB on 10 May 2018, this paper asked the HSCP Board to consider the proposed budget allocation from East Dunbartonshire Council. SM advised that a period of discussion has commenced and she is confident that an agreed budget will be set at the June meeting of the HSCP Board.	
6.	**Draft Staff Governance Plan 2018/19** TQ spoke to the plan that was previously circulated with the agenda. TQ advised that a number of the targets set in the 2018/18 plan had not been met and these would be taken forward in the current year. It has been agreed that Oral Health will formulate their own plan but discussions are still ongoing with regards to Specialist Children's Services	
7.	**iMatter** LT spoke to paper which updated on the HSCP iMatters. LT reiterated the importance of staff being encouraged to complete their iMatters survey as the HSCP needs to reach a 60% completion rate to ensure the reports have valid meaning. Work is underway to support the Homecare Section as the majority of their returns will be paper based.	
8.	**School Nursing** SM spoke about the ongoing review and advised that each HSCP was required to undertake analysis within their own area and report back to the group prior to the job description being finalised. A GGC wide meeting will be held in early July	

DRAFT

9.	**Staff Governance** Was discussed under point 6.	
10.	**HR Updates** MH spoke to paper that was circulated with the agenda and focussed on March 2018. The paper reports that both Oral Health and EDC absence has decreased during this period; however the HSCP has shown a slight increase. TURAS – new system stated on 1 April 2018 but it will be mid July before and usable data can be reported on. MH gave an overview of the new ESS system, that will be implemented late summer/early autumn. MH advised localised training programme will be available, with the training sessions published in the training calendar on Staffnet.	
11.	**Primary Care Improvement Plan** It was noted that the first draft of the Primary Care Improvement Plan is to be ready by the end of July. SM informed that the working group are engaging with local GP practices to finalise the first draft of the plan which will go to the HSCP Boards in June.	
12.	**Values and Behaviours Launch** LT advised roll out of the values and behaviours will be commence in June. Sessions will be lead by member of the senior management team, it is envisaged that team leads will attend and cascade information back to their teams. It was agreed that all relevant information would be placed on the HSCP website for all to access.	

DRAFT

13.	**Business Development Plan 2018-19 and Transformational Board** SM gave a brief overview of the plan in JC absence. The transformational Board will be responsible for overseeing the actions from the plan. It was agreed that the Plan and Terms of Reference for the Transformation Board should be brought to the next meeting.	
14.	**Enhanced CPD – Public Dental Service** FM advised that from 1 January 2018, each Dentist is required to evidence 100 hours of continuing professional development, over a 5 year period. In order to support staff through this change a number of training sessions have been organised. Details can be found within the team brief or from line managers.	
15.	**Communication sessions for Public Dental Service review** FMS advised the group the review is now at the stage of engaging with staff and meetings have been arranged at a number of venues across the Board to ensure as many staff as possible have been given the opportunity to comment. FMc confirmed that the final document will be taken to the Area Partnership Forum for approval.	
16.	**Moving Forward Together** TQ advised that an MFT session had taken place within KHCC and had been well attended. NHS GG&C are now in the process of collating the feedback which will inform how services are delivered in the future.	
17.	**Smoking Cessation Review** DR advised that the review will shortly be complete. Updates will be brought to the next meeting.	
18.	**Workforce & Organisational Development Plan 2018-21** TQ gave background to this plan and advised it was still in draft format. The plan will be amalgamated across all Scottish NHS Board for the future and it is anticipated this could be a useful tool for recruitment drives as would demonstrate all career opportunities within the NHS.	

DRAFT

19.	**Health Improvement Plan** DR advised this 3 year plan had been out for consultation and all comments and feedback received had been approved by the Community Planning Partnership and included in the final plan. The plan details a 3 year collaborative resource with 5 priority themes with Multi Agency Sub groups and a review will take place on an annual basis.	
20.	**Specialist Children's Services Forum** Stephen McLeod was present and provided an overview of discussions from the meeting held on 22 February 2018, minutes of future meetings will be circulated for information purposes.	
	AOCB Healthy Working Lives - DR advised that progress towards maintaining the gold award for the HSCP is now underway. Mentally healthy workplace training is part of this maintenance but attendance at the sessions was poor. SM asked how staff can be encouraged to attend these sessions. Staff Stress Survey - The survey is a key component to maintaining the gold HWL award. Both the H&S sub group and HWL working group have approved the content of survey and it is anticipated it will run for two weeks from late August 2018. Recommendations and action plan will be brought back to future SPF meetings. Staff Awards – nominations are now open with a closing date of 27 July 2018, when a panel will be pulled together to judge submissions prior to the Award ceremony on 7 September 2018.	
	DATE & TIME OF NEXT MEETING 23 July 2018, F33 A&B, Kirkintilloch Health & Care Centre	

DRAFT

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	28 June 2018
Subject Title	Transformational Change Programme – Sexual Health Services
Report By	Caroline Sinclair, Head of Mental Health, Learning Disability and Addiction Services
Contact Officer	David Radford, Health Improvement and Equalities Manager

Purpose of Report	To seek Board approval in principle for the direction of travel set out in the sexual health services Transformational Change Programme. A paper for final approval will be submitted in December 2018.

Recommendations	The Integration Joint Board is asked to: a) Note the findings of the service review that underpinned the direction of travel set out in the sexual health services Transformational Change Programme; b) approve in principle the direction of travel set out in the paper; c) note the intention to submit a final paper for approval following further engagement; d) note that the final paper will be informed by local input and local engagement.

Relevance to HSCP Board Strategic Plan	The Transformational Change Programme – Sexual Health Services supports delivery of all nine of the National Health and Wellbeing Outcomes.

Implications for Health & Social Care Partnership

Human Resources	There are no Human Resource implications for the Health and Social Care Partnership arising directly from this report.

Equalities:	The most vulnerable individuals are often at a significantly higher risk of experiencing barriers to services and ill health. Consistent with the Sexual Health Strategic Plan 2017-20 (www.sandyford.org/media/3262/strategic-plan-full-plan.pdf), the transformational change programme will aim to ensure services are equalities sensitive and targeted appropriately. A baseline overall service Equality Impact Assessment (EqIA) was undertaken to inform the review. A follow-up EqIA will be undertaken in relation to specific recommendations as part of the development plan.

Financial:	The financial implications are set out in the body of the report at section 5.

Legal:	There are no legal implications arising directly from this report.

Economic Impact:	There is no economic impact arising directly from this report.

Sustainability:	The focus of the review is, amongst other things, on the development of a sustained service model that recognises and responds to both service need and workforce challenges. The Transformational Change Programme therefore aims to support sustainability.

Risk Implications:	The Transformational Change Programme is required in order to achieve the sexual health service efficiencies which are part of NHS Greater Glasgow & Clyde's Adult Services programme. The detailed risk implications will be included in a risk register in the Development Plan. Overall, the Transformational Change Programme aims to minimise risks associated with the existing model of service delivery in relation to service and workforce sustainability.

Implications for East Dunbartonshire Council:	East Dunbartonshire Council will wish to be assured that the recommendations arising from the review continue to make a significant contribution to improving the public health of its population. There are no other direct implications for East Dunbartonshire Council.

Implications for NHS Greater Glasgow & Clyde:	NHS Greater Glasgow & Clyde will wish to be assured that the recommendations arising from the review continue to make a significant contribution to improving the public health of its population. There will be implications for NHS Greater Glasgow & Clyde in terms of workforce and working locations for staff. These will be considered in detail in the full final report and subject to appropriate engagement processes.

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

1.0 MAIN REPORT

1.1 To seek the HSCP's support and approval in principle to the recommendations set out in this sexual health services Transformational Change Programme, including the proposed contribution towards efficiency savings plans for Greater Glasgow and Clyde Health Board.

1.2 The service review has been undertaken, options appraisals and equality impact assessments completed and a direct of travel for the future of the service is described in this report. The next stage is for detailed work to be undertaken to agree the balance and form of service delivery received in each area, and centrally.

1.3 East Dunbartonshire HSCP will be engaged in the negotiation and development of this more detailed work through participation in the overarching programme board and the programme board's accessibility work stream. In addition, the Public Service User and Carer Representative Support Group will receive and have the opportunity to comment on the detailed plans as they are developed.

2.0 BACKGROUND

2.1. Sandyford Sexual Health Service (SHS) is a service for the whole of NHS Greater Glasgow and Clyde, hosted by Glasgow City HSCP. The service provides universal sexual health services for the population provided for by NHS Greater Glasgow and Clyde as well as specialist services for complex procedures and presentations and specific population groups. Many of the specialist services are provided on a regional or national basis. A summary of the current service model, including service locations, is shown in **appendix 1**.

2.2. Sandyford vision is that the population enjoys good and positive sexual health and wellbeing. Where people need support, care or treatment they can easily access specialist sexual health services. Our focus will be on prevention of poor sexual health, early intervention and supported self-management.

2.3. In February 2017, Glasgow City IJB gave its approval to commence a review of Sandyford sexual health services under the auspices of GCHSCP's Transformational Change Programme. The review aimed to:

- Improve the use of existing resources and release efficiencies through service redesign, with consideration of team structures, skill mix, localities and patient pathways.
- Encourage those who could be self-managing to be supported differently.
- Ensure that Sandyford services are accessible and targeting the most vulnerable groups.

2.4. A programme board was established in May 2017 to oversee the review and agreed the establishment of the following 4 workstreams:

i. **Clinical Services** – to develop a service specification detailing what services Sandyford offers and specifying the services which Sandyford will no longer offer, including detail on where these needs will now be met. This will set the direction for the other workstreams particularly the access and workforce streams.

ii. **Accessibility** – to develop proposals to deliver sexual health services to the right people in the right place at the right time, ensuring that services are accessible and target the most vulnerable groups, and developing innovative ways to support people to self-manage their own sexual health.

iii. **Young People** – engage with young people on their sexual health service access needs in order to define an efficient and cost effective service model for young people's sexual health care which is acceptable to them.

iv. **Workforce and Localities** – to develop proposals for a revised team structure for the service to be delivered across localities or specific geographic areas; the medical, nursing and administrative staffing complement and skill mix required to deliver this; and the overarching management arrangements required to support this.

3.0 REVIEW FINDINGS

3.1. Clinical Services

Key Principles

- The new model of service will provide the same level of urgent care activity or higher than the current model
- Urgent sexual health care should be available within 48 hours
- Most clients need timely access to routine sexual health care

3.2. In order to maintain the public health function of reducing unwanted/unplanned pregnancy and transmission of sexually transmitted infections (STIs), Sandyford must continue to provide open access in a timely fashion; allowing clients to self- refer or be referred into the service. Specialist staff time and resource must be free to be used more appropriately to ensure these public health responsibilities are met and high quality healthcare provided.

3.3. Teenage Conceptions

3.4. At a health board level NHSGGC has the third lowest rate of teenage pregnancy of the mainland health boards in Scotland. However at a local HSCP level the rates vary considerably with West Dunbartonshire having the highest rate followed by Glasgow City, both higher than the Scottish average. For those aged under 20 (in2015):

- East Renfrewshire has the second lowest rate in Scotland at 15.6 per 1,000
- East Dunbartonshire has the lowest rate in Scotland at 15.3 per 1,000
- Glasgow City is 34.1 per 1,000
- Inverclyde is 29 per 1,000 – a marginal increase on the preceding year
- Renfrewshire is 29.9 per 1,000
- West Dunbartonshire is 36.5 per 1,000 and has again become the local authority with the highest rate in the Board.

3.5. **Appendix 2** shows the 10 highest intermediate data zones (IDZ) within GGC for teenage conceptions. Teenage conception rates have continued to fall across

Scotland, NHSGGC and every local authority in all age groups (source ISD 2015 data). The boundaries for IDZ changed in 2016 and the current rates have been calculated to the revised boundaries. 2016 three year average shows that there are two IDZ with a triple-figure rate. (source SMR1,SMR2)

- Govanhill West continues to be an area of concern with over one in five teenage girls in the area having a conception. (source SMR1,SMR2)
- Other areas showing upwards trends are Bridgeton, Strathbungo, Drumry East, Whiteinch and Shettleston North. (source SMR1,SMR2)

3.6. Sexually Transmitted Infections

3.7. Episodes of gonorrhoea have doubled in the last 10 years with GGC having the highest number and rate of gonorrhoea in Scotland. Gonorrhoea is more commonly detected in males across Scotland. It is an infection of significant concern given both the increase in its prevalence and the recent emergence of treatment resistant strains in England which we are likely to see in Scotland. While gonorrhoea is common across the health board, the greatest concentration is in Glasgow City (**see appendix 3**).

3.8. Infectious syphilis is mostly found in MSM. Within GGC the greatest concentration of infectious syphilis is within Glasgow City (**appendix 4**).

3.9. HIV is now a long term condition and there is excellent treatment success if it is diagnosed early and patients are able to commence anti-retrovirals. UNAIDS has set the 90 -90-90 target for countries to reach by 2020 to eradicate HIV. The model has been proven in a range of cities across the world, most notably in London which for the first time ever noted a reduction in incidence during 2017 as a result of scaling up HIV testing and meeting the 90-90-90 targets. By the end of 2016 we saw a decrease in the overall numbers of new HIV diagnoses in Scotland. In GGC we have exceeded the second two parts of the UNAIDS target, however because 17%of those with HIV are undiagnosed our incidence has not declined. There is a clear need to improve our testing rate. Although there are no more recent figures than 2013/14, we know that in GGC the greatest concentration of HIV is within Glasgow City. The outbreak of HIV among people who inject drugs which began in 2014 has continued despite control measures.

3.10. Activity

3.11. There are a large number of clients who currently attend the service with undifferentiated presentations who may not be able to articulate their needs prior to consultation and who require assessment in a time sensitive manner. This results in a significant amount of generalist work (in addition to specialist sexual health work). Appendix 5 shows that in 2017, there was no great variance between HSCP areas as to the booked clinics attended by residents. Glasgow residents attend fewer LARC clinics and that will be addressed. It also shows that attendance at Urgent Care clinics is low in comparison to attendance at Routine Care clinics, this will also be addressed in the recommended new service model.

3.12. **Appendix 5** also shows that in 2017, in each HSCP area (with only slight variation) around 30% of attendances were for contraception and around 20% for asymptomatic screening.

3.13. We know that in 2016[2]:

- 55% of all contraceptive attendances at all Sandyford services were for routine contraceptive pills and injections (n=11798) and the remaining 45% (n=9172) were for very Long Acting Reversible Contraception (vLARC), i.e. implants and IUDs;
- There were 14584 attendances for asymptomatic STI testing;
- 5284 routine cervical smears were performed.

3.14. While some of these presentations may be appropriate due to the priority or vulnerable nature of the clients, each of these were seen by a highly skilled and specialist member of clinical staff.

3.15. Some of this undifferentiated presentation is currently managed by the wider NHS workforce. In the light of the new GP contract there is an opportunity to look at how Sandyford and Primary Care can work together to deliver some of this in different ways. This will allow specialist sexual health staff to work with clients presenting with complex needs for reasons of clinical complexity, social and personal vulnerabilities and as part of high risk groups without shifting the non-complex work directly to GP practices. Senior clinical decision makers need to be available to support the entire service and provide quality care across multiple locations.

3.16. Clients living with vulnerabilities or belonging to known groups at risk of poor sexual health are a key target population for Sandyford services. Flexibility in time spent with these patients and how they are supported into care and between services is essential.

3.17. Sandyford services are located in each HSCP area throughout GGC. Glasgow City has the biggest population and there are more services located here than in other areas. **Appendix 6** shows where residents from each HSCP area attend Sandyford services.

3.18. People who live in Glasgow tend to visit Glasgow services and most people who live in the area attend Sandyford Central as it is the service with most capacity.

- More East Dunbartonshire residents attended Sandyford Central than their local Kirkintilloch service.
- More adults attended Springburn service than their local areaMore East Renfrewshire residents attend Sandyford Central than their local service and high numbers of adults also attend Paisley and Pollok
- Adults and young people especially tend not to travel out of Inverclyde to attend services
- A high proportion of Renfrewshire residents attend services at Sandyford Central but the majority do visit Renfrewshire services
- Equal numbers of young people from West Dunbartonshire attend Clydebank (1 day service) as the Vale of Leven service (2 days), but a higher number than either attended at Sandyford Central.
- More adults also attended Sandyford Central than their local area.

3.19. Accessibility

Key principles:

- The service needs to better support clients who are able to self manage their sexual health needs in order that access for the most vulnerable people is improved
- Outreach provision of sexual health services is supported in principle if evidence shows that it increases the reach to priority groups or vulnerable people
- Services will be provided during daytime hours with the exception of Steve Retson, Termination of Pregnancy assessment (TOPAR) and Young People services

3.20. For the majority of clients, the only route into the service is through a central telephone number. This results in queues and long waiting times on the phone, high proportion of abandoned calls, and high rates of DNA as clients find it difficult to get through to cancel an appointment.

3.21. Throughout the service, the key performance areas (with the exception of TOPAR) do not meet the set waiting times targets. Over recent months urgent care has been further challenged by the introduction of PrEP. The ability for patients to access vLARC services has continually caused concern and there seems to be little prospect of improving this performance unless the service changes to achieve this.

Table 1 – Waiting times for key Sandyford services June-Nov 2017

CLINIC	TARGET	June 17	July 17	August 17	Sept 17	Oct 17	Nov 17	Dec 17
IUD	10 working days	22	19	24	22	22	26	24
Implants	10 working days	16	14	14	13	15	15	16
Urgent Care	2 working days	2	3	4	4	4	4	4
R20's	20 working days	23	22	23	24	24	26	26
Test Only	15 working days	13	14	15	16	19	19	18
Complex FP	20 working days	35	46	45	40	42	35	34
TOPAR	5 working days	4	6	6	4	5	4	5

3.22. Young People

Key principles:

- Young people refers to all young people aged up to and including 17 years of age
- If a young person is receiving aftercare/ throughcare services, they should continue to be provided care beyond the age of 18 by Sandyford's young people service until they have been clinically assessed as being suitable to be managed by Sandyford's adult service.
- Services need to be open and accessible at times that suit young people attending school

3.23. Dedicated young people drop-in clinic slots are provided in all Sandyford services on

most of the days they are each open. However this is variable, and with the exception of Sandyford Central, there is very limited clinic time dedicated for young people.

Table 2 – Provision of Sandyford Young Peoples Clinics weekly.

Sandyford Clinic	Monday	Tuesday	Wednesday	Thursday	Friday
Sandyford Central	4-6pm	4-6pm	4-6pm	4-6pm	
Drumchapel		6.30-9 pm (YHS)**		3.30-4.30pm	
Possilpark			6.30-9 pm (YHS)**		
Maryhill				6.30-9 pm (YHS)**	
Parkhead*	3.30-4.30pm			3.30-4.30pm	3.30-4.30pm
Easterhouse			3.30-4.30pm		
Springburn			3.30-4.30pm	3.30-4.30pm	
Govanhill	3.30-4.30pm		3.30-4.30pm		3.30-4.30pm
Castlemilk				3.30-4.30pm	
Pollok	3.30-4.30pm		3.30-4.30pm		
Barrhead	3.30-4.30pm				3.30-4.30pm
Paisley			3.30-4.30pm	3.30-4.30pm	3.30-4.30pm
Johnstone			2.30-4.30pm		
Greenock			3.30-4.30pm	3.30-4.30pm	
Vale of Leven			3.30-4.30pm		
Clydebank				3.30-4.30pm	
Kirkintilloch				3.30-4.30pm	

**At the time of writing Parkhead is running a pilot of extended opening hours from 3.30 to 7pm on Monday and Thursday evenings.*
*** The Youth Health Service (YHS) is a holistic health service for young people delivered by Glasgow HSCP in the Northwest Locality, and drop in sexual health care is provided. These clinics are not provided by Sandyford and are included as context.*

3.24. The young people clinics are staffed by a wide range of Sandyford staff including staff grade doctors, consultant, nurses of varying grades and receptionists. Again, this is variable, depends on which staff are available at each location on the day, and means that some generalist work is being done by specialist staff. There is a lead nurse and lead consultant for young people who work from Sandyford Central. This team manages complex cases for young people and carries the overview of child protection cases. Some outreach sessions are provided to secure residential care settings and intensive social work services for vulnerable young women.

3.25. The numbers of young people attending all Sandyford services decreased every year from 2011-2015. As well as a decline in absolute numbers, the proportion of young people estimated to be sexually active who attend the service has also decreased over the same period of time[3].

Table 3 - Numbers of young people attending Sandyford 2011-2015

		Numbers of YP attending Sandyford	
Age	**Year**	**Boys**	**Girls**
13-15	2011	159	1,845
	2012	122	1,101
	2013	91	928
	2014	73	834
	2015	53	687
16-17	2011	487	2,930
	2012	440	2,642
	2013	446	2,476
	2014	337	2,165
	2015	231	1,934

Table 4 - Proportion of young people estimated to be sexually active attending Sandyford 2011-2015

		% estimated sexually active YP attending Sandyford	
Age	**Year**	**Boys**	**Girls**
13-15	2011	5	74
	2012	4.7	58
	2013	3.6	50.5
	2014	3	46
	2015	2.3	39
16-17	2011	11.6	72
	2012	10.1	64
	2013	10.2	58
	2014	8	52
	2015	5.6	49

3.26. Exploring the reasons why young people attend Sandyford across 2015 to 2017 it is evident that while young people presentations can be complex, in the main the complexity relates to the social contexts of their sexual relationships rather than being medically complex. Only 2.5% of attendances in this time period have been medically complex. The range of skills and competencies required for the young people's service are consistent with a nurse delivered service with the opportunity for staff to contact medical support remotely if required. Therefore it is appropriate that the young people's service can safely be delivered by nursing practitioners with prescribing, symptomatic and implant fitting competencies. One of the features stressed throughout the life of the group is the importance to young people of continuity of practitioner when they attend.

3.27. Workforce

Key principles:

- The service requires a highly skilled, flexible workforce providing the appropriate level of service
- Clients should be able to have their needs addressed through the efficient and effective use of the specialist staff resource

3.28. Sandyford has a highly skilled clinical workforce of with a mix of consultant and specialty grade doctors, training grade doctors, advanced nurse practitioners (ANP), specialist sexual health nurses, sexual health advisors (SHA), Biomedical Scientists (BMS), health care support workers (HCSW) and administrative staff who are all trained to work with clients with specialist sexual health presentations. The new model needs to ensure that the integrated workforce is working in an efficient way that allows a degree of flexibility and builds capacity to manage both scheduled care and urgent/undifferentiated care services.

3.29. In recent years, it has become increasingly difficult to recruit speciality doctors. This is a national issue and not specific to Greater Glasgow. The service has become more centralised as there are fewer doctors to cover all locations across the Board area. This has presented some skill mix challenges and the service has responded with the development of Advanced Nurse Practitioners. There are currently four ANPs and two in training.

3.30. The nursing workforce has been delivered predominantly at a band 6 grade, with

some band 5 grades introduced. A more recently extended Band 6 role for non-medical prescribing and IUD fitting means there is a small number of nurses who can carry out IUD fitting.

3.31. The Health care support worker role supports clinical service delivery through a range of activities including maintaining infection control standards in clinical rooms, chaperoning role during procedures, supporting specialist clinic service delivery and minor ops and facilitating asymptomatic testing of clients self selecting for test only clinics. This is a valued role and needs to be expanded to allow clinicians to carry out more complex clinical tasks.

3.32. Locality Management arrangements

Key principles:

- Management and team structure within the service needs to support good team work and consistent and reliable service delivery

3.33. The service covers a large geographical area with varying levels of service provision across a number of sites. The community sites vary in their size, in the frequency of opening times, and in the amount and types of service they provide. Consistency and equity of service provision across 15 sites, therefore, is difficult to deliver, as well as ensuring the right staff skill mix. Increasingly, provision at some of the smaller sites is suspended to deal with staffing shortages in other locations and having staff managed centrally does not lend itself to effective annual leave management or a sense of shared responsibility across a team.

3.34. The service has always been clinically led with no service management arrangements in place, other than at Head of Service level. There is an acknowledgement that this should now fall into line with other services across the HSCP and across the Board, and this should include separate professional and operational management arrangements.

4.0 REVIEW RECOMMENDATIONS

4.1. **Clinical Service Model**

4.2. It is recommended that the future service model should comprise 3 tiers of service provision for clients who need to see specialist sexual health services:

- Tier 3 - one specialist service which will deliver routine scheduled, emergency and urgent/undifferentiated care, and all specialist services;
- Tier 2 - a few larger connecting services which will offer routine scheduled, emergency and urgent/undifferentiated care;
- Tier 1 - a number of smaller, local services which will offer routine scheduled and emergency care.

4.3. This proposed model for service modernisation will aim to offer care to clients with non-complex sexual health needs in innovative ways and with involvement of other stakeholders and partners. It will release the highly trained specialist workforce to see clients with specialist sexual health presentations. It will allow better use of clinical time, improve accessibility, and make better use of resources. The model also allows

further development of the nursing role and will address the shortfall of medical staff, particularly over levels 1 and 2.

4.4. In line with the Board's Transformational Strategy Programme (Moving Forward Together)[4], this tiered provision of services makes best use of resources by providing specialised and complex care in a properly equipped specialist centre with an appropriately skilled workforce.

4.5. Part of what Sandyford delivers (HIV treatment and care) is in the Acute setting, integrated with the rest of infectious diseases. Discussions will take place with Acute partners, and any proposed service change or redesign will be taken through a separate process.

4.6. Sandyford currently provides all assessment services for termination of pregnancy across Greater Glasgow, and discussions and engagement is underway acute colleagues regarding recent changes in guidance which will allow the service at Sandyford to expand, as well as to standardise the current assessment service across all of Greater Glasgow and Clyde.

4.7. Tier 3

The specialist service will be the main site for delivery of urgent/undifferentiated, complex and specialist care. It will enable concentration of the most clinically skilled staff to maintain capacity and ensure there is a clear system for managing complex patients. It will also make best use of necessary equipment and resources (e.g. the laboratory and scanning equipment, theatre space). This will also allow a greater concentration of staff to provide the broad range of training that Sandyford delivers. The specialist service will open 5 days a week and will offer:

- Consultant support and advice to all Sandyford sites including support clinical governance requirements at all levels
- Consultant led care for undifferentiated and complex cases
- Complex GUM scheduled care
- Complex SRH scheduled care
- Specialised STI management/partner notification
- Specialist HIV treatment and care and risk reduction (partially delivered at Brownlee).
- Steve Retson Project – MSM targeted service
- Abortion service
- Vasectomy service Archway – Sexual Assault referral service
- Gender identity clinic
- Psychosexual/sexual dysfunction services counselling
- Sandyford Counselling and Support Services.

4.8. Tier 2

To meet the requirements of a tier 2 service, the site will be open on a *minimum* of 3 full days a week, but ideally 5 days a week, in order to ensure that access to urgent/ undifferentiated care within 48 hours is available. This will be offered each morning the service is open, to allow time for review of urgent laboratory results and timely

management that day. Most urgent/undifferentiated care clients will be able to be managed in the tier 2 setting, with consultant support and advice from the specialist service. A small number of clients may need to be physically seen by a consultant, and this will be co-ordinated to allow consultant level care at the specialist service on the same day if necessary. The remainder of the day will offer scheduled and emergency care, as per the tier 1 service specification.

4.9. Tier 2 services will offer all services which are also offered at tier 1 services, as well as:

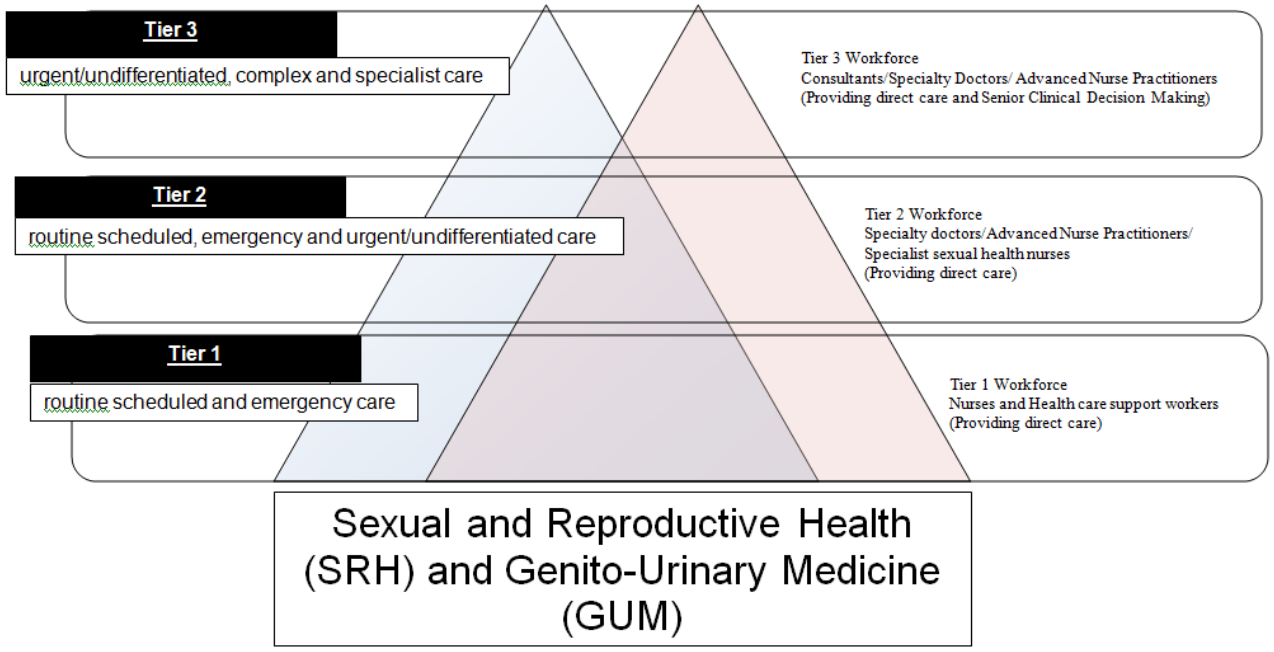
- Assessment, testing, treatment and support of symptomatic/complex people including Young People, Men who have Sex with Men, and Black Africans
- Face to face / complex Partner Notification
- PEPSE (Post Exposure Prophylaxis for Sexual Exposure) – risk assessment, prescribing, follow up
- Management of PrEP (Pre Exposure Prophylaxis) – risk assessment, prescribing, follow up/ ongoing assessment

4.10. Tier 1

To meet the requirement of a tier 1 service, the site will be open on a *minimum* of 2 full days a week. These services will offer:

- Sexual history and risk assessment
- STI testing for asymptomatic low risk women and men
- HIV testing
- Hepatitis A and B and HPV immunisation Provision of non vLARC hormonal contraception Provision of vLARC contraception
- Information about choice of full range of contraceptive methods and where these are available
- Cervical cytology screening for women unable to access primary care regnancy testing and referral
- Dedicated clinic slots for young people

Proposed Service Model - Tiers of service provision



4.13 Service Locations

4.14 The proposed future service model will consist of a network of sexual health clinics, with one specialist (tier 3) service, four tier 2 services (covering east, south, west and north-west areas), and a number (to be determined) of tier 1 services which will be located in areas of need and which cover the geographical spread of Greater Glasgow and Clyde.

4.15 The specialist service will remain in the Sandyford Place building for the foreseeable future, until such times as a more fit-for-purpose building is identified.

4.16 The tier 2 service for North West area will initially be located with the specialist service due to the space available at the current Sandyford Place site. However, it is the aspiration for this service to be relocated to another area within the North West area should suitable accommodation become available.

4.17 Tier 1 services will be located in the most appropriate areas where accommodation can be made available. The proposed locations for all tier 1 and 2 services will be subject to further discussion and engagement with HSCPs and community and service user representatives, and be supported by an Equality Impact Assessment (EqIA).

4.18 A recommendation on the proposed locations will be brought to the IJB, with a detailed development plan, workforce plan and financial framework for final approval in December 2018.

4.19 Accessibility

4.20 Developing and harnessing digital engagement with clients is essential to prioritising resources and encouraging self management. The Sexual Health website will need to support and guide clients who are looking for sexual health information and/or care to access it in ways appropriate to their needs. It will direct clients with non- complex presentations to access care that uses minimal specialist staff time while ensuring that they receive appropriate care and that Sandyford continues to meet its public health responsibilities and delivers high quality healthcare. The website must also enable clients who do need to see a specialist sexual health clinician to enter the service in a timely manner and be directed to the appropriate service to best meet their needs and minimise the number of attendances. It is proposed that online tools, such as e-triage, symptom checkers, live web-chat, and online registration are developed via the website in order to better inform clients of the services they can access and the best routes for them to do so.

4.21 The ability to book appointments online, as well as to text and email to arrange, cancel and change appointments will be developed. This will improve access routes into the service by easing telephone traffic and allowing more choice for clients. It is proposed that telephone access and call-waiting times also be improved with the introduction of a call handling system, through training and development of staff, offering call-back options, and extending the telephone line opening hours. A mix of walk in and bookable appointments will be offered to improve access to priority and vulnerable people.

4.22 It is recommended that the client journey through the service is improved through the implementation of self arrival kiosks at all Sandyford services, enhanced information on clinic waiting times and signage, the use of language-line at the specialist service reception, and also through the development of Test Express services where clients can pre-book a test only appointment with a Health Care Support Worker or can collect a pre-ordered a test kit for self-testing. We will also engage with primary care partners to develop Test Express services. It is recommended that a similar model is investigated for the provision of repeat routine contraception.

4.23 Young People

4.24 It is proposed that Sandyford re-engages with young people to realise the levels of service attendance experienced in 2011. In order to achieve this, the future service model will continue to have dedicated Young People clinics as a priority component of the Sandyford services. The clinics will run after school hours and into the evening (7.30pm), will offer a mix of walk in services with some appointments, and will have dedicated nursing staff with higher levels of competencies for working with young people.

4.25 The preferred location for delivering Sandyford Young People clinics is in settings where other organisations and services working with young people are already located. Where this is not possible, and in the meantime until suitable locations/partners are identified, the clinics should continue to be provided from Sandyford's own clinics.

4.26 It is also proposed that an outreach clinic should be developed in the city centre on Saturday afternoons, on a pilot basis, and in partnership with other service providers. This will address the gaps in location availability in areas of very high teenage conception, and could be located with a young people's organisation or in a larger pharmacy premise.

4.27 A communication strategy and a marketing plan should also be developed to support and promote Young People services.

4.29 Workforce

4.30 In order that the specialist sexual health workforce is re-shaped in line with the recommended future service model, it is proposed that some key workforce shift and development takes place.

4.31 Admin switchboard role will be developed with the introduction of the call handling system, which will reduce the need for clinical staff to be engaged in phoning back clients. It is estimated that the admin switchboard resource will increase.

4.32 Admin reception workforce will also encounter a shift with the introduction of self arrival kiosks and online booking reducing the number required, although developments in email and text communication will still require some resource. A review of the Admin workforce will determine the final structure.

4.33 The HCSW role will be developed to provide Test Express at tier 1 and 2 services, and a phlebotomy role will be introduced. Further discussion is required to determine the AfC band (mix of band 2 and 3), but it is estimated that this staff group will increase.

4.34 The Sexual Health nurse role (AfC band 5) will be developed and standardised across Sandyford. Sexual Health nurses will provide a range of services at all Sandyford locations and that the proportion of band 6/band 5 nurses shifts.

4.35 Advanced Nurse Practitioners will have a key leadership role across the tier 1 and 2 services, supported by medical staff. It is not anticipated that the level of ANPs will change under the proposed model.

4.36 The full range of trained and untrained nursing staff will still be required for the specialist services at the specialist tier 3 service.

4.37 All medical staff will be located at the specialist service which will centralise the most clinically skilled staff; allowing for complex care to be directly provided, co-ordination of same day consultant level care to those clients who are not able to be managed completely at a tier 2 service, and maintain capacity across the service. Specialty doctors will be required to provide the specialist and complex services at the specialist service, working closely with senior medical staff. Consultants will be able to provide support and advice across all services from the specialist site. This concentration will also benefit the broad training programme delivered by Sandyford. It is proposed that a review of medical workforce is undertaken to determine the future shape of this part of the service.

4.38 The skilled medical workforce will be key in leading and supporting the move to the new proposed model. A training plan will be developed to enable staff to deliver the vision, and the support of the Specialty doctors in particular will help support this transition.

4.39 Localities Management

4.40 General Management arrangements will be extended in Sandyford and there will be a move to have a professional leadership model separate from the operational management, which is in line with other services across the HSCP with the development of a Service Manager role and a review of the remaining management structure.

4.50 It is proposed to move to a locality management model based around the 4 tier 2 services and incorporating the local tier 1 services. These 4 teams will be led by a Nurse Manager who will have management of teams in the tiers 1 and 2 in that locality. Sexual health nurses, who work in the specialist service, including Sexual Health Advising, will be part of this team structure. Practice Development will be split from nursing staff management; and the current Hub Lead Nurse responsibilities will be absorbed into the Nurse Manager role.

4.51 All of these staffing proposals will be undertaken in line with the Organisational Change and job planning processes. Some of these discussions will rely on the outcome of the decision on where the Sandyford tier 1 and 2 services will be ultimately located.

5.0 FINANCE

5.1 The review was initially predicated on the achievement of £250,000 efficiencies for 2017/2018 and this has been achieved. Further financial pressure has resulted in the scope of the review process widening to consider an additional 15% over the next three years. This requires a transformative redesign of the current workforce, the development of a tiered model which will improve the use of existing resources and release further efficiencies. The use of spend to save to develop new technology which will improve accessibility and the service user experience is vital as is the requirement for transitional funding to facilitate the workforce changes required. This is also in light of additional service commitments; the development of the Archway Sexual Assault Referral Centre, which has required additional investment and the Scottish Government's role out of the HIV prevention drug, PrEP.

6.0 RISK

6.1 This transformational change programme is required in order to achieve the sexual health efficiencies which are part of the Adult Services programme. The detailed risk implications will be included in a risk register in the Development Plan

7.0 ENGAGEMENT AND DEVELOPMENT

7.1. Development of this paper and its supporting Workstream papers has had multi-partner and multi-agency involvement, and 2 of the workstream groups have included some user engagement (Young People and Accessibility). Staff Partnership Forum has been represented and Sandyford staff have also been involved and informed.

7.2. This paper has been approved by the Programme Board, and noted by the Chief Officers Group, the GC Staff partnership Forum and a joint meeting of the Clinical Directors and LMC.

7.3. Further engagement on the recommendations will take place during the 3 months after this paper has been approved by the IJB. The proposed locations for all Sandyford tier 1 and 2, will be subject to further discussion and engagement with HSCPs, primary care colleagues and community and service user representatives throughout Greater Glasgow and Clyde.

7.4. All of the recommendations contained within this paper will be supported by an Equality Impact Assessment (EqIA).

7.5. A Development Group(s) will be established to develop detailed implementation plans and timescales to realise the proposals put forward here, reporting to an overarching Programme Board.

7.6. The East Dunbartonshire HSCP will be engaged in this ongoing work through participation in the location and access development group and the overarching Programme Board. In addition, the Public Service User and Carer Representative Support Group will receive and have the opportunity to comment on the detailed plans as they are developed.

Appendix 1
Current Sandyford Service Model

The service covers a large geographical area with a large number of sites with varying service provision based on availability of sites in HSCP premises. The community sites vary in their size and frequency of opening times and do not all provide all services.

Sandyford Central is the main service based near the city centre, providing routine and urgent integrated sexual health services, and a range of specialist booked appointment clinics. Sandyford Central is open 5 week days and Mon-Thurs evenings.

Sandyford Hub services are provided under the leadership of a specialist sexual health nurse, and with a multi-disciplinary team. Each Hub runs for 3-5 days, and has a mix of routine and urgent sexual health services and specialist service provision. The level of service provided is dependent on local communities and resource / accommodation availability. Each hub has a specialist young people's clinic at least once a week.

Sandyford Satellite services are provided over a single 8-hour daytime session. Two satellite services are provided in the evening due to lack of community accommodation in the morning. Service provision at the satellites is more generic with onward referral to Hubs or Sandyford Central for complex need or more specialist requirement.

Sandyford Central at Sauchiehall Street

<u>Hubs</u>
Sandyford East at Parkhead
Sandyford East Renfrewshire at Barrhead
Sandyford Greenock
Sandyford North at Springburn
Sandyford Renfrewshire at Paisley
Sandyford South East at Govanhill
Sandyford South West at Pollok
Sandyford West Dunbartonshire at the Vale of Leven

<u>Satellites</u>
Sandyford Castlemilk
Sandyford Clydebank
Sandyford Drumchapel
Sandyford Easterhouse
Sandyford Johnstone
Sandyford Kirkintilloch

Appendix 2

Ten Highest IDZ in NHSGGC for Teenage conceptions
3 year average for 2014-2016

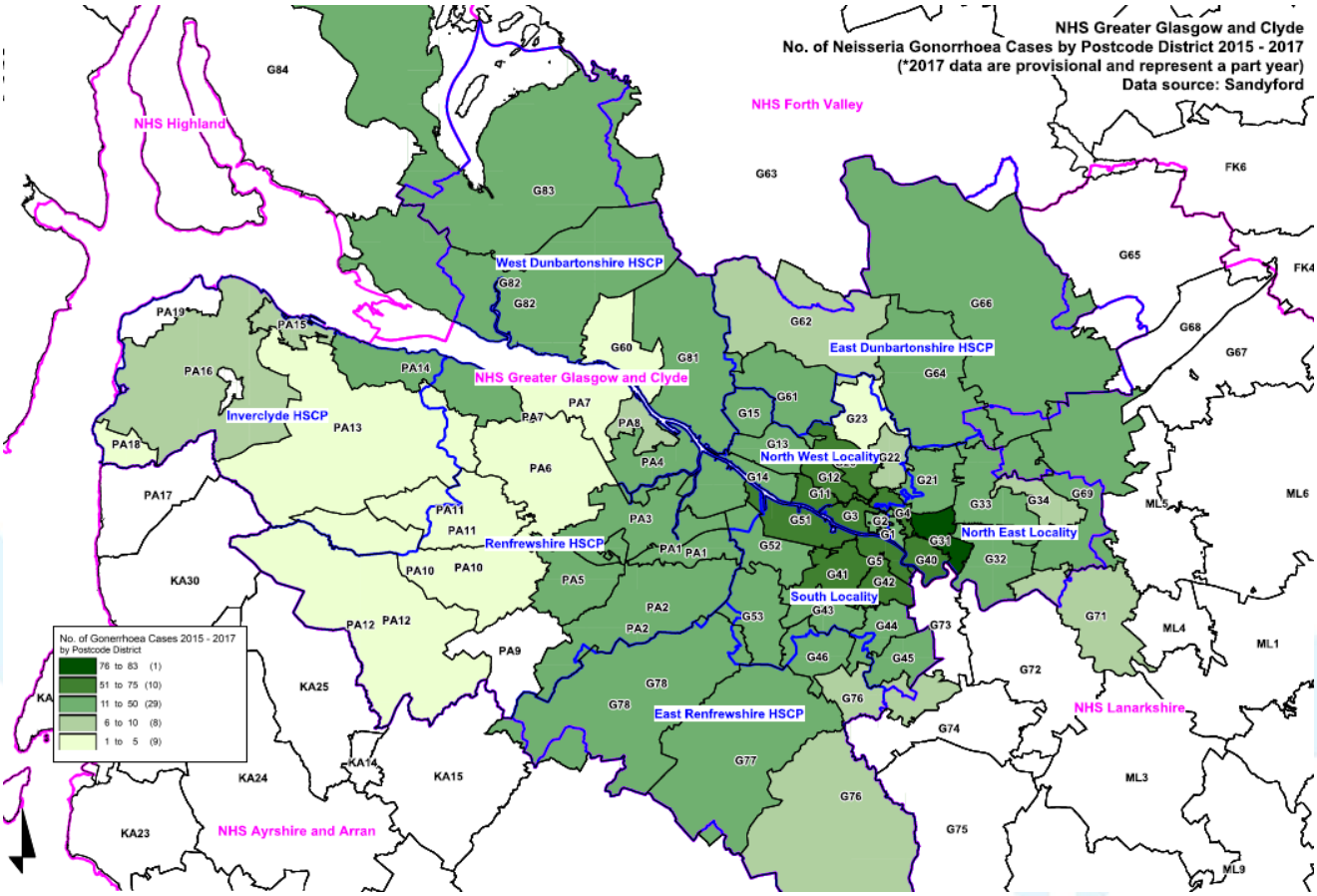
Rank	Area	Rate per 1,000	Rate in 2013-2015	Rate in 2012 – 2014	Rate in 2010-2012	Rate in 2009-2011
1	Govanhill West	**212**	178	153	111	80
2	Central Easterhouse	**119**	123	108	118	115
3	Bridgeton	**99**	87	- (82)	-(84)	-(79)
4	Strathbungo	**91**	90	85	84	109
5	Drumry East	**88**	73	65	69	89
6	Linwood South	**85**	87	65	62	88
7	Tollcross	**84**	92	78	69	58
8	Maryhill West	**83**	96	98	90	123
9	Whiteinch	**78**	71	61	67	81
10	Shettleston North	**74**	62	68	112	140

Commentary

- Teenage conception rates have continued to fall across Scotland, NHSGGC and every local authority in all age groups (source ISD 2015 data)
- West Dunbartonshire is the local authority in the Health Board area with the highest rate (source ISD 2015 data)
- The boundaries for IDZ changed in 2016 and the current rates have been calculated to the revised boundaries. Bridgeton was formerly part of the Calton, Gallowgate and Bridgeton IDZ and previous figures for this IDZ are included in brackets for context.
- 2016 three year average shows now only two IDZ with a rate with triple figures. (source SMR1,SMR2)
- Govanhill West continues to be an area of concern with over one in five teenage girls in the area having a conception. (source SMR1,SMR2)
- Other areas showing upwards trends are Bridgeton, Strathbungo, Drumry East, Whiteinch and Shettleston North. (source SMR1,SMR2)

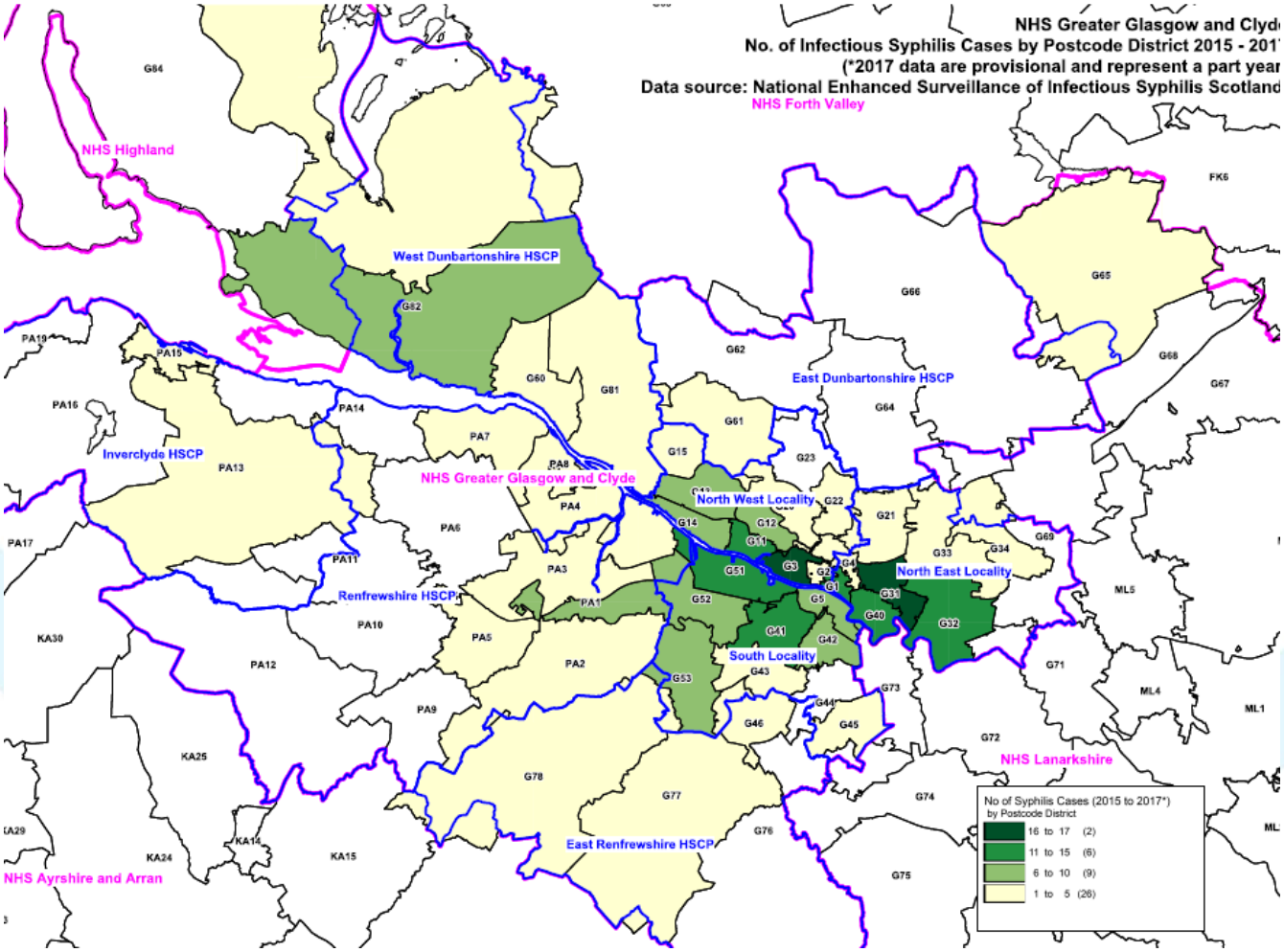
Appendix 3

Gonorrhoea cases by postcode area in GGC 2015-(part)2017



Appendix 4

Syphilis cases by postcode area in GGC 2015-(part)2017



Appendix 5
Clinic attendance and episode reason by HSCP area 2017

Proportion of HSCP residents attending named booked clinics in 2017

	East Dun	East Ren	Glasgow	Inver	Ren	West Dun
LARC clinic	15%	13%	10%	19%	14%	12%
Routine care clinic	20%	19%	17%	26%	17%	19%
Urgent care clinic	8%	8%	10%	10%	11%	8%
All Other / Specialist clinics	55%	57%	61%	43%	57%	58%

Proportion of HSCP residents attending all clinics in 2017 for reason listed

	East Dun	East Ren	Glasgow	Inver	Ren	West Dun
Contraception (all)	30%	31%	29%	29%	29%	29%
Asymptomatic testing	19%	20%	18%	19%	19%	20%
Symptomatic testing / treatment	14%	14%	15%	16%	15%	14%
Women's Health / Gyn	10%	9%	11%	11%	11%	11%

Appendix 6

Sandyford locations attended by East Dunbartonshire residents in 2017

(Total 3450)

Name of Service	**Numbers <20**	**Numbers >20**
Castlemilk	0	7
Central	**256**	**2133**
Clydebank	7	47
Drumchapel	12	142
East	9	100
East Dunbartonshire	**89**	**513**
East Renfrewshire	2	5
Easterhouse	9	28
Greenock/Boglestone	2	15
Johnstone	2	5
North	**61**	**650**
Renfrewshire	4	49
South East	1	23
South West	5	15
West Dunbartonshire	5	38

Sandyford locations attended by East Renfrewshire residents in 2017

(Total 3129)

Name of Service	**Numbers <20**	**Numbers >20**
Castlemilk	3	47
Central	**174**	**1707**
Clydebank	1	5
Drumchapel	3	11
East	4	61
East Dunbartonshire	0	1
East Renfrewshire	**152**	**941**
Easterhouse	2	24
Greenock/Boglestone	1	29
Johnstone	4	18
North	4	43
Renfrewshire	29	**362**
South East	16	155
South West	31	**271**
West Dunbartonshire	0	31

Sandyford locations attended by Glasgow residents in 2017

(Total 30776)

Name of Service	Numbers <20	Numbers >20
Castlemilk	**103**	**527**
Central	**1913**	**20181**
Clydebank	25	240
Drumchapel	**104**	**681**
East	**418**	**3720**
East Dunbartonshire	4	40
East Renfrewshire	20	258
Easterhouse	**72**	**491**
Greenock/Boglestone	11	235
Johnstone	8	61
North	**211**	**2030**
Renfrewshire	47	528
South East	**229**	**2289**
South West	**254**	**1836**
West Dunbartonshire	11	204

Sandyford locations attended by Inverclyde residents in 2017

(Total 2222)

Name of Service	Numbers <20	Numbers >20
Castlemilk	0	1
Central	111	687
Clydebank	0	13
Drumchapel	0	7
East	0	12
East Dunbartonshire	0	1
East Renfrewshire	0	8
Easterhouse	0	0
Greenock/Boglestone	249	1546
Johnstone	3	13
North	0	6
Renfrewshire	8	206
South East	0	6
South West	0	4
West Dunbartonshire	0	14

Sandyford locations attended by Renfrewshire residents in 2017

(Total 6490)

Name of Service	Numbers <20	Numbers >20
Castlemilk	0	7
Central	**351**	**2816**
Clydebank	4	30
Drumchapel	2	28
East	5	40
East Dunbartonshire	0	4
East Renfrewshire	15	130
Easterhouse	0	31
Greenock/Boglestone	16	207
Johnstone	**104**	**348**
North	5	53
Renfrewshire	**591**	**3615**
South East	1	31
South West	10	80
West Dunbartonshire	5	64

Sandyford locations attended by West Dunbartonshire residents in 2017

(Total 3209)

Name of Service	**Numbers<20**	**Numbers >20**
Castlemilk	0	2
Central	**207**	**1587**
Clydebank	**148**	**595**
Drumchapel	13	112
East	0	18
East Dunbartonshire	0	3
East Renfrewshire	0	10
Easterhouse	0	5
Greenock/Boglestone	0	38
Johnstone	1	5
North	0	26
Renfrewshire	5	118
South East	3	10
South West	0	7
West Dunbartonshire	**144**	**978**

Agenda Item Number: 14

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	28 June 2018
Subject Title	What is Integration? Audit Scotland Report April 2018
Report By	Susan Manion, Chief Officer
Contact Officer	Caroline Sinclair, Head of Mental Health, Learning Disability and Addiction Services

Purpose of Report	To present to members the most recent report by Audit Scotland on the integration of health and social care.

Recommendations	The Integration Joint Board is asked to: a) Note the Audit Scotland report 'What is integration?', and b) note that, reflecting on the report, officers will consider the governance processes of the Board including the use of directions, and bring forward any recommended changes to practice to a future meeting.

Relevance to HSCP Board Strategic Plan	This report relates to the governance of the Integration Joint Board.

Implications for Health & Social Care Partnership

Human Resources	There are no Human Resource implications for the Health and Social Care Partnership arising from this report.

Equalities:	There are no equalities impacts arising directly from this report.

Financial:	There are no financial implications arising directly from this report.

Legal:	There are no legal implications arising directly from this report.

Economic Impact:	There is no economic impact arising directly from this report.

Sustainability:	This report does not directly relate to the sustainability of the partnership or services delivered by it.

Risk Implications:	The process of external audit and changes in practices as a result of lessons learned contribute to positive management of risk.

Implications for East Dunbartonshire Council:	There are no other direct implications for East Dunbartonshire Council.

Implications for NHS Greater Glasgow & Clyde:	There are no other direct implications for East Dunbartonshire Council.

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

1.0 MAIN REPORT

1.1 Background

In April 2018 Audit Scotland published their most recent national report on the integration of health and care services, titled 'What is integration? A short guide to the integration of health and social care services in Scotland'

The report summarises the policy journey that has led to the current legal position as asset out in the Public Bodies (Joint Working) (Scotland) Act 2014 and notes that the application of that Act has been approached differently in differently areas.

The report goes on to illustrate how Integration Authorities, whichever model of constitution they have adopted (ie Lead Agency or Integration Joint Board), are to exercise their planning remit and their remit for direction of operational service delivery and oversight of performance.

1.2 Implications for the HSCP

The Audit Scotland report provides a helpful summary of what is a complicated landscape of governance and responsibility, which can often be misunderstood by

those not closely involved in that landscape themselves.

As with the production of any national guidance, it is appropriate for the partnership to reflect on the report, and consider whether there are any lessons to be learned.

1.3 Next Steps

In the context of this specific Audit Scotland report, officers of the partnership will reflect on the processes currently in place that support the partnership's responsibility for strategic planning and for oversight of service delivery including how the partnership utilises direction. Should any changes to process be required, a paper will be brought to future Board meeting to outline proposals.

Appendix 1 - 'What is integration? A short guide to the integration of health and social care services in Scotland'

What is integration?

A short guide to the integration of health and social care services in Scotland

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
April 2018

The Accounts Commission

The Accounts Commission is the public spending watchdog for local government. We hold councils in Scotland to account and help them improve. We operate impartially and independently of councils and of the Scottish Government, and we meet and report in public.

We expect councils to achieve the highest standards of governance and financial stewardship, and value for money in how they use their resources and provide their services.

Our work includes:

- securing and acting upon the external audit of Scotland's councils and various joint boards and committees
- assessing the performance of councils in relation to Best Value and community planning
- carrying out national performance audits to help councils improve their services
- requiring councils to publish information to help the public assess their performance.

You can find out more about the work of the Accounts Commission on our website: www.audit-scotland.gov.uk/about-us/accounts-commission

Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Environment Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website: www.audit-scotland.gov.uk/about/ags

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

Introduction

The integration of health and social care services is a major programme of reform, affecting most health and care services and involving over £8 billion of public money.

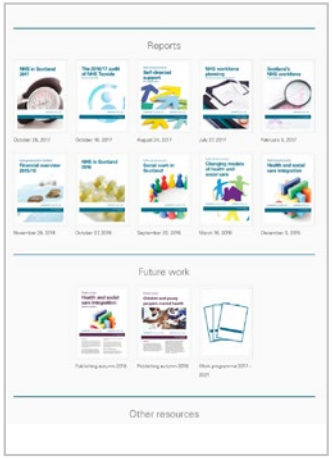
The aim of this reform is to meet the challenges of Scotland's ageing population by shifting resources to community-based and preventative care at home, or in a homely setting.

To achieve this, the Public Bodies (Joint Working) (Scotland) Act 2014 requires councils and NHS boards to work together to form new partnerships, known as integration authorities (IAs). The aim is to ensure services are well integrated and that people receive the care they need at the right time, and in the right place.

IAs across Scotland are very different in terms of their size, resources and local context. But all IAs are responsible for the governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. Some areas have also integrated additional services including children's services, social work, criminal justice services and all acute hospital services. Integration authorities manage the budget for providing all integrated services.

This guide summarises some key information on the background of health and social care integration in Scotland, and outlines how IAs are structured and function.

Transforming health and social care in Scotland
e-hub



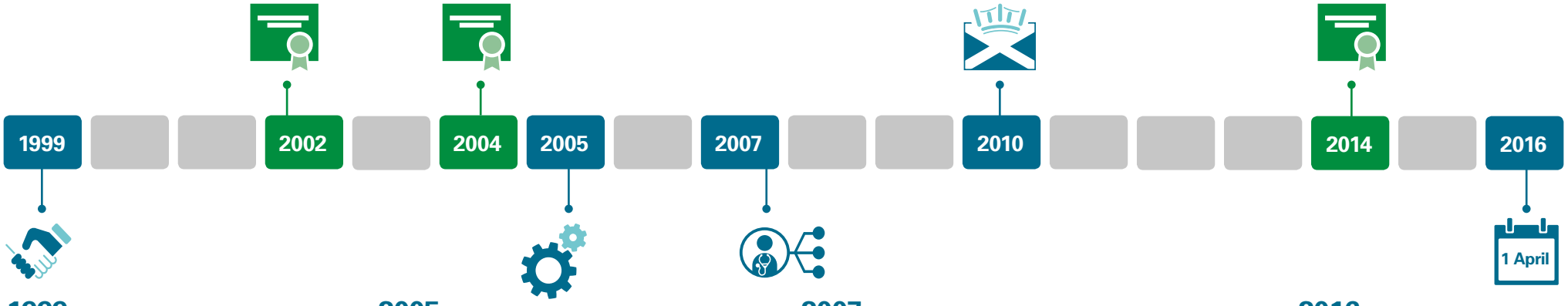
Links

PDF download

Web link

A brief history of integration in Scotland

Integrating health and social care services has been a key government policy for many years.



1999
Seventy-nine Local Health Care Cooperatives (LHCCs) were established, bringing together GPs and other primary healthcare professionals in an effort to increase partnership working between the NHS, social work and the voluntary sector.

2002
Community Care and Health (Scotland) Act introduced powers, but not duties, for NHS boards and councils to work together more effectively.

2004
NHS Reform (Scotland) Act required health boards to establish Community Health Partnerships (CHPs), replacing LHCCs. This was a further attempt to bridge gaps between community-based care, such as GPs and hospital-based care and between health and social care.

2005
Building a Health Service Fit for the Future: National Framework for Service Change set out a new approach for the NHS. It focused on more preventative healthcare, with a key role for CHPs in shifting the balance of care from acute hospitals to community settings.

2007
Better Health, Better Care set out the Scottish Government's five-year action plan, giving the NHS lead responsibility for working with partners to move care out of hospitals and into the community.

2010
Reshaping Care for Older People Programme was launched by the Scottish Government. It introduced the Change Fund to encourage closer collaboration between NHS boards, councils and the voluntary sector.

2014
Public Bodies (Joint Working) (Scotland) Act 2014 introduced a statutory duty for NHS boards and councils to integrate the planning and delivery of health and social care services. It required the creation of IAs and abolished CHPs.

2016
All integration arrangements set out in the 2014 Act, including the creation of 31 new IAs, had to be in place by 1 April 2016.

The aim of health and social care integration

There are nine National Health and Wellbeing Outcomes that seek to measure the impact that integration is having on people's lives.

They are high-level statements of what health and social care partners are attempting to achieve through integration, and ultimately through the pursuit of improvement across health and social care.

By working with individuals and local communities IAs will support improvement in the nine outcomes. Each IA publishes an annual performance report outlining the progress they have made towards improving outcomes.

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

What is integration?

A short guide to the integration of health and social care services in Scotland

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
April 2018

The Accounts Commission

The Accounts Commission is the public spending watchdog for local government. We hold councils in Scotland to account and help them improve. We operate impartially and independently of councils and of the Scottish Government, and we meet and report in public.

We expect councils to achieve the highest standards of governance and financial stewardship, and value for money in how they use their resources and provide their services.

Our work includes:

- securing and acting upon the external audit of Scotland's councils and various joint boards and committees
- assessing the performance of councils in relation to Best Value and community planning
- carrying out national performance audits to help councils improve their services
- requiring councils to publish information to help the public assess their performance.

You can find out more about the work of the Accounts Commission on our website: www.audit-scotland.gov.uk/about-us/accounts-commission

Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Environment Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website: www.audit-scotland.gov.uk/about/ags

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

Introduction

The integration of health and social care services is a major programme of reform, affecting most health and care services and involving over £8 billion of public money.

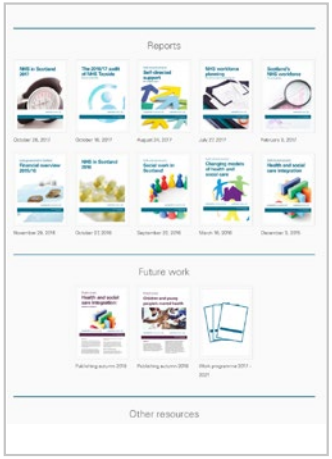
The aim of this reform is to meet the challenges of Scotland's ageing population by shifting resources to community-based and preventative care at home, or in a homely setting.

To achieve this, the Public Bodies (Joint Working) (Scotland) Act 2014 requires councils and NHS boards to work together to form new partnerships, known as integration authorities (IAs). The aim is to ensure services are well integrated and that people receive the care they need at the right time, and in the right place.

IAs across Scotland are very different in terms of their size, resources and local context. But all IAs are responsible for the governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. Some areas have also integrated additional services including children's services, social work, criminal justice services and all acute hospital services. Integration authorities manage the budget for providing all integrated services.

This guide summarises some key information on the background of health and social care integration in Scotland, and outlines how IAs are structured and function.

Transforming health and social care in Scotland
e-hub



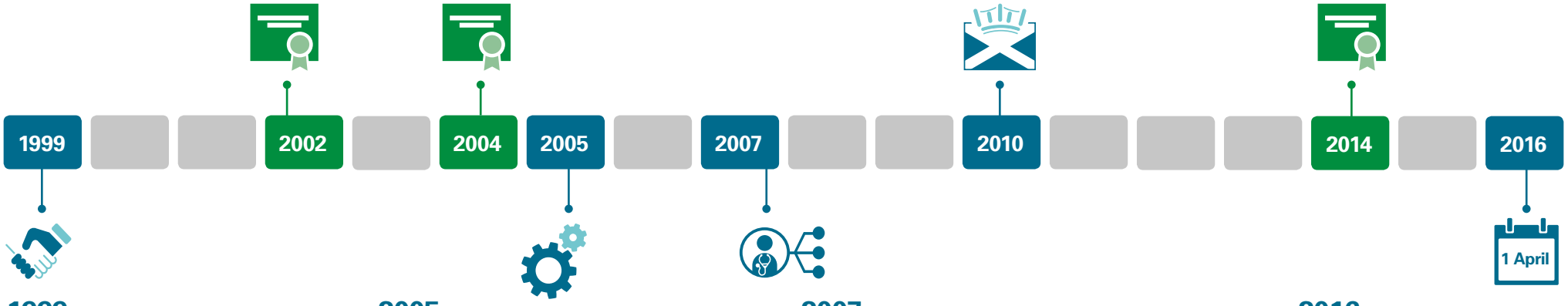
Links

PDF download

Web link

A brief history of integration in Scotland

Integrating health and social care services has been a key government policy for many years.



1999
Seventy-nine Local Health Care Cooperatives (LHCCs) were established, bringing together GPs and other primary healthcare professionals in an effort to increase partnership working between the NHS, social work and the voluntary sector.

2002
Community Care and Health (Scotland) Act introduced powers, but not duties, for NHS boards and councils to work together more effectively.

2004
NHS Reform (Scotland) Act required health boards to establish Community Health Partnerships (CHPs), replacing LHCCs. This was a further attempt to bridge gaps between community-based care, such as GPs and hospital-based care and between health and social care.

2005
Building a Health Service Fit for the Future: National Framework for Service Change set out a new approach for the NHS. It focused on more preventative healthcare, with a key role for CHPs in shifting the balance of care from acute hospitals to community settings.

2007
Better Health, Better Care set out the Scottish Government's five-year action plan, giving the NHS lead responsibility for working with partners to move care out of hospitals and into the community.

2010
Reshaping Care for Older People Programme was launched by the Scottish Government. It introduced the Change Fund to encourage closer collaboration between NHS boards, councils and the voluntary sector.

2014
Public Bodies (Joint Working) (Scotland) Act 2014 introduced a statutory duty for NHS boards and councils to integrate the planning and delivery of health and social care services. It required the creation of IAs and abolished CHPs.

2016
All integration arrangements set out in the 2014 Act, including the creation of 31 new IAs, had to be in place by 1 April 2016.

The aim of health and social care integration

There are nine National Health and Wellbeing Outcomes that seek to measure the impact that integration is having on people's lives.

They are high-level statements of what health and social care partners are attempting to achieve through integration, and ultimately through the pursuit of improvement across health and social care.

By working with individuals and local communities IAs will support improvement in the nine outcomes. Each IA publishes an annual performance report outlining the progress they have made towards improving outcomes.

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

What is integration?

A short guide to the integration of health and social care services in Scotland

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
April 2018

The Accounts Commission

The Accounts Commission is the public spending watchdog for local government. We hold councils in Scotland to account and help them improve. We operate impartially and independently of councils and of the Scottish Government, and we meet and report in public.

We expect councils to achieve the highest standards of governance and financial stewardship, and value for money in how they use their resources and provide their services.

Our work includes:

- securing and acting upon the external audit of Scotland's councils and various joint boards and committees
- assessing the performance of councils in relation to Best Value and community planning
- carrying out national performance audits to help councils improve their services
- requiring councils to publish information to help the public assess their performance.

You can find out more about the work of the Accounts Commission on our website: www.audit-scotland.gov.uk/about-us/accounts-commission

Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Environment Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website: www.audit-scotland.gov.uk/about/ags

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

Introduction

The integration of health and social care services is a major programme of reform, affecting most health and care services and involving over £8 billion of public money.

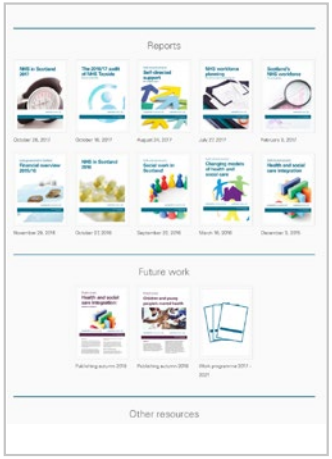
The aim of this reform is to meet the challenges of Scotland's ageing population by shifting resources to community-based and preventative care at home, or in a homely setting.

To achieve this, the Public Bodies (Joint Working) (Scotland) Act 2014 requires councils and NHS boards to work together to form new partnerships, known as integration authorities (IAs). The aim is to ensure services are well integrated and that people receive the care they need at the right time, and in the right place.

IAs across Scotland are very different in terms of their size, resources and local context. But all IAs are responsible for the governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. Some areas have also integrated additional services including children's services, social work, criminal justice services and all acute hospital services. Integration authorities manage the budget for providing all integrated services.

This guide summarises some key information on the background of health and social care integration in Scotland, and outlines how IAs are structured and function.

Transforming health and social care in Scotland
e-hub



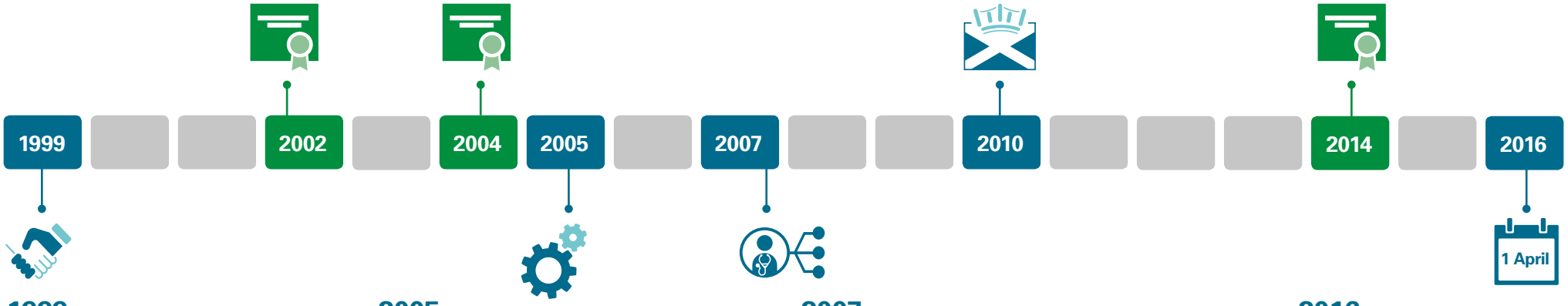
Links

PDF download

Web link

A brief history of integration in Scotland

Integrating health and social care services has been a key government policy for many years.



1999
Seventy-nine Local Health Care Cooperatives (LHCCs) were established, bringing together GPs and other primary healthcare professionals in an effort to increase partnership working between the NHS, social work and the voluntary sector.

2002
Community Care and Health (Scotland) Act introduced powers, but not duties, for NHS boards and councils to work together more effectively.

2004
NHS Reform (Scotland) Act required health boards to establish Community Health Partnerships (CHPs), replacing LHCCs. This was a further attempt to bridge gaps between community-based care, such as GPs and hospital-based care and between health and social care.

2005
Building a Health Service Fit for the Future: National Framework for Service Change set out a new approach for the NHS. It focused on more preventative healthcare, with a key role for CHPs in shifting the balance of care from acute hospitals to community settings.

2007
Better Health, Better Care set out the Scottish Government's five-year action plan, giving the NHS lead responsibility for working with partners to move care out of hospitals and into the community.

2010
Reshaping Care for Older People Programme was launched by the Scottish Government. It introduced the Change Fund to encourage closer collaboration between NHS boards, councils and the voluntary sector.

2014
Public Bodies (Joint Working) (Scotland) Act 2014 introduced a statutory duty for NHS boards and councils to integrate the planning and delivery of health and social care services. It required the creation of IAs and abolished CHPs.

2016
All integration arrangements set out in the 2014 Act, including the creation of 31 new IAs, had to be in place by 1 April 2016.

The aim of health and social care integration

There are nine National Health and Wellbeing Outcomes that seek to measure the impact that integration is having on people's lives.

They are high-level statements of what health and social care partners are attempting to achieve through integration, and ultimately through the pursuit of improvement across health and social care.

By working with individuals and local communities IAs will support improvement in the nine outcomes. Each IA publishes an annual performance report outlining the progress they have made towards improving outcomes.

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

What is integration?

A short guide to the integration of health and social care services in Scotland

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
April 2018

The Accounts Commission

The Accounts Commission is the public spending watchdog for local government. We hold councils in Scotland to account and help them improve. We operate impartially and independently of councils and of the Scottish Government, and we meet and report in public.

We expect councils to achieve the highest standards of governance and financial stewardship, and value for money in how they use their resources and provide their services.

Our work includes:

- securing and acting upon the external audit of Scotland's councils and various joint boards and committees
- assessing the performance of councils in relation to Best Value and community planning
- carrying out national performance audits to help councils improve their services
- requiring councils to publish information to help the public assess their performance.

You can find out more about the work of the Accounts Commission on our website: www.audit-scotland.gov.uk/about-us/accounts-commission

Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Environment Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website: www.audit-scotland.gov.uk/about/ags

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

Introduction

The integration of health and social care services is a major programme of reform, affecting most health and care services and involving over £8 billion of public money.

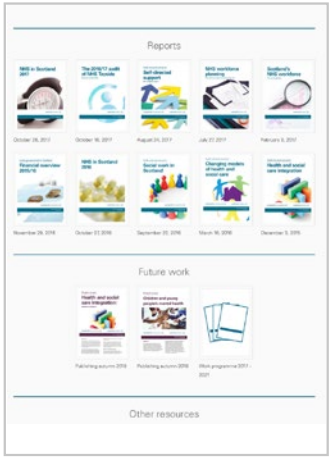
The aim of this reform is to meet the challenges of Scotland's ageing population by shifting resources to community-based and preventative care at home, or in a homely setting.

To achieve this, the Public Bodies (Joint Working) (Scotland) Act 2014 requires councils and NHS boards to work together to form new partnerships, known as integration authorities (IAs). The aim is to ensure services are well integrated and that people receive the care they need at the right time, and in the right place.

IAs across Scotland are very different in terms of their size, resources and local context. But all IAs are responsible for the governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. Some areas have also integrated additional services including children's services, social work, criminal justice services and all acute hospital services. Integration authorities manage the budget for providing all integrated services.

This guide summarises some key information on the background of health and social care integration in Scotland, and outlines how IAs are structured and function.

Transforming health and social care in Scotland
e-hub



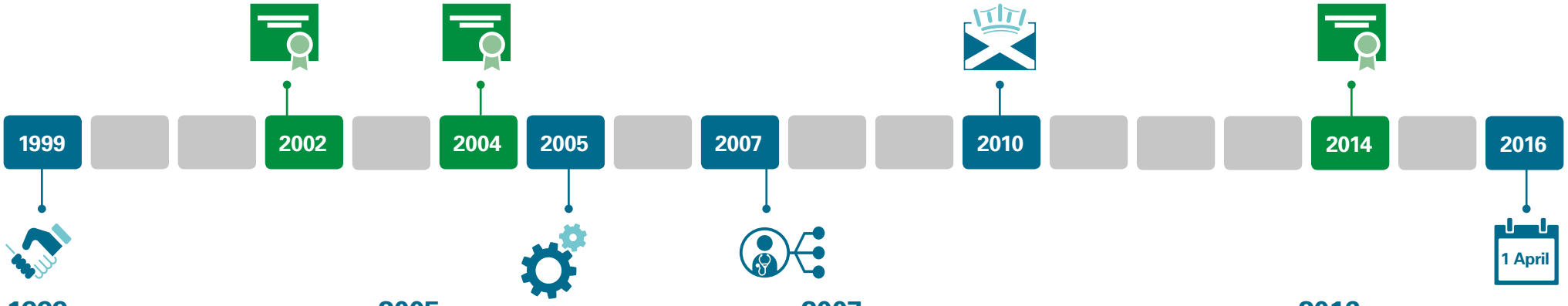
Links

PDF download

Web link

A brief history of integration in Scotland

Integrating health and social care services has been a key government policy for many years.



1999
Seventy-nine Local Health Care Cooperatives (LHCCs) were established, bringing together GPs and other primary healthcare professionals in an effort to increase partnership working between the NHS, social work and the voluntary sector.

2002
Community Care and Health (Scotland) Act introduced powers, but not duties, for NHS boards and councils to work together more effectively.

2004
NHS Reform (Scotland) Act required health boards to establish Community Health Partnerships (CHPs), replacing LHCCs. This was a further attempt to bridge gaps between community-based care, such as GPs and hospital-based care and between health and social care.

2005
Building a Health Service Fit for the Future: National Framework for Service Change set out a new approach for the NHS. It focused on more preventative healthcare, with a key role for CHPs in shifting the balance of care from acute hospitals to community settings.

2007
Better Health, Better Care set out the Scottish Government's five-year action plan, giving the NHS lead responsibility for working with partners to move care out of hospitals and into the community.

2010
Reshaping Care for Older People Programme was launched by the Scottish Government. It introduced the Change Fund to encourage closer collaboration between NHS boards, councils and the voluntary sector.

2014
Public Bodies (Joint Working) (Scotland) Act 2014 introduced a statutory duty for NHS boards and councils to integrate the planning and delivery of health and social care services. It required the creation of IAs and abolished CHPs.

2016
All integration arrangements set out in the 2014 Act, including the creation of 31 new IAs, had to be in place by 1 April 2016.

The aim of health and social care integration

There are nine National Health and Wellbeing Outcomes that seek to measure the impact that integration is having on people's lives.

They are high-level statements of what health and social care partners are attempting to achieve through integration, and ultimately through the pursuit of improvement across health and social care.

By working with individuals and local communities IAs will support improvement in the nine outcomes. Each IA publishes an annual performance report outlining the progress they have made towards improving outcomes.

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

Map of integration authorities

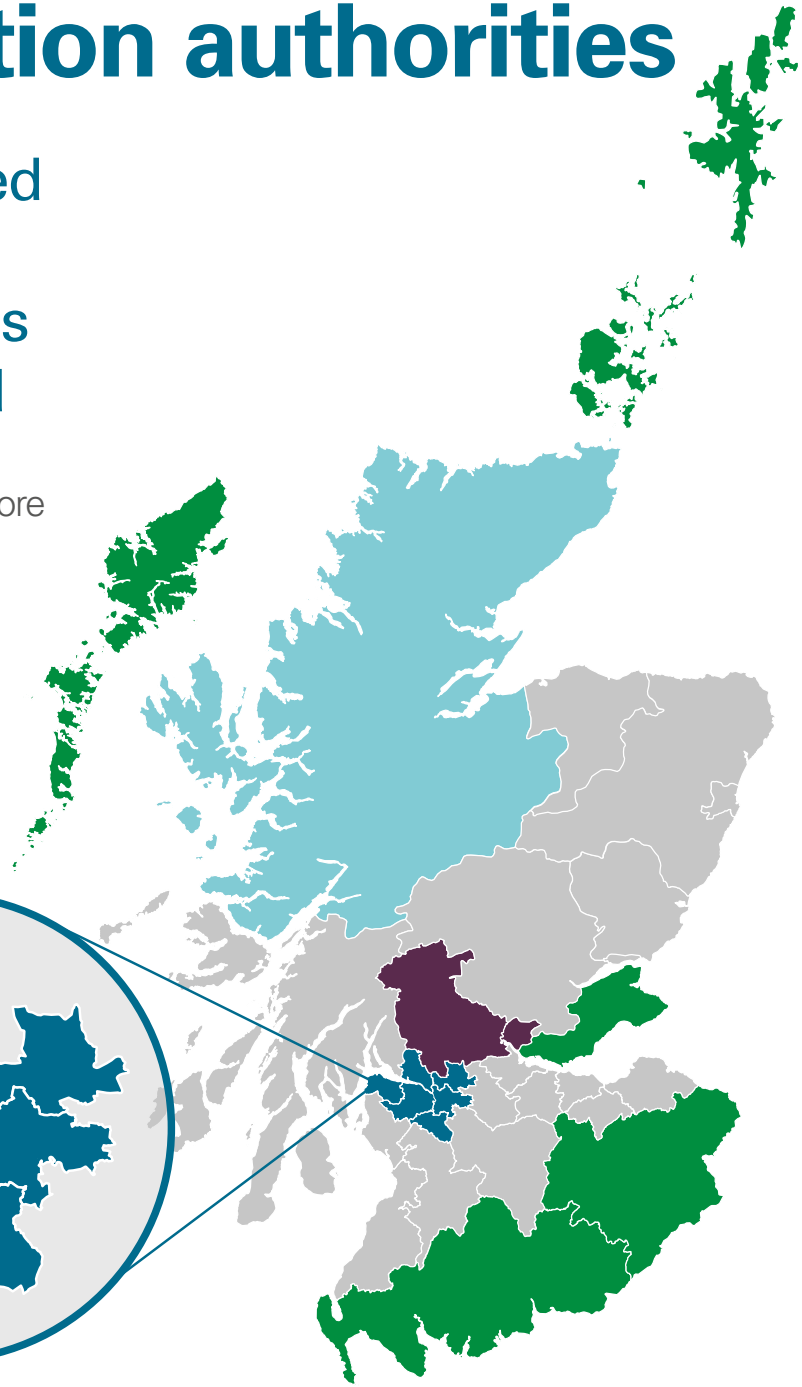
There are 31 IAs, established through partnerships between the 14 NHS boards and 32 councils in Scotland

The size of IAs varies depending on council boundaries. Most NHS boards have two or more IAs within their boundary, but there is a range from a single IA to six. Variations include:

1 NHS board, 6 IAs

NHS Greater Glasgow and Clyde has six IAs within its boundary, one in each local council area:

East Dunbartonshire, East Renfrewshire, Glasgow City, Inverclyde, Renfrewshire and West Dunbartonshire.



1 NHS board, 1 IA

Six NHS boards have a single integration authority within their boundary:

Borders, Dumfries and Galloway, Fife, Orkney, Shetland and Western Isles.

1 Lead agency

In Highland the NHS board and council have taken a different approach - a lead agency model. NHS Highland leads on adult services and Highland Council leads on children's services.

2 Councils, 1 IA

Clackmannanshire and Stirling councils have created a single IA with NHS Forth Valley.

Map of integration authorities

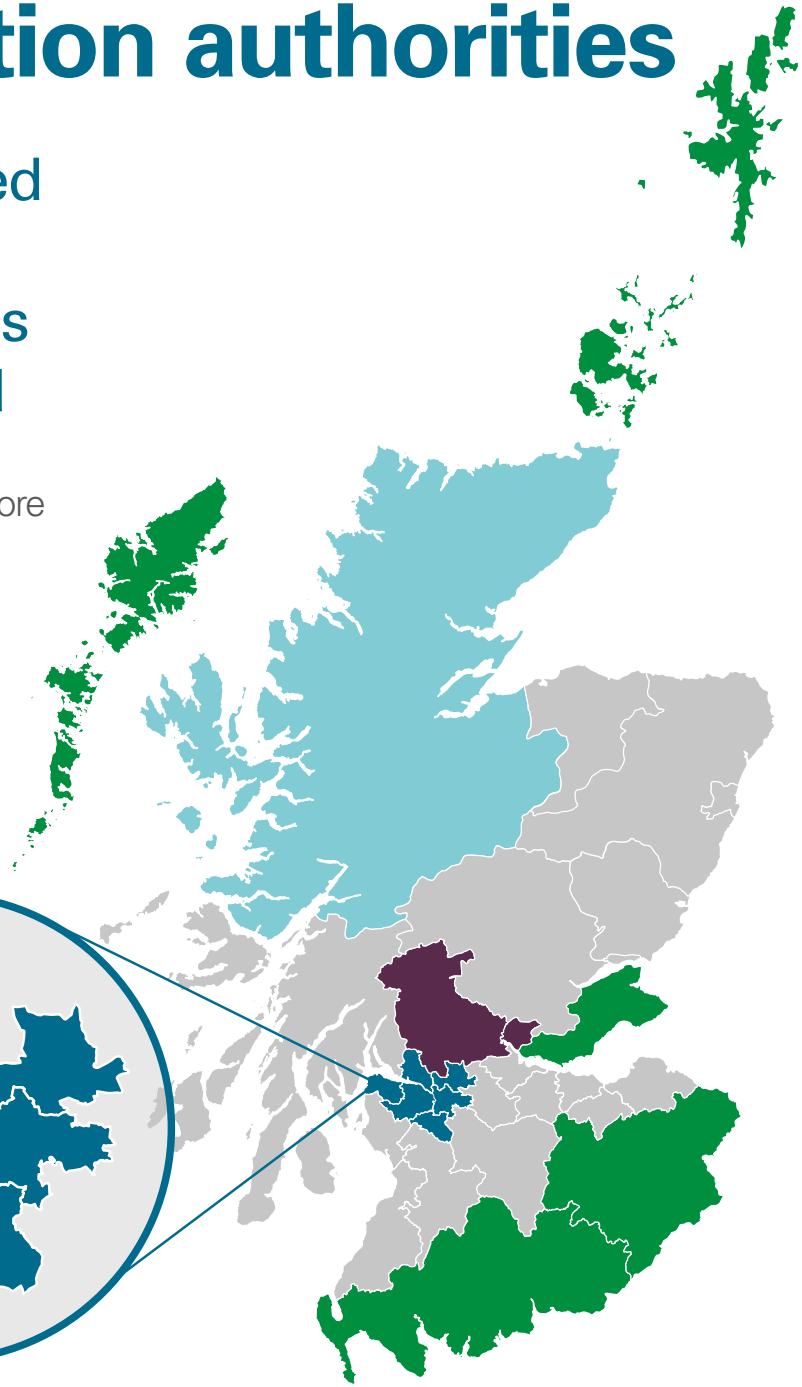
There are 31 IAs, established through partnerships between the 14 NHS boards and 32 councils in Scotland

The size of IAs varies depending on council boundaries. Most NHS boards have two or more IAs within their boundary, but there is a range from a single IA to six. Variations include:

1 NHS board, 6 IAs

NHS Greater Glasgow and Clyde has six IAs within its boundary, one in each local council area:

East Dunbartonshire, East Renfrewshire, Glasgow City, Inverclyde, Renfrewshire and West Dunbartonshire.



1 NHS board, 1 IA

Six NHS boards have a single integration authority within their boundary:

Borders, Dumfries and Galloway, Fife, Orkney, Shetland and Western Isles.

1 Lead agency

In Highland the NHS board and council have taken a different approach - a lead agency model. NHS Highland leads on adult services and Highland Council leads on children's services.

2 Councils, 1 IA

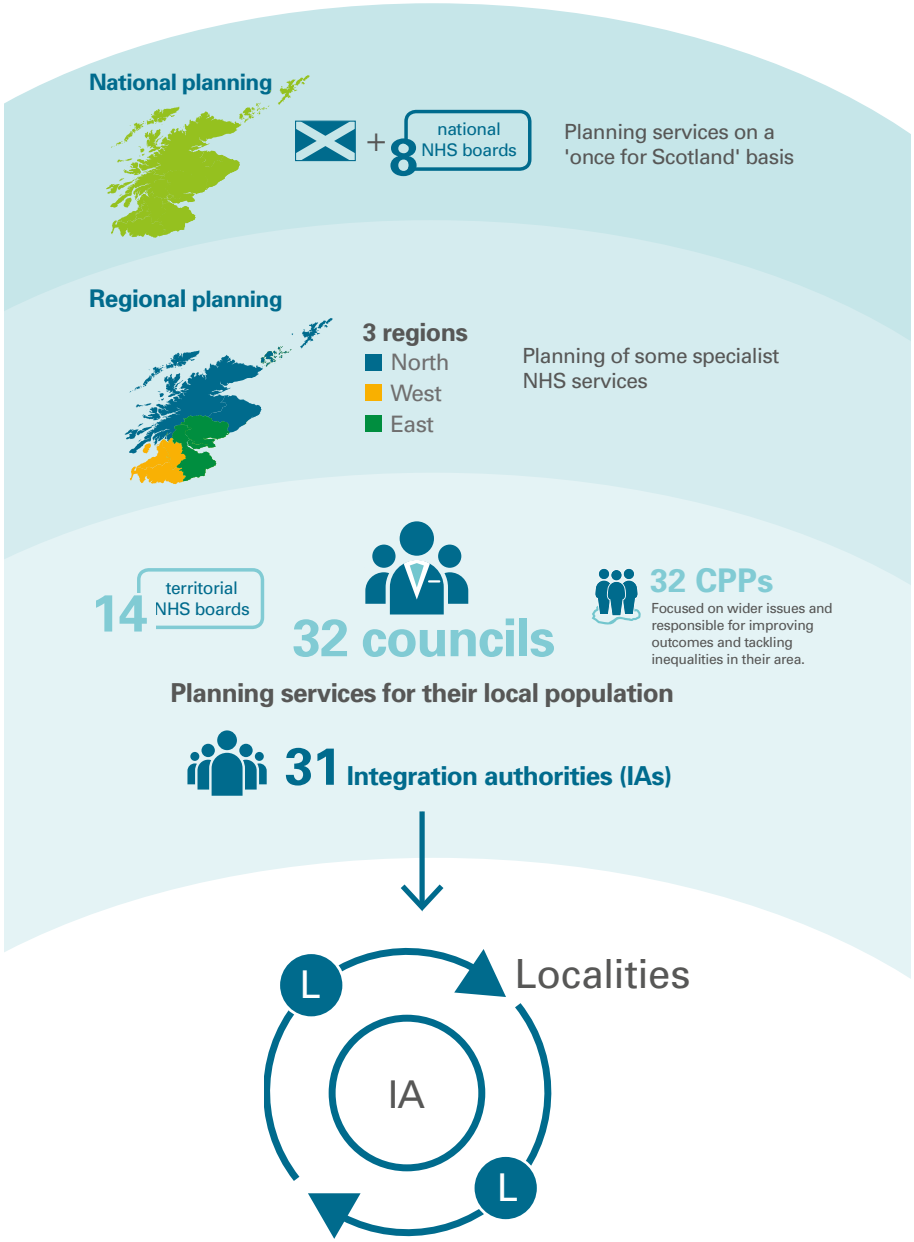
Clackmannanshire and Stirling councils have created a single IA with NHS Forth Valley.

Integration authorities and planning of services

Historically, health and social care services have been planned on a geographical basis by health boards and councils, with some services being provided regionally or nationally.

IAs must now work alongside NHS boards, councils and community planning partnerships when delivering health and social care services.

IAs must divide their area into at least two localities, but they can choose to create more. Localities have an important role in reforming how services are delivered. They bring together local GPs, social workers, other health and care professionals, and service users to help plan and decide how to make changes to local services. This approach allows the views and priorities of local communities to have real influence over how resources are used within their local population.



IAs can be structured in two ways, either through establishing a 'lead agency' or an 'integration joint board'

Whichever model is chosen, the underlying objective remains the same. The IA is expected to plan and deliver services that provide care for individuals in their community or in a homely setting and avoid unnecessary admissions to hospital.

Lead agency model

Lead agency

- eg NHS Highland is the lead agency for adult health and social care services
- Responsible for the planning and delivery of both its own services and services delegated to it
- Has full power to decide how to use resources to improve service quality and people's outcomes.

Other partner body

- eg Highland Council delegates adult social care services to NHS Highland as the lead agency
- Delegates services, money and staff to the lead agency.

Integration Joint Monitoring Committee

- Monitors the carrying out of integrated functions
- Ensures recommendations and responses from the partners relating to performance are considered and appropriately acted upon
- Membership of the IJMC is made up of elected members from the council, non-executive directors from the health board and representatives from service users, carers and the voluntary sector.

Service delivery

- The lead agency has full operational responsibility for the delivery of delegated services.

IJB model

There are 30 IJBs

Council

- Delegates specific services to the IJB
- Provides money and resources

Accountable to:

the electorate

IJB

- Responsible for planning health and care services
- Has full power to decide how to use resources and deliver delegated services to improve quality and people's outcomes

Jointly accountable to:

Council and NHS board through its voting membership (See page 10) **and reporting to the public**

NHS board

- Delegates specific services to the IJB
- Provides money and resources

Accountable to:

Scottish ministers and Scottish Parliament, and ultimately the electorate

Service delivery

- IJB directs the NHS board and council to deliver services
- The extent of the IJB's operational responsibility for delivering services is defined by the level of detail included in its directions to each partner. The more detailed its directions, the more it will monitor operational delivery.

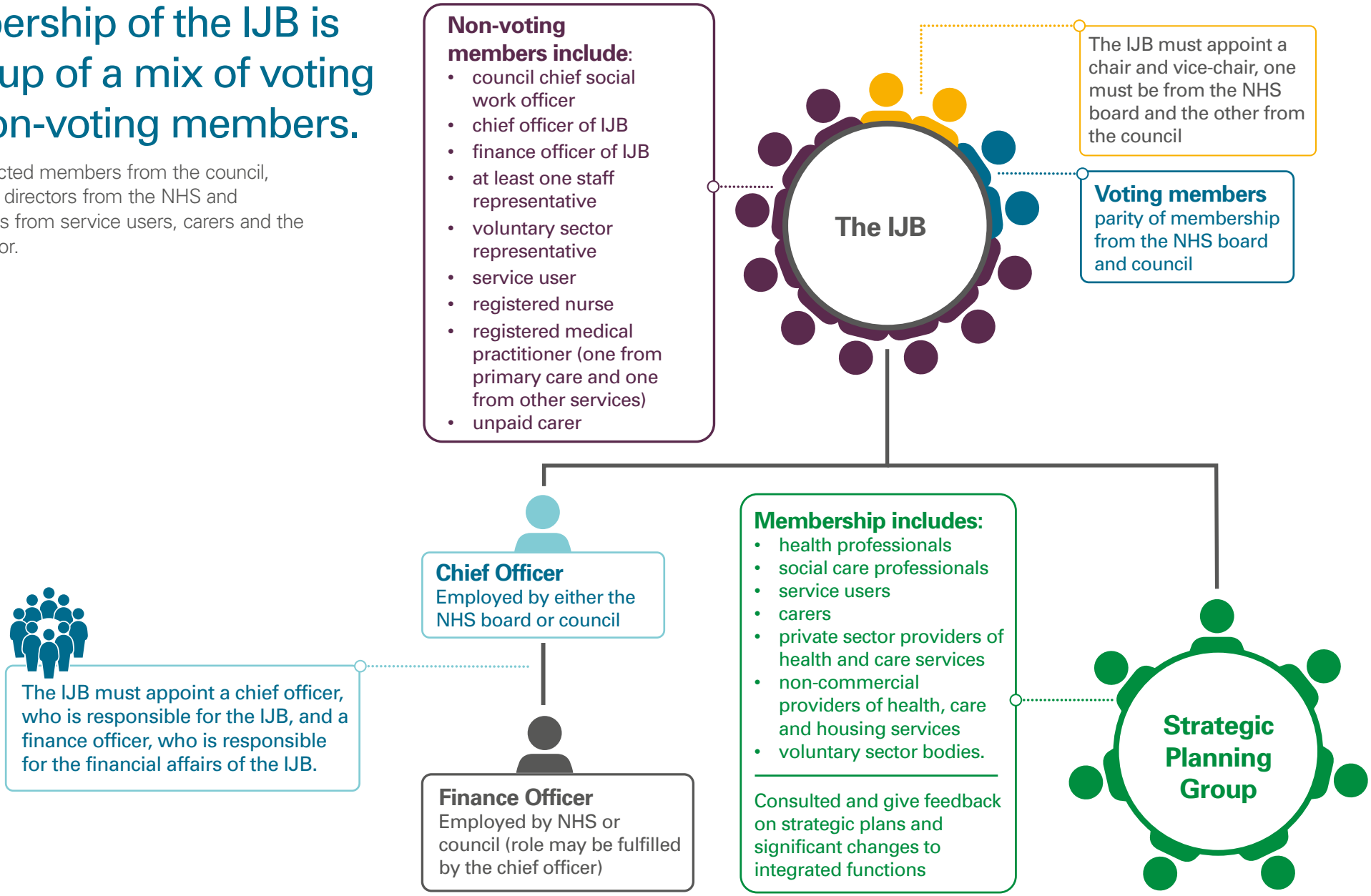
NHS board and council accountable to IJB for the delivery of services as directed

IJB accountable for overseeing the delivery of services

IJB membership

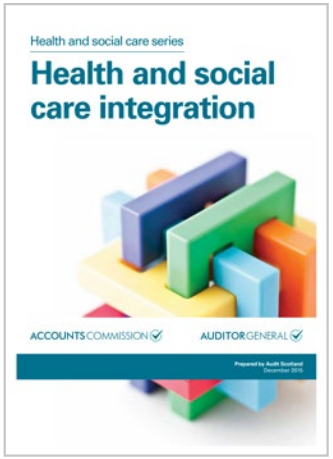
Membership of the IJB is made up of a mix of voting and non-voting members.

It includes elected members from the council, non-executive directors from the NHS and representatives from service users, carers and the voluntary sector.



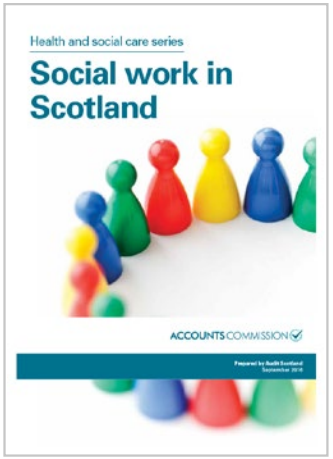
Our recent health and social care reports

2015
Health and social care integration
December 2015



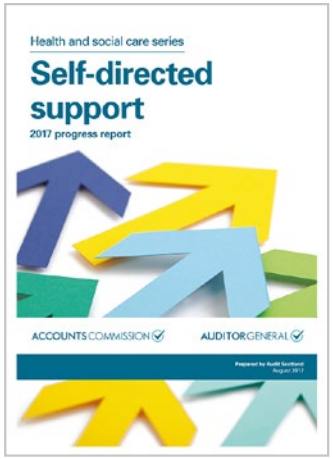
2016
Changing models of health and social care
March 2016

2016
Social work in Scotland
September 2016



2017
NHS workforce planning
July 2017

2017
Self-directed support
August 2017



2017
NHS in Scotland
October 2017

Find out more at our Transforming health and social care e-hub

What is integration?

A short guide to the integration of health and social care services in Scotland

This report is available in PDF format
www.audit-scotland.gov.uk

If you require this publication in an alternative format and/or language, please contact us to discuss your needs: 0131 625 1500
or **info@audit-scotland.gov.uk**

For the latest news, reports and updates, follow us on:

AUDIT SCOTLAND

Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
T: 0131 625 1500 E: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

ISBN 978 1 911494 53 9

Agenda Item Number:15

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	28 June 2018
Subject Title	Equal, Expert and Valued, Enhancing Carer Representative involvement on Integration Joint Boards, Second Edition, February 2018
Report By	Caroline Sinclair, Head of Mental Health, Learning Disability and Addiction Services
Contact Officer	Anthony Craig, Community Development Worker

Purpose of Report	To make members aware of the publication of the report, Equal, Expert and Valued, Second Edition, and to advise that officers will consult with the Public Service User and Carer Support Group on the report and bring forward any identified recommendations to a future meeting.

Recommendations	The Integration Joint Board is asked to: a) Note the publication of the report, Equal, Expert and Valued, Second Edition; and b) note the intention to submit a further report to the Board following consideration of the report through the Public Service User and Carer Support Group.

Relevance to HSCP Board Strategic Plan	Appropriate engagement of stakeholders including carers underpins the development of all aspects of the Board's Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	There are no Human Resource implications for the Health and Social Care Partnership arising directly from this report.

Equalities:	This report aims to ensure that carers are appropriately involved in the business of Integration Joint Boards and so contributes to addressing inequalities brought about through lack of appropriate engagement.

Financial:	There are no financial implications arising directly from this report.

Legal:	There are no legal implications arising directly from this report.

Economic Impact:	There is no economic impact arising directly from this report.

Sustainability:	The report makes a positive contribution to sustainability by ensuring appropriate engagement of carers as key stakeholders in the business of Integration Joint Boards.

Risk Implications:	The report makes a positive contribution to the management of risk by aiming to ensure appropriate engagement of carers as key stakeholders in the business of Integration Joint Boards.

Implications for East Dunbartonshire Council:	There are no direct implications for East Dunbartonshire Council.

Implications for NHS Greater Glasgow & Clyde:	There are no direct implications for NHS GG&C.

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

DRAFT

1.0	**MAIN REPORT**
1.1	The Carers Collaborative is a project that seeks to evaluate, support and improve carer representation on Integration Joint Boards (IJBs). The Collaborative has gathered evidence and facilitated events since March 2016, involving 46 Carer Reps from 29 local authority areas. The first 'Equal Expert and Valued' report was published in February 2017. It identified good practice and set out recommendations to enhance carer involvement on IJBs. This update report is based on a further year's research, revisiting evidence and presenting new resources to improve carer representation.
2.0	**BACKGROUND**
2.1	The recommendations of the first 'Equal Expert and Valued' report were considered as part of the development process of the Integration Joint Board. It is recognised in the report that East Dunbartonshire demonstrate areas of good practice.
2.2	The second report will be considered in the Public Service User and Carer Support Group if any further recommendations are identified they will be submitted to a future meeting of the IJB. **Appendix 1 -** Equal, Expert and Valued, Enhancing Carer Representative involvement on Integration Joint Boards, Second Edition, February 2018

DRAFT

coalition
of carers in Scotland

EQUAL, EXPERT *and* VALUED

Enhancing Carer Representative involvement on Integration Joint Boards

SECOND EDITION:
Update Report, February 2018

Background

The Carers Collaborative is a project that seeks to evaluate, support and improve carer representation on Integrated Joint Boards (IJBs). The Collaborative has gathered evidence and facilitated events since March 2016, involving 46 Carer Reps from 29 local authority areas. The first 'Equal Expert and Valued' report was published in February 2017. It identified good practice and set out recommendations to enhance carer involvement on IJBs. This update report is based on a further year's research, revisiting evidence and presenting new resources to improve carer representation.

AIM

This update report, published while IJBs are making plans for the Carers (Scotland) Act 2016, aims to:

- Contribute constructive insights and recommendations
- Provide resources and ideas for improving carers' involvement on IJBs
- Help Integration Authorities benchmark and continue improving their practice
- Start conversations and stimulate further progress.

Methodology

The Carers Collaborative met four times between January and November 2017, providing a forum for Carer Representatives to explore evidence and practice. Representatives and other IJB members also completed self-assessments against the **'Equal and Expert'** best practice standards, with a comprehensive scoping exercise also being conducted by an independent researcher. The scoping exercise reviewed every Integration Authority's most recent strategic plan, annual report, committee papers and minutes for references to carers, carer outcomes, carer involvement and the Carers Act.

Note on language: The report typically uses the words 'Carer Reps' or 'representatives' to refer to Carer Representatives. These are usually unpaid carers (or former carers), but in some areas staff from local carers centres fulfil the role.

Introduction

The requirement for carer representation in planning and commissioning public services is increasing. The Public Bodies (Joint Working) Scotland Act 2014 requires Integration Authorities to include a Carer Representative on their IJB[1]. The Carers (Scotland) Act 2016[2] extends the expectation of carer engagement to other areas of Health and Social Care planning. Scottish Government guidance on Health and Social Care commissioning states that services should be

> "Planned and led locally in a way which is engaged with the community (including those who look after service users and those who are involved in the provision of health and social care)". [3]

In 2013 the Coalition of Carers in Scotland developed 'Equal and Expert: 3 Best Practice Standards for Carer Engagement'.[4] While good practice is evident in some areas, the standards have not been consistently applied. In 2017 the Scottish Government's Health and Sport Committee described this as a 'piecemeal' approach.[5]

This report offers positive and practical insights to help improve standards and consistency. It begins by defining Carer Representatives' role and purpose before examining evidence for the three Equal and Expert standards. The three standards are:

STANDARD ONE: Carer engagement is fully resourced

STANDARD TWO: Carers on strategic planning groups represent the views of local carers

STANDARD THREE: The involvement of carers on strategic planning groups is meaningful and effective

A national overview of involvement practices is followed by local good practice examples. The report concludes with a review of progress towards the recommendations made in 2017, with straightforward suggestions for improving involvement.

1. Public Bodies (Joint Working) Scotland Act 2014
2. http://www.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Implementation/Carers-scotland-act-2016
3. Scottish Government (2015) Strategic Commissioning Plans Guidance
4. http://www.carersnet.org/policy-legislation/best-practice-standards-for-carer-engagement/
5. Are they involving us? Integration Authorities' engagement with stakeholders Scottish Parliament Health and Sport Committee Published 12 September 2017 SP Paper 188

Defining the Role: who are Carer Representatives and what do they do?

This section of the report is based on mapping and scoping activities carried out during the three Carer Collaborative meetings. It aims to put a spotlight on good practice and to draw attention to practice that can be improved.

The first 'Equal, Expert and Valued' report identified that although the Public Bodies Act requires Integration Authorities to involve *'a person who the integration authority considers to be representative of'* carers[6], the purpose of doing so is not specified. This led to the requirement being interpreted and implemented in quite different ways. The report recommended that Carer Reps have a clear remit, roles and expectations. A draft role description is now available[7], identifying three main functions, the principles behind them, and the resources required to support them:

CONTRIBUTE TO GOOD GOVERNANCE

- Contribute to discussions and provide advice and scrutiny from carers' perspective.
- Contribute to ensuring that Integration Authorities implement their statutory obligations.
- Add relevant items to the meeting agenda, to be discussed and minuted. Mechanisms should be in place for this.
- Be prepared to raise relevant points and question meeting papers and accompanying evidence appropriately, for example about the extent to which the recommendations are inclusive of, or impact on, carers.

REPRESENT CARERS – AND THE IJB

- Champion carers' involvement as *Equal and Expert*[8] partners at all levels and link in with other champions and carers to enlarge the pool of views being collected and represented locally.
- Access their 'constituency' of carers via carer networks, local forums (including social media where appropriate) to encourage and maintain links with the IJB.
- Nominate a Depute to represent the role in the case of absence.
- Ensure their involvement is reflective of the views of the widest range of carers by engaging as fully as possible with other carer representatives.

HAVE ROLES OUTWITH IJB MEETINGS

- Join one or more sub committees/working groups (such as Audit and compliance committees), where appropriate and where carer capacity allows. IJBs should be upfront about expected time commitment, to enable planning and informed decisions.
- Take part in appropriate training and induction.
- Play an active role in IJB & HSCP events.
- Be active in local carers group(s)

6. Public Bodies (Joint Working) Scotland Act 2014
7. http://www.carersnet.org/wp-content/uploads/2018/01/Download-the-Role-Description-Here.pdf
8. http://www.carersnet.org/policy-legislation/best-practice-standards-for-carer-engagement/

Equal and Expert: Overview of evidence

This section presents an overview of the 'Equal and Expert' Carer Engagement standards, and the extent to which they were evident in IJB practice from the Collaborative's work and research.

STANDARD ONE: CARER ENGAGEMENT IS FULLY RESOURCED

IJBs vary in their commitment to resourcing engagement. Good practice examples include IJBs providing full-Board development sessions, paying out of pocket expenses and providing replacement care. Practice appears to be improving in giving Representatives time to read and prepare meeting papers, but in many areas still falls short.

KEY:

- **Several good examples – overall practice is good**
- **Some good examples exist - but experience is mixed**
- **Limited examples – some local good practice may exist but overall practice is poor**

STANDARD ONE: CARER ENGAGEMENT IS FULLY RESOURCED		
Outcomes 1. Carer Representatives will feel confident in undertaking the responsibilities of their role and be able to express clearly and fully the views of other carers. 2. The strategic groups will benefit from the views of carers being regularly and directly represented and will produce work which address the needs and meets the aspirations of carers more fully.		
Evidence of implementation Carers in representative roles will:		
1. Receive training and a full induction.	Some areas involve Carer Reps in IJB Development sessions and others arrange regular support meetings before IJB meetings to allow discussion of agenda items (East Renfrewshire, Midlothian). However, most Carer Reps still report that they receive no training or induction.	
2. Be supplied with the information they require timeously.	Only a third of Carer Reps report receiving papers 7 days in advance. Getting 300+ page papers within 2-3 days of meetings is still common, as is the practice of issuing previous meeting minutes only days ahead of the next one.	
3. Be mentored.	More than two thirds of Carer Reps have not been mentored. In our research, two IJBs provide mentoring through an Engagement Officer (Midlothian; Perth and Kinross). Carers Centres sometimes provide informal mentoring.	
4. Be able to obtain the views of other carers via a strong network of carers.	Carer Reps in all but one area reported having access to networks like carer forums, Carers Voice Groups and Carer Reference Groups. Time is more of an issue than opportunity.	
5. Have the full costs of their work in and for the strategic groups met – this includes the costs of any substitutionary care that is required.	From 20 self-assessments, only 5 areas have a written expenses policy. 4 do not pay expenses. 5 cover travel and parking costs, 6 provide additional resources such as subsistence, tea and coffee but only two reportedly provide lunch (Moray; Perth & Kinross) or printing costs (Angus; Midlothian). Five areas provide replacement care.	

CHANGES SINCE 2016/17 REPORT:

Several areas have made efforts to issue meeting papers in a timelier way. More Carer Reps appear to be better connected to local networks. The common absence of induction and training is a concern: Carer Rep posts were unfilled in five IJBs at the time of writing, an increase on 2016 (three vacant posts). There is concern among Carer Reps about potential difficulty in recruiting (and retaining) their replacements without improvements in resourcing.

Spotlight on expenses

'I have never been asked about expenses...No-one has ever asked about who is caring for my daughter when I am at meetings.'
Carer Representative

'We expect the integration authorities to ensure that those who participate in the process can do so without detriment.'
Cabinet Secretary for Health and Sport
[Are they involving us? Integration Authorities' engagement with stakeholders Scottish Parliament Health and Sport Committee Published 12 September 2017 SP Paper 188]

There are costs involved for any member of an IJB. To avoid being worse off, they and Carer Reps should receive out-of-pocket expenses such as travel and printing costs. However, there are additional costs in being a Carer Rep:

- Time away from the caring role (preparing for, travelling to and attending meetings)
- Replacement care – the stress and cost of finding and/or paying someone else to provide care. (Some Carer Reps use Direct Payments to purchase replacement care to attend IJB meetings, leaving less for proper breaks from caring)
- Time and cost of consulting and communicating with other carers
- Loss of income and time off work (or other commitments)

There are positive signs of improvement since 2016, but carer involvement is still under-resourced by most Integration Authorities. Sometimes this is due to limited budgets, sometimes to do with limited understanding of carers' lives, and occasionally both. The true costs of involvement are only rarely understood or provided for. Whatever the reasons, lack of appropriate expenses is becoming an impediment to involvement. It is also an equalities issue, excluding carers who cannot afford to finance the public duties they carry out on behalf of Integration Authorities.

STANDARD TWO: CARERS ON STRATEGIC PLANNING GROUPS REPRESENT THE VIEWS OF LOCAL CARERS

In 2016/17, this was the best evidenced of the three standards. There is still good evidence that Carer Reps receive quality resources and support from carers' centres, including access to local carer networks. Local engagement is growing, but in some areas Representatives struggle to reach carers, and to encourage more carers to take on representative roles.

STANDARD TWO: CARERS ON STRATEGIC PLANNING GROUPS REPRESENT THE VIEWS OF LOCAL CARERS		
Outcomes 1. Carers on strategic groups will be: (a) representative of the various communities of carers (b) able to express in informed ways the views of a range of carers 2. The other partners on the strategic groups will know with confidence that they are learning of the views of a range of carers. 3. The work produced by the strategic groups will fully take into account the views of carers		
Evidence of implementation		
1. Carer organisations will be properly resourced to establish and support a strong carer network, which offers a variety of ways for carers to get involved	Some Carers Centres are funded to support Carer Reps and facilitate access to carer networks. Changes in funding have increased support in some areas (e.g. Argyll and Bute; Shetland) but reduced it in others (e.g. Inverclyde).	
2. The number of carers involved in exchanging views through the network will grow.	Local carer engagement is growing but progress is slow. Carer Reps are often seeking new ways of reaching carers. Midlothian, for example, use social media and online videos for this.	
3. The diversity of carers involved in the network will be broad.	Experience is mixed, with some Carer Reps reaching diverse groups but others struggling to engage new or different audiences.	
4. There will be a continual emergence of new carers willing to undertake representative roles.	All areas report difficulty in attracting potential Carer Reps or deputies, listing time, expense, workload and 'tokenism' as barriers.	
5. The information provided through and by the supported network will be of a high quality.	Carer Reps value the information they get from carer networks, though experience of having it recognised by IJBs is mixed. Some Carer Reps are known to have stepped down in the last year because of the demands of the role.	

CHANGES SINCE 2016/17 REPORT:

The most significant challenge is in the lack of new carers emerging who are willing to undertake representative roles. As with Standard One, resourcing is identified as the primary obstacle. The last year has also seen changes in the funding environment. Some Carers Centres have increased resource for carer outreach and engagement, others are reviewing services due to changes in commissioning or funding.

STANDARD THREE: THE INVOLVEMENT OF CARERS ON STRATEGIC PLANNING GROUPS IS MEANINGFUL AND EFFECTIVE

There are signs that Carer Reps's expertise (and equality) are becoming better recognised, with some structures and meetings becoming more inclusive. Challenges persist in contributing to agenda setting. Carer Awareness Training has not taken place to the extent that was anticipated in 2016. Overall, Integration Authorities continue to overlook the importance of measuring the impact of policies – and involvement – on carers.

STANDARD THREE: The involvement of carers on strategic planning groups is meaningful and effective (This standard was written before the emergence of IJB 'Strategic Planning Groups'. It should be taken to mean any strategic forum, including the IJB itself.)		
Outcomes 1. Carers will be treated as equal and expert partners in strategic groups. 2. The views of Carer Representatives will be evident in the strategic decisions taken and the plans that are developed. 3. Carers will be treated as equal and expert partners in the provision of care.		
Evidence of implementation		
1. Carers will be placed on the right strategic planning groups including at the top level of governance structures.	Carer Reps are generally well involved in Strategic Planning Groups and IJB sub-committees. Some Carer Reps chair committees (e.g. in Argyll and Bute and Midlothian, Carer Reps chair the Audit Committees). But several have had limited opportunities to join SPGs, and some are unable to give more time to join extra committees. Best practice would feature different carers at different levels, with good structures for communication and involvement.	
2. Other partners in strategic groups will have had Carer Awareness training so that the perspectives brought by carers are understood and accepted as the statements of people who are "equal and expert" partners.	Several areas planned to provide Carer Awareness training, but few have. Good practice examples include Carer Reps delivering Carers Awareness Sessions to the IJB (Argyll & Bute; East Lothian); Carer Reps briefing on carer issues during business meetings; and an IJB (Fife) whose agenda features a regular 'Personal Story', including carers' experiences.	
3. Meetings will be open and inclusive, allowing time for discussion and contributions from all members of the group. Language will be accessible and jargon will be avoided.	Although agendas are still reported to be full, and meetings full of jargon, Carer Reps appear to have more opportunities to contribute. One IJB uses support group meetings to ask Reps for feedback and include this as a standing item on the agenda (Midlothian).	
4. Sufficient time will be given for preparation. Papers will be sent out in advance in a timely fashion and Carer Representatives will have the opportunity to clarify any information in advance.	See above – some improvements in receiving IJB papers, but SPG and other papers are often last-minute. Some areas welcome contact with authors or Integration Manager to clarify information.	
5. The agenda will be jointly owned with all group members having the opportunity to place items on it or raise issues of concern.	Most IJBs still lack processes for contributing to agendas, and/or transparency about how agendas are set. Good practice examples include East Dunbartonshire, where there is a set item on IJB board agendas for service users and carers; and Shetland, where weekly sub-committee meetings consider items raised by members.	
6. All plans and policies produced by strategic groups will be 'carer proofed' so that the impact on carers is explicitly stated to ensure that carers needs and aspirations have been fully considered.	There was very little evidence of this. Some IJBs require report authors to note the consideration of (and impact on) carers, but this is perceived as cursory.	
7. Through their network carers will be supplied with information about the opportunities for participation in strategic planning groups.	Carer Reps remain very knowledgeable about the systems and structures in which their work takes place. With the move to Locality planning and Carers Act implementation, some areas are stepping up actions to inform, recruit and train more carers.	
8. The outcomes of carer engagement will be evaluated.	No evidence of IJBs measuring the outcomes of carer involvement. In a small number of areas, other carer engagements are evaluated (e.g. following community consultations). See below for more information on carer outcomes.	

CHANGES SINCE 2016/17 REPORT:

Carer Reps appear to be more integrated in IJBs and their associated Planning Groups and committees (see below). Further change may follow as IJBs adjust to locality planning, the Carers Act and the Community Empowerment Act, albeit that the structural and resource barriers identified above may still need to be removed.

Spotlight: Strategic Planning Group involvement

‘I am on all the relevant groups - for all the difference it makes.’

Carer Representative

The 2016/17 report identified that Carer Representative effectiveness was improved when they were included in Strategic Planning Groups. SPGs were perceived as the place where agendas were set and decisions made.

Over the last year, Carers have had some modest success in being represented on these groups. At a Carer Collaborative meeting in 2017, five out of 13 participants were on an SPG. Four of these could suggest agenda items. Carer Representative’s independence and experience has also been recognised in some areas, for example by being invited to Chair their Finance, Audit and Risk committees. Reasons posited for increased involvement included changes in IJB membership and personnel; Joint Inspection from the Care Inspectorate; and anticipation of the Carers Act.

However, changes are underway which might again change the level and nature of Carer Rep involvement. The move to locality planning is likely to require IJBs to review their structures and representation. As noted in the 2016/17 report, local networks of carers ‘underneath’ and around the IJB will help Carer Reps’ ability to represent carers more effectively.

In some areas SPGs appear to be in abeyance, with no meetings having taken place for several months. And in the Carer Collaborative meeting mentioned above, only one of the 13 Representatives felt that communication between their SPG and IJB was effective. SPG involvement may not live up to the hopes Carer Reps had for it.

Scoping carer inclusion: IJB plans, reports and outcomes

As with the 2016/17 report, a scoping exercise sought to create a picture of national practice, analysing every Integration Authority's Strategic Plan; Annual Report; and IJB meeting minutes. References to carers (and Carer Representatives) were used as simple indicators of the extent to which carers and carers' outcomes had been identified and prioritised by Integration Authorities.

Year	Strategic Plans available	Annual Reports available	Meeting minutes available	IJB minutes referencing carers	IJB meeting dates available
2016	30	n/a	28	17 IJBs – with 29 total references to carers	26
2017	31	31	31	30 IJBs - with 89 references to carers	31

OBSERVATIONS

All Integration Authorities now have publicly available Strategic Plans and records of meetings. This is useful for Carer Rep involvement, allowing time for meeting preparation, carer engagement etc. The increase in minutes referencing carers is mainly due to preparations for the Carers Act (23 areas record planning for the Carers Act - 8 do not).

All annual reports measure progress towards National Health and Wellbeing Outcome Six[9], comparing local achievement with the Scotland-wide result of 41% carer satisfaction[10]. 18 areas report achievements above 41% (two areas claim 99% carer satisfaction), with 10 below, and three at exactly 41%. These figures raise questions as to whether reporting is accurate, consistent and meaningful. The usefulness and validity of the 41% benchmark is also doubtful. 41% hardly represents 'success' - and Outcome 6 is the lowest performing outcome in the National Health and Wellbeing survey.

Some areas appear to use additional measures to Outcome Six. Scottish Government guidance on data collection for the Carers Act[11] may encourage IJBs to use additional indicators, allowing for a more rounded picture of carer outcomes to emerge. As noted above, no Integration Authorities measure the outcomes of carer involvement, though the three Standards above provide a useful template should they wish to do so.

9. 'People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being'. www.gov.scot\Topics\Health\Policy\Health-Social-Care-Integration\National-Health-WellbeingOutcomes
10. Health and Care Experience Survey 2015/16 - National Results, A National Statistics Publication for Scotland published by the Scottish Government, May 2016 http://www.gov.scot/Resource/0050/00500340.pdf
11. Carers Census Data Specification, Scottish Government, 2017 http://www.gov.scot/Topics/Statistics/Browse/Health/DataSupplier/CarersData

Recommendations to improve Carer Representation

This section reviews progress towards the recommendations in the 2016/17 report and identifies next steps for improving carer representation.

2017 Recommendation	Progress	Next steps – 2018+
1. Include Carers' Representatives in decision making 1.1 Find ways to involve carers in consultation and decision-making 1.2 Include Carer Reps in different IJB groups	Carers appear to be better represented and consulted within IJB structures, but still lack decision-making authority and opportunities to contribute to agendas.	IJBs can continue to improve carer involvement in SPGs, locality groups and carer networks. However, recruiting and retaining Carer Reps will require improving practice regarding training and expenses. As noted in our previous report, good practice would involve providing Carer Reps with email addresses and publicising these for easy contact. The benefits and outcomes of carer involvement can be measured using 'Equal and Expert'.
2. Increase awareness and profile 2.1 Raise profile of Carer Reps 2.2 Raise IJB awareness of carers	IJBs have generally not followed through on intentions to run Carer Aware training. The profile of Carer Reps has increased, with better access to carer networks.	
3. Value and resource Carer Representatives 3.1 Value Carers Representatives and their contributions 3.2 Train and support Carer Representatives 3.3 Resource representation 3.4 Ensure Carer Representatives have a clear remit	Training, induction and expenses remain absent for Carer Reps in most IJBs. This now affecting retention and recruitment.	Develop and publish expenses policies for IJB Representatives. Improve practice regarding providing subsistence and replacement care. Use or adapt the suggested role description to provide clarity on roles, remits and expectations.
4. Share practice and learning 4.1 Share practice between IJBs 4.2 Improve communication	IJB networks now explore similar issues to those in the Carer Collaborative (e.g. Chief Officers' Ministerial Group). Agendas and minutes are more publicly available than 2016/17. Papers remain lengthy and often last-minute.	Continue with efforts to issue papers sufficiently in advance to allow Carer Reps to read and prepare, particularly minutes of previous meetings. Develop clearer links between IJBs and their sub-committees, including Locality Planning as it develops. Improve transparency as to how agendas are formed and create opportunities for Representatives to contribute. Some IJBs use 'Any other business' to do this.
5. Make meetings better 5.1 Create structures to allow agenda items to be raised 5.2 Make meetings, minutes and papers accessible	Some IJB meetings have become more accessible, with less jargon and more opportunities for carers to contribute. Links between SPGs and IJBs remain unclear, as does the process for tabling agenda items.	

SPOTLIGHT: LOCAL PRACTICE – INVOLVING CARERS IN PREPARATIONS FOR THE CARERS ACT IN EAST LOTHIAN

East Lothian HSCP has set up a Carers Strategic Group as one of seven groups leading work towards achieving its strategic outcomes. The Group will lead the development of a Carers Strategy and workplan in line Carers Act requirements. In the East Lothian IJB Annual Report 2016/17 the HSCP Director David Small commented that,

> 'The planning groups give us the opportunity to make sure that stakeholders are equal partners in planning, enabling us to develop innovative, flexible and responsive answers that really meet the health and social care needs of people in East Lothian.'

Local preparations for the Carers Act have also been informed by carers and carers' organisations. For example, a Carers Strategy Team worked with Carers of East Lothian to develop a new outcome-focused, strengths-based tool to pilot the new Adult Carer Support Plans. Feedback from a carer engagement event was used to develop the Eligibility Criteria Framework, based the National Carer Organisations framework contained in the Draft Statutory Guidance[12].

The IJB chair also met individually with the IJB Carer Representative. This led to an IJB development session, organised by the Carer Representative, to increase understanding of issues affecting carers, and to inform IJB members of the provisions of the Carers Act.

SPOTLIGHT: LOCAL PRACTICE – 'CARER AWARE' IN DUMFRIES & GALLOWAY

Dumfries and Galloway HSCP provide Carer Aware training to help staff understand who carers are, what they do and the support available for to them. The aim of this training is to help staff to identify carers and be better informed about issues impacting on their lives. NHS D&G and D&G Council have also achieved Carer Positive status, a Scottish Government funded initiative to recognise employers who offer the best support to carers, for demonstrating a genuine commitment to supporting staff who have to balance work with a caring role.

A recent development day also helped IJB members to get to know each other, beyond just their day jobs. It also helped IJB members recognise each other's expertise and to agree some simple actions that would improve the Board's functioning. A 'buddying' session as part of the day proved so popular that a buddying away day is now being considered.

SPOTLIGHT: LOCAL PRACTICE – ACHIEVING AND MEASURING CARER OUTCOMES IN ARGYLL & BUTE

Improving the support to unpaid carers is one of six priority areas for Argyll and Bute HSCP. In turn, every Locality Planning Group has a section in their action plan focusing on unpaid carers. Argyll and Bute's 2016/17 Annual Report[13] notes that only one Health & Wellbeing outcome (Outcome 6) is being used to measure carers' experience. Although local results are in line with the Scottish average, the report acknowledges that more needs to be done. The IJB is therefore working with Carer Reps and the local carers' network to develop additional performance measures to supplement the existing Outcome 6 measure.

In developing their annual report, the HSCP asked a range of people who may have an interest to give feedback as 'critical friend reviewers' (e.g. on content, readability, etc). In 2016/17 two of these reviewers were unpaid/family carers.

12. Carers (Scotland) Act 2016 – Draft Statutory Guidance: Local eligibility criteria, Appendix A. Scottish Government, 2017
13. https://www.argyll-bute.gov.uk/sites/default/files/ab_hscp_annual_performance_report_21072017_5.pdf

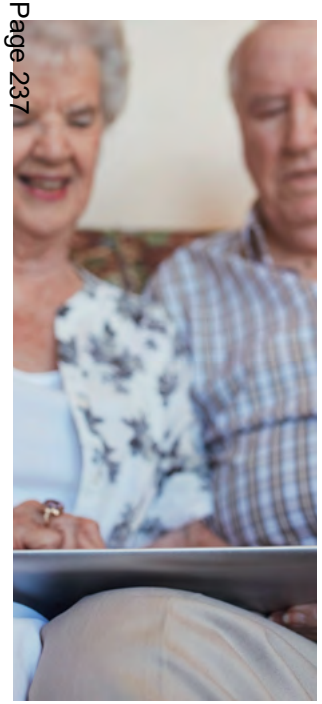
Thanks and acknowledgements

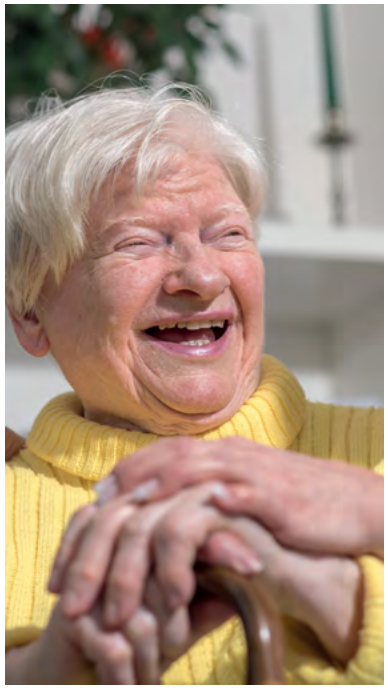
This report was produced by the Coalition of Carers in Scotland, authored by Graeme Reekie of Wren and Greyhound Limited.

We would like to thank the Carer Representatives involved in Integrated Joint Boards across Scotland, without whose input and involvement over the last two years this report would not have been possible.

The work was funded and supported by the Scottish Government.

Published April 2018





Contact Details

The Coalition of Carers in Scotland
PO Box 21624
STIRLING
FK7 1EF

Tel: **01786 850 247**

Email: **coalition@carersnet.org**

Web: **www.carersnet.org**

Twitter: **@CarersCoalition**

Facebook: **www.facebook.com/CoalitionofCarers**

Registered Charity: SC 039434

Agenda Item Number: 16

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	28 June 2018
Subject Title	NHS Health Scotland new resource - The Role of Health and Social Care Partnerships in Reducing Health Inequalities
Report By	Caroline Sinclair, Head of Mental Health, Learning Disability and Addiction Services
Contact Officer	David Radford, Service Manager Health Improvement and Equalities

Purpose of Report	To make Board members aware of the production of a new resource by NHS Health Scotland titled - The Role of Health and Social Care Partnerships in Reducing Health Inequalities

Recommendations	The Integration Joint Board is asked to: a) Note the production of this new resource b) Note that East Dunbartonshire HSCP is credited as a contributor to the development of the resource

Relevance to HSCP Board Strategic Plan	This new resource can be used to support delivery of areas of the Strategic Plan that focus on addressing health inequalities

Implications for Health & Social Care Partnership

Human Resources	There are no Human Resource implications for the Health and Social Care Partnership arising from this report.

Equalities:	The new resource aims to support health and social care partnerships in their efforts to address health inequalities.

Financial:	There are no financial implications arising directly from this report.

Legal:	There are no legal implications arising directly from this report.

Economic Impact:	There is no economic impact arising directly from this report.

Sustainability:	NA

Risk Implications:	There are no risk implications arising from this report.

Implications for East Dunbartonshire Council:	There are no direct implications for East Dunbartonshire Council.

Implications for NHS Greater Glasgow & Clyde:	There are no direct implications for NHS Greater Glasgow & Clyde.

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

1.0 MAIN REPORT

1.1 NHS Health Scotland has produced a new practical resource for reducing health inequalities within health and social care. It follows on from the publication of Maximising the role of NHS Scotland in Reducing Health Inequalities (2017) which was targeted at NHS staff, endorsed by Dr Paul Gray, Director General of Health and Social Care at the Scottish Government.

1.2 While the challenge in terms of addressing health inequalities in the present climate is acknowledged NHS Health Scotland urges all Health and Social Care Partnerships to build on their plans already in place and use this resource as a guiding framework for reducing health inequalities.

1.3 The target audience for the resource is people working within HSCPs, planners and managers, who are well placed to act on the practical actions while making crucial decisions about services, and for all employees working within HSCPs delivering frontline services. There is signposting to tools and guidance to support some of the actions.

1.4 This resource strengthens the case that HSCPs, and the people working in them, have opportunities to address health inequalities through leadership and governance.

1.5 Members are asked to note that East Dunbartonshire Health and Social Care

Partnership is credited as a contributor to the development of the tool.

1.6 The resource will now be used where deemed appropriate to inform service planning and service change.

Appendix 1 - The Role of Health and Social Care Partnerships in Reducing Health Inequalities

NHS Health Scotland

The role of Health and Social Care Partnerships in **reducing health inequalities**

We would like to thank the following Health and Social Care Partnerships and organisations who we consulted with in the development of this resource.

Argyll & Bute Health & Social Care Partnership

Midlothian Health & Social Care Partnership

We would also like to thank Scottish Government, Scotland Excel, COSLA and the Care Inspectorate for their steer and input.

Contents

Foreword

People are living longer in Scotland. This is a success story and to be celebrated. But it also brings challenges for health and social care services as many of us are living longer in ill health. Changing needs of health and social care service users and our workforce, as outlined in the Health and Social Care Delivery Plan, mean that we all need to be clear about the standards and principles we work and adhere to. Maintaining consistently high standards through a period of substantial change is a challenge for all of us, but to the people who rely on health and social care services it is vitally important that we achieve this.

Inequalities in health outcomes across our population remain a key challenge and have a significant impact on the demands on health care and social care services. Many of the root causes of these inequalities are societal. Health and Social Care Partnerships (HSCPs) have roles in planning and empowering communities to take actions to reduce inequalities, not just through health care, but across a range of sectors.

The design of health and social care services also influences the enjoyment and protection of people's human rights, as well as the opportunity to actively participate in decision making that affects their lives. Using a human rights approach reinforces our integration aim of putting people at the centre of our decisions on planning, service design and delivery.

As HSCPs are required to produce and deliver strategic plans, they are continuously in a cycle of planning, implementing and reviewing their work. These planning, implementation and review processes provide the ideal opportunity to consider the actions to address inequalities and develop relevant measures.

This statement provides a framework of actions that HSCPs should consider when developing their strategic plans, and also aims at employees of local authorities and NHS Boards when delivering frontline services. There is signposting to tools and guidance throughout the resource which may help with some of the actions.

To build on this strategic resource, NHS Health Scotland is developing a suite of resources which will help to think about new and innovative ways of working to reduce health inequalities.

We would like to thank the HSCPs, national and local partners who helped in the development of this resource and gave us feedback, and we hope to continue building strong relationships with the HSCPs to work towards reducing health inequalities in Scotland.

We hope that this resource helps HSCPs to recognise the challenge presented by health inequalities and to take the actions necessary to address them.

Gerry McLaughlin
Chief Executive
NHS Health Scotland

Introduction

Health inequalities are the **unfair** and **avoidable** differences in people's health across social groups and between different population groups. They represent thousands of unnecessary premature deaths every year in Scotland. The gaps between those with the best and worst health and wellbeing still persist, and some are widening.[1]

Health and Social Care Partnerships (HSCPs) **have a duty to contribute to reducing heath inequalities as one of the National Health and Wellbeing outcomes**[2], and the actions in this resource help to address this outcome.

This resource strengthens the case that HSCPs, and the people working in them, have a **vital role in providing leadership and governance around reducing inequalities**.

The purpose of this resource is to **offer practical actions** of good practice as a way of considering health inequalities right from the start of developing plans and priorities.

Many of the actions suggested should be familiar and some may already be in place. These actions will be more relevant for some HSCPs than others depending on their scope and structure. The role of the Community Planning Partnership in reducing inequalities and their contribution in delivery of some of these actions is also key.

This resource is **targeted at people working within HSCPs – planners and managers** who are **well placed** to act on the practical actions while making crucial decisions about services and all employees working within HSCPs delivering frontline services.

This resource **can be used as a framework to inform strategic and local governance**. It may also help **identify gaps and actions** not considered in priorities and plans.

[1] See www.healthscotland.scot/media/1086/health-inequalities-what-are-they-how-do-we-reduce-them-mar16.pdf
[2] See www.gov.scot/Resource/0047/00470219.pdf

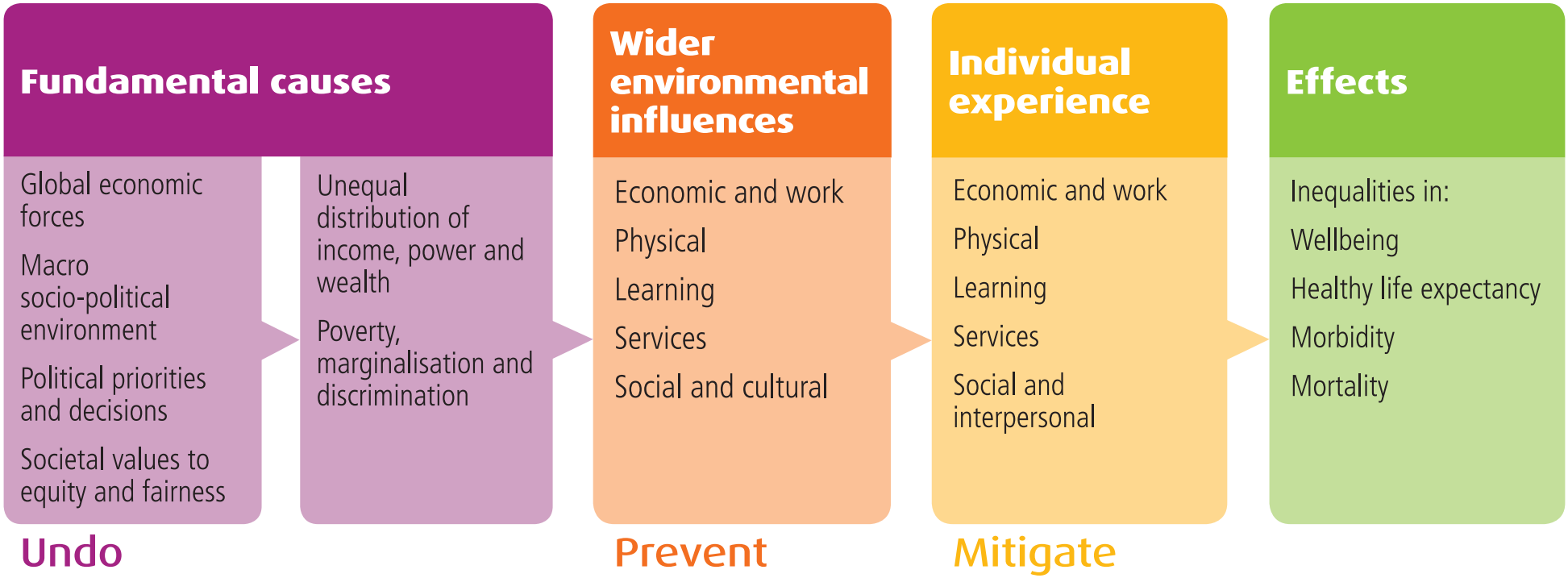
What are health inequalities?

Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. Fundamental causes of health inequalities are an unequal distribution of income, power and wealth. This can lead to poverty and marginalisation of people in society. These fundamental causes also affect the distribution of wider environmental influences on health, such as the availability of work, education and good quality housing. They can also influence access to services and social and cultural opportunities in an area. The wider environment where people live and work then shapes their individual experiences of low income, poor housing, discrimination and access to health services[3].

There is ample opportunity to lead, advocate and influence on reducing health inequalities, albeit some of these fundamental causes may be driven by agencies outwith the control of the Health and Social Care Partnerships. This resource highlights some of the practical actions that could help to reduce health inequalities.

The diagram below illustrates the fundamental causes leading to the influences and experiences they can cause.

Figure 1: Health inequalities: theory of causation



[3] See www.healthscotland.scot/media/1086/health-inequalities-what-are-they-how-do-we-reduce-them-mar16.pdf

Tackling health inequalities requires a blend of action to **undo** the fundamental causes, **prevent** the harmful wider environmental influences and **mitigate** (make less harmful) the negative impact on individuals. Action must be based on evidence of need, understanding of barriers to social opportunities and what is most likely to work.[4]

To prevent environmental factors causing health inequalities, action is needed to ensure equity in the distribution of, for example, good work, high quality and accessible education and public services. People with high levels of need benefit most from preventative services, highlighting the need to invest in community development and community capacity building, as this has long-term impacts on individuals' skills, health and resilience.

[4] Macintyre S. *Inequalities in health in Scotland: What are they and what can we do about them?* Glasgow: MRC Social & Public Health Sciences Unit; 2007.

Acknowledging the challenges and embracing opportunities for prevention

There is a challenge for integration in balancing the increasing demand from demographic changes, the pressure on the existing system and the provision of care and treatment. This is set against the immediate need to find new and improved ways of delivering services as well as increasing opportunities for cost saving.

Health and Social Care Partnerships often find themselves responding to their financial pressures by concentrating services on people assessed as critical or at substantial risk, at the expense of upstream, preventative action. However, a lack of prevention can lead to increased demand on those frontline services under pressure.

Through effective collaboration, Health and Social Care Partnerships have the opportunity to make services universally available and accessible to all people, in proportion to their need, which will help to address the inequalities gap and improve the health of the whole population.

At strategic level, proportionate universalism might involve provision of higher numbers of community addictions support workers, or health visitors in areas of higher deprivation. At the operational level the approach might involve staff undertaking a more targeted promotion and follow-up of vulnerable patients for immunisation, screening or primary/secondary prevention. **Community Planning Partnerships** also have a key role in prevention.

Planning for and investing in preventative action can have a positive impact on improving health and reducing health inequalities, while managing the increasing demand for services and a reduction in spend. This investment in prevention does require resources, but can reduce public spending pressures by:

- reducing the length of time people spend in ill health
- preventing ill health and high rates of crisis management
- reducing the demands for public services
- freeing up resources for other uses.

Practical actions to help reduce health inequalities

This section focuses on six themes which can help strengthen the contribution to reducing health inequalities, founded on international evidence[5] and drawn from local practice. The actions included in the following tables will apply and interface between Health and Social Care Partnerships (HSCPs), NHS Boards and Local Authorities (LAs).

[5] See www.local.gov.uk/marmot-review-report-fair-society-healthy-lives

1. Quality services with allocation of resources proportionate to need

Allocating services in proportion to need and understanding the nature of need within the communities is crucial for Health and Social Care Partnerships (HSCPs) and vital for reducing health inequalities. Better value means more than just living within our means; it means improving outcomes by delivering value from all our resources. It is not just about increasing the efficiency of what we currently do, but also innovating and redesigning services to deliver outcomes in different and more effective ways.

HSCPs could consider using data and service user experience and outcomes to inform decisions about the allocation of funding to tackle health inequalities. This includes making decisions about spending money on prevention to reap benefits at a later date.

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
Quality services with allocation of resources proportionate to need. • Health and social care services are planned and delivered in proportion to need. • Inequities in access, outcomes and the experience of care are accounted for and addressed.	• Undertake **health inequalities/equalities/human rights impact assessment** with new policies, plans and investment decisions. • **Understand the health of your population** and the factors that shape it. • **Understand the impact** of inequalities on service users and demand on services through the use of available data and feedback and comments from service users, their families and local community. • Ensure **meaningful and effective engagement with community**, individuals and individual service users to understand community needs and to inform the development and implementation of strategic plans. Influencing and having conversations with the wider community about inequalities. • Consider that access to goods and services can depend on where service users live, and the impact on inequalities has to be considered – for example the impact on those who live in the islands or remote areas, or access needs of people who are homeless. • Use the **Place Standard Tool** which helps find those aspects of a place that need to be targeted to improve people's health, wellbeing and quality of life	Integration chief officers Chief social work officers Heads of services and planning Public health and inequalities leads Health intelligence Service and clinical managers Third sector Communities

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
	• Set up a risk assessment process to identify service users at risk of vulnerability – for example routine questions at initial discussions with service users. • Have governance arrangements in place to check progress and actions to address inequalities. • Provide and refer to welfare and money, employability and home energy advice, through working in partnership with relevant agencies such as Citizens Advice Bureau. • Provide appropriate and relevant support, including the use of technology, for people to engage meaningfully in planning services. • If in the scope of the partnership, link the planning with the planning duties under the Children's and Young People (Scotland) Act, which requires partners to focus on early intervention.	

2. Training the workforce to understand their role in reducing inequalities

Evolving health and social care services must also be rooted in a widespread culture of improvement. It is vital to support the people working within Health and Social Care Partnerships (HSCPs) to consider building upon their existing knowledge and skill sets to deliver services that help reduce health inequalities, enabling them to respond to the social and economic circumstances affecting an individual's health, recovery and circumstance. Local Authorities (LAs) and NHS Boards have a major role to play in considering social issues and looking at the wider determinants in order to improve health.

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
Training people working within HSCPs to understand and help reduce health inequalities. • People working in HSCPs have the knowledge and skills to design and deliver services that are sensitive to inequalities.	• Support all people working within the HSCPs, including independent and voluntary sector, to increase knowledge and skills in: - reducing health inequalities, including cultural competence, human rights, equality and diversity such as **NHS Health Scotland's VLE** and **Public Health Intelligence Training Course**. - building knowledge, understanding, skills and confidence in service users to use health information, to be active partners in their care, and to navigate health and social care systems. This is known as **health literacy**. - embedding inequalities sensitive practice and risk assessment, for example, taking into account issues such as broader social history, financial inclusion, gender-based violence, homelessness support, carer responsibilities, and fuel poverty. • Use innovative ways to get messages across to employees about inequalities, for example via the **power animation developed by NHS Health Scotland**. • Support employees to join networks to increase knowledge in health inequalities. • Support employee development and confidence in contributing to the reduction of health inequalities via existing personal development performance (PDP) and appraisal systems. • **Support people** working in HSCPs to have increased knowledge in public health, and help demonstrate where their skills align with the **Public Health Knowledge and Skills Framework**.	Organisational development Human resources and workforce Equality and diversity leads Public health and health inequalities leads Quality improvement leads Volunteer services managers

More suggestions for information/tools and training for the workforce are at the end of this resource.

3. Effective partnership across sectors to help reduce health inequalities

Health and Social Care Partnerships (HSCPs) cannot tackle health inequalities by working on their own. It is often the health services, local government and/or HSCPs who fund the third sector to deliver local services, and are often best placed to respond to frontline service users. Many third sector organisations have specialist knowledge and skills that could help reduce inequalities much more efficiently. In addition, strong relationships with Community Planning Partnerships are a prime opportunity for ensuring that reducing health inequalities is a shared objective.

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
Effective partnership with different sectors to help reduce health inequalities. • Strategic plans could support action to address the fundamental and environmental causes of health inequalities by working in partnership with the third sector, and strengthening community engagement and empowerment.	• Ensure there are aims to reduce inequalities in strategic plans, and ensure these are not only aspirational but deliverable through integrated structures. • Mainstream inequalities in development plans, as well as in separate equality and diversity plans, with specific actions, leadership and accountability for particular population groups. • Make clear links from evidence on inequalities with aims and actions in priorities and plans. • Ensure plans reflect effective partnerships with a range of community and third sector organisations for their implementation, such as local housing and welfare rights associations to help those most vulnerable in the community. • Ensure **meaningful and effective engagement** with community individuals and individual service users to understand that community needs to inform the development and implementation of strategic plans. • **Measure and report on the impact** of reducing inequalities for local people and communities as required for the **National Health and Wellbeing Outcomes**.	Integration chief officers Chief social work officers Heads of planning and service Health intelligence Community Planning Partnerships Local improvement support team analysts allocated to each HSCP Third sector Communities

4. Mitigation of inequalities through employment processes

Everyone Matters: 2020 Workforce Vision sets out the health and social care workforce policy for Scotland. The Health and Social Care Partnerships (HSCPs) are not employers themselves, and so the following 'employment' actions are aimed at the Local Authorities (LAs) and NHS Boards working within the partnerships.

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
Mitigation of inequalities through employment processes. • Mitigating and preventing the impact of inequality is integrated within employment policy and practice.	• Ensure effective governance and monitoring is in place to support the right of an individual employee to the best attainable health by implementing a workforce and **health (including mental health) and wellbeing** strategy. • Ensure the dimensions of the **Fair Work Framework** are embedded into organisation policies, practices and procedures. • Commit to paying, and build on existing commitments to, the **Scottish Living Wage**. • Ensure fair recruitment policy embeds practice to reduce health inequalities. • Support a diverse composition of workforce that reflects the communities they serve, and regularly monitor the workforce composition. • Enhance opportunities within the workforce for young people and vulnerable individuals to progress within the health and social care workforce structures. • Monitor employment processes and ensure that practices, such as flexibility and access to workforce development, are fair and equitable. • Ensure a sustainable workforce planning process that supports progression of existing staff, and creates opportunities to enter the health and social care workforce. • Ensure employees have opportunities to enhance qualifications, skill sets and competence. Provide targeted employment opportunities for vulnerable citizens within the community such as young carers and those with additional needs.	Integration chief officer Heads of service Human resources Workforce leads Trade unions Partnership bodies

5. Mitigation of inequalities through procurement and commissioning processes

Health and Social Care Partnerships (HSCPs) should ensure the strategic commissioning process is equitable and transparent, and is undertaken in partnership with stakeholders via an ongoing collaboration with people who use services, their unpaid carers and providers. This principle needs to be applied when services are delivered on behalf of the HSCP by a partner organisation.

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
Mitigation of inequalities through procurement and commissioning processes. • Mitigating and preventing the impact of inequality is integrated within procurement policy and practice.	• Embed **community benefit clauses** in procurement activity to strengthen community cohesion, health and wellbeing. • Encourage payment of the Scottish living wage through innovative procurement practice and transparent assessment of the cost of care provision. • Commissioning and procurement processes, undertaken directly or on behalf of HSCP, incorporate good work principles, ensuring the workforce across HSCP commissioned services, and supply chain, benefits from the same employment standards at work as the HSCP partner organisations. • Ensure commissioning and procurement processes undertaken directly or on behalf of the HSCP measure and score impact on inequalities and have monitoring systems in place to ensure the contribution to addressing health inequalities is realised. • Embed good procurement practice through adherence to the guidance on the procurement of care and support services. Ensure support for local SMEs, third sector, supported businesses and the independent sector to compete in public commissioning and procurement processes to enhance local economic benefits. • Ensure capital investment decisions and procurement undertaken on behalf of the HSCP both consider the impact on communities and contribute to reducing inequalities.	Integration chief officer Heads of planning and commissioning Procurement leads Commissioning leads

6. Leadership and advocating to reduce health inequalities

Health and Social Care Partnerships (HSCPs) have an important role in advocating for action at national and local level to address health inequalities. This means advocating for fairer policy and fairer planning when engaging with chief officers, elected members, non-executives, heads of planning as well as policymakers at community planning levels. This sort of leadership and momentum is challenging to create and sustain, but it is at the heart of the Christie recommendations.[6]

The way HSCPs can lead	Actions for HSCPs, NHS and LAs	Who can help make this happen
Advocating to reduce health inequalities. • Integration authorities, elected members and other senior managers actively advocate for action on inequalities in partnership with local authorities, Community Planning Partnerships, the third sector and others in their community.	• Discuss what role and steps could be taken for HSCPs to contribute to reducing health inequalities, and agree how this can be monitored. • Advocate at partnership and policy level for fair and equitable access to services. • Advocate for and highlight the key opportunities that address inequalities in health, such as routine payment of at least Scottish living wage, and Fair Work Framework principles. • Advocate for planning policies that deliver positive place making, particularly for communities with high levels of need. • Advocate for economic policies that are most likely to support fair, high quality employment. • Support partners to use socioeconomic impact assessments and other approaches to ensure their plans and policies support people with highest levels of need. • Chief officers and elected members constructively advocate for policy change at a national level on inequalities.	Integration chief officers Chief social work officers Elected members Non-executives Councillors[7] Heads of services Commissioning Planning Heads of strategy Third sector partners

[6] See www.gov.scot/Publications/2011/06/27154527/0
[7] See www.improvementservice.org.uk/documents/em_briefing_notes/em-briefing-health-inequalities.pdf

Key policies and drivers strengthening the role of Health and Social Care Partnerships in reducing health inequalities

- Public Bodies (Joint Working) (Scotland) Act 2014 provided the legislative framework for the integration of health and social care service in Scotland.
- The Equality Act (2010) underpins all of the work that HSCPs and Health Boards and councils do. In its simplest form the general duty is about taking a person-centred preventative approach to the delivery and planning of our services.
- The 2020 Vision for Health and Social Care describes actions on how health and social care can strengthen its role in preventing and reducing health inequalities through its opportunity of an integrated system.
- The Health and Social Care Delivery Plan (2016) recognises the vital contribution health and social care integration plays to reduce health inequalities.
- HSCPs' strategic plans are an opportunity to embed actions and governance which help to reduce inequalities.
- National Health and Wellbeing Outcomes are strategic statements which HSCPs aim to achieve. Strategic commissioning plans are based on these outcomes and Outcome 5 asks HSCPs to demonstrate how their services can contribute to the reduction of health inequalities.
- Socioeconomic duty will be introduced by Scottish Government, where public bodies like local councils and NHS Boards will have to think carefully about how to reduce poverty and inequality whenever they make big decisions that are important to all of us.
- The Community Empowerment (Scotland) Act 2015 aims to raise the level of ambition for community planning, which has ample opportunity to embed actions to help reduce health inequalities. Community planning has strong connections with HSCPs and will often involve people working across the two planning structures.
- Children and Young People Scotland Act (2014) (part 9) places responsibilities on local authorities and their partners to improve outcomes for looked after children. A focus on health outcomes is explicit.
- Scotland's Mental Health Strategy (2017–27) is a 10-year vision describing the link between social inequalities and poor mental health.
- National Health and Social Care Workforce Plan (due end of 2017) aims to ensure health and social care staff are resourced to be better targeted, aligning demand and supply to ensure people get the right support at the right time, which has the opportunity to look at inequalities and services proportionate to need.

- National health and social care standards (2017) take a human-rights based approach to ensure everyone in Scotland receives the same high quality care no matter where they live. One of the principles is ‘equality and diversity’.

- Social Care (Self-directed Support) (Scotland) Act (2014) places a duty on local authority social work departments to offer people who are eligible for social care a range of choices over how they receive their support.

Support

Below is a list of where to go for support to help with the practical actions outlined in this resource.

Organisations

- **NHS Health Scotland's tools and resources**
- **Scottish Human Rights Commission**
- **Health and Social Care ALLIANCE (Scotland)**
- **I Hub – Supporting health and social care**
- **Community Planning in Scotland Portal**
- **The national improvement service for local government in Scotland**
- **Glasgow Centre for Population Health**
- **Information Services Division**
- **The King's Fund**

Workforce training and networks

- NHS Health Scotland's **Virtual Learning Environment**: e-modules on 'health inequalities aimed at health and social care staff'
- NHS Health Scotland: **Scottish Health and Inequalities Impact Assessment Network**
- University of Dundee: **Tackling inequalities through health and social care design**
- Royal College of Physicians: **Introduction to the Social Determinants of health**
- ScotPHO: **Public Health Information Network**

- Glasgow University: **Health Economics and Health Technology Assessment**
- Scottish Health Council: **Participation Tooklit**
- Scottish Community Development Centre: **Communities Matter**

Staff health and wellbeing

- **Healthy Working Lives** Adviceline: 0800 019 2211

Measuring data on health inequalities

- NHS Health Scotland: **Public Health Data**
- Each Health and Social Care Partnership will have a Local Improvement Support Team who can help with data and measuring performance

Additional papers to read

- Public Health England: **Reducing health inequalities: system, scale and sustainability**
- UCL Institute of Health Equity, Department of Epidemiology and Public Health, University College London: **Working for Health Equity: The Role of Health Professionals**
- Audit Scotland: **Health and Social Care Integration**
- Scottish Parliament: **Integration Authorities' Engagement with Stakeholders**
- Scottish Health Council: **Evaluation Participation: A guide and toolkit for health and social care practitioners**
- NHS Health Scotland: **Maximising the role of NHS Scotland in reducing health inequalities**

Further information

We hope you find this publication useful and use it to further develop your understanding of the role of Health and Social Care Partnerships in contributing to reducing health inequalities. If you would like any advice or further information please contact:

Lorna Renwick
Organisational Lead – NHS team, NHS Health Scotland
lornarenwick@nhs.net

Arma Sayed-Rafiq
Senior Health Improvement Officer – NHS team, NHS Health Scotland
arma.sayed-rafiq@nhs.net

This publication is aimed at people working in Health and Social Care Partnerships (HSCPs). It describes practical actions as a way of considering health inequalities at the beginning when developing plans and priorities.

This resource may also be made available on request in the following formats:

0131 314 5300

nhs.healthscotland-alternativeformats@nhs.net

Corporate member of Plain English Campaign
Committed to clearer communication
489

EFQM
Recognised for excellence
3 star - 2016

We are a Living Wage Employer

Published by NHS Health Scotland

1 South Gyle Crescent
Edinburgh EH12 9EB

© NHS Health Scotland 2018

www.healthscotland.scot @NHS_HS nhshealthscotland

6218 4/2018

East Dunbartonshire Health & Social Care Partnership

Item 19

East Dunbartonshire HSCP Schedule of Topics / HSCP Board Development and Seminars
Business plan for HSCP Board meetings
2017 / 2018 /2019

Half day Seminars Topic Specific seminars to be added at 9am to the HSCP Board Agenda
TOPIC SPECIFIC SEMINARS
6th September 2018 – Topic Specific Seminar – GP Contract
17th January 2019 - Topic Specific Seminar – Unscheduled Care
HALF DAY DEVELOPMENT SESSIONS
June 2018 – Finance
5th October 2018 – Fair allocation to care & Strategic Commissioning– Enterprise House
8th February 2019 – Mental Health and visit to Woodlands Resource Centre
STANDING ITEMS (every meeting)
Expressions of Interest
Minutes of HSCP Board –previous meeting
Chief Officers report
HSCP Board Meeting – 6th September 2018
Joint Health Improvement Plan
Finance and Planning Monitoring arrangements
Moving forward together
Update on Scheduled Care Plan
Update on Governance arrangements
Prescribing Update
Annual Clinical & Care Governance Report
Refresher for Business Plan
HSCP Board Meeting – 15th November 2018
Winter Plan 2018-19 (FMcC))

Performance Improvement Report – Quarter 1 (FMcC)
Draft Carers Strategy (FMcC)
Short Breaks Statement (FMcC)
HSCP Board Meeting – 17th January 2019
Performance Improvement Report – Quarter 2 (FMcC)

ED HSCP BOARD - DISTRIBUTION LIST at May 2018

ED HSCP BOARD MEMBERS - VOTING		
Name	**Designation**	
Ian Fraser	Chair - NHS Non Executive Board Member	1
Susan Murray	Vice Chair -EDC Elected member	1
Sheila Mechan	EDC Elected member	1
Alan Moir	EDC Elected member	1
Jacqueline Forbes	NHS non-executive Board Member	1
Ian Ritchie	NHS non-executive Board Member	1
ED HSCP BOARD MEMBERS - NON VOTING		
Susan Manion	Chief Officer	1
Jean Campbell	Chief Finance & Resources Officer	1
Gordon Thomson	Voluntary Sector Representative	1
Martin Brickley	Service User Representative	1
Jenny Proctor	Carers Representative	1
Wilma Hepburn	Professional Nurse Advisor -NHS	1
Andrew McCready	Trades Union Representative	1
Gillian Cameron	Trades Union Representative	1
Lisa Williams	Clinical Director for HSCP	1
Adam Bowman	Acute Services Representative	1
Paolo Mazzoncini	Chief Social Work Officer	1
ED HSCP SUPPORT OFFICERS - FOR INFORMATION		
Linda Tindall	Organisational Development Lead	**e-copy only**
Caroline Sinclair	Head of Mental Health, LD, Addictions and HI	1
Derrick Pearce	Head of Adult and Primary Care Services	1
Fiona McCulloch	Planning & Performance Manager	**e-copy only**
Gillian McConnachie	Chief Internal Auditor HSCP	**e-copy only**
Karen Donnelly	EDC Chief Solicitor and Monitoring Officer	**Paper copy/e-copy only**
Martin Cunnigham	EDC Corporate Governance Manager	3
Jennifer Haynes	Interim Corporate Services Manager	**e-copy only**
Louise Martin	Head of Administration, ED HSCP	**e-copy only**
Frances McLinden	General Manager, Oral Health Directorate	**Paper copy / e-copy**
Tom Quinn	Head of Human Resources	**e-copy only**
Gerry Cornes	Chief Executive	**Paper copy/e-copy only**
Ann Davie	Depute Chief Executive - Education People & Business	**Paper copy/e-copy only**
Thomas Glen	Depute Chief Executuve - Place, Neighbourhood & Corp	**Paper copy/e-copy only**
Pauline Halligan	Strategic Lead -Organisational Transformation	**Paper copy/e-copy only**
Jamie Robertson	Chief Finance Officer	**Paper copy/e-copy only**
Sharon Bradshaw	Human Recources	**e-copy only**
For information only (Substitutes)		
Councillor Mohrag Fischer	EDC Elected member	**e-copy only**
Councillor Graeme McGinnigle	EDC Elected member	**e-copy only**
Councillor Rosie O'Neil	EDC Elected member	**e-copy only**
A. Jamieson	Carers Representative	**1 copy**
I Twaddle	Service User Representative	**1 copy**