Agenda

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board

Date: Wednesday, 19 August 2015

Time: 14:00

Venue: Committee Room 3,
Council Offices, Garshake Road, Dumbarton

Contact: Nuala Borthwick, Committee Officer
Tel: 01389 737594 Email: nuala.borthwick@west-dunbarton.gov.uk

Dear Member

Please attend a meeting of the **West Dunbartonshire Health & Social Care Partnership Board** as detailed above.

The business is shown on the attached agenda.

Yours faithfully

KEITH REDPATH

Chief Officer of the
Health & Social Care Partnership

Distribution:-

Councillor G. Casey (Chair)
Councillor J. McColl
Councillor M. Rooney
Dr H. Cameron
Ms R. Micklem (Vice Chair)
Mr A. Macleod

Senior Management Team – Health & Social Care Partnership

Date of issue: 13 August 2015

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE

PARTNERSHIP BOARD

WEDNESDAY, 19 AUGUST 2015

AGENDA

1. APOLOGIES

2. DECLARATIONS OF INTEREST

Members are invited to declare if they have an interest in any of the undernoted items of business on this agenda and, if so, state the reasons for such declarations.

3. MINUTES OF PREVIOUS MEETING **7 - 12**

Submit, for approval as a correct record, the Minutes of Meeting of West Dunbartonshire Health & Social Care Partnership held on 1 July 2015.

4. NHS GREATER GLASGOW & CLYDE CLINICAL SERVICES STRATEGY **13 - 78**

A presentation will be given by Jennifer Armstrong, Medical Director, NHS Greater Glasgow and Clyde on the NHS Greater Glasgow & Clyde Clinical Strategy.

In this respect, submit report by the Head of Strategy, Planning and Health Improvement providing background information relating to this presentation.

5. MINUTES OF MEETINGS FOR INCLUSION ON PARTNERSHIP BOARD AGENDAS **79 – 82**

Submit report by the Head of Strategy, Planning and Health Improvement providing information on the formal meetings whose minutes will be routinely presented to the Partnership Board for information.

6. CLINICAL & CARE GOVERNANCE **83 - 110**

Submit report by the Clinical Director:-

(a) providing information on the West Dunbartonshire CHCP Clinical Governance Annual Report for 1 January 2014 to 31 March 2015;

(b) providing information on the National Clinical & Care Governance Framework; and

(c) seeking endorsement of the positions expressed within the submission made to the Scottish Parliament's Health & Sports Committee's call for written views on Health (Tobacco, Nicotine etc and Care) (Scotland) Bill.

7. AUDIT ARRANGEMENTS **111 - 118**

Submit report by the Chief Financial Officer providing information on proposed audit arrangements for the Partnership Board.

8. RISK MANAGEMENT POLICY & STRATEGY **119 - 136**

Submit report by the Head of Strategy, Planning and Health seeking approval of the Risk Management Policy & Strategy prepared for the new Health & Social Care Partnership.

9. PROPOSED RELOCATION OF CLYDEBANK OLDER ADULT CONTINUING CARE DEMENTIA BEDS FROM GARTNAVEL ROYAL HOSPITAL TO THE DUMBARTON JOINT HOSPITAL **137 - 140**

Submit report by the Head of Mental Health, Learning Disability and Addiction providing information on proposals to relocate four Older Adult Continuing Care Beds currently within Gartnavel Royal Hospital to Glenarn Ward based at the Dumbarton Joint Hospital.

10(a). CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S CARE HOMES OPERATED BY INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE **141 - 146**

Submit report by the Head of Strategy, Planning and Health providing information on the most recent Care Inspectorate assessments for three independent sector residential older peoples' Care Homes within West Dunbartonshire.

10(b). CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S RESIDENTIAL AND DAY CARE SERVICES OPEARTED BY WEST DUNBARTONSHIRE COUNCIL **147 - 154**

Submit report by the Head of Community Health & Care Services providing information on the most recent inspection reports for three of the Council's own Older People's Residential Care Home and Day Care Services.

10(c). CARE INSPECTORATE REPORTS FOR CHILDREN & YOUNG PEOPLE'S SERVICES OPERATED BY WEST DUNBARTONSHIRE COUNCIL (THROUGHCARE & AFTERCARE SERVICES AND CRAIGELLACHIE CHILDREN'S HOUSE) **155 - 158**

Submit report by the Head of Children's Health, Care and Criminal Justice providing information on the most recent inspection reports for Throughcare/After Service and Craigellachie, one of the Council's own Residential Services for Children and Young People.

11. RESPONSE TO HEALTH CARE IMPROVEMENT SCOTLAND **159 - 180**

Submit report by the Head of Strategy, Planning and Health:-

(a) providing information on the Healthcare Improvement Scotland consultation 'Building a comprehensive approach to review the quality of care'; and

(b) presenting the proposed response to the consultation for submission by the Health & Social Care Partnership.

12. FINANCIAL REPORT 2015/16 AS AT PERIOD 3 (30 JUNE 2015) **181 - 196**

Submit report by the Chief Financial Officer providing an update on the financial performance and capital work progress of the Health & Social Care Partnership for the period to 30 June 2015 (period 3).

13. FINANCIAL REGULATIONS **197 - 212**

Submit report by the Chief Financial Officer seeking approval of its Financial Regulations.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

At a Meeting of the West Dunbartonshire Health and Social Care Partnership Board held in Committee Room 3, Council Offices, Garshake Road, Dumbarton, on Wednesday, 1 July 2015 at 2.00 p.m.

Present: Councillors Gail Casey, Jonathan McColl and Martin Rooney (West Dunbartonshire Council); and Ms Ros Micklem (Vice Chair), Dr Heather Cameron and Mr Allan Macleod, Non-Executive Members, NHS Greater Glasgow & Clyde Health Board.

Non-Voting Members: Keith Redpath, Chief Officer (Designate); Jeanne Middleton, Chief Finance Officer (Designate); Dr Kevin Fellows, Clinical Director of the Health & Social Care Partnership; Wilma Hepburn, Lead Nurse for the Health & Social Care Partnership; Selina Ross, Chief Officer of West Dunbartonshire Council for Voluntary Services; Ross McCulloch, NHS Staff Side Co-Chair, Joint Staff Forum; Anne McDougall, Co-Chair, Public Engagement Forum/Chair of the Local Engagement Network (Clydebank area) and Lindsay Lockhart, Chair of Carers of West Dunbartonshire.

Attending: Chris McNeill, Head of Community Health & Care Services; John Russell, Head of Mental Health, Learning Disability & Addictions; Soumen Sengupta, Head of Strategy, Planning and Health Improvement; Peter Hessett, Head of Legal, Democratic and Regulatory Services and Nuala Borthwick, Committee Officer, West Dunbartonshire Council.

Councillor Gail Casey in the Chair

WELCOME AND INTRODUCTIONS

Councillor Casey welcomed everyone present to the inaugural meeting of the West Dunbartonshire Health & Social Care Partnership Board and thereafter introductions were made around the table.

APPOINTMENT OF CHIEF OFFICER

A report was submitted by the Head of People and Change requesting consideration of the appointment of the Partnership Board's Chief Officer.

Following discussion and having heard the Chief Officer (Designate) in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to formally appoint Keith Redpath as the Chief Officer of the Partnership Board.

APPOINTMENT OF CHIEF FINANCE OFFICER

A report was submitted by the Head of People and Change seeking consideration of the appointment of the Partnership Board's Chief Finance Officer.

The Partnership Board agreed to formally appoint Jeanne Middleton as its Chief Finance Officer.

MEMBERSHIP OF THE PARTNERSHIP BOARD

A report was submitted by the Head of Strategy, Planning and Health Improvement seeking appointment of the non-voting members of the Partnership Board including confirmation of the designated professional advisors named in the report.

After discussion and having heard the Chief Officer in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to appoint the non-voting members of the Partnership Board including confirmation of the designated professional advisors listed in the report.

STANDING ORDERS AND CODE OF CONDUCT

A report was submitted by the Head of Legal, Democratic and Regulatory Services:-

(a) seeking approval of the Standing Orders; and

(b) asking the Board to note the terms of the Model Code of Conduct for Members of Devolved Public Bodies.

Having heard the Head of Legal, Democratic and Regulatory Services in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to approve the Standing Orders subject to the undernoted amendment to paragraph 15.4 under the heading 'Voting' so that reference to the cut of cards where there is an equality of votes is removed:-

"15.4 Where there is an equality of votes, the status quo shall prevail. Standing Order 12 shall not preclude reconsideration of any such item within a six month period";

(2) that, subject to clarification by the Council's Head of Legal, Democratic & Regulatory Services, Standing Order 6.1 be amended so that in order to be quorate, at least one voting representative of each of the parties to the Partnership is present;

(3) that a separate Register of Interests for Members of the Partnership Board would be held and maintained by the Chief Officer; and

(4) to note the terms of the Model Code of Conduct for Members of Devolved Public Bodies.

INTEGRATION SCHEME

A report was submitted by the Head of Strategy, Planning & Health Improvement providing information on the Integration Scheme for West Dunbartonshire as approved by the Scottish Government.

Having heard the Chief Officer and the Head of Planning, Strategy and Health Improvement in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note the correction to the last sentence of paragraph 4 on page 12 of the Integration Scheme which should read that "Any redesign of service requires to be agreed across the six Integration Joint Boards and be reflected in the Strategic Plans";

(2) that advice would be sought from the Scottish Government on whether the diagram on page 35 of the Integration Scheme can be simplified for ease of reference; and

(3) to otherwise note the approved Integration Scheme that underpins the new arrangements within West Dunbartonshire.

STRATEGIC PLAN 2015/16

A report was submitted by the Head of Strategy, Planning & Health Improvement seeking approval of the first Strategic Plan for the West Dunbartonshire Health & Social Care Partnership.

There was submitted (tabled) an updated version of the Strategic Plan 2015/16 which contained minor revisions.

Following discussion and having heard the Chief Officer, the Head of Strategy, Planning and Health Improvement and the Head of Community Health & Care Services in further explanation of the report and in answer to Members' questions, the Board agreed:-

(1) to approve the updated Strategic Plan 2015/16 and thereby enable full delegation of responsibilities and resources to the Partnership Board;

(2) that the first performance report for the Strategic Plan would highlight those indicators currently reported on with regards to deprivation and protected characteristics groups for monitoring purposes; and

(3) that a further set from the agreed indicators would be reported on with regard to deprivation and protected characteristic groups in the future.

2015/16 ANNUAL REVENUE BUDGET

A report was submitted by the Chief Finance Officer outlining the budget available to the Health & Social Care Partnership for 2015/16 from NHS Greater Glasgow & Clyde and West Dunbartonshire Council.

Following discussion and having heard the Chief Officer, the Chief Financial Officer and the Head of Community Health & Care Services in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to note the report.

FINANCIAL PROCESSES AND PROCEDURES

A report was submitted by the Chief Financial Officer advising of work carried out to date on establishing a set of processes and procedures to determine the governance arrangements for a range of matters in relation to financial management and accountability within the Partnership Board.

Following discussion and having heard the Chief Financial Officer in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to approve the report.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP DUE DILIGENCE PROCESS AND 2015/16 BUDGET

A report was submitted by the Chief Financial Officer advising of the due diligence undertaken in respect of the proposed 2015/16 revenue budget which has been carried out in light of the 2012/13, 2013/14 and 2014/15 financial information.

Following discussion and having heard the Chief Officer and the Chief Financial Officer in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note the due diligence work undertaken as the basis for 2015/16; and

(2) to approve the 2015/16 budget.

SCHEDULE OF MEETINGS

The Board agreed the undernoted dates, times and venues for future meetings:-

Wednesday, 19 August 2015 at 2.00 p.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU

Wednesday, 18 November 2015 at 2.00 p.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU

Wednesday, 17 February 2016 at 2.00 p.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU

Wednesday, 18 May 2016 at 2.00 p.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU

VALEDICTORY

The Chair, Councillor Casey, advised the Board that this would be the first and last meeting that Ross McCulloch would attend as NHS Staff Side Co-Chair of the Joint Staff Forum given that he was standing down after almost 10 years of service.

Councillor Casey acknowledged Ross's work and commitment and advised that during his time as NHS Staff Side Co-Chair of the Joint Staff Forum, the West Dunbartonshire Community Health and Care Partnership was the first to be established in Scotland and proved to be the model that other areas sought to emulate. It was noted that Ross played a huge part in the successful operation of the local forum, particularly after the earlier integration phase in 2010. His personal contribution was recognised in 2013 when Ross and Serena Barnatt, Head of People and Change, were presented with the Healthcare People Management Association - Social Partnership Forum Award for Partnership Working.

On behalf of the Partnership Board, Councillor Casey then thanked Ross for his considerable contributions to achievements during this time and wished him well in his future endeavours.

The meeting closed at 3.20 p.m.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 19th August 2015

Subject: NHS Greater Glasgow & Clyde Clinical Services Strategy 2015

1. Purpose

1.1 To present the NHS Greater Glasgow & Clyde Clinical Services Strategy.

2. Recommendations

2.1 The Partnership Board is recommended to endorse the NHS Greater Glasgow & Clyde Clinical Services Strategy.

3. Background

3.1 In February 2012, NHS Greater Glasgow and Clyde (NHSGGC) agreed to establish the Clinical Services Fit for the Future Programme to review services and prepare a single clinical strategy for NHSGGC for 2015 onwards. In establishing the Review the Health Board recognised the need to:

- Integrate acute services across the whole Board area and ensure that there is equity of access to this level of care across NHSGGC.
- See acute services are part of a wider system of care including primary and community care that also requires to be considered to meet the challenges of the 2020 Vision and to deliver the integrated health and social care changes from 2015 onwards.
- Recognise the changing landscape of health care with the developments in technology and treatments.

3.2 The former Community Health & Care Partnership Committee was consequently briefed on the review's emerging conclusions at its November 2013 meeting.

3.3 At its meeting of 20th January 2015, the Health Board was presented with the final output of that clinical service review process by its Medical Director; and then approved it as a clinical strategy to provide the basis for future service planning. This Clinical Services Strategy was then launched in April 2015 (attached).

4. Main Issues

4.1 The key aims of the Strategy are to ensure:

- Care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway.

- Services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements.
- Sustainable and affordable clinical services can be delivered across NHSGGC.
- The pressures on hospital, primary care and community services are addressed.

4.2 The Strategy provides a framework to ensure that best clinical outcomes are achieved for patients and that services are:

- Safe and sustainable.
- Patient centred.
- Integrated between primary and secondary care.
- Efficient, making best use of resources.
- Affordable, provided within the funding available.
- Accessible, provided as locally as possible.
- Adaptable, achieving change over time.

4.3 In approving this Strategy, the Health Board's intention has been to continue to engage with stakeholders, including the new Integration Joint Boards within the Greater Glasgow & Clyde area as they are each established – the latter to specifically:

- Seek their support in adopting this as a shared clinical strategy.
- Seek to work together on planning service changes.
- Seek to engage on the refresh of the Health Board's Primary Care Strategy and the further development of primary and community services.

5. People Implications

5.1 The Strategy recognises the importance of supporting the workforce to meet these future changes; and that effective implementation will require strong clinical leadership and commitment as well as a significant cultural shift across NHSGGC.

6. Financial Implications

6.1 One of the drivers for the Strategy is the reality that the health service is facing a period of rising demand resultant from demographic pressures at the same time as facing a period of significant financial constraint. It is therefore important that in planning for future services the funding available is spent effectively to ensure the best outcomes for patients. It should be noted that that imperative equally holds true for social care services as it does for the health care services described within the Strategy.

7. Professional Implications

7.1 The groups which developed the service models were clinically led and were formed with representatives of the hospital, primary care and academic clinicians.

8. Locality Implications

8.1 The Strategic Plan 2015-16 affirms the commitment of the Health & Social Care Partnership to work with and through its refreshed locality planning arrangements to foster improvements to the interface and relationships between community and hospital services; and support the implementation of overall NHSGGC Clinical Services Strategy.

9. Risk Analysis

9.1 The case for change underpinning the Strategy estimates that future demand pressures resulting from demographic and health changes mean that if a significant change strategy is not adopted, then the Health Board and the six Integration Joint Boards would need an additional 500 acute beds by 2020. In an environment of constrained resources, the investment required for this would result in a vicious circle, with growing expenditure in acute hospital admissions and less money for investment in community services, which in turn reduces our ability to support people at home.

10. Impact Assessments

10.1 An acknowledged theme of the services model within the Clinical Services Strategy is the imperative on them to support and comply with the relevant duties under the Equality Act 2010.

11. Consultation

11.1 NHSGGC has undertaken has been extensive consultation and engagement throughout the development of the Clinical Services Review.

11.2 The clinical working groups which developed the service models included patient representatives and were supported by wider patient reference groups, involving patients, carers and voluntary organisations.

12. Strategic Assessment

12.1 The Clinical Services Strategy acknowledges that the successful development of the new integrated partnerships within the Greater Glasgow & Clyde area will be key to the achievement of all of the strategic priorities and service models set out in this strategy (as these will provide a framework for the joint working necessary across the six Integration Joint Boards and the Health Board with respect to their shared responsibility for the strategic planning of acute services).

12.2 The Strategic Plan 2015-16 was informed by an understanding of this Clinical Services Strategy; and identified the following key priority areas for acute services development with respect to West Dunbartonshire which are emphasised within the Clinical Services Strategy:

- Reduction in bed days lost to delayed discharge.
- Reduction in the number of Accident & Emergency presentations.
- Reduction in the number of emergency admissions.
- Relationship building between Primary and Acute Care Services.

Author: Soumen Sengupta – Head of Strategy, Planning & Health Improvement

Date: 19 August 2015

Person to Contact:	Soumen Sengupta Head of Strategy, Planning & Health Improvement West Dunbartonshire Health & Social Care Partnership, West Dunbartonshire HSCP HQ, West Dunbartonshire Council, Garshake Road, Dumbarton, G82 3PU. E-mail: soumen.sengupta@ggc.scot.nhs.uk
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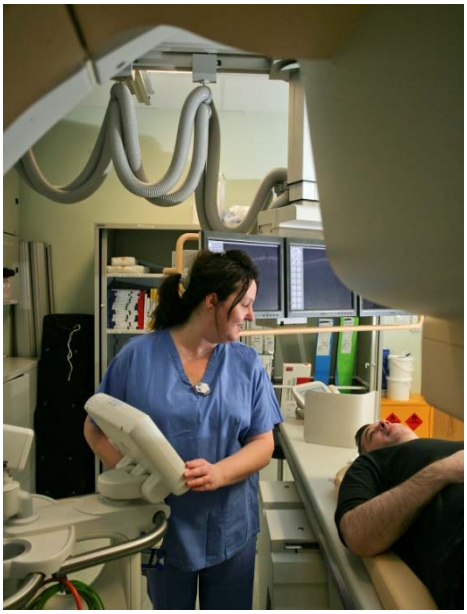
Appendices:	NHSGGC Clinical Services Strategy 2015 - Summary
Background Papers:	Community Health and Care Partnership Committee Report (November 2013): Clinical Services Fit For The Future – Service Models NHSGGC Clinical Services Strategy 2015: http://www.nhsggc.org.uk/media/233577/clinical-services-strategy.pdf
Wards Affected:	All

NHS
Greater Glasgow and Clyde

Clinical Services Strategy 2015



Foreword

Dr Jennifer L. Armstrong
Medical Director, NHS Greater Glasgow and Clyde

In April 2012, as part of the Scottish Government's 2020 Vision, we launched a Clinical Services Review to consider how best to deliver services to meet the changing needs of patients beyond 2015 to 2020.

The review was led by NHS clinicians with substantial involvement from patients and special interest groups, the third sector and with wider public engagement.

Together, all of these interests analysed the changing population needs, the modernisation of approaches to care and technological developments and how best to deliver sustainable, safe and effective services going forward.

The review has been approved and the final Clinical Strategy is now available on our website at: http://www.nhsggc.org.uk/about-us/clinical-services-fit-for-the-future/

The key aims of the Clinical Strategy are to ensure that:

- care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway
- services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements
- sustainable and affordable clinical services can be delivered across NHSGGC
- pressures on hospital, primary care and community services are addressed

The Clinical Strategy is the blueprint to develop innovative and redesigned services to meet future demands of the population we serve. It provides the opportunity to engage with the six new Integration Joint Boards (local authority social care and NHS community care integrated boards) across Greater Glasgow and Clyde to adopt this as a shared clinical strategy to work together on planning service changes as we go forward from 2015 to 2020.

In addition, the innovative new approaches being trialled in the Renfrewshire Council area to integrate community health services, social care and the acute hospital teams will influence a new approach for our entire Board area.

The Clinical Review Report sets out high quality models of care from better prevention and self management right through to highly specialised hospital care and is evidence based with learning from what works across the UK and beyond. The work that has gone into this intense and crucial Review is the bedrock of how we will plan to deliver and plan clinical services to meet all of our hospital and community health needs.

On behalf of NHSGGC I would like to thank everyone who has been involved in leading and shaping this work. The input from staff in hospitals and in the community along with patients and public representatives, special interest groups and charities has been invaluable.

1. INTRODUCTION AND PURPOSE

In February 2012 NHS Greater Glasgow and Clyde agreed to establish the Clinical Services Fit for the Future Programme to review services to prepare a single clinical strategy for NHSGGC for 2015 onwards. This document sets out the Clinical Strategy for NHS Greater Glasgow and Clyde, developed from the output of the clinical service review process, which will provide the basis for future service planning from 2015 to 2020.

The key aims of the strategy are to ensure:

- care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway;
- services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements;
- sustainable and affordable clinical services can be delivered across NHSGGC;
- the pressures on hospital, primary care and community services are addressed.

This strategy provides a framework to ensure that best clinical outcomes are achieved for patients and that services are:

- safe and sustainable;
- patient centred;
- integrated between primary and secondary care;
- efficient, making best use of resources;
- affordable, provided within the funding available;
- accessible, provided as locally as possible;
- adaptable, achieving change over time.

The approved strategy provides a platform for the Board to:-

- deliver the Governments 2020 Vision
- engage with the new Integration Joint Boards to adopt this as a shared clinical strategy and to work together on planning service changes;
- develop implementation plans, including delivering changes to reflect the output of the Renfrewshire Development Programme across the Board area;
- engage with GPs, wider primary care contractors and with the new Health and Social Care Partnerships to refresh the Board's Primary Care Strategy and plan the further development of primary and community services.
- continue the dialogue with stakeholders on the delivery of care and the models we use;

2. SETTING THE SCENE: NHS SCOTLAND POLICY CONTEXT

In 2012 the Cabinet Secretary for Health, Wellbeing and Cities set out her strategic narrative and vision for achieving sustainable quality in the delivery of healthcare services across Scotland.

This vision for NHS Scotland is:

- **"By 2020 everyone is able to live longer healthier lives at home or in a homely setting with a healthcare system.**

There will be integrated health and social care, a focus on prevention, anticipation and supported self management.
When hospital treatment is required, and cannot be provided in a community setting,

day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the patient at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as possible, with minimum risk of re-admission."

Achieving Sustainable Quality in Scotland's Healthcare: A 20:20 Vision

This vision provides the context for taking forward the implementation of the Healthcare Quality Strategy for Scotland and the required actions to improve efficiency and achieve financial sustainability and for the development of our approach to planning clinical services fit for the future.

The actions outlined for NHS Scotland which drive the requirement to reshape our services are:

- We need a shared understanding with everyone involved in delivering healthcare services which set out what they should expect in terms of support, involvement and reward alongside their commitment to strong visible and effective engagement and leadership which ensures a real shared ownership of the challenges and solutions.

- We need to develop a shared understanding with the people of Scotland which sets out what they should expect in terms of high quality healthcare services alongside their shared responsibility for prevention, anticipation, self management and appropriate use of both planned and unscheduled/ emergency healthcare services, ensuring that they are able to stay healthy, at home, or in a community setting as long as possible and appropriate.

- We need to secure integrated working between health and social care, and more effective working with other agencies and with the Third and Independent Sectors.

- We need to prioritise anticipatory care and preventative spends, e.g. support for parenting and early years.

- We need to prioritise support for people to stay at home/in a homely setting as long as this is appropriate, and avoid the need for unplanned or emergency admission to hospital wherever possible.

- We need to make sure people are admitted to hospital only when it is not possible or appropriate to treat them in the community - and where someone does have to go to hospital, it should be as a day case where possible.

- Caring for more people in the community and doing more procedures as day cases where appropriate will result in a shift from acute to community-based care. This shift will be recognised as a positive improvement in the quality of our healthcare services, progress towards our vision and therefore the kind of service change we expect to see.

The direction underpinning this vision sees further focus on improving the quality of services, with expanded primary and community care, a focus on multi-morbidity and improving unscheduled and emergency care out with hospital where clinically appropriate. National work is currently underway between Boards and the Scottish Government to set out the steps which will need to be taken to deliver the 2020 Vision. This strategy provides our local basis to develop those changes.

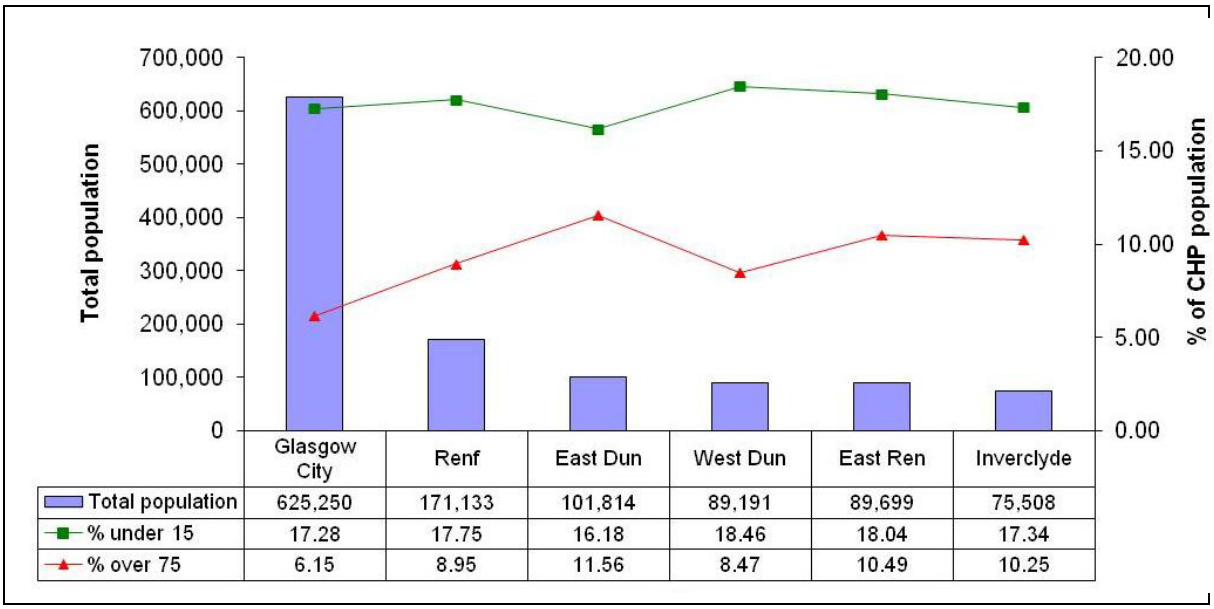
In addition to this context, a further important point of context for this clinical strategy is the establishment from April 2015 of Integrated Health and Social Care Partnerships. Successful development of the new integrated partnerships will be key to the achievement of all of the strategic priorities and service models set out in this strategy which will frame our joint working with the Partnerships with shared responsibility for the strategic planning of acute services.

3. THE NHS GREATER GLASGOW AND CLYDE POPULATION HEALTH

In bringing forward this outcome of the CSR it is also important to restate the local context in which the CSR has been developed.

The Population of NHSGGC: Demographics

The current population and age profile is shown below. Our population is relatively young compared to other parts of Scotland, although this varies significantly between local authority areas. Women predominate in the older age groups.



	Glasgow City	Renf	East Dun	West Dun	East Ren	Inverclyde
Total population	625,250	171,133	101,814	89,191	89,699	75,508
% under 15	17.28	17.75	16.18	18.46	18.04	17.34
% over 75	6.15	8.95	11.56	8.47	10.49	10.25

The population of the NHS Greater Glasgow and Clyde area in 2010 was 1,203,870. This population is expected to increase overall by 2.4% by 2020. (See table below)

Age Group	Population 2010	Population 2015	% change by 2015	Population 2020	% change by 2020	Population 2025	% change by 2025
0-14	194,562	197,268	1.4	202,876	4.3	199,911	2.7
15-24	166,320	150,265	-9.7	137,743	-17.2	139,286	-16.3
25-34	176,434	193,672	9.8	184,614	4.6	166,623	-5.6
35-44	167,002	156,647	-6.2	172,422	3.2	187,458	12.2
45-54	177,130	177,566	0.2	159,827	-9.8	149,426	-15.6
55-64	136,201	147,198	8.1	164,852	21.0	165,878	21.8
65 & over	186,221	197,206	5.9	210,174	12.9	233,297	25.3
All Ages	1,203,870	1,219,822	1.3	1,232,508	2.4	1,241,879	3.2

During this time, the age profile of the population will continue to change. In common with much of Scotland, in most areas there will be a steep rise in the numbers and proportion of older people. The over 65 population will increase by 12.9% by 2020. This will impact differently across Greater Glasgow and Clyde with areas like East Dunbartonshire and East Renfrewshire already experiencing significant rises in numbers of older people, whilst Glasgow City is projected to see a short term decline in the numbers of older people, before following the same longer term trends. A small increase in the number of children together with a larger decrease in the number of people aged 15-29 will result in an overall reduction in the 0-19 age group.

It is a population with high levels of deprivation compared to the rest of Scotland. 30.4% of people in NHSGGC live in the 15% most deprived data zones (Scottish Index of Multiple Deprivation). This ranges from 3.1% in East Dunbartonshire, to over 50% North and East Glasgow.

Summary of key trends:

- The **top 10 causes of death** in Scotland account for 44% of all deaths. Each of the causes of death are amenable to prevention by not smoking; being a healthy weight; being physically active; drinking within recommended levels of alcohol and maintaining a healthy diet.

- **Population projections** estimate that Glasgow City is due to have a modest rise in population to 2033, whereas, all other local authorities in NHSGGC will have a decrease in population. This will be most marked in Inverclyde and East Dunbartonshire.

- **Our population is ageing**. Between 1911 and 2008 there has been an increase in the number of people aged over 65 years in Scotland of 221%. However, NHSGGC is ageing at a markedly slower rate than the rest of Scotland.

- There are **wide variations within NHSGGC**. East Dunbartonshire experienced a 47% increase in people aged 65+ and Glasgow city a 25% decline between 1982-2007.

- **Forecasts predict the under 50's will shrink** from 70% in 2008 to 62% in 2033; whereas the over 50's will expand from 30% to 38%. The biggest increase is expected in the over 65's age group.

- **Dependency ratios are due to increase** to 2040 across NHSGGC. Within NHSGGC there are marked variations. Current dependency ratios vary from 44% in Glasgow City to 60% in East Renfrewshire by 2031 these are predicted to increase to 51% in Glasgow City to 91% in East Dunbartonshire and 89% in East Renfrewshire. A male born in East Glasgow can expect to live in a healthy state for 15 years less than a male born in East Dunbartonshire.

- **Older single person households are expected to increase**. It is anticipated these will account for 54% of households by 2031.

- Life expectancy and healthy life expectancy is lower in NHSGGC than the rest of Scotland. People living in NHSGGC can expect to have the **longest period of unhealthy life at 10.5 years.**

- Aging is associated with an increased burden on long term conditions and chronic disease.

- There will be a significant growth in the numbers of people with dementia as the population ages. There will be an estimated 18% increase in dementia in NHSGGC by 2020. One in three people aged over 65 will die with a form of dementia and one in four hospital inpatients will have dementia (Alzheimer's Research Trust 2010).

In recent years across NHSGGC, there have been some significant improvements in health. Overall life expectancy has risen; rates of premature mortality have fallen, with particular improvements for Coronary Heart Disease. Cancer survival has improved significantly across a range of cancers.

However, there remain many significant health challenges and marked inequality across NHSGGC. Overall, average life expectancy in NHSGGC is well below the Scottish average (see below). Again, there is considerable variation between different parts of NHSGGC.

Healthy life expectancy in NHSGGC is even lower compared to the Scottish average. People in NHSGGC live for many years in ill health, with the consequent impact on quality of life, economic and societal contribution and need for services. Over the past 10 years, the gap in healthy life expectancy between the 20% most deprived and the 20% least deprived areas has increased from 8 to 13 years.

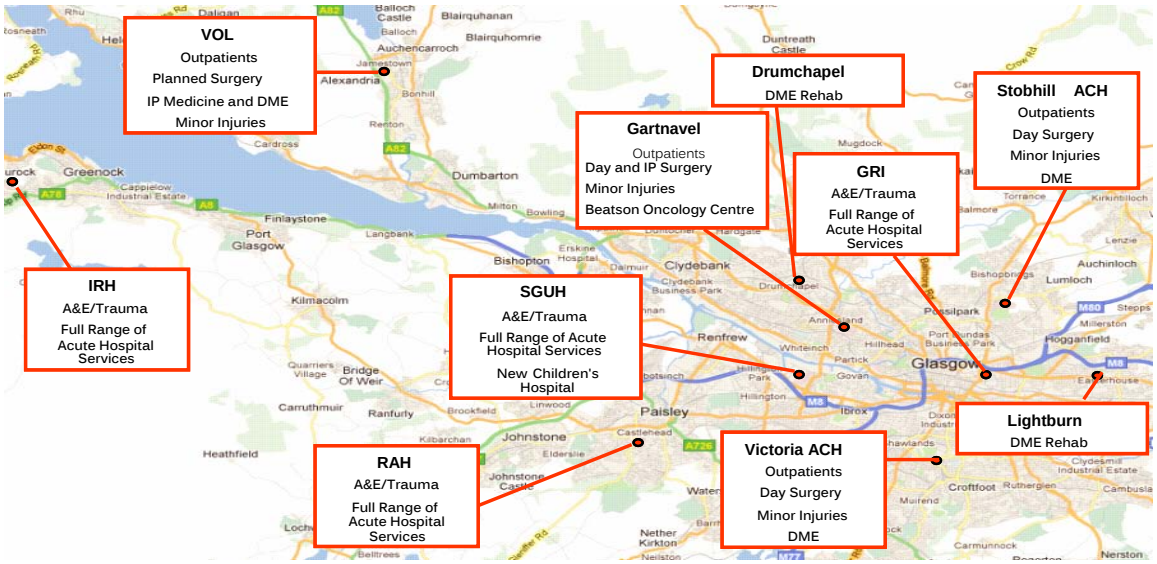
Life Expectancy at Birth by Gender 2007 - 2009 Source: NRS (formerly GRO(S))

CH(C)P	Male	Female
Glasgow City	71.1	77.5
East Dunbartonshire	78.3	83.1
East Renfrewshire	77.8	82
Renfrewshire	73.7	79.2
Inverclyde	73.1	79
West Dunbartonshire	72.5	78.4
NHSGGC	**73.1**	**78.9**
Scotland	**75.4**	**80.1**

4. THE CONTEXT OF ACUTE SERVICES PROVISION IN NHSGGC

Prior to the CSR NHSGGC had two separate approved acute strategies - one for Greater Glasgow, the Acute Services Review (ASR) agreed in 2002 and the other for Clyde (South Clyde in 2006/7 and North Clyde in 2009). The Clyde strategy has already been fully implemented and the Greater Glasgow ASR will be delivered during 2015. At that point the Acute Services Provision across NHSGGC will be as follows:

2015 GGC
Delivery of the Acute Services Review



In establishing the CSR the Board recognised the need to:

- integrate acute services across the whole Board area and ensure that there is equity of access to this level of care across NHSGGC;
- see acute services are part of a wider system of care including primary and community care that also requires to be considered to meet the challenges of the 2020 Vision and to deliver the integrated health and social care changes from 2015 onwards;
- recognise the changing landscape of health care with the developments in technology and treatments and the requirement to ensure care is provided in a patient centred way.

The following sections describe the approach we took to review the organisation of clinical services and to consider what would be required to achieve the best health outcomes for patients. The critical characteristics of the review work were clinical leadership, whole system clinical engagement and intensive patient and public engagement.

5. THE CASE FOR CHANGE AND CHALLENGES THIS STRATEGY NEEDS TO ADDRESS

The first stage in the CSR was to establish the Case for Change. This part of the process was also based on the views of a wide range of clinicians on what is currently affecting the clinical services and what is likely to impact on services in the future, as well as the opinions of patients of what they value in the current service and what they would want of future services.

Following extensive engagement with stakeholders the Case for Change was published in December 2012.

This identified 9 key themes:

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

Together these issues paint a picture of health services which need to change to make sure that we can continue to deliver high quality services and improve outcomes. As outlined in the earlier sections the years ahead will see significant changes to the population and health needs of NHSGGC. It is clear that not enough focus on prevention and support for people at an early stage in their illness can lead to poorer health outcomes, and to people accessing services and support at crisis points or at later stages of illness. The growing complexity of need, including multi morbidity and a wide range of care and support needs, mean that users and carers can feel inadequately supported and services can feel complex and fragmented.

This poses significant challenges to the way we deliver health services and work with partner agencies, to ensure that our services adapt to these changing needs.

The health service is facing a period of rising demand resultant from demographic pressures at the same time as facing a period of significant financial constraint. It is therefore important that in planning for future services the funding available is spent effectively to ensure the best outcomes for patients. A more consistent and joined up approach is required across all parts of the system, targeting interventions and support where they are most needed. The Case for Change tells us that we need to improve outcomes by organising and delivering services differently to prevent ill health in the first place, to support patients with multiple conditions more effectively and to enable older people to live more independently. We also need to change our hospitals to ensure that high quality care is consistently available, that there is timely access for all to specialist care and that we have 24 /7 access to specialised emergency care.

The full case for change is at http://www.nhsggc.org.uk/about-us/clinical-services-fit-for-the-future/the-case-for-change-documents/

The core of this clinical strategy is based on the Case for Change and the detailed work done in eight workstreams to consider how we can address these challenges. These workstreams, to determine the service strategy for 2015-2020 and identify the future clinical service provision, cover:

- Population Health
- Emergency Care and Trauma
- Planned Care
- Child and Maternal Health
- Older People's Services
- Chronic Disease Management
- Cancer
- Mental Health

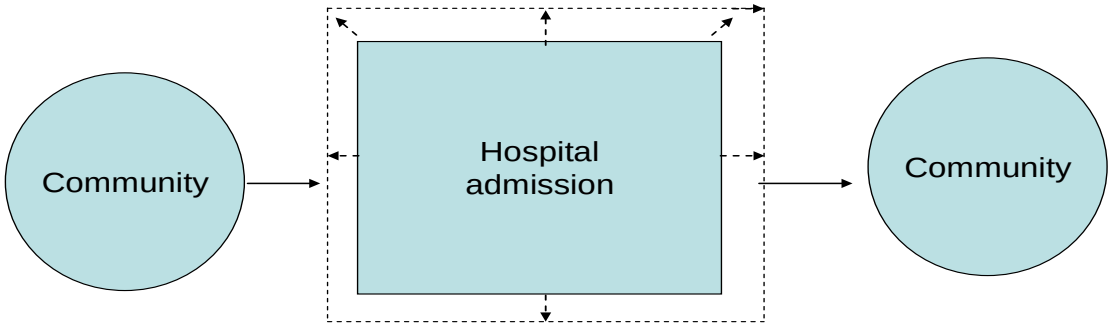
The detailed conclusions of this service models work are set out later in this paper.

Meeting the challenge across the whole system

The diagrams below show the challenge we face across NHSGGC and the system we need to move towards in the future.

The current position is one where we face challenging demand pressures across a system in which 'hospital' and 'community' services are largely seen as separate, with often poor communication and joint planning across the system. While there are some good examples of joint working, these are not systematic and often on a small scale. The future demand pressures we face as a result of demographic and health changes mean that if we continue with the system as it is now, we would need an additional 500 acute beds by 2020. In an environment of constrained resources, the investment required for this would result in a vicious circle, with growing expenditure in acute hospital admissions and less money for investment in community services, which in turn reduces our ability to support people at home.

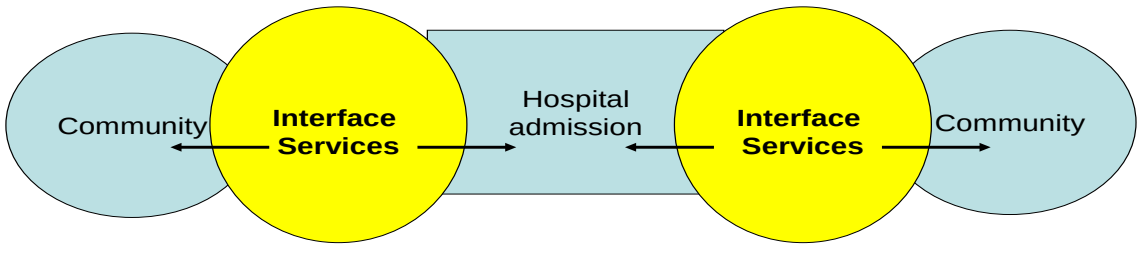
Figure 2



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

Working differently at the interface (represented by the yellow circles below) may involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system.

Figure 3



It is recognised that to change the system will require strong clinical leadership and commitment as well as a significant cultural shift across the organization to undertake this size of system change. To achieve this we require to:

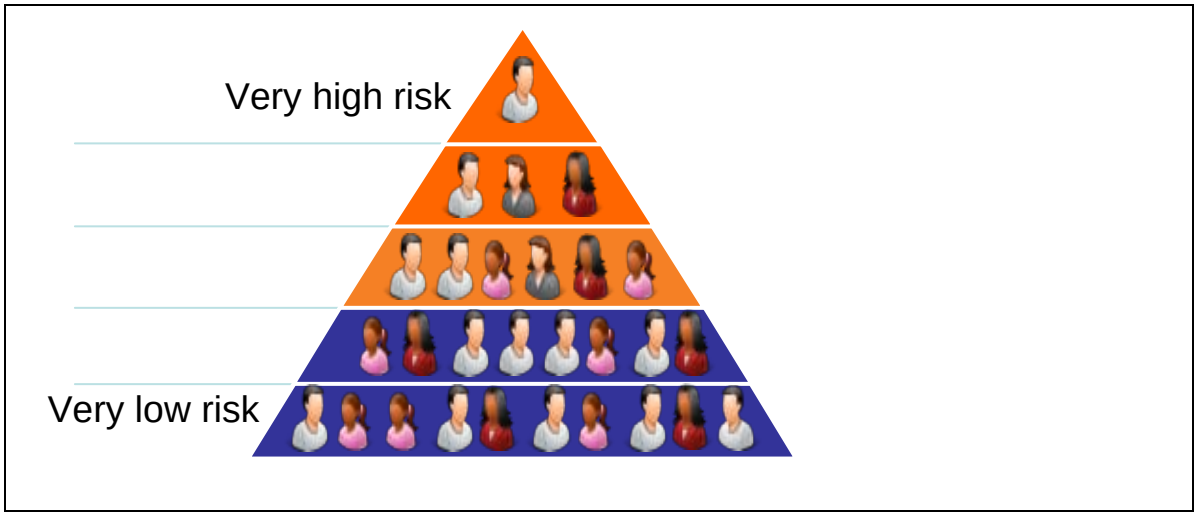
- think beyond artificial boundaries of 'hospital' and 'community';
- focus on patient pathway and needs at each stage;
- change the delivery of acute care: assess and direct to appropriate place of care;
- change the provision and accessibility of community services;
- create different ways of working at the interface.

This needs to build on the work of bringing clinical teams together to consider the problems and challenges facing the services, to jointly problem solve and plan services across the organisation for the future with shared responsibility for delivery of the new service models to maximise success.

Core components of the future health system

The overarching aim of this clinical strategy, based on the service models work, is to provide **a balanced system of care where people get the right care in the right place** from people with the right skills, working across the artificial boundary of 'hospital' and 'community' services.

At the heart of this approach is the requirement to understand our population and provide care at the most appropriate level. Getting this right will enable more intensive support for those most in need, and supported self management with rapid access into services when required for the majority of the population.



This approach relies on a strong emphasis on prevention. It is therefore important that as part of the strategy we continue to emphasise the importance of health improvement and disease prevention. We need to encourage the population to improve their health and prevent disease, recognising that lifestyle choices in modifiable behaviours are responsible for around 80% of our current LTC disease burden. This requires all health care professionals to promote healthier lifestyles and to support the population to take responsibility for improving their own health by adopting healthier lifestyles. It also requires patients and the public to work together to support each other in managing their health and health care needs.

The key characteristics of the clinical services required to support this approach are:

1. A system underpinned by timely access to **high quality primary care** providing a comprehensive service that deals with the whole person in the context of their socio-economic environment:

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

2. A comprehensive range of **community services,** integrated across health and social care and working with the third sector to provide increased support at home:

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

3. Co-Coordinated care at **crisis / transition** points, and for those **most at risk**:

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

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

   - Senior clinical decision makers at the front door.
   - Specialist care available 24/7 where required.
   - Rapid transfer to appropriate place of care, following assessment.
   - In-patient stay for the acute period of care only (see Fig 4).
   - Early supported discharge to home or step down care.
   - Early involvement of primary and community care team in planning for discharge.

5. **Planned care** which is locally accessible on an outpatient / ambulatory care basis where possible:

   - Wider range of specialist clinics in the community, working as part of a team with primary care and community services.
   - Appropriate follow-up.
   - Diagnostic services organised around patient needs.
   - Interventions provided as day case where possible.
   - Rapid access as an alternative to emergency admission or to facilitate discharge.

6. **Low volume and high complexity care** provided in defined units equipped to meet the care needs:

   - Driven by clear evidence of the relationship between volume and outcome.

The service models which follow at section 6 onwards consider what needs to be in place to deliver these core components of care for specific groups of patients.

Enablers

Changing the system on this scale will require a significant cultural shift and clinical commitment across the organisation. In order to achieve this, services will have to be underpinned by a series of enablers and improvements to supporting systems, including:

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

Benefits

It is anticipated that a successful move towards this system of care would result in:

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

Figure 4

What is Acute Care? Who needs to be admitted for inpatient care?

The definition of Acute Inpatient Care we propose is:

"Acute care is where people receive specialised support in an emergency or following referral for surgery, complex tests or other things that cannot be done in the community.

Acute care usually provides treatment for a short period, until the person is well enough to be supported in the community again."

The European Appropriateness Evaluation Protocol Approach has been developed and used in a number of countries to support this definition. This considers admission criteria in relation to both severity of illness and intensity of service required:

Admission criteria – intensity of service

- Surgery or other procedure in 24 hours requiring general/ regional anaesthesia or equipment or other facilities only for inpatients.
- Vital signs monitoring at least every 2 hours.
- Intravenous medications and or/ fluid replacement.
- Continuous or intermittent (at least every 8 hours) respiratory assistance.

Admission criteria – severity of illness

- Severe electrolyte or blood gas abnormality.
- Acute loss of sight or hearing (within 48 hours of admission).
- Acute loss of ability to move any body part (within 48 hours of admission).
- Persistent fever >38 for more than 5 days.
- Active bleeding.
- Pulse rate <50 or >140 per minute.
- Blood pressure systolic <90 or >200, diastolic <60 or >120.
- Sudden onset of unconsciousness (except transient unconsciousness).
- ECG evidence of acute ischaemia, suspicion of new myocardial infarction.

Experience of applying this tool indicates:

- The most influential factor determining the appropriateness of bed utilisation is how the care system in place manages the patient, rather than the characteristics of the patient.
- Therefore it is important to consider the service configuration and care delivery to effect change.

Significant additional and different capacity is required if patients are to be treated more appropriately:

- A shift away from acute inpatient setting to provide a wide spectrum of home and community based care.
- Improved assessment and diagnosis.
- Non acute beds with therapy support.

Going forward we need to determine where the threshold for acute inpatient care is set

- ***Too high: difficult to implement, risk of readmission, significant impact.***
- ***Too low: won't be radical enough to address the problems we face.***

We need to develop a more comprehensive range of services in community settings based on the services we currently have. This will require us to determine what capacity is needed to ensure that core primary care and community services are accessible when required. It will require us to test the alternatives to ensure they are safe and cost effective.

The next section of this document sets out the high level service models to support the delivery of care in a more balanced system as we go towards 2020, indicating the areas where services should be further developed and the core components to underpin the health care provision.

6. SERVICE MODELS

The groups which developed the service models were clinically led and were formed with representatives of the hospital, primary care and academic clinicians. The clinical working groups included patient representatives and were supported by wider patient reference groups, involving patients, carers and voluntary organisations. The process was also supported by a series of cross-cutting events to consider specific issues across the groups, including primary care and the third sector. In addition work has been undertaken in relation to tertiary services which has been fed into the work of the different clinical groups where indicated.

The groups focused on:

- Reviewing current services, future changes and possible models of care;
- Looking at evidence from research, good practice and innovation;
- Thinking about what needs to change – and what doesn't;
- Reviewing feedback from the engagement sessions with the patient reference groups.

Underpinning each work stream was a core set of activities to consider current pathways, delivery models, workforce requirements and the relationship between primary and secondary care to ensure efficient and effective patient pathways.

The outputs from each of the groups were brought together into a discussion paper and summary document in June 2013, which set out how the models developed by all of the groups come together into a series of changes to the overall system of care in NHSGGC, as well as highlighting specific service models from individual groups.

The discussion paper was shared widely across NHSGGC, with partner organisations and with patients and third sector organisations. This included:

- Presentations and discussions with groups of clinicians, including Medical Staff Associations, Senior Nurses and AHPs
- Through each of our Directorates in the Acute Division, and all six of our Community Health (and Care) Partnerships
- Discussions with GPs through locality groups
- A session with all Patient Reference Groups
- A dedicated session for third sector organisations
- Discussions with West of Scotland Regional Boards and other partner organisations.
- Discussion at joint planning groups with Local Authorities
- Information in StaffNews and through papers available on the intranet
- Discussion with the Area Partnership Forum and Staff Partnership Forums across GGC
- Regular updates to the Area Clinical Forum and advisory committees

The general feedback was very supportive of the direction of travel set out in the service models paper and welcomed the approach being taken to involve the whole system.

The approach described in the service models paper was considered an appropriate response to the issues raised in the Case for Change. Issues raised in the feedback included:

- Interface services require to be further defined: there was some concern about what it might mean for specific services and seeking details about how it will be taken forward
- The need for more emphasis on the role and implications for primary care.
- The need for explicit mention of health and social care integration, and effective working with social care.
- Request for inclusion of some patient stories to illustrate the proposed changes more clearly.
- Lots of examples of good practice, where services are already moving towards the sorts of models set out in the paper.
- Strong support for the emphasis on assessment and senior decision makers.
- Strong support for the focus on multi-morbidity.
- The need to make sure that the service models recognise the different needs and approaches required for frail elderly patients, and younger patients with multiple chronic diseases.
- Respondents were keen to see the approach tried out before it is fully implemented, particularly to test out the affordability of the model.
- An appreciation of the level of engagement so far, and a request for reassurance that all parties will be involved in working through the details to understand the implications and the detailed models.
- An emphasis on the need for increased engagement and involvement of social care going forward, particularly to consider the interrelationship with the integrated health and social care agenda.
- Patients were keen to stay involved with and informed about the process.

The comments received were incorporated into the final version of the Service Models paper which forms the basis of this clinical strategy. The detail of the outputs of the service models work is set out later in this paper but it is particular important to highlight a number of key consistent themes.

<u>Equalities</u>

- In addition to this, future service models will have to support NHSGGC to comply with its duties under the Equality Act 2010 to remove discrimination, close the health gap as a consequence of poverty and social class, and address the needs of marginalised groups.

<u>Overarching principles</u>

- Focus on what care the patient needs
  - care provided based on need and individual circumstance
  - care delivered in the best way
- Focus on improving clinical outcomes and delivering a good patient and carer experience.
- Locally accessible on an outpatient / ambulatory care basis where possible
- In-patient care only where necessary.
- Low volume and high complexity care provided in defined units equipped to meet specialist care needs.
- Consistently meeting core standards of care: patients should be able to access the same standard of care wherever they are in Greater Glasgow and Clyde.
- Continually evolving to ensure the most appropriate treatment / intervention is offered.

- Care should be focused on reducing inequalities by ensuring access for the most disadvantaged.
- Services should be provided in a non-discriminatory manner.
- Supporting patients to have the best health possible.
- Research should be strongly supported and fostered.
- Services should be sustainable, both clinically and financially.

Issues for patients

- Concern about lack of joined up care, particularly for those with multiple conditions receiving support from different teams across primary care, community services and hospital outpatients and / or inpatients.
- Lack of communication between teams and with patients.
- A desire to be able to manage conditions better themselves, with appropriate support.
- The need for patients and carers to be valued as partners in care.
- The importance of access to services, in terms of both time and physical location.
- A broad range of issues impacting on people's health and ability to benefit from services, including the impact of the recession and welfare reform.
- The challenge of ensuring that changes to services add up to real benefits for
- individual patients.

The following comments reflect a view of what success would look like from a patient perspective:

"I know who the main person in charge of my care is. I have one first point of contact. They understand both me and my condition."

"The professionals involved with me talk to each other. I can see that they work as a team."

"There are no big gaps between seeing the doctor, going for tests and getting the results."

"I am as involved in decision making as I wish to be."

"I understand my condition and am supported to manage my care."

"Having someone identified to help coordinate my care is important."

"Understanding who can help and support me, not just with my clinical care, is important."

"Receiving care in a specialist unit is fine as long as I can access local services for follow up and advice."

7. FRAIL ELDERLY AND CHRONIC DISEASE

Core Elements of Service Models

There is significant overlap in the models emerging for frail elderly patients, and for those with chronic diseases. However, there are also areas where a dedicated focus on frailty, distinct from single or multiple long term conditions, is essential. And there is a clear group of younger patients, particularly in deprived areas, who experience multiple long term conditions long before they would be defined as 'older'. The common approaches and specific requirements are set out below, followed by the areas where separate emphasis or approach is required.

The evidence suggests that getting the basics right – integrated, multifaceted and coordinated primary, secondary and social care are much more important than any single tool approach.

The following interventions are supported by consistent evidence (http://library.nhsgg.org.uk) and should be linked into a coherent whole as part of a future strategic approach to change in NHSGGC:

- Shared, high-quality protocols across care settings
- Collaborative relationships between specialists and generalists
- Planned systems of collaborative care involving case management, systematic follow-up
- Improved integration of primary and secondary care
- High quality primary care
- Effective coordination of care and use of IT to support communication
- Effective self management/supported self care
- Multi-professional teams
- Explicit care planning
- information sharing with patients and among care providers
- Reliable methodology and application of risk stratification
- Ensuring that all health professionals ask about diet, smoking and physical activity in their consultations with patients
- Ensuring that all health professionals can direct people towards appropriate computerised decision support tools to ensure coherent protocols available and used by clinical staff
- Use of a range of professional specialists nurses (e.g. Specialist nursing has demonstrable benefits for asthma, COPD and heart failure and may be replicable for analogous long term conditions).

The core elements of the service model to deliver this include:

- **Anticipatory care planning** enables patients and professionals to plan for a change in health or social status, particularly for those at high risk of crisis.

  Plans need to be developed by multi-disciplinary teams including primary care, community services and hospital specialists.

  Successful implementation of plans require the ability to mobilise a wide range of support in community, including home care, aids and adaptations, housing, befriending and carer support in a timely manner, based on a 7 day model that can also support care in the evening and overnight.

- **High Quality Primary Care** Age and chronic diseases represent a significant proportion of patient contacts in primary care, and the majority of care is managed in a primary care setting. General practice and the services it connects to are critical to a focus on prevention, management of risk factors and continuity of care for those with long term conditions.

- **Front door assessment model** will require early comprehensive assessment with senior decision makers at the front door, identifying specialist input and appropriate management plans guiding treatment and care packages in all settings, to support chronic disease management and / or frailty.

- **Non-acute beds may have a place as alternative to admission or to enable step down care** – this model requires a smaller 'acute' element of care with more non-acute and community infrastructure.

- The non acute beds would need to have rigorous standards for patient throughput and clear outcomes. Further work is required to define this approach.

- **Managing multi-morbidity** -better integration of services across specialties within hospital, between hospital and the community, and between health and social services are crucial to the management of multi morbidity.

- **Inpatient Care focused on acute episode of care, with planning for rehabilitation and return home** – ensuring rehabilitation is available dependent on need not age, focused on ensuring return home at the earliest opportunity by supporting rehab care in the community.

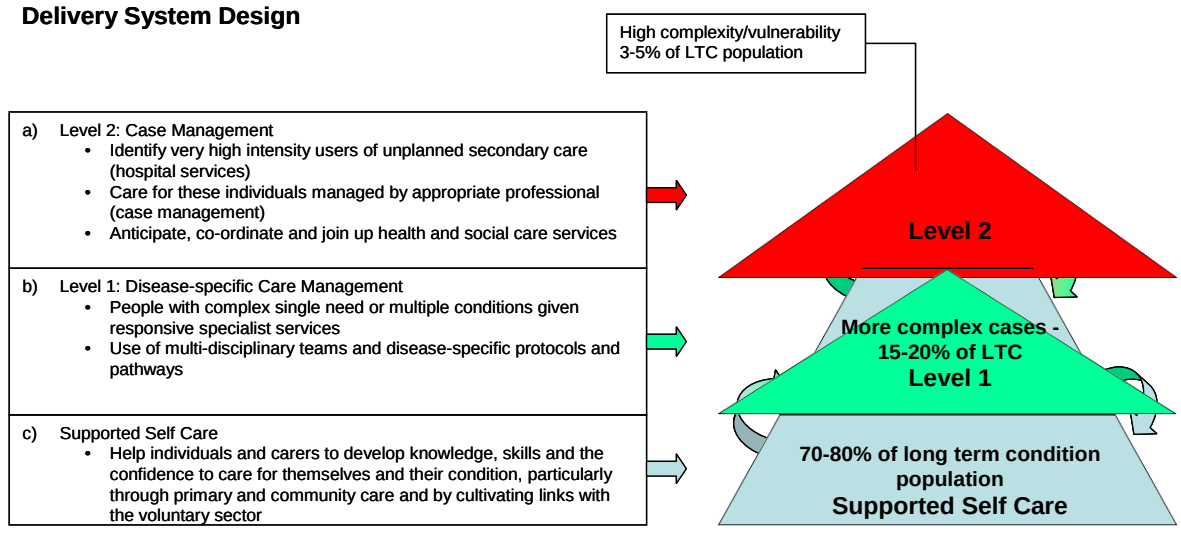
These are considered in more detail below in relation to both Chronic Disease and Frail Elderly pathways.

7.1 Chronic Disease

Overall approach

The proposed approach is based on risk stratifying the population by complexity and vulnerability, and providing care accordingly:

Figure 5



The key building blocks to support these models are listed below. A number of these are already in place, however the challenge is to ensure that they are consistently in place across the system, based on a 24/7 model, addressing the timing and volume issues currently facing many of these services.

Tailored Care - Care assistant - Physiotherapist/ OT - District Nurse - Community Pharmacy - Advanced Nurse Practitioner (generic) - Specialty Liaison Nurse - GP - Hospital Physician - Clinical Psychologist	**Advice** - Expert patient - GP - Nurse Specialist - Hospital Specialist - Acute Physician - Specialty Physician
	Access to Hospital facilities and outpatients
	Intermediate care
	Out of hours advice and assessment - Nurse provided - Expert Patient - 'Buddy system
Communication: Portal; e referral / direct referral	

These services need to work together effectively to provide both routine care, and to escalate support in response to a crisis or significant change in condition. These pathways are shown below at figures 6 and 7.

Fig 6: Chronic Disease Routine Care

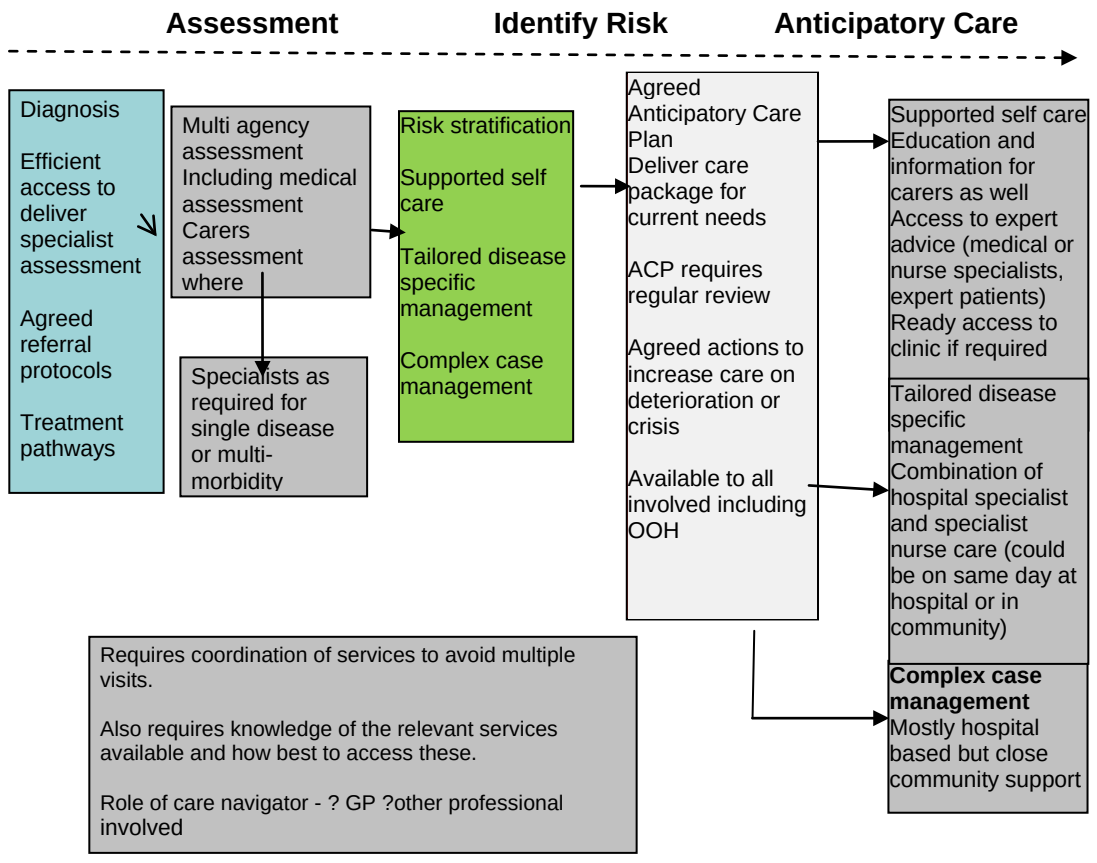
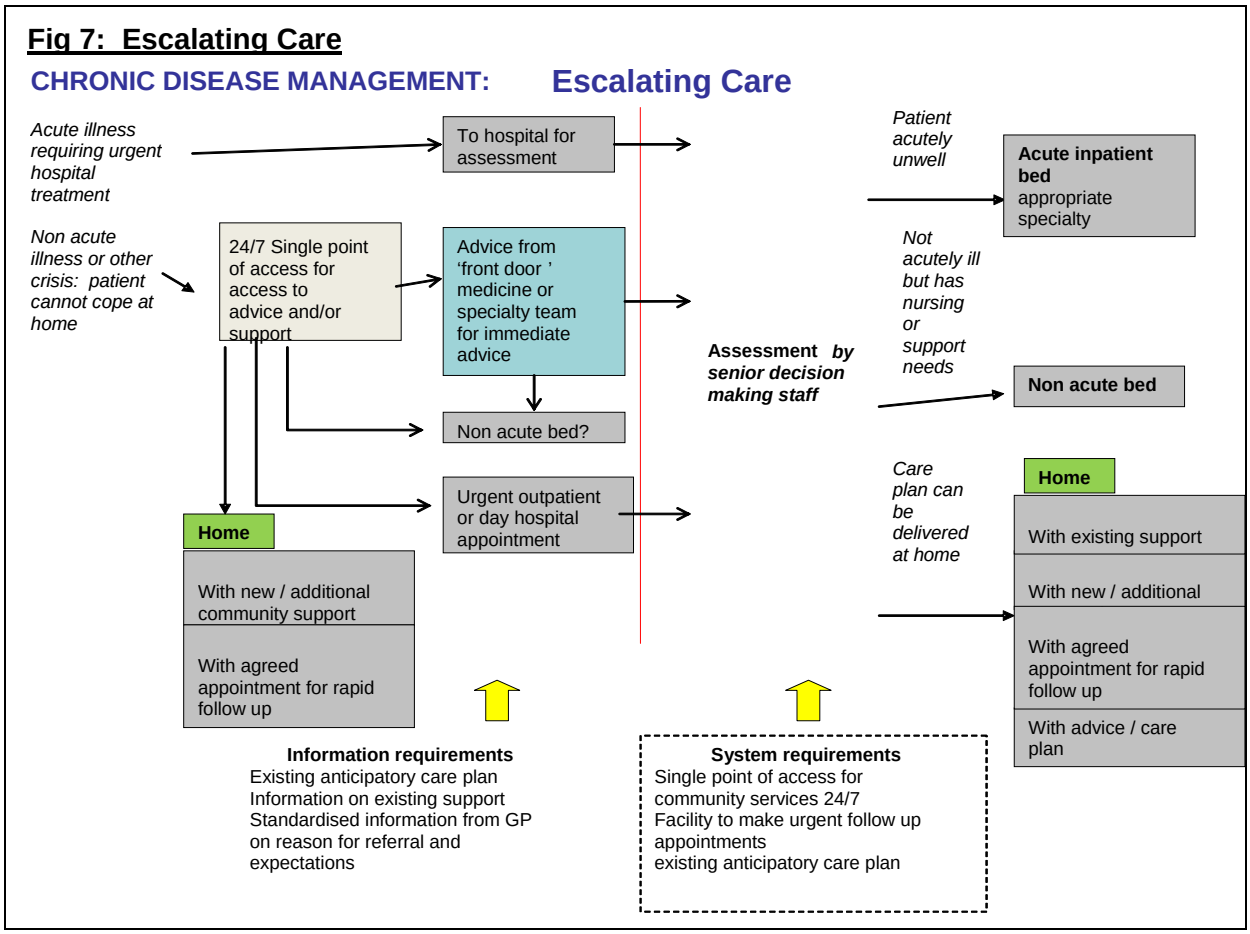


Fig 7: Escalating Care



Anticipatory care

A clear and responsive anticipatory care plan, which follows the patient and informs care in all settings, is a core part of this approach. While anticipatory care planning has been in development in NHSGGC in recent years, it is not yet a systematic multi-disciplinary approach focusing on those who would most benefit.

The agreed definition of anticipatory care in NHSGGC is "An integrated programme of defined preventive interventions delivered to individuals, operating across the continuum of primary, secondary and tertiary prevention. Its overall aim is to shift focus of service provision from reactive to preventive care, by adopting a whole population perspective across all aspects of service planning and delivery".

Anticipatory care planning is, by definition, planning of the above. It can be considered at an individual or population level. In both cases, it involves planning appropriate interventions that are i) evidence based; ii) connected to other interventions and services; and iii) applied across the entire continuum of disease, not just the latest stages.

Anticipatory care planning should be undertaken as early as possible – needs to start with diagnosis. Effective interventions relevant to that patient's needs should be delivered across the anticipatory care continuum, from primary prevention to end of life care. At each point along the continuum of primary, secondary and tertiary prevention, the objective is to control the underlying condition and prevent or delay progression of disease. Each stage of intervention in this process has a preventive component, a clinical management component and a self care component.

Health related behaviours, life circumstances and psychosocial factors all play an equally important role at each stage, not solely in primary prevention.

> There are some good existing examples within NHSGGC of effective anticipatory care planning, including:
>
> The Heart Failure Liaison Nurse Service cares for a well defined population of patients with chronic heart failure. These are referred from hospital and risk stratified to community or clinic care by the HFLNS. The HFL nurse will communicate with both the GP and the cardiologist about aspects of the care.
>
> We would seek to roll out models such as this across NHSGGC.

Multi morbidity

Developing better approaches to multi-morbidity has been a key theme of this Clinical Services Review. Within the pathways described above, the following elements will need to be developed further to establish a better approach to multi-morbidity:

- Continuing the work on QOF and Enhanced Services within primary care to bring together the management of different chronic diseases into a combined approach focusing on individual patient needs.

- Developing a better 'combined approach' to providing specialist input where patients are currently attending multiple outpatient clinics. This would focus on co-ordinating investigations, treatment and management so that any specialist input is managed in the context of the whole person and their environment not just narrow disease specific guidelines. This could be done through:

    - Shared clinics where there are common co-morbidities
    - Access to additional specialist input at chronic disease clinics (for example, specialist nurse input)
    - Improved access for GPs to specialist advice and opinion.

- Development of care navigator or case management roles to co-ordinate care and minimise visits and duplication, as well as improving co-ordination in some cases, this could be the GP, district nurse or specialist nurse as long as some form of designation occurs. There may be a need for another individual or care navigator in complicated cases. As with anticipatory care planning case management has been in development in NHSGGC in recent years, but is not as yet systematically in place focusing on those who would most benefit.

- Improving the identification and management of co-morbidities in emergency and inpatient settings. Co-morbidities are often a major reason for prolonged stays in hospital. Early generalist assessment to establish a comprehensive treatment and care plan for an individual will support better management of co-morbidities. Where a patient's care is transferred to a specific single condition specialist, we need to find better ways to enable input from generalist and / or other specialist, including the patient's general practitioner.

- Polypharmacy is often associated with multi-morbidity and carries with it a number of risks to patients.

Medication reviews should be available on a regular basis to all patients experiencing polypharmacy, and should be triggered by any acute or emergency episode of care.

- We know that multi-morbidity occurs is strongly linked to deprivation, occurring 10-15 years earlier in areas of high deprivation and encompassing both physical and mental health. Approaches to multi-morbidity therefore need to take account of a range of wider complex and challenging life circumstances which may act as barriers to patients' participation in new service models. Approaches to multi morbidity also need to focus on the changes in practice and behaviour required to take account of this.
- Multi-morbidity is a particular feature of patient contact in primary care, and we need to ensure that there is both sufficient capacity and support for effective approaches to managing multi-morbidity in a primary care setting, learning from current research activity in this area.

Illustration: for a patient, moving to the new model of care described might look like this:
Patient story

58 year old woman with diabetes, hypertension, chronic kidney disease and rheumatoid arthritis, is overweight and smokes and is unable to work.

Now: Has frequent appointments at hospital diabetic clinic, GP chronic disease reviews, podiatrist, renal clinic, hypertension clinic, rheumatology clinic. Frequent DNA because forgets appointments, doesn't see the point or doesn't have the bus fare to get there. This results in several acute admissions per year.

Future: Risk stratification flags up patient as high risk due to multi-morbidity; case review highlights multiple teams involved in care – case manager identified to develop a co-ordinated care plan involving the GP and appropriate specialists. Routine outpatient review minimised and clear triggers in place for return. Targeted support put in place and advice on diet and weight loss, smoking and benefits maximisation.

7.2 Frail Elderly

Overview

The older people group focused on 'frailty' as distinct from older people with other single conditions or multiple chronic diseases, with no additional functional problems. This reflects the fact that older people are cared for across all services, that amongst older people there is wide variety in terms of health and function, and that treatment should be needs based and not age based.

The main premise of the group is that specialist geriatric input should be focused on the frail elderly or those with 'frailty syndromes'. Stroke pathways are described in section 7.

What is frailty?

Frailty can be defined as a syndrome of multi-system reduction in physical capacity as the result of which an older person's function may be severely compromised by minor environmental challenges giving rise to the condition of 'unstable disability'.

Older people tend to present to clinicians with non-specific presentations or frailty syndromes, in contrast to the classical presentations seen in younger people.

The reasons behind the non-specific presentations include the presence of multiple co-morbidities, disability and communication barriers. The ability to recognise and interpret non-specific syndromes is key, as they are markers of poor outcomes:

- ***Falls***
- ***Immobility***
- ***Delirium and dementia***
- ***Polypharmacy***
- ***Incontinence***
- ***End of life care***

These indicators should be the basis of simple assessment tools adapted to all settings – community, hospital 'front door' and inpatient.

The core pathways and components of care for frail elderly are set out in the diagrams below (figures 8-10):

Figure 8: Community support

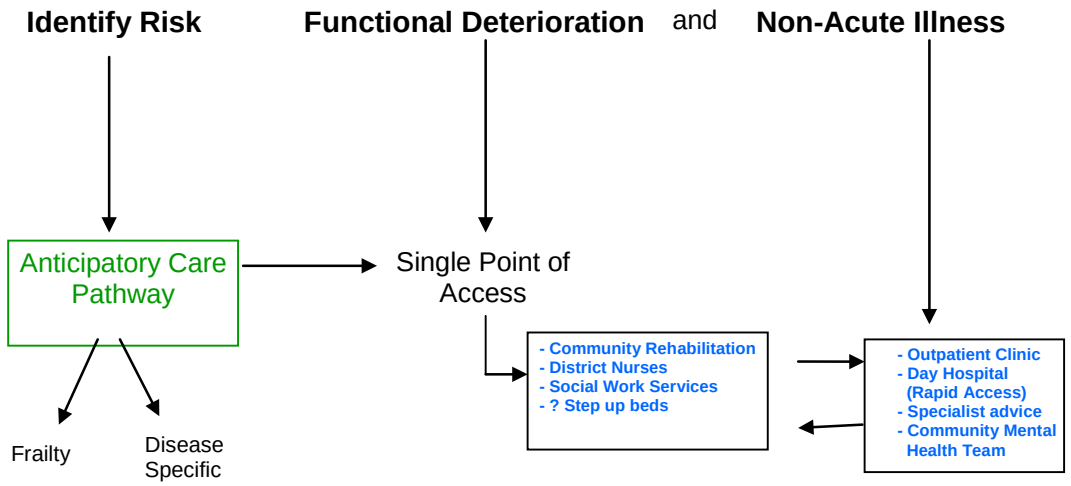


Illustration: For a patient, moving to the new model of care described might look like this:

Patient story

80 year old man with mild dementia and mobility problems, lives alone, has daily home care visits. Daughter lives 10 miles away, works full time and has small children but tries to visit several evenings a week.

Arrives one evening to find her father has an upset stomach and has been unable to get to the toilet quickly enough, and has fallen.

Now: Daughter unsure of where to get help, so phones NHS24. GP arrives, suggests admission to hospital. Patient admitted, investigated and treated for stomach bug. Confusion increases in strange environment, and mobility decreases as he stays in bed until his stomach is better. Stays in hospital for several weeks and now doubt about return home.

Future: Patient has been identified at risk due to mobility issues, dementia and living alone and has anticipatory care plan, informed by Comprehensive Geriatric Assessment, which sets out steps to take if he is ill or needs additional support.

Daughter is able to see on the plan who to contact. Crisis team responds quickly, assesses father and helps to clean up and get him to bed. Arrangements made for GP to visit in the morning. Additional support put in place for a few days to ensure he is drinking enough and to support mobility until he is better. Care needs are reassessed and patient is given an alarm and increased support, with planned ongoing review.

Figure 9: Front door/hospital pathway

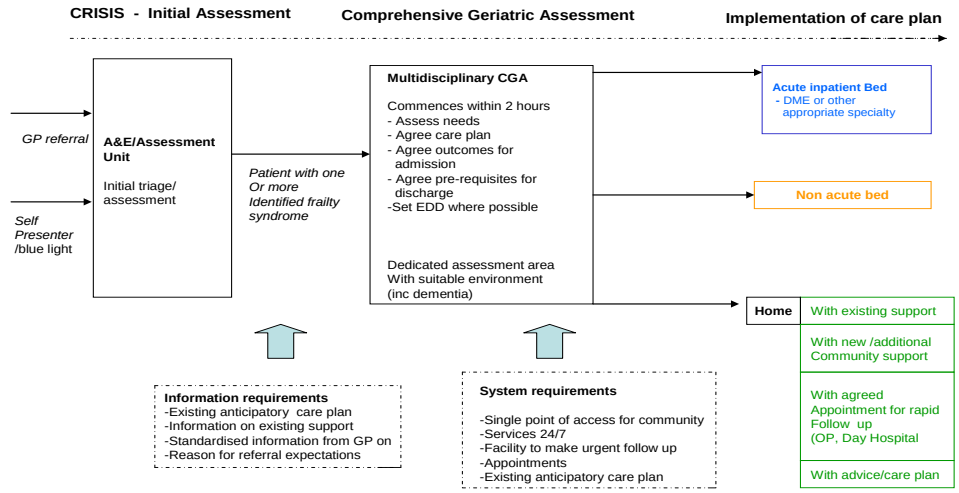
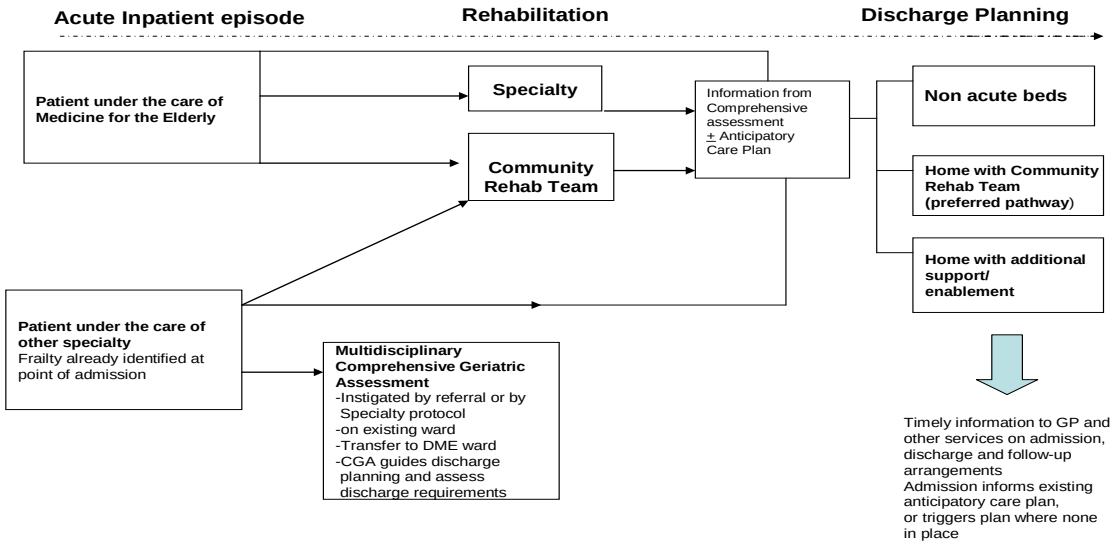


Figure 10: Inpatient Pathway (Frailty)



Anticipatory care

Anticipatory care plans must include frailty as well as chronic disease management. This includes consideration of social care needs, carer support, isolation, function and ability to manage the activities of daily living, supported by the multi agency single shared assessment process. It should explicitly include consideration of options for when carers are unwell or unable to provide support for any reason. The plans must enable rapid escalation of support from health, social care and third sector agencies supported by a 24/7 single point of access.

Comprehensive Geriatric Assessment (CGA)

CGA is strongly evidence based and drives the model for frail elderly. The pathways set out above enable CGA to be carried out in a community setting with specialist input through geriatric outpatients and day hospital services, and in acute settings with the presence of senior geriatric specialists at the front door.

Figure 11: The evidence base for comprehensive geriatric assessment

There is robust evidence to support multidimensional assessment and multi-agency management of older people leading to better outcomes, including reduced readmissions, reduced long term care, greater satisfaction and lower costs.

Comprehensive Geriatric Assessment (CGA) is defined as 'a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up'.

While integrating standard medical diagnostic evaluation, CGA emphasises a quality of life and functional status, prognosis, and outcome that entails a workup of more depth and breadth. The hallmarks of CGA are the employment of interdisciplinary teams and the use of standardised instruments to evaluate function, impairment, and social support.

Comprehensive Geriatric Assessment should be available to patients with one or more identified frailty syndrome within 2 hours of A&E attendance (14 hours overnight) and should drive the treatment and care plan both within hospital and in the community. CGA needs to be available within the community, at the hospital front door and in inpatient settings. It is a key requirement that information which may inform CGA, and the outcome of the assessment, is passed through the system consistently and is easily accessible and useable in a fast paced environment.

Delivering CGA in an emergency environment is challenging, and will require access to a separate quieter area (such as a medical assessment unit) with an appropriate environment.

Patients who have been admitted as inpatients (either emergency or elective) to any specialty, may subsequently exhibit frailty syndromes and require access to Comprehensive Geriatric Assessment. This should be available in all settings and specialties, as an assessment which drives a care or discharge plan, or to consider the appropriateness of transfer to specialist Geriatrics.

Figure 12: Falls

Falls are a common trigger of an emergency episode, and a key indicator of frailty. Falls must be a core part of broader approaches to risk assessment and care planning. This approach should include the following components, with timescales in line with the National Falls Bundles:

- Primary prevention based on falls assessment as part of general frailty assessment and anticipatory care planning, including self assessment
- Secondary prevention based on rapid notification of falls in both community and inpatient settings, leading to:
  - Falls assessment as part of more comprehensive frailty assessment
  - Individualised plan agreed with patient and actioned within 6 weeks. The plan should cover a range of interventions to prevent future falls taking account of related clinical needs, mobility issues, home and social environment and medication.
- Inpatient treatment where required (e.g. fracture) with access to Comprehensive Geriatric Assessment 7 days a week for Orthopaedic patients.
- Rehabilitation. Transfer to Geriatric Orthopaedic Rehabilitation Unit where appropriate. Multi-disciplinary discharge planning and discharge to community rehab teams for ongoing falls assessment and intervention.

Review and follow up. Review of plan within 6 months of commencement to update or close the plan

7.3 Dementia

Dementia is a syndrome caused by a number of illnesses in which there is a progressive functional decline in memory, reasoning, communication skills and the ability to carry out daily activities. It is increasingly present in patients presenting for a range of other health needs. Alongside this decline, individuals may also develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering. These cause problems in themselves, complicate care, and can occur at any stage of the illness. Dementia was reviewed jointly by the Older People and Mental Health groups and is considered further in section 8, but assessment and response to dementia and associated symptoms must be a core part of assessment throughout the older people's pathways described above, in all settings of care.

Implementation challenges for this model

- Defining the alternative models to admission such as advice service to support patients in the community non-acute beds to enable step down care considering the how this might impact to create a smaller 'acute' element of care with more non-acute and community infrastructure. This will require further definition of categories of 'non-acute' patients and support required including the risk of change and deterioration in patients, level of nursing care required and any ongoing diagnostic requirements.

- Front door model – general assessment with quick access to specialist care for treatment where required and the staffing model to support.

- Sizing the different groups and input required, for example likely numbers with frailty syndromes will drive front door geriatric staffing model.

- This will be based on assessment of known demographic changes, assumptions re potential for avoiding admissions, and an assessment of the current proportion of admissions with frailty syndromes.

- Work to assess further potential for home based rehabilitation / re-ablement.

- Particular consideration needs to be given to end of life care and supporting alternatives to acute hospital admission, particularly where patients wish to die at home or supported in a community setting (see figure 13).

Figure.13: End of Life Care

A key group where acute admission may not be desirable is for end of life care. The approach to palliative and end of life care should be based on:

- Palliative care needs being identified as soon as possible with more effective use of the **Gold Standards Framework** (GSF) in primary care, the use of the **Support and Palliative Care Indicators Tool** (SPICT) in in/outpatient settings and the use of the **Support and Palliative Action Register** (SPAR) in care home/continuing care settings. This would allow appropriate, timely engagement in the process of **Anticipatory Care Planning** (ACP).
- Ongoing holistic assessment being undertaken by professionals with good communications skills and a knowledge and understanding of the disease process, likely symptomatic issues and an appreciation of where these needs could be met, in order that the ACP process can be engaged with in a realistic way by the patient and family. This may be the GP, District Nurse, Consultant, disease specific specialist nurse, ward staff, care home staff or any of this combination in partnership.
- Effective communication of priorities of care. Conversations could be initiated using the My Thinking Ahead and Making Plans (MTA&MP) communication tool and further details placed on **Key Information Summary** (KIS) or the **electronic Palliative Care Summary** (ePCS) which can be accessed by unscheduled care areas, the Out of Hours Services and the Scottish Ambulance Service.

The preferred place of care is influenced by many factors. Options should include:

- **Care at home**, with the facility for patients to be assessed at any time in a 24hour period with rapid access rehabilitation teams, increased home care provision or equipment. The need for an appropriately skilled, well coordinated multi agency service in the community with effective communication systems is essential to this.

- Patients, who need less acute interventions sometimes simply observed care, may be suitable for rapid admission to **non acute bed**.

- There will be an ongoing need for Acute Admission for patients with symptom issues that cannot be managed at home.

There is also a need for a "wider team" (or "virtual team") assessment of patients on admission so that their palliative care needs are assessed promptly, their co-morbidities are taken into account and prioritised and a plan is made for that individual based on the above assessment. This could include referring patient immediately for Hospice admission or being able to get the patient home with enhanced community care.

- Rapid access to **hospice beds** for assessment, complex symptom control and end of life care may be appropriate for those with more complex care needs, not needing or wishing admission to an acute bed.

7.4 Mental Health

Introduction

The mental health clinical groups focused on the models of care required for:

- Adult Mental Health
- Dementia
- Drug and Alcohol Services

The overall approach which applies across these services is set out below, with condition specific examples given where appropriate.

Overview of the approach

The purpose of prevention, treatment and care activity in mental health is to deliver health outcomes, a positive user and carer experience from contact with services, and to contribute to user's progress towards recovery/living well with their illness.

Achievement of that purpose requires:

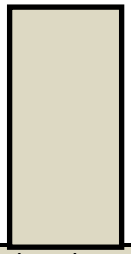
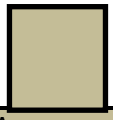
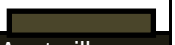
- A needs led structure of service delivery based on condition and frailty
- Interventions which are organised and delivered by condition
- Levels of intervention determined by the intensity and severity of the condition
- Interventions which are systematically delivered based on agreed condition specific care pathways consistent with evidence based/ best practice standards
- Users to be able to see their place on the care pathway
- Operational and team processes, practice, culture and pathways within and between teams which are organised and delivered to ensure:
  - Clinical interventions are systematically delivered based on the condition specific care pathways
  - Positive user experience in which carers and users are partners in care and feel well supported
  - Services are "easy in and easy out"
  - Interventions provide "everything you need and nothing more"
  - Patients with multiple morbidities receive coordinated rather than fragmented care
  - Care planning supports personal outcome based progress towards recovery/living well with the condition

Clinical framework for prevention, treatment and care

As with the approach described for physical chronic conditions, the overall approach is based on a stratified system of care, identifying need and responding at the most appropriate level of intensity.

The diagram (figure 17) below describes the overarching framework for mental health services. The Framework will be populated for each major clinical condition to set out the condition specific interventions and care pathway for that condition.

Figure 17

Numbers					
Need for help	Education and promotion of well being Targeted prevention for groups at risk	Anyone concerned about their own health or other peoples health	A prompt response for people who develop symptoms associated with a condition	Progress towards recovery whilst living with ongoing mental health problems	Acute illness
Type of Intervention	Information, screening, self-help	Education, self-help, peer support, group classes	"Low intensity" work: brief interventions, psychological therapies, guided self-help	Longer-term psychological therapies; community rehabilitation;	Risk management, physical health care
Access	Everyone	Open, self-referral	Self-referral and GP referral	GP or secondary care referral	GP or secondary care referral
Care level	Public	Open access /supported self care	ERBI: early response, brief intervention	Ongoing care and support	Intensive treatment

Personal outcomes for service users and carers

In their contact with services Service Users can expect:

- To define recovery goals together with the service
- Services support progress towards recovery /living well with their condition

People with mental health problems should be able to say that they have a positive experience of their contact with services and through this contact:

- I get the treatment and support I need when I need it

- Accessing services is straightforward
- I was diagnosed early
- I & those around me and looking after me feel well supported
- I am actively involved in decisions about my care
- I am treated with dignity and respect
- My care plan focuses on my recovery as I have defined it
- I have meaningful occupational interests and social involvement

Changes required to deliver the model

Moving towards this model will require the following changes:

1. Cease age based exclusions from access to service supports such as psychological interventions/crisis services and liaison psychiatry.

2. Shift from age based service configuration of adult and older people mental health services to needs based configuration of:

    - Mental Health 18+ (no upper age cut off, needs led transition based on physical frailty).
    - Dementia and Functional mental health combined with physical frailty service.

3. Consideration of service models for people with dementia given apparent commonality of health needs of people in acute wards and Older People Mental Health acute wards.

4. Address service gaps within the dementia care pathway:

    - Memory assessment service for early diagnosis of 2300 new patients per year in community setting.
    - Post diagnostic support services.

5. Review the functionality of services and teams to ensure their detailed operational processes are aligned to deliver the principles set out in sections 3, 4 & 5 above & in particular:

    - Systematic interventions of agreed condition specific care pathways.
    - Health outcomes.
    - Positive user and carer experience.
    - Recovery/living well with your condition.
    - “Easy in easy out”.
    - Coordinated management of multiple morbidities.

Implementation challenges for this model

Mental Health 18+

- Components of comprehensive service system are in place and no major service gaps per se
- Modest incremental further acute bed closures/balance of care shifts.
- Need to scope & size operational implications of shift to 18+ service for inpatient and community services.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

Dementia services

Resolve service model and relationships between mainstream acute and specialist dementia services to determine:

- Configuration of dementia services as integrated mainstream acute service or specialist dementia service.
- Size the dementia cohort and the challenging behaviour cohort to model workload implications of the configuration options for both acute and community services.
- Rework the bed model and site alignments between acute and MH sites to reflect the eventual agreed model and configuration of dementia services.
- Develop detailed service model and configuration of community based memory assessment services & post diagnostic support services.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

Drug and alcohol services

- Improve management of co morbidity between addictions and MH.
- Improve alignment between day services and community services.
- Improve access and support to substitute prescribing.
- Improve alignment of operational processes and recovery outcomes for service users.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

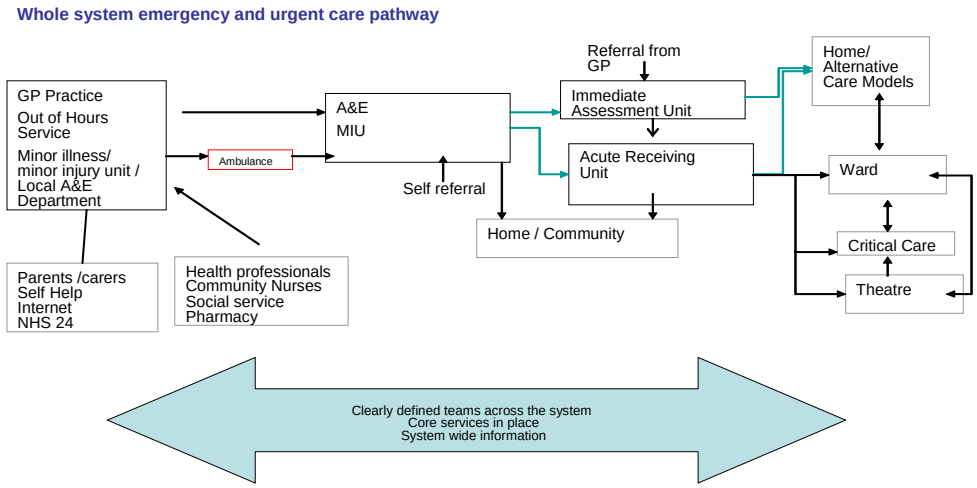
8. EMERGENCY CARE AND TRAUMA

Overview

Emergency services have to be able to respond appropriately to all patients who present. This section describes the proposed overall model for emergency services to meet standards and requirements for all patients and the changes to emergency services required to respond to the chronic disease and frailty pathways set out above (which form the majority of emergency admissions).

The overall pathway is summarised in the following diagram

Figure 14: Whole system emergency and urgent care pathway



Accessing emergency care

The key routes in to emergency care are set out below.

In-hours patients may:

- Call GP for an emergency appointment
- Call NHS 24 for advice and onward referral as appropriate
- Call other community service for an emergency appointment (e.g. Dental, Ophthalmology; Mental Health)
- Go to their pharmacy
- Call the Scottish Ambulance Service – who may treat on site, take to the Emergency Department or refer to another service (e.g. GP)
- Go directly to the Emergency Department/Minor Injury Units

Out of Hours patient may:

- Call NHS24 for advice with onward referral as appropriate and may be offered either GP OOH telephone advice, GP Out of Hours appointment; Minor Injury Unit or Emergency Department.
- Patients may choose to go directly to Minor Injury Unit, Emergency Department or walk-in to the GP Out of Hours service.
- Call the Scottish Ambulance Service – who may treat on site, take to the Emergency Department or refer to another service (e.g. GP).
- Call the Out of Hours District Nursing Service or other Community Services.

Response to emergency assessment in all settings

When a patient is assessed in an emergency at any of the entry points above, a more flexible range of responses is required. A number of studies support the position that a much greater proportion of work could be undertaken as an outpatient or in an ambulatory setting including many acute medical emergencies.

This requires our services to develop a more “planned” urgent clinic approach to manage medical emergencies. Some examples are set out below:

Figure 15

Respiratory	Cardiology	Gastroenterology
- Community acquired pneumonia with a low CURB-65 score - Small pneumothorax - Asthma following British Thoracic Society guidance - Chronic obstructive pulmonary disease with supported home care - Asymptomatic pleural effusion	- Cardiac failure - Atrial fibrillation	- Upper gastro intestinal bleed with Rockall score of 0 - Lower gastro intestinal bleed with no haemodynamic compromise - Painless obstructive jaundice - Non-acute abdominal pain - Diarrhoea and vomiting
Endocrinology	**Infectious Diseases**	**General Medicine**
- Hyperglycaemia without ketosis - Hypoglycaemia with full recovery - Type 1 diabetes without ketosis - Electrolyte imbalances	- Cellulitis - Osteomyelitis	- DVT - Pulmonary embolism - Anaemia with no haemodynamic compromise - Syncope with low cardiac risk - Urinary tract infection

Based on the above position a number of services to support ambulatory emergency care are identified. These could be services that sit as part of the interface service model.

- Chronic obstructive pulmonary disease outreach
- Pleural disease clinics
- Rapid access chest pain clinics
- Transient ischaemic attack /stroke clinics
- Epilepsy clinic
- Pain management service
- Functional assessment teams and support teams
- Falls clinic
- Nurse specialists - diabetes, cancer, palliative care etc.
- Outpatient parenteral antibiotic teams
- Endoscopy services
- Heart failure team

A pre-requisite to changing how urgent and emergency care is provided is to ensure that there is quick and reliable access to GP appointments. This will allow patients to connect into the relevant services through their GP thus supporting patients accessing care in the right place at the earliest appropriate opportunity.

For most patients, the GP practice will be the first port of call for help or advice. Moving forward, we need to ensure that we have the right capacity in primary care to provide timely access to appointments for those who need to see a GP, and to build on the work of the access toolkit and productive general practice to provide a range of options for patients, including telephone advice where appropriate.

This includes supporting GPs to free up appointments by understanding and addressing the growing demand on primary care from multiple sources.

In addition to the disease specific approaches set out above, additional support to manage patients appropriately in the community could be provided through:

- Urgent access to specialist advice, for GPs to be able to discuss patients in an emergency situation.
- Urgent access to outpatient clinics (e.g. within 24 hours), directly bookable, where an immediate admission is not required.
- Single point of access to health and social care community services to provide immediate support at home where required.
- Access to step up beds where a patient requires additional support which cannot be provided at home, but does not require an acute admission.

It is also important that all services where people present as emergencies, work to the same common protocols with access to a consistent range of support services across GGC to ensure there is equity of access to care and that care is not escalated beyond the lowest level required.

To support this it will be important that all parts of the system can access the information about the patient, their ongoing care, e.g. their anticipatory care plan where applicable, to ensure the right intervention can occur.

Hospital Assessment and Admission

Once at hospital it is important to have clear patient pathways through each of the services. The major components of hospital emergency services are described below:

- Minor Injury Service
- Emergency Department
- Immediate Assessment Unit
- Acute Receiving Unit

Minor Injury Service

Nurse led Minor Injury Service led by Emergency Nurse Practitioners (ENPs) to provide treatment for a wide range of conditions including:

- Fractures of nose, shoulder, upper arm, elbow, forearm, wrist, hand (inc. fingers), knee, lower leg, ankle, foot and toes.
- Soft tissue injury including strains and sprains.
- Dislocations.
- Wounds.
- Burns.
- Minor head and neck injuries.
- Eye injuries and conditions.

This may be provided as part of a standalone Minor Injury Unit, or as an integral part of the Emergency Department, where the ENPs will work with medical staff as part of the wider emergency team.

Emergency Department

The Emergency Department provides care to patients with:

- Acute injury or illness associated with physiological derangement or threats to life or limb.
- Acute undiagnosed illness or injury that requires time critical intervention to prevent long term impairment, disability or death.
- Acute illness or injury resulting in acute severe pain until once made comfortable, they can have appropriate investigations or additional treatment before being directed to definitive care.

The Emergency Department does not provide services for:

- Minor non-urgent illnesses that can be better managed in a non time critical manner by other community or primary care services both in and out of hours.
- Non acute exacerbations of chronic conditions that are under the management of specialist inpatient or outpatient services.
- Non acute complications, enquiries or requests for advice following elective surgical procedures (including urology, orthopaedics, ENT, maxillofacial surgery, obstetrics and gynaecology etc).

The key role of the Emergency Department is to assess and treat quickly, and ensure that patients receive care in the most appropriate setting. Destinations from the Emergency Department will include home, home with community support which can be arranged directly from the Emergency Department, move to the Immediate Assessment Unit for a further assessment period, or admission to the Acute Receiving Unit.

Immediate Assessment Unit

GP referred patients will go directly to the Immediate Assessment Unit (IAU). The purpose of the unit is to provide rapid assessment of patients by senior decision makers.

The focus of the IAU will be to pursue appropriate alternatives to admission including: urgent out patient clinic appointments, rapid access to diagnostics, access to Comprehensive Geriatric Assessment by specialist multi disciplinary teams, initiating specialist care and opinion by the relevant specialty team and prioritising the timely admission of acute patients into the Acute Receiving Unit. Specific pathways will support patient management through this unit. Inter hospital transfers should not pass through Immediate Assessment Unit but should go directly to a specialty bed by agreement with the relevant specialty senior decision maker.

Care will be provided on a 24/7/365 basis. It is envisaged that the consultant input within the IAU for medicine will be predominantly from acute care physicians and the geriatric specialist team and will be supported by junior medical trainees and medical nurse practitioners.

The surgical model of care sees general surgery GP referrals, undiagnosed urology and undiagnosed vascular patients directed into the IAU.

The surgical receiving team under the control of the senior decision maker will provide opinion and admission or diagnostic decision making to the IAU 24 hours a day every day.

Orthopaedic, ENT and diagnosed vascular and urology patients should be directed from the Emergency Department for the relevant surgical specialist team to take the decision to discharge or admit to downstream wards or treatment facilities as appropriate.

It is proposed that all necessary imaging and diagnostic work is commenced in the IAU this should be available 24 hours a day 365 days a year; recognizing that these patients have the same diagnostic and imaging requirements as those within the ED.

Acute Receiving Unit

The Acute Receiving Unit (ARU) provides the initial period of acute management for patients assessed in the Emergency Department or Immediate Assessment Unit as requiring admission.

The ARU will enable senior decision makers to manage the patient's assessment with fast access to diagnostic tests and the ability to discharge home or for suitable patients for return to the emergency department outpatient department. The ability to care for patients in the ARU for periods over 24 hours will allow complex diagnostic investigations to be completed without the need to admit to a downstream ward. The aim is for all imaging of patients within the ARU to be completed whilst the patient is in ARU.

8.1 Principles and standards

For patients requiring attendance and or admission to hospital for emergency care the following principles and standards are proposed:

Principles

- Patients are managed in an area designated for their acuity of illness by a 'generalist' (this includes Emergency Department or Acute Care Physician, Care of the Elderly Physician, Intensive Care Medicine Physician or General Physician) with early input from a specialist where required to ensure the most effective treatment plans are put in place as quickly as possible.
- Consistent standards of care are in place across the systems which maximise patient outcomes.
- Prompt commencement of time critical treatment.
- Prompt access to appropriate imaging (CT, U/S, plain radiography) to allow immediate diagnosis of life threatening conditions.
- Availability of appropriate critical care expertise and skills across the system.
- Early informed decision making regarding patient disposition.
- An extended presence of senior clinicians providing expert direct patient care, leadership and supervision.
- Timely, planned discharge to an appropriate setting and with appropriate support.

Process standards

- Emergency admissions should be seen promptly by someone who is appropriately trained to make an assessment of their care needs, and with prompt consultant input where required. The different needs of medical and surgical patients should be managed appropriately.
- The Assessment Unit approach is a core component of emergency care, providing protocolised periods of investigation, observation, and review for patients who would otherwise be admitted to scarce and expensive hospital beds or discharged potentially unsafely.
- Ambulatory care- care should be instigated in the Emergency Department / Immediate Assessment Unit / Acute Receiving Unit and continued in the community where clinically appropriate.
- A comprehensive 24-hour interventional radiology service should be available.

- To maximise patient outcomes, where specialist care is required, it should be provided by senior clinicians undertaking high volumes of cases/ operations in line with national guidelines.
- Emergency day case surgery should be available where clinically appropriate.
- Patients should be provided with any necessary care, treatment and support in the most appropriate setting and environment, compatible with the delivery of safe and effective care, including the community where appropriate.

Disease/condition specific standards

- Frail elderly patients should have early access to comprehensive geriatric assessment to support effective management.
- Appropriate and timeous access to mental health services should be in place for people with mental health needs.
- Patients suffering major trauma injuries should be taken directly to a major trauma centre.
- Patients suffering from chest pain should have timeous access to angiography services.
- Patients suffering from a stroke should be taken directly to a specialist centre (see figure 16).
- Acute hospitals providing care for patients with GI bleeding should meet the national recommendations and provide 7 days a week access to out-of-hours endoscopy services; within 1-2 hours of admission for severe bleeding and within 12 hours for moderate bleeding. Appropriate assessment systems should be in place in all sites, with appropriate care pathways in place to treat patients or to transfer patients to the appropriate site for definitive treatment.
- National guidelines should be met where available; for example in the care of patients with myocardial infarction, head injury, bleeding in early pregnancy, suicide prevention and child protection.

Diagnostics

- Underpinning the new models will be a heavy focus on access to diagnostics to support the assessment of patients. This will require changes to how the services are currently organised to support early investigation to support decision making without the need to admit patients to organise tests.

Illustration: for a patient, moving to the new model of care described might look like this:

Now: Present to A&E and is admitted to hospital.

Future: assessed by a consultant, not acutely unwell requiring admission, sent home with an appointment for a diagnostic test the following day with an outpatient appointment. GP informed, community team informed where indicated. Patient has information on what to do if condition changes / warning signs to look for.

Figure 16: Example of future models: Stroke

- **Prevention:** Primary prevention and management of risk factors [Rapid assessment of high risk TIA patients within 1 day of referral. All GPs using rapid assessment service; cardiac and vascular services resourced to meet demand from stroke.

- **Hyper acute stroke service (HASS):** Scottish Ambulance Service take patients with FAST +ve suspected stroke directly to hospital with HASS beds; early specialist stroke team assessment; immediate imaging and investigations; treatment commenced (including thrombolysis where indicated); rehab commenced in HASS; 35% patients discharged home from HASS bed.

- **Integrated acute/rehab stroke unit:** transfer from HASS at average of 2.5 days post admission; 7 day stroke specialist Multi Disciplinary Team assessment and rehab (AHPs, nursing, medical); planning for discharge and support for carers; average length of stay in unit 21 days.

- **Early Supported Discharge within Community Stroke Team:** 6/7 day stroke specialist rehab; multiple visits per day to support early discharge from hospital; close links with re-ablement care services; time limited intervention with review/follow up.

- **Support in the Long Term:** local community and voluntary sector services with awareness of stroke; GP Enhanced Service for stroke.

Implementation challenges for this model

How we can consistently support a model of the 'generalist' as first line approach supported by specialist rotas allowing timely intervention. It will also consider the implications of this model across Glasgow and Clyde in terms of:

- Activity and patient flows
- The staffing model of generalist and specialists required to support the model
- Accommodation requirements to allow for the effective components of the models to manage patient flows as described.
- Assessment / Decision Unit approach and availability of urgent outpatient service across GGC.
- Contact system for GPs to discuss patients prior to referral to hospital.
- Develop a more detailed position on key areas identified for a change in specialist approach:
  - Stroke
  - Angiography / angioplasty
  - GI bleeding
  - Vascular
- Develop the major trauma centre in line with regional and national planning, considering the critical clinical adjacencies to support this.

9. PLANNED CARE

Key Components of the approach

Local provision of outpatient and ambulatory care facilities

It is proposed that wherever possible outpatients, investigations, day surgery and short stay surgery should be provided as locally as possible across NHSGGC. This would provide a full range of core clinical services locally to meet the majority of patient needs with patients travelling only where clinically required to other sites.

Outpatient model modernisation

Outpatient model of referral and attendance at outpatient clinic needs to be modernised to provide alternatives to clinic consultation. This should include telephone consultation, telephone advice services for GPs to manage patients without referral to hospital; direct to test approach where appropriate.

Return appointment models should be reviewed with the aim to reduce the return appointments where appropriate and to facilitate alternative follow-up arrangements where possible. This should include telephone follow up; discharge with patient driven return initiation. The recent cancer services group and the work on Quality Performance Indicators suggest that the follow up arrangements could be reduced. For chronic disease management, different approaches to ongoing management and follow-up are also being considered with both groups considering how community based follow –up and patient initiated follow up could be part of the future models.

Community based service provision

Care should be provided within the community wherever possible. This could include:

- Further development of local phlebotomy services and monitoring of patients in community.
- Nurse/AHP led clinical services in the community or in hospital where applicable. This would build on the currently available services such as the diabetes and respiratory services. Some of the areas currently proposed to be developed could include:
  - Lower urinary tract and incontinence service;
  - Raised PSA clinic – Nurse led triage clinic where TRUS biopsy is provided;
  - Chronic pain service.
- Specialist clinics in community settings, working with GPs and community teams to develop joint care plans for patients.

Consolidation of low volume/ high complexity care

The evidence suggests that there is a case for improving outcomes by providing complex investigations and treatments in only a few specialist centres. This applies in particular to cancer care, which is covered in the next section.

Maximisation of ambulatory care including day surgery and the development of short stay surgical models within Ambulatory Care Hospital type facilities

There is scope to improve the use of Greater Glasgow and Clyde's inpatient beds for planned care. This is in part by maximising day case surgery / day treatment but also by managing the time patients spend in hospital after elective care, which can be quite variable across sites.

This variation is caused by a number of factors, including availability and the quality of home and community support as well as the surgical techniques used.

Programmes such as the Enhanced Recovery after Surgery (ERAS) should be in place to ensure that patients spend no longer than they need in hospital. These programmes also encourage active participation of patients in the care plan and recovery process. This type of approach should be encouraged across surgery. Similarly, less invasive techniques should be used where clinically appropriate to improve the patient experience and the speed of recovery.

Reducing length of stay, where clinically appropriate, will be important to improve the patient experience and to bring financial benefit to allow investment in other parts of the service.

Planned 'urgent' care clinics

Through the work of the Emergency Care work stream there are a number of areas being identified to develop a more planned approach to care to avoid emergency admissions. This was detailed in the earlier part of this report and requires the service to consider different approaches.

New service models

New service models to better support the management of patients are being considered such as the digestive diseases service combining gastroenterology and upper and lower GI surgery to provide a single coordinated service for GGC.

Illustration: for a patient, moving to the new model of care described might look like this:

Patient Story
70 year old woman lives in Argyll and Bute, 4 hour travel time to services in Glasgow, main carer for husband. She attends outpatient clinic once a year for specialist follow up.

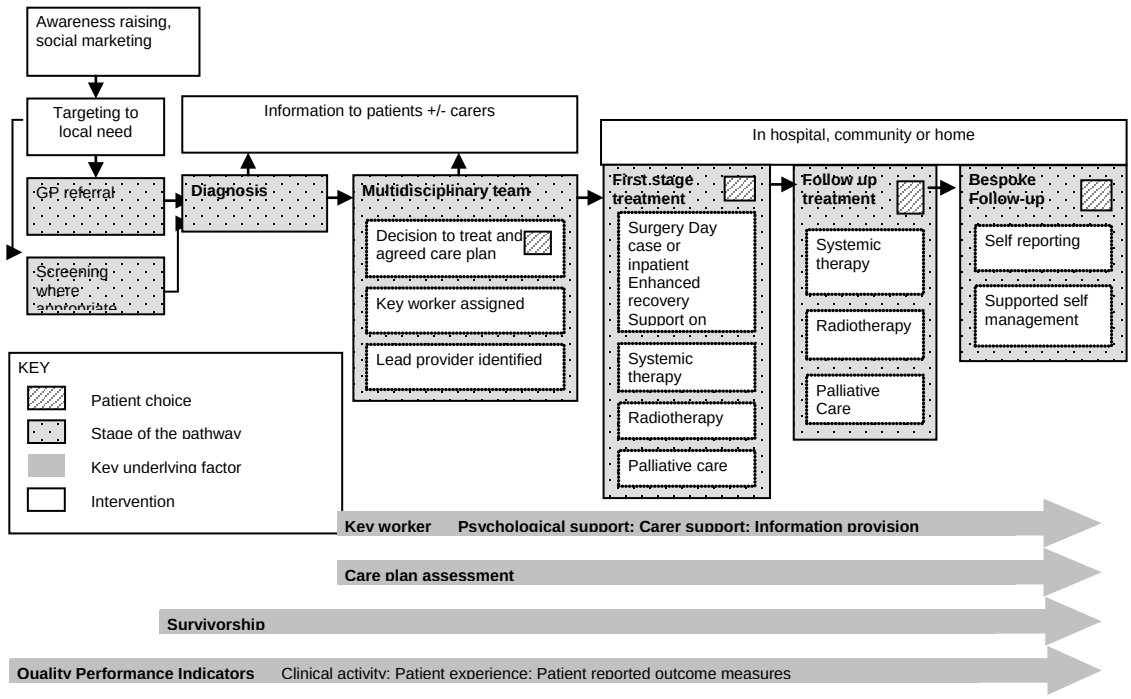
Now:
Sent an appointment for 9am, has to change to a time she can travel for
Makes arrangement for husband to be cared for
Travels all morning for rearranged early afternoon appointment
Has bloods taken and sees consultant for 5 minutes to be told everything is fine
Travels 4 hours home again – arriving late evening

Future:
Blood tests done locally, OP only arranged if indicated from results. Phone consultation or via telemedicine link for follow up where clinically appropriate.

10. CANCER

Key Components of Approach

Figure 18: Cancer Pathway



The key aspects of the care pathway identified to enhance survival and quality of life are shown on figure 18 above. In general the cancer pathways are considered to be well established and working well. Some areas were identified as areas where further consideration and development is required which are discussed below. Clinical evidence suggests that common cancer care such as systemic anti cancer therapy and patient follow-up should be provided as locally as possible and where possible outside the hospital setting. The evidence also makes the case for improving outcomes by providing complex investigations and treatments in only a few specialist centres.

Cancer surgery

The number of site(s) providing cancer surgery should be based on numbers of patients and outcomes achieved. The proposed model of care recommends some further consolidation of surgical services for both common and rarer cancers. This will ensure that clinical teams and environments are in place to provide high quality care and improved outcomes for patients across NHSGGC.

Impact for Common Cancer Surgery

- **Breast cancer surgery**

  Breast cancer surgery can be delivered as a day case, with surgeons using less invasive techniques so that patients do not have to stay in hospital unnecessarily. Guidelines suggest that 60-70% of breast surgery should be day case.

  To improve outcomes and experience, day case breast services should be available locally to all patients who require less complex surgery.

Patients undergoing more complex surgery should have the opportunity to discuss their breast reconstruction options and have immediate breast reconstruction if appropriate.

- **Colorectal surgery**

  The number of patients being seen and patient outcomes from cancer audit results should determine the number of sites. Where clinically appropriate this should be delivered locally. Complex colorectal surgery with plastic surgical involvement should be delivered in a specialist unit.

Impact for rarer cancers

Over recent years NHSGGC has consolidated services into single sites for some rarer cancers such as upper gastrointestinal cancer. For a number of cancers this has also resulted in supporting other boards within the region to provide a tertiary level service such as ovarian cancer. However there are still some areas where we are providing care on a number of sites for relatively small numbers of cases. Consolidating services into fewer hospitals would create and maintain complete clinical environments that can enable the delivery of best practice providing improvements and benefits for patients by focusing experience in limited areas within services.

There are a number of rarer cancers where volumes mean that the service can only be provided from a single site.

- **Rarer urological cancers**

  As with other small volume cancers urological cancers need to be provided from a specialist urology team. General urology services should be able to refer patients with complex needs to the specialist team. To ensure the best outcomes and experience, rarer urological services should have access to all of the requirements of a high quality service such as 24 hour access to interventional radiology, appropriate consultant cover and resident surgical juniors. NHSGGC needs to consider creating a centralised specialist team and unit to support the provision of complex urological cancer care. Currently there is ongoing work with other Boards within the region to realign small volume surgery into one service within NHSGGC.

Changes to Treatment

Systemic Anti-Cancer Therapy (SACT)

Guidelines recommend that to provide patient centred care the inpatient delivery of systemic anti-cancer therapy (SACT) should be minimised. Over recent year's local provision has developed in many areas linked to the central unit at the Beatson to provide more convenient treatment to patients where it is safe and clinically appropriate to do so. As therapies evolve with the development of oral preparations it will be important to develop the service to increase the care delivered locally and where possible and clinically appropriate out with the hospital setting.

Managing emergency care

For patients admitted as an emergency the guidelines indicate that arrangements should be in place to assess cancer patients immediately when they arrive at hospital to expedite care.

It is proposed to provide an acute oncology assessment unit (OAU) and 24 hour phone to provide a dedicated service for all adult oncology /haematology patients who are currently receiving /or have received treatment (chemotherapy /radiotherapy) in the past 6 weeks at the cancer centre, or are at risk from disease / treatment related immuno-suppression.

It will also support all patients attending the cancer centre who are identified to be at risk of developing malignant spinal cord compression (MSCC) as per the National Institute for Clinical Effectiveness (NICE) and the West of Scotland Cancer Network Guidelines.
It is expected that this will prevent unnecessary hospital admissions, and where hospital admission is required, ensure patients are seen /and or admitted to the right facility to support the care they require, improving patient outcomes and care.

Haematological cancers

The management of haematological (blood) cancers is increasingly dependent on the detection of particular genetic changes within the cancer cells. These require highly specialised molecular techniques and many new agents are being developed. These genetic changes are important for determining both prognosis and appropriateness of therapies, including the need for stem cell transplants. Molecular techniques can be used to monitor response to treatment.

Access to modern diagnostic techniques is critical to ensure appropriate use of therapies and to monitor effectiveness.

Follow up and Support

The follow-up of most cancer patients is done on a routine basis in hospital outpatient departments. Recent regional and national work through the Managed Clinical Networks (MCNs) indicates that there is a requirement to change the follow-up arrangements for many areas. This includes providing monitoring and follow–up within the community where possible including patient blood tests.

With changes to survivor rates it is recognised that the approach needs to be altered to offer more individualised aftercare services and more responsive to patient needs as some patients can become ill again between outpatient appointments and not feel able to see a specialist until their next scheduled visit. Changing the method of follow-up will improve outcomes and quality of life for patients and could free up specialists' time to continue to improve quality of care for all patients across GGC in other ways and could support a more person-centred interaction with the clinical team. To support this it will be important that patients are given the relevant information to make an informed choice on their preferred model of follow-up.

Supportive and palliative care

This is a key part of care, especially with the changes in survivor rates, and so needs to meet the needs of patients both living with cancer as well as to support advanced care planning for the end of life.

Across NHSGGC the Gold Standard Framework has been implemented as has the use of advanced care pathways. This has helped improve both palliative care and end of life care planning. See figure 13 on End of Life Care.

As future services are planned it is recognised that there is a need to ensure that holistic assessments are part of the patient pathway including assessment of psychological needs and the support requirements of carers with advanced care plans in place consistently across NHSGGC to support patient care.

Implementation challenges for this model

- Modelling of the capacity required to meet the future predicted increase in cancer patient numbers.
- Consolidation of complex / low volume surgery / care – impact on patient activity changes / clinical team and infrastructure changes required.
- Front door model to support emergency care of patients with cancer.
- Provision of increased chemotherapy in the community – estimating the impact of chemotherapy changes and the community / local service capacity requirements or changes.
- Service requirements in primary care to support monitoring and follow up including links with the 3rd Sector to support patients and carers.
- Requirements to support palliative care and end of life care out with hospital with effective advanced care planning – this is linked to other work in relation to long term condition management and management of the frail elderly to consider alternatives to hospital care.

11. CHILDREN SERVICES

The emerging models from the Children's Services group in some respects mirror the developments in other work streams, such as emergency care and the management of patients with complex care needs, particularly in relation to the development of primary care, community services and better working at the interface. The specific drivers and proposed changes for children's services are set out in this section.

The Children's Group focused primarily on services provided to the NHSGGC population rather than on the wide range of regional and tertiary services provided by the Royal Hospital for Sick Children (RHSC). This acknowledges the national and regional planning fora which cover these more specialist areas, as well as the significant amount of work and redesign going into the planning for the new RHSC.

The work of the group focused on general paediatrics, long term conditions, links to the community and providing support in an emergency, as well as on effective transition between children's and adult services. These were the priority areas highlighted during the development of the Case for Change.

Core principles

- Care should be focused on the needs of children and families.
- Care should be provided in dedicated child friendly environments.
- The approach to care in settings should uphold the Rights of the Child
- There should be a focus on co-ordination of care and clear points of contact.
- There should be an appropriately trained, skilled and senior workforce: complying with relevant standards.
- Information should be shared and available across the system to inform care.
- There should be robust child protection systems in place.
- Emotional support has to be central.

- Clear transition arrangements should be in place when children move to adult services.
- Standards of care and access to range of children's services should apply equally across the whole of NHSGGC.
- Care should be focused on reducing inequalities by ensuring access for the most disadvantaged and supporting children to have the best start in life.

Key components of approach

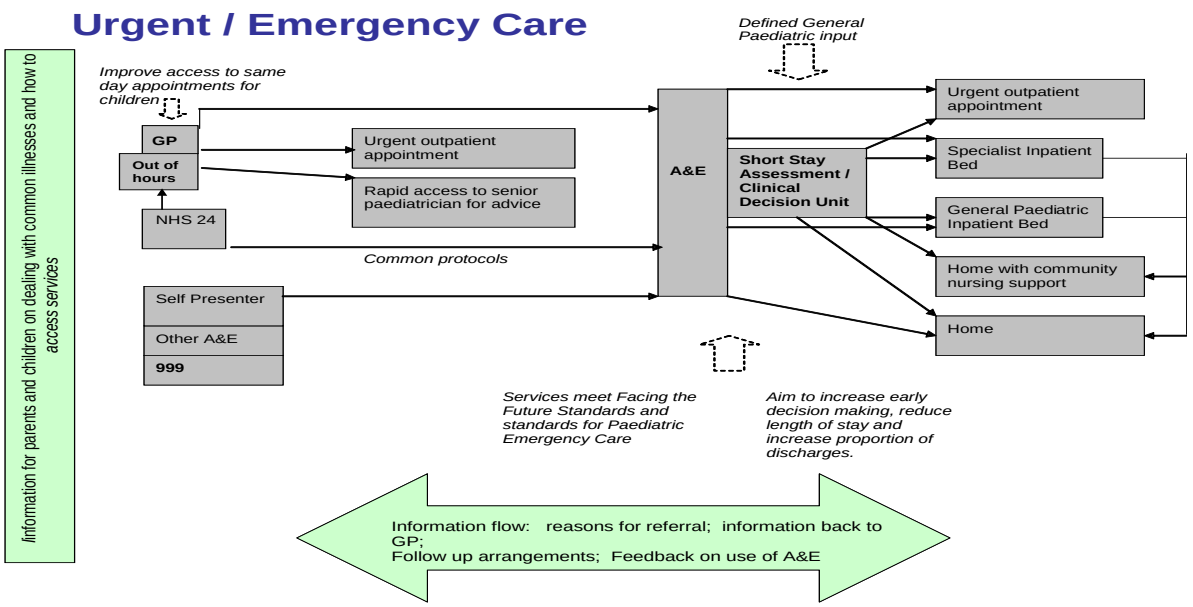
Emergency care

As with the model for adult emergency care there are a number of ideas being proposed to provide a range of alternatives to admission, which are accessible from the Emergency Department such as urgent outpatient appointment and community nursing support to enable earlier discharge.

This needs to be underpinned by the effective flow of information from the GP to the hospital and vice versa, supported by clear follow-up arrangements and feedback to practices on Emergency Department attendances and outcomes.

Where there are admissions for exacerbation of chronic disease this needs to prompt review of the care plan. The diagram below sets out the urgent / emergency care pathways.

Figure 19



This model requires a greater focus on the development of dedicated General Paediatric input as a focal point for the management of emergencies and alternatives to emergency admission. It also requires further development of nursing roles and closer working across acute and community services, facilitating earlier discharge and ensuring children can be supported at home were possible.

The 'Facing the Future' standard and Standards of Care for Paediatric Emergencies set out clear expectations for the skills, expertise and specialist opinion which should be available for children in all emergency settings. We need to ensure that we can provide this required range of specialist paediatric services to all children presenting as emergencies and those requiring inpatient care.

Key elements of this pathway will be implemented as part of the move to the new Royal Hospital for Sick Children on the South Glasgow Hospitals site. This move will enable all 'blue light' emergency cases for children in Glasgow to come to the dedicated paediatric unit which represents a gold standard in terms of access to the definitive place of care with specialist treatment, a dedicated child friendly environment and dedicated paediatric staff across a range of services and disciplines, including triple co-location between children's, adult and maternity services.

The changes described above will support that move and we need to consider further the pathways for 'blue light' emergencies and inpatient care, as well as minor injuries and self-presenters, across NHSGGC to ensure that patients can access the right level of care as quickly as possible.

While this diagram focuses on access to urgent and emergency care from the community to hospital settings, we recognise that neonatal services also deal with a significant emergency workload with a pathway to urgent care from maternity units to neonatal units and that this is an additional route into emergency care. As such, it needs to be supported by clear criteria for identifying and transferring sick newborns both in maternity wards and in the early days following discharge home.

Planned care and long term conditions

The emerging service model seeks to establish local **Integrated Children's Centres.** This supports:

- Local provision of a range of services, enabling better joint management of patients across services and agencies, with locally accessible specialist care.
- Promote different way of working: not current hospital activity in a different place but rather a focus on effective joint care planning across primary care, community services and specialist paediatrics.
- Point of contact for families with long term conditions / complex disabilities, including being a focal point for transition.

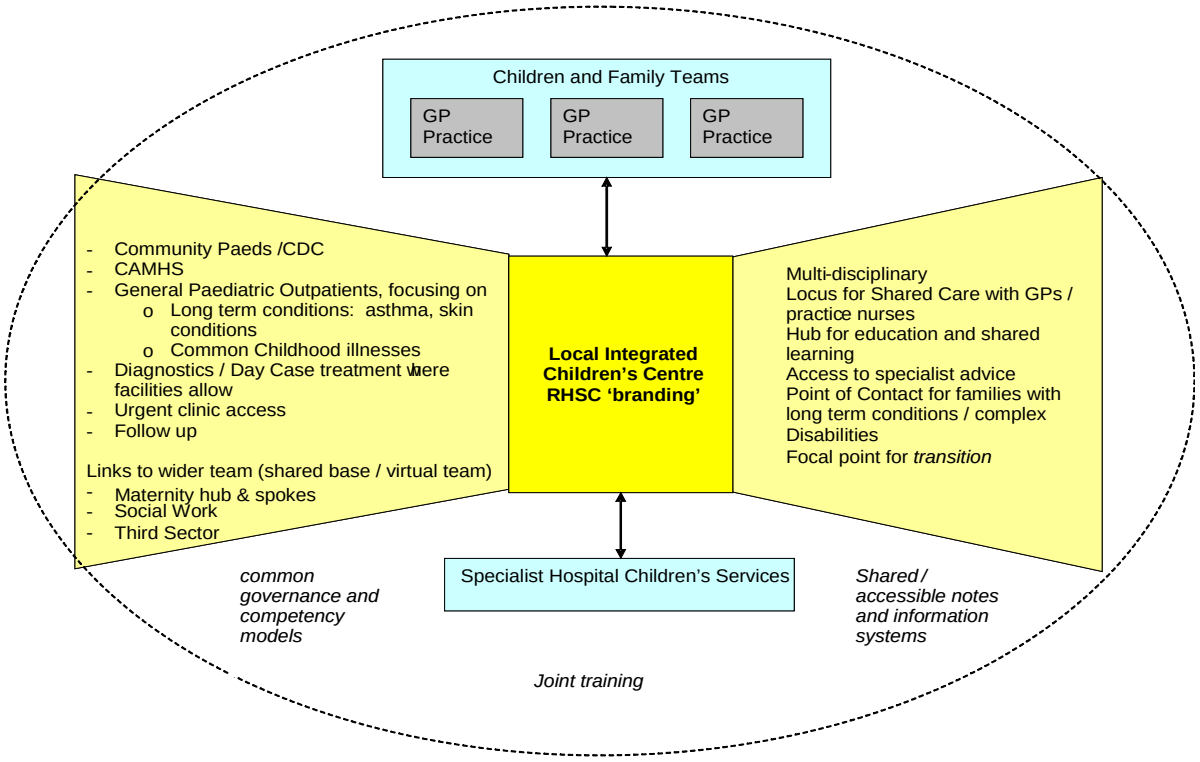
Core components of the **Integrated Children's Centres** would include:

- Community Paediatrics / Child Development Centres
- Child and Adolescent Mental Health Services
- General Paediatric Outpatients, focusing on
    - Long term conditions: asthma, skin conditions
    - Common childhood illnesses
- Diagnostics / Day case treatment where facilities allow
- Urgent clinic access
- Follow up
- Links to wider teams and services (shared base / virtual team)
    - Maternity hub and spokes
    - Social Work
    - Third Sector
- Link to localities / clusters of GP practices
    - Locus for Shared Care with GPs / practice nurses
    - Hub for education and shared learning
    - Local point of access for specialist advice

This model will only work if it is seen as a very different way of doing things, rather than providing the same services in a different location. The real potential of integrated children's centres is to enable services and families to work together in a different way, across current service boundaries. The Royal College of Paediatrics and Child Health estimate that 50% of paediatric outpatients could be

seen in a community setting, and that a greater community focus will lead to better long term conditions management and a more holistic social and behavioural approach. The centres also offer the opportunity to look at different ways of working to support children and families at home, and to set the foundations for effective chronic disease management for a lifetime. This includes using new technologies and making the most of opportunities for home monitoring and supported self care.

Figure 20: Integrated Children's Centres



Transition

Transition has been a recurring theme of discussions with patients and professionals. The model described above will support effective transition through the integrated children's centres, enabling a clear point of contact and co-ordination for families, and by involving GPs at an earlier stage in the management of long term conditions and complex care packages for children which will give greater continuity into adulthood. In addition to this, good practice in the approach to transition has been identified as including the following components:

- Transition should be viewed as a process, not an event. Services need to view transition as a period of at least 2 years, which starts in early adolescence, and allows gradual, coordinated transfer of care to primary care and adult health services. The aim of the transition process is therefore to enable and empower young people and their families to confidently access adult services.

- A key worker should be identified to coordinate the transition from paediatric to adult health services.

- In order to develop workable transition care pathways, there should be good communication and cooperation between paediatric and adult services and GPs.

- Joint transition clinics for paediatric and adult health services would help support the transition of young people with more complex needs and/or those requiring ongoing active management. The future co-location of adult and paediatric hospital services at the South Glasgow Hospitals site might help to facilitate this joint working for some hospital-based teams.

- The collation and sharing of information between health professionals needs to be improved to ensure effective transfer of health information to adult services. This sharing of information may be facilitated by improved IT systems. The use of a patient-held health record should also be considered.

12. MATERNITY SERVICES

Principles

- Focus on providing safe, accessible and effective care which improves outcomes for women and babies and reduces inequalities.
- Care focused on the health and social needs of women and families.
- Promotion of normal childbirth and reduction of interventions.
- Appropriately trained, skilled and senior workforce: complying with national workforce recommendations.
- Strengthen communication and collaboration between services which include other key NHS services and local authorities.
- Women are able to make informed decisions about their care.
- Use women's experience of care to drive service improvements.

Key components of approach

The key components of the approach of the service model for maternity care are set out below:

- Pre-pregnancy advice and health promotion.
- Early booking.
- Comprehensive assessment as early as possible, informed by shared information.
- Early identification of red / green pathway: midwife led care where possible, with regular review and ability to move between pathways when required. Identification of risk and appropriate support is critical to successful outcomes, and to defining future service and workforce needs both for maternity and neonatal services.
- Early pregnancy assessment service available 7 days a week.
- Increased support for vulnerable women and families in pregnancy: identification of vulnerability based on broad assessment of individual family and social circumstances.
- Supporting access to wider services including financial inclusion, welfare advice, and family support.
- Health visitor involvement as early as required, especially for vulnerable families: co-ordination of care and handover between midwife and health visitor.
- Team based approach with a central role of midwives as autonomous practitioners of normal pregnancies, working as a team with obstetricians, anaesthetists and paediatricians, in the care of women with complex and complicated pregnancies.
- Delivery suites meet required staffing standards: Midwife, Obstetrician and Anaesthetic cover. Move to 24 hour consultant obstetrician presence. Increasingly this will require to be covered by dedicated Obstetricians, with the increasing specialisation of gynaecology.
- 'Timely' discharge from hospital: reducing length of stay.

- Neonatal units which comply with Neonatal Quality Framework standards, with clearly defined pathways to ensure that babies are identified in post-natal settings and transferred in a safe and timely manner.

13. UNDERPINNING SYSTEM CHANGE

As we move to develop implementation plans for this strategy there are a number of areas of work which need to underpin system change. These include:

- Diagnostics and diagnostic Systems
- Information and Information Systems
- Communications
- New Ways of Working - appointment systems / technology
- Ways we deliver care – person centred care. Equalities sensitive practice

There are also implications for Other NHS Organisations including the SAS, NHS 24 and other territorial health Boards.

Each of these areas will be considered further as we develop plans going forward.

14. PUBLIC AND PATIENT ENGAGEMENT

There has been extensive engagement through clinical services review which has informed the development of this Clinical Strategy. The Scottish Health Council (SHC) have been involved in this process throughout. The formal approval of the Clinical Strategy offers opportunity for further and ongoing engagement. As we develop specific change proposals engagement will continue to be fundamental. We will continue to ensure the approach taken is in line with SHC guidance in relation to engagement, pre consultation and consultation, where this is indicated.

15. WAY FORWARD

The clinical service review has enabled us to develop this clinical strategy to provide a basis for the development of detailed service change to deliver the Government's 2020 vision.

As we go forward we will engage with the Integration Joint Boards of the Health and Social Care Partnerships to adopt this as a shared clinical strategy and work together on planning service changes. We need to work together to deliver:

- Improving health and prevention of ill health; empowering patients and carers through the development of supported self care.
- Developing primary care and community service models; simplification of community models; focus on anticipatory care and risk stratification to prevent crisis.
- Improving the interface between the community and hospital to ensure care is provided at the right time in the right place; Community and primary care services inward facing and hospital services outward facing; focused on patient and carers needs.
- Developing the ambulatory approach to hospital care, with inpatient hospital care focused on those with greatest need ensuring equitable access to specialist care.
- Redesign of specialist pathways to establish a consistent service model delivering the agreed clinical standards and good practice guidelines.

- Developing the rehabilitation model based on need not age; working across the service within primary and secondary care and with partner organisations to provide rehabilitation in the home setting where clinically appropriate.
- Changing how care is delivered - patient centred care; shifting the paradigm to deliver care differently for patients particularly for patients who have multiple conditions; helping patients and the public to develop and understand the new approaches to care.

We will develop implementation plans, including delivering changes to reflect the results of the Renfrewshire Development Programme, which is testing new ways of working at the interface, across the Board area.

We will engage with GPs, wider primary care contractors and with the new Health and Social Care Partnerships to refresh the Board's Primary Care Strategy and plan the further development of primary and community services.

We will continue the dialogue with stakeholders on the delivery of care and the models we use.

If you require further information or would like to comment on the strategy summary please email Community.Engagement@ggc.scot.nhs.uk or contact Community Engagement Team on 0141 201 5598.

April 2015

Source Documents for the NHSGGC Clinical Strategy 2015

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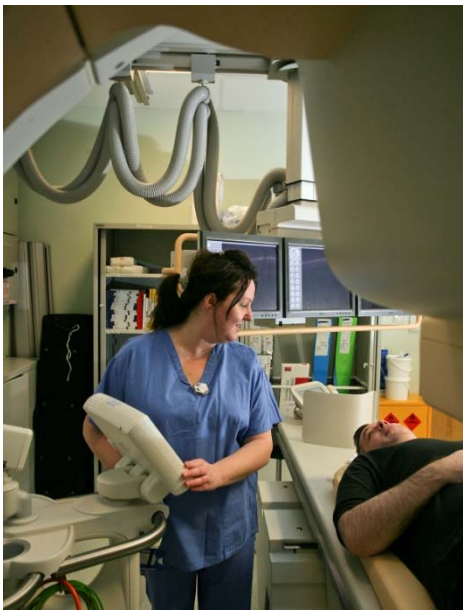
We acknowledge thanks to McKinsey & Company for their input to this work. Copies of conference presentation materials are available on request.

NHS Greater Glasgow and Clyde

Clinical Services Strategy 2015 Summary



NHS Greater Glasgow and Clyde

Clinical Services Strategy Summary

1. Introduction

Dr Jennifer L. Armstrong
Medical Director, NHS Greater Glasgow and Clyde

In April 2012, as part of planning the delivery of the Scottish Government's 2020 Vision, we launched a Clinical Services Review to consider how best to deliver services to meet the changing needs of patients beyond 2015 to 2020.

The review was led by NHS clinicians with substantial involvement from patients and special interest groups, the third sector and with wider public engagement.

Together all of these interests analysed the changing population needs, the modernisation of approaches to care and technological developments and how best to deliver sustainable, safe and effective services going forward.

The review has been approved and the final Clinical Strategy is now available on our website at: http://www.nhsggc.org.uk/about-us/clinical-services-fit-for-the-future/

The key aims of the Clinical Strategy are to ensure that:

- care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway
- services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements
- sustainable and affordable clinical services can be delivered across NHSGGC
- pressures on hospital, primary care and community services are addressed

The Clinical Strategy is the blueprint to develop innovative and redesigned services to meet future demands of the population we serve. It provides the opportunity to engage with the six new Integration Joint Boards (local authority social care and NHS community care integrated boards) across Greater Glasgow and Clyde to adopt this as a shared clinical strategy to work together on planning services changes as we go forward from 2015 to 2020.

In addition, the innovative new approaches being trialled in the Renfrewshire Council area to integrate community health services, social care and the acute hospital teams will influence a new approach for our entire Board area.

The Clinical Review Report sets out high quality models of care from better prevention and self management right through to highly specialised hospital care and is evidence based with learning from what works across the UK and beyond. The work that has gone into this intense and crucial Review is the bedrock of how we will plan to deliver and plan clinical services to meet all of our hospital and community health needs.

On behalf of NHSGGC I would like to thank everyone who has been involved in leading and shaping this work. The input from staff in hospitals and in the community along with patients and public representatives, special interest groups and charities has been invaluable.

2. Clinical Services Fit for the Future

Looking at 2015 and beyond – how do we design our services and the resources available in a way which will support us all in the future? The clinical strategy sets out the context and background to the review of clinical services, details the high level population position, it sets out the case for change and core components of the future healthcare system and details service models and implementation challenges.

3. Case for change

The case for change was developed based on the views of a wide range of clinicians on what is currently affecting clinical services and what is the likely impact on services in the future, as well as the opinions of patients of what they value in the current service and what they would want of future services. Following extensive engagement with stakeholders 9 key themes were identified.

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

The full case for change is available at http://www.nhsggc.org.uk/about-us/clinical-services-fit-for-the-future/the-case-for-change-documents/

4. Developing Future Services

Building on the work on the case for change service models were developed and are set out in the clinical strategy.

The overarching aim of this clinical strategy, based on this work, is to provide **a balanced system of care where people get the right care in the right place** from people with the right skills, working across the artificial boundary of 'hospital' and 'community' services.

At the heart of this approach is the requirement to understand our population and provide care at the most appropriate level. Getting this right will enable more intensive support for those most in need, and supported self management with rapid access into services when required for the majority of the population.

This approach relies on a strong emphasis on prevention. It is therefore important that as part of the strategy we continue to emphasise the importance of health improvement and disease prevention.

We need to encourage the population to improve their health and prevent disease, recognising that lifestyle choices and modifiable behaviours are responsible for around 80% of our current long term condition disease burden. This requires all health care professionals to promote healthier lifestyles and to support the population to take responsibility for improving their own health by adopting healthier lifestyles. It also requires patients and the public to work together to support each other in managing their health and health care needs.

The key characteristics of the clinical services required to support this approach are:

Timely access to **high quality primary care** providing a comprehensive service that deals with the whole person recognising their home circumstance:

- Building on universal access to primary care.
- Focused on prevention, anticipatory care planning with early intervention.
- Care where possible within a primary care setting.
- Focus for continuity of care and co-ordination of care for patients with multiple conditions.

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

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

Co-Coordinated care at **crisis / transition** points, and for those people **most at risk**:

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

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

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

Planned care which is locally accessible on an outpatient / ambulatory care basis where possible:

- Wider range of specialist clinics in the community, working as part of a team with primary care and community services.
- Appropriate follow-up.
- Diagnostic services organised around patient needs.
- Interventions provided as day case where possible.
- Rapid access as an alternative to emergency admission or to facilitate discharge.

Low volume and high complexity care provided in defined units equipped to meet the care needs:

- Driven by clear evidence of the relationship between volume and outcome.

To achieve a balanced system of care where people get care in the right place. This means:

- **thinking beyond artificial boundaries of "hospital" and "community"**
- **focusing on patient pathway and needs at each stage**
- **changes to delivery of acute care: assess and direct to appropriate place of care**
- **changes to provision and accessibility of community services**
- **different ways of working at the interface, for example, comprehensive assessment and inreach from community teams to prevent admission to hospital.**

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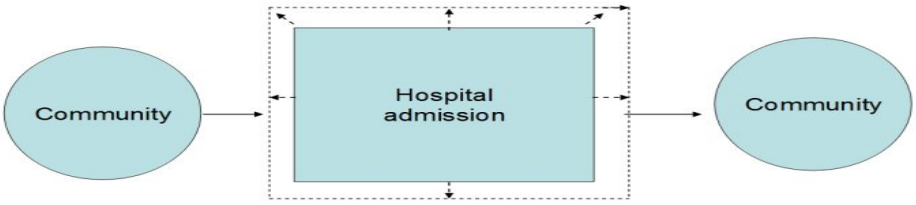

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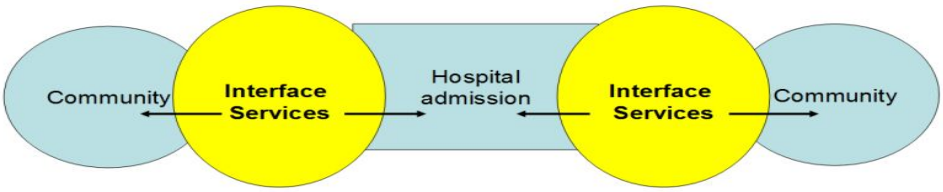

5. PUBLIC AND PATIENT ENGAGEMENT

There has been extensive engagement informing the development of this Clinical Strategy. As we develop specific change proposals engagement will continue to be fundamental. We will continue to ensure the approach taken is in line with Scottish Health Council guidance in relation to engagement, pre consultation and consultation, where this is indicated.

6. WAY FORWARD

The Clinical Service Review has enabled us to develop this clinical strategy to provide a basis for the development of detailed service change to deliver the Government's 2020 Vision.

As we go forward we will engage with the new Integration Joint Boards of the Health and Social Care Partnerships to adopt this as a shared clinical strategy and to work together on planning service changes.

We will develop implementation plans, including delivering changes to reflect the results of the Renfrewshire Development Programme, which is testing new ways of working at the interface, across the Board area.

We will engage with GPs, wider primary care contractors and with the new Health and Social Care Partnerships to refresh the Board's Primary Care Strategy and plan the further development of primary and community services.

We will continue the dialogue with stakeholders on the delivery of care and the models we use.

To view the full Clinical Strategy document visit: http://www.nhsggc.org.uk/about-us/clinical-services-fit-for-the-future/

If you require further information or would like to comment on the strategy summary please email Community.Engagement@ggc.scot.nhs.uk or contact Community Engagement Team on 0141 201 5598.

April 2015

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آین آگهی با فونت بزرگ، به زبان بریل، به صورت آسان خوان یا سی دی صوتی در دسترس است. همچنین می‌توانیم آن را به هر زبانی از جمله زبان اشاره بریتانیایی یا هر قالب دیگری که نیاز داشته باشید ارائه دهیم.

لطفاً با شماره 0800 027 7246 تماس بگیرید

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ويتوافر هذا المنشور في طبعة كبيرة أو بلغة بريل وفي إصدارات سهلة القراءة أو على أقراص صوتية مدمجة. ويمكننا توفيره كذلك بجميع اللغات؛ بما في ذلك لغة الإشارة البريطانية، أو أي تنسيقات تطلبها.

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یہ اشاعت بڑے حروف، بریل، آسانی سے پڑھے جانے کی شکل میں یا آڈیو سی ڈی میں دستیاب ہے۔ ہم اسے برطانوی اشارتی زبان سمیت کسی بھی زبان میں یا آپ کی ضرورت کے مطابق کسی بھی فارمیٹ فراہم کر سکتے ہیں۔

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本出版物已按英國國民醫療保健服務系統大格拉斯哥 (*Greater Glasgow*) 和克萊德 (Clyde) 地區的所有政策發佈。

本出版物設有大字、盲人點字、簡易及音訊光碟版本。我們亦提供任何語言，包括英國手語或任何所需的格式。

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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 19th August 2015

Subject: Minutes of Meetings for Inclusion on Partnership Board Agendas

1. Purpose

1.1 To confirm the formal meetings whose minutes will be routinely presented to the Partnership Board for information.

2. Recommendation

2.1 The Partnership Board is recommended to approve the list of formal meetings whose minutes will be routinely included for information on Partnership Board agendas.

3. Background

3.1 Audit Scotland have emphasised that health and social care integration requires effective governance arrangements for the new joint bodies.

4. Main Issues

4.1 In order to further support effective oversight of the delivery of the approved Strategic Plan and the operation of Health & Social Care Partnership (HSCP) services it is proposed that the most recent minutes of the following meetings/forums are routinely included in the agendas for the Partnership Board for noting:

- HSCP Audit Committee (as a sub-committee of the Partnership Board).
- HSCP Clinical and Care Governance Group (currently being refreshed as per Strategic Plan).
- HSCP Joint Staff Forum (constitution currently being revised).
- HSCP Locality Groups – Clydebank and Alexandria & Dumbarton (currently being established refreshed as per Strategic Plan).
- HSCP Locality Engagement Networks - Clydebank and Alexandria & Dumbarton (currently being established refreshed as per Strategic Plan).
- Argyll, Bute and Dunbartonshire Criminal Justice Social Work Partnership Joint Committee.

4.2 In addition, the Partnership Board will receive reports advising of any complaints heard by the local Social Work Complaints Review Sub-Committee.

5. People Implications

5.1 None.

6. Financial Implications

6.1 None.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 As stated above, Audit Scotland have emphasised that health and social care integration requires effective governance arrangements for the new joint bodies.

10. Impact Assessments

10.1 Not applicable.

11. Consultation

11.1 None.

12. Strategic Assessment

12.1 Inclusion of the minutes of the meetings proposed above will further support effective oversight of the delivery of the approved Strategic Plan.

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Date: 19th August 2015

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Appendices: None

Background Papers: None

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 19th August 2015

Subject: Clinical & Care Governance

1. Purpose

1.1 To present the West Dunbartonshire CHCP Clinical Governance Annual Report for 1st January 2014 to 31st March 2015; and brief the Partnership Board on the National Clinical & Care Governance Framework and the clinical and care governance related aspects of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill.

2. Recommendation

2.1 The Partnership Board is recommended to:

1) Approve for its interests, The West Dunbartonshire CHCP Clinical Governance Annual Report for 1st January 2014 to 31st March 2015;

2) Note The National Clinical & Care Governance Framework; and

3) Endorse the positions expressed within the submission made to the Scottish Parliament's Health & Sport call for written views on the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill.

3. Background

3.1 Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured, supporting staff in continuously improving the quality and safety of care and ensuring that wherever possible poor performance is identified and addressed. Effective clinical and care governance arrangements need to be in place to support the delivery of safe, effective and person-centred health and social care services within integrated services.

3.2 Clinical and care governance for integrated health and social care services requires co-ordination across a range of services, (including procured services) so as to place people and communities at the centre of all activity relating to the governance of clinical and care services.

3.3 The Integration Scheme for West Dunbartonshire emphasises the importance of effective clinical and care governance across Health & Social Care Partnership services.

4. Main Issues

Clinical Governance Annual Report

4.1 The Clinical Governance Annual Report (Appendix 1) provides a summary of clinical governance activity and key achievements during the 2014 calendar year and then the final quarter of the 2014/15 financial year.

4.2 To-date it has been the custom-and-practice for Clinical Governance Annual Reports produced by CH(C)Ps for the Health Board to cover the duration of a calendar year. However, for this final CHCP Clinical Governance Annual Report the opportunity has been taken to produce a report covering an extended 15 month period: this will enable the next such annual report to align with the financial year (2015/16) and the broader performance reporting for the HSCP as a whole.

National Clinical & Care Governance Framework

4.3 At the end of 2014 the Scottish Government published its first unified framework for clinical and care governance (Appendix 2). This framework was based on the Governance for Healthcare Quality in Scotland – An Agreement (2013) and also a comparable document which was produced by Social Work Scotland: within the context of the Public Bodies (Joint Working) Act it was decided that that due to the commonality across the NHS and social work landscape one single framework should be created moving forward.

4.4 The Scottish Government's Clinical and Care Governance Framework states that all aspects of the work of Integration Authorities, Health Boards and local authorities should be driven by and designed to support efforts to deliver the best possible quality of health and social care.

4.5 The national framework has been developed on the understanding that Integration Authorities will build on the existing professional and service governance arrangements already in place within Health Boards and Local Authorities. As such, it is being brought to the Partnership Board's attention in tandem with the final Clinical Governance Annual Report for the former Community Health & Care Partnership.

4.6 The national framework directly informed the development of the Clinical & Care Governance section of the approved Integration Scheme for West Dunbartonshire and of the Strategic Plan for the Health & Social Care Partnership approved by the Partnership Board at its inaugural meeting (July 2015).

4.7 The national framework is being presented to the Partnership Board to ensure that all members are aware of and understand the key elements and principles that should be reflected in the clinical and care governance processes within the Health & Social Care Partnership (as described within the Strategic Plan and Integration Scheme).

4.8 As confirmed within the Integration Scheme, the Chief Officer will ensure that clear strategic objectives for clinical and care governance are agreed, delivered and reported through an annual clinical and care governance action plan. This will include actions to: ensure the quality of service delivery (including that delivered through services procured from the third and independent sector); address organisational and individual care risks; promote continuous improvement; and ensure that all professional and clinical standards, legislation and guidance are met.

4.9 As confirmed within the approved Strategic Plan, the Chief Officer is currently in the process of establishing a new local Clinical and Care Governance Group for integrated services within the Partnership. Its membership will include the Partnership's Senior Management Team; Clinical Director; Lead Nurse; Allied Health Professions Lead; and Council's Chief Social Work Officer. Through its representative membership, the Clinical and Care Governance Group will interface with the Health Board Clinical Governance Forum; Health Board professional committees; the Area Clinical Forum; Managed Care Networks; and local Multi-Agency Public Protection Arrangement, Adult Support & Protection and Child Protection Committees as appropriate. Once established the minutes of the local Clinical and Care Governance Group will be routinely brought to the Partnership Board for noting.

Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill

4.10 The Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill was introduced in the Scottish Parliament on 4 June 2015. The Health and Sport Committee has been designated by the Parliament as the lead Committee. The Health and Sport Committee issued a call for written views on the Bill on 3 July 2015.

4.11 The Bill is of particular relevance to clinical and care governance in relation to the inclusion within its stated policy objectives to make provision about:

- A duty of candour following serious incidents in the course of providing care.

  The Bill proposes to place a duty of candour on health and social care organisations. This would create a legal requirement for health and social care organisations to inform people (or their carers/families) when they have been harmed as a result of the care or treatment they have received.

- Offences applying to ill-treatment or neglect where care is provided, and for connected purposes.

The Bill would establish a new criminal offence of ill-treatment or willful neglect which would apply to individual health and social care workers, managers and supervisors. The offence would also apply to organisations.

4.12 On behalf of the Health & Social Care Partnership Senior Management team, the Head of Strategy, Planning & Health Improvement submitted a response to the call for view that expressed support for both the proposed duty of candour; and the proposal to make wilful neglect or ill-treatment of patients a criminal offence.

4.13 As the deadline for submission of written views was the 12th August, this submission was made prior to this meeting of the Partnership Board; and so the Partnership Board is being retrospectively asked if it would endorse those views expressed in 4.12 above.

5. People Implications

The National Framework reaffirms the regulatory frameworks within which health and social care professionals practice and the established professional accountabilities that are currently in place within the NHS and local government; and that all health and social care professionals remain accountable for their individual clinical and care decisions.

As committed to within the Integration Scheme, the Council and the Health Board will work together and with the Partnership Board to deliver an organisation in which those individual staff delivering care will:

- Practice in accordance with their professional standards, codes of conduct and organisational values.
- Be responsible for upholding professional and ethical standards in their practice and for continuous development and learning that should be applied to the benefit of the public.
- Ensure the best possible care and treatment experience for service users and families.
- Provide accurate information on quality of care and highlight areas of concern and risk as required.
- Work in partnership with management, service users and carers and other key stakeholders in the designing, monitoring and improvement of the quality of care and services.
- Speak up when they see practice that endangers the safety of patients or service users in line with local policies for public interest disclosure and regulatory requirements.
- Engage with colleagues, patients, service users, communities and partners to ensure that local needs and expectations for safe and high quality health and care services, improved wellbeing and wider outcomes are being met.

6. Financial Implications

6.1 None.

7. Professional Implications

7.1 The Health Board Chief Executive, as the accountable officer, is responsible for clinical governance, quality, patient safety and engagement, supported by the Health Board's professional advisers. The Health Board's Medical Director is responsible for the systems which support the delivery of clinical governance and medicines governance. The professional leads nominated by the Health Board to the Partnership Board will relate to and be supported by the Health Board's Medical Director and Director of Nursing.

7.2 With respect to governance of social care, the Chief Social Work Officer reports to the Council on the delivery of safe, effective and innovative social work services and the promotion of values and standards of practice. The Chief Social Work Officer will provide appropriate professional advice to the Chief Officer and the Partnership Board in relation to statutory social work duties and make certain decisions in terms of the Social Work (Scotland) Act 1968. The Chief Social Work Officer will provide a separate annual report on care governance to the Partnership Board.

7.3 The Chief Officer has delegated responsibilities, through the Chief Executives of the Council and the Health Board, for the professional standards of staff working in integrated services. The Chief Officer, relevant lead health professionals and the Council Chief Social Work Officer will work together to ensure appropriate professional standards and leadership.

8. Locality Implications

8.1 The new Clinical and Care Governance Group will provide advice to the new locality planning arrangements as approved within the Strategic Plan; and reciprocally seek advice on clinical and care governance directly from the Clinical and Care Governance Group.

9. Risk Analysis

9.1 Effective clinical and care governance arrangements need to be in place to support the delivery of safe, effective and person-centred health and social care services within integrated services.

9.2 Healthcare Improvement Scotland, The Care Inspectorate and Scottish Ministers will use this national framework when reviewing the effectiveness of clinical and care governance arrangements in place to support the delivery of safe, effective and person-centred health and social care services within integrated services.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 The Clinical Governance Annual Report has been compiled with contributions from and reflects the commitment of the staff across the former CHCP (now Health & Social Care Partnership).

11.2 The Partnership Board's appointed professional advisers were consulted on the preparation of this response.

12. Strategic Assessment

12.1 The National Framework and the learning from the work summarised within the Clinical Governance Annual Report directly informed the development of the approved Strategic Plan.

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Date: 19 August 2015

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Appendices: The National Clinical & Care Governance Framework

The West Dunbartonshire CHCP Clinical Governance Annual Report for 1st January 2014 to 31st March 2015.

Background Papers: HSCP Board Report (July 2015): Integration Scheme

HSCP Board Report (July 2015): Strategic Plan 2015/16

Wards Affected: All

Health and Social Care Integration

Public Bodies (Joint Working) (Scotland) Act 2014

Clinical and Care Governance Framework

Background

Clinical and Care Governance Working Group

1. At the request of the Integration Governance and Accountability Group, a short-life working group was established in May 2013 to look at Clinical and Care Governance. The group was co-chaired by Dr Frances Elliot, Deputy Chief Medical Officer and Alan Baird, Chief Social Work Adviser. Membership of the group was made up of senior health and social care professional leads, and included representatives from scrutiny bodies and the third and independent sectors. The group's remit was to support the development of guidance that may be required for Health Boards and Local Authorities to assure clinical and care governance across the new integrated arrangements.

2. The group felt that it was essential to develop a framework for oversight of clinical and care governance for those integrated services which will be the responsibility of Integration Authorities. The framework has been developed on the understanding that Integration Authorities will build on the existing professional and service governance arrangements already in place within Health Boards and Local Authorities. This document sets out this framework, based on the Governance for Healthcare Quality in Scotland – An Agreement (2013) and also a comparable document which was produced by Social Work Scotland. The working group agreed that due to the commonality across the NHS and social work landscape one single framework should be created.

3. The Framework provides Integration Authorities with an overview of the key elements and principles that should be reflected in the clinical and care governance processes implemented by Integration Authorities. It can be used to determine how best to integrate the governance mechanisms in place for services within partnerships, highlighting areas where revised and new processes will be needed to deliver requirements across all of the dimensions outlined. Integration Authorities will develop local mechanisms to deliver clinical and care governance which will inform national learning and further refinements of the framework and supporting resources.

Public Bodies (Joint Working) (Scotland) Act 2014

1. The Public Bodies (Joint Working) (Scotland) Act 2014 requires that Health Boards and Local Authorities integrate adult health and social care services. The minimum scope of this integration covers adult social care, adult community health and a proportion of acute hosptial provision that broadly relates to the emergency pathway of care, though this can be extended locally, primarily to include children's health and social care services.

2. What the Act does is draw together the planning and delivery of services to better support the delivery of improved outcomes for the individuals who receive care and support across health and social care.

3. The Act contains a number of integration principles (Annex A) that must be taken into account when services are planned and delivered,and Scottish Ministers will put in regulation nine national health and wellbeing outcomes (Annex B) that Integration Authorities are required to improve and deliver.

4. To achieve these requirements, professionals and the wider workforce, will need to work in an integrated way to ensure that the different skills, experience, knowledge and perspectives they bring are best used and aligned to support the outcomes that individuals seek from the care and support they receive. This will require an explicit clinical and care governance framework within which professionals and the wider workforce will operate and a clear understanding of the contributions and responsibilities of each person.

5. It is important to note that the Act does not change the current or future regulatory framework within which health and social care professionals practice, or the established professional accountabilities that are currently in place within the NHS and local government. These arrangements may need adaptation to the circumstances of each Integration Authority to reflect the services and local circumstances of each partnership, but the core principles of clinical and care governance must be consistently applied across those services which are integrated and those which are not.

Clinical and Care Governance Framework for Integrated Health and Social Care Services in Scotland

Introduction

1. This framework outlines the proposed roles and focus regarding clinical and care governance for the range of professionals and staff involved with the planning and delivery of integrated health and social care services in Scotland.

2. The framework identifies the roles, accountabilities, responsibilities and actions that will be required to ensure governance arrangements in support of the Act's principles (Annex A) and the required focus on improved health and wellbeing outcomes (Annex B). Neither the Act, nor this guidance, change the regulatory arrangements for health and social care professionals or their current professional accountabilities but describe a shared framework within which professionals and the workforce discharge their accountabilities and responsibilities. Key existing guidance is set out in Annex D.

3. Effective implementation of clinical and care governance for integrated health and social care services in Scotland will require co-ordination across a range of services, including the third sector. This rightly places people and communities at the centre of all activity in relation to the governance of clinical and care services.

4. Healthcare Improvement Scotland, The Care Inspectorate and Scottish Ministers will use this framework when reviewing the effectiveness of clinical and care governance arrangements in place to support the delivery of safe, effective and person-centred health and social care services within integrated services.

5. Annex C provides details in support of the implementation of clinical and care governance for integrated health and social care services.

People and communities

The people who use services or support and communities (both of need and locality) are at the heart of this framework. They:

- Are recognised as having experience and expertise and are both encouraged and enabled to contribute to the design, monitoring and improvement of the safety and quality of care.

- Will be an essential and integral part of the service's quality monitoring and improvement systems, with a central role in designing and shaping of services – contributing to assurance of the quality of integrated health and social care services and identifying areas where improvements are required.

- Will have a single point of access to provide feedback or make a complaint about integrated health and social care services.

NHS Chairs and Council Leaders, NHS Non-Executive Directors and Elected members will:

- Create an organisational culture that promotes human rights and social justice, values partnership working through example; affirms the contribution of staff through the application of best practice including learning and development; is transparent and open to innovation, continuous learning and improvement.

- Establish that integrated clinical and care governance policies are developed and regularly monitor their effective implementation.

- Require that the rights, experience, expertise, interests and concerns of service users, carers and communities inform and are central to the planning, governance and decision-making that informs quality of care.

- Ensure that transparency and candour are demonstrated in policy, procedure and practice.

- Seek assurance that effective arrangements are in place to enable relevant health and social care professionals to be accountable for standards of care including services provided by the third and independent sector.

- Require that there is effective engagement with all communities and partners to ensure that local needs and expectations for health and care services and improved health and wellbeing outcomes are being met.

- Ensure that clear robust, accurate and timely information on the quality of service performance is effectively scrutinised and that this informs improvement priorities. This should include consideration of how partnership with the third and independent sector supports continuous improvement in the quality of health and social care service planning and delivery.

- Seek assurance on effective systems that demonstrate clear learning and improvements in care processes and outcomes.

- Seek assurance that staff are supported when they raise concerns in relation to practice that endangers the safety of service users and other wrong doing in line with local policies for whistleblowing and regulatory requirements.

- Establish clear lines of communication and professional accountability from point of care to Executive Directors and Chief Professional Officers accountable for clinical and care governance. It is expected that this will include articulation of the mechanisms for taking account of professional advice, including validation of the quality of training and the training environment for all health and social care professionals' training (in order to be compliant with all professionals regulatory requirements).

Chief Executives/Chief Officers/Directors of Health and Social Care and Senior Managers of Health & Social Care Services will:

- Embed a positive, sharing and open organisational culture that creates an environment where partnership working, openness and communication is valued, staff supported and innovation promoted.

- Provide a clear link between organisational and operational priorities; objectives and personal learning and development plans, ensuring that staff have access to the necessary support and education.

- Implement quality monitoring and governance arrangements that include compliance with professional codes, legislation, standards, guidance and that these are regularly open to scrutiny. This must include details of how the needs of the most vulnerable people in communities are being met.

- Implement systems and processes to ensure a workforce with the appropriate knowledge and skills to meet the needs of the local population.

- Implement effective internal systems that provide and publish clear, robust, accurate and timely information on the quality of service performance.

- Develop systems to support the structured, systematic monitoring, assessment and management of risk.

- Implement a co-ordinated risk management, complaints, feedback and adverse events/incident system, ensuring that this focuses on learning, assurance and improvement.

- Lead improvement and learning in areas of challenge or risk that are identified through local governance mechanisms and external scrutiny.

- Develop mechanisms that encourage effective and open engagement with staff on the design, delivery, monitoring and improvement of the quality of care and services.

- Promote planned and strategic approaches to learning, improvement, innovation and development, supporting an effective organisational learning culture.

All those providing care and services will:

- Practice in accordance with their professional standards, codes of conduct and organisational values.

- Be responsible for upholding professional and ethical standards in their practice and for continuous development and learning that should be applied to the benefit of the public.

- Ensure the best possible care and treatment experience for service users and families.

- Provide accurate information on quality of care and highlight areas of concern and risk as required.

- Work in partnership with management, service users and carers and other key stakeholders in the designing, monitoring and improvement of the quality of care and services.

- Speak up when they see practice that endangers the safety of patients or service users in line with local whistle-blowing policy and regulatory requirements.

- Engage with colleagues, patients, service users, communities and partners to ensure that local needs and expectations for safe and high quality health and care services, improved wellbeing and wider outcomes are being met.

The Scottish Government will:

- Work with all stakeholders to develop strategic and policy direction for the delivery of high quality care.

- Will make sure that clinical and care governance arrangements are appropriately reflected in integration schemes.

ANNEX A: Public Bodies (Joint Working) (Scotland) Act 2014

Integration Planning and Delivery Principles

(1) The integration planning principles are:

(a) that the main purpose of services which are provided in pursuance of integration functions is to improve the wellbeing of service-users

(b) that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible:

(i) is integrated from the point of view of service-users

(ii) takes account of the particular needs of different service-users

(iii) takes account of the particular needs of service-users in different parts of the area in which the service is being provided

(iv) takes account of the particular characteristics and circumstances of different service-users

(v) respects the rights of service-users

(vi) takes account of the dignity of service-users,

(vii) takes account of the participation by service-users in the community in which service-users live

(viii) protects and improves the safety of service-users,

(ix) improves the quality of the service,

(x) is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)

(xi) best anticipates needs and prevents them arising

(xii) makes the best use of the available facilities, people and other resources.

ANNEX B: Public Bodies (Joint Working) (Scotland) Act 2014

National Health and Wellbeing 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 using health and social care services are safe from harm.

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

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

ANNEX C: Clinical and Care Governance of Integrated Health and Social Care Services

What is Clinical and Care Governance?

1. Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality of care and support is understood to be the responsibility of everyone working in the organisation - built upon partnership and collaboration within teams and between health and social care professionals and managers.

2. It is the way by which structures and processes assure Integration Joint Boards, Health Boards and Local Authorities that this is happening - whilst at the same time empowering clinical and care staff to contribute to the improvement of quality - making sure that there is a strong voice of the people and communities who use services.

3. Clinical and care governance should have a high profile, to ensure that quality of care is given the highest priority at every level within integrated services. Effective clinical and care governance will provide assurance to patients, service users, clinical and care staff and managers, Directors alike that:

    - Quality of care, effectiveness and efficiency drives decision-making about the planning, provision, organisation and management of services;

    - The planning and delivery of services take full account of the perspective of patients and service users;

    - Unacceptable clinical and care practice will be detected and addressed.

4. Effective clinical and care governance is not the sum of all these activities; rather it is the means by which these activities are brought together into this structured framework and linked to the corporate agenda of Integration Authorities, NHS Boards and Local Authorities.

5. A key purpose of clinical and care governance is to support staff in continuously improving the quality and safety of care. However, it will also ensure that wherever possible poor performance is identified and addressed. All health and social care professionals will remain accountable for their individual clinical and care decisions.

6. Many clinical and care governance issues will relate to the organisation and management of services rather than to individual clinical decisions. All aspects of the work of Integration Authorities, Health Boards and local authorities should be driven by and designed to support efforts to deliver the best possible quality of health and social care. Clinical and care governance, however, is principally concerned with those activities which directly affect the care, treatment and support people receive.

Five Process Steps to Support Clinical and Care Governance

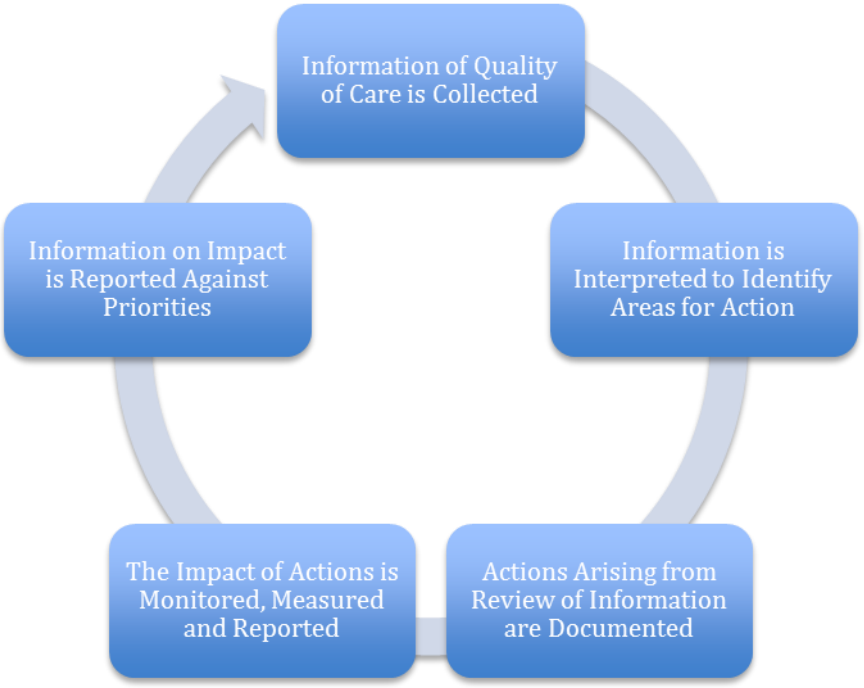
1. Information on the safety and quality of care is received

2. Information is scrutinised to identify areas for action

3. Actions arising from scrutiny and review of information are documented

4. The impact of actions is monitored, measured and reported

5. Information on impact is reported against agreed priorities



Five Key Principles of Clinical and Care Governance

1. Clearly defined governance functions and roles are performed effectively.
2. Values of openness and accountability are promoted and demonstrated through actions.
3. Informed and transparent decisions are taken to ensure continuous quality improvement.
4. Staff are supported and developed.
5. All actions are focused on the provision of high quality, safe, effective and person-centred services.

ANNEX D: Existing Guidance on Governance and Accountability

Nursing and Midwifery Professional Assurance Framework for Scotland (2014).
Scottish Executive Nurse Directors & Chief Nursing Officer for Scotland.

Codes of Practice for Social Service Workers and Employers (2014)
Scottish Social Services Council
http://www.sssc.uk.com/about-the-sssc/multimedia-library/publications/60-protecting-the-public/61-codes-of-practice/1020-sssc-codes-of-practice-for-social-service-workers-and-employers

Governance for Healthcare Quality in Scotland – An Agreement. (2013)
Scottish Government Health Directorates
http://www.tinyurl.com/qualitygovernance

Governance for Quality Social Care in Scotland – An Agreement. (2013).
Social Work Scotland – available via the Social Work Scotland website
http://www.socialworkscotland.org/

Practice Governance Framework: Responsibility and Accountability in Social Work Practice (2011)
http://www.scotland.gov.uk/Resource/Doc/347682/0115812.pdf

The Role of the Chief Social Work Officer (2010)
Scottish Government
http://www.scotland.gov.uk/Publications/2010/01/27154047/0

The Role of Registered Social Worker in Statutory Interventions: Guidance for local authorities (2010)
Scottish Government
http://www.scotland.gov.uk/Resource/Doc/304823/0095648.pdf

Governance for Joint Services. Principles and Advice. (2007)
COSLA, Audit Scotland and Scottish Government.
http://www.chp.scot.nhs.uk/wp-content/uploads/Governance-for-joint-Services.pdf

NHS HDL (2001) 74 Clinical Governance Arrangements.
Scottish Executive
http://www.sehd.scot.nhs.uk/mels/HDL2001_74.htm

NHS MEL (2000) 29 Clinical Governance.
Scottish Executive
http://www.sehd.scot.nhs.uk/mels/2000_29final.htm

NHS MEL (1998)75 Clinical Governance
Scottish Executive
http://www.sehd.scot.nhs.uk/mels/1998_75.htm

West Dunbartonshire
Community Health and Care Partnership

CLINICAL GOVERNANCE ANNUAL REPORT

1st January 2014 to 31st March 2015

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West Dunbartonshire
Community Health & Care Partnership

NHS Greater Glasgow and Clyde

West Dunbartonshire COUNCIL

INTRODUCTION

This report is a summary of West Dunbartonshire's CHCP clinical governance and clinical effectiveness activity during 2014 calendar year and then the final quarter of the 2014/15 financial year – an important transitional period for the organisation. During 2014/15 the CHCP entered its shadow year of becoming a fully fledged Health and Social Care Partnership (HSCP) during 2015/16. We have taken this opportunity to provide a report here covering a 15 month period on this occasion so that our next year's report aligns with the broader performance reporting for the new HSCP as a whole. Moving forward, and with the agreement of the Council's Chief Social Work Officer, I am please that we will also be updating our former Clinical Governance Group to become a refreshed HSCP Clinical and Care Governance Group (reflecting the recent national Clinical and Care Governance Framework published by the Scottish Government).

Through this period of transition, I am reassured that there has been continued sharing of predominantly clinical significant events at locality-level meetings, alongside scrutiny at the former CHCP Clinical Governance Group. We are conscious of the newspaper and television news headline horror stories that continue unabated. Whilst the Francis Report seemed to dominate 2013 (which was reflected in our November Protected Learning 2013), this year has sadly seen the focus turn to more child abuse scandals. In our autumn protected learning event 2014 we deliberately took time to concentrate on two topics that spanned both health and social care, namely child protection and dementia. These highlight how care can improve with a co-ordinated approach. The event is summarised here, capturing the value of spending time to understand each others role in an individuals care.

Closer to home, this year saw us complete the implementation of the recommendations of the CHCP-led Multiagency Review that followed the tragic deaths of 3 young women residing at the Blue Triangle Supported Housing projects between July 2012 and September 2012. The review engaged and critically reflected upon contributions from the range of responsible disciplines and services of West Dunbartonshire Council, NHS Greater Glasgow and Clyde, Strathclyde Police, Third Sector organisations (including the Blue Triangle) and importantly sought the views and comments from the family members of the three young women. The Multi-Agency Review found no deficit in the care in any of the three tragic cases, but did identify developmental recommendations based on learning that emerged – all of which have been taken forward with partners.

November 2014 saw the publication of the Vale of Leven Hospital Inquiry Report, with its emphasis on the importance of infection control and sobering lessons for the Health Board as a whole. A recurrent theme that always seems to come out of these inquiries is the lack of effective communication or sharing of information. Once shared, there is also the question of who has responsibility to deal with it. We should all think how best we can translate the vast amount of information now available in guidance into our daily work. There would be no problem if we were judged on the number of guidelines and advice in our combined in-boxes. However it is simply not good enough to be content to say I sent you several attachments in an e-mail! We should not underestimate the importance of involving service users, carers and staff from the frontline in our governance work, in order to use the parts of guidance that will improve the quality of care we deliver. It will cost us in spending precious time, but it could make a real difference to many people's lives.

Kevin P Fellows - Clinical Director

EXAMPLES OF QUALITY IMPROVEMENT INITIATIVES

Is the Community Mental Health Team (CMHT) following patients up within 7 days of hospital discharge?

Background

In March 2013 an email was sent from the Medical Director of Greater Glasgow and Clyde to General Adult Psychiatry Consultants; this indicated that within the NHSGGC area all of the recommendations made by the National Confidential Inquiry into Suicide and Homicide by people with Mental Illness had been implemented, except for following patients up within 7 days of hospital discharge. It was therefore stated that we should strive to implement this recommendation.

Purpose of project

The purpose of this audit was to assess whether patients at our Resource Centre were being followed up within 7 days of hospital discharge.

Methodology

On each audit cycle the CMHT reviewed the last 30 patients discharged. The first cycle was performed in May 2013, the second in September 2013. The CMHT examined whether patients were followed up within 7 days; and if not, whether they were referred to another service or offered an appointment for a later date. They also examined the mode of initial contact, documentation of plans, attendance and who within the CMHT followed the patient up.

Results

- Comparison of the results showed an improvement from 50% to 73% of patients being followed up within 7 days.
- The crisis team were following up 77% of these patients.
- During this period the number of patients who were not seen within 7 days but were offered an appointment for a later date was reduced from 33% to 3%.

Conclusions

- The results demonstrated a significant improvement simply by raising awareness within the CMHT.
- The crisis team followed up the majority of the patients and this may be of interest to areas where a crisis team is not in place. (Although a 24 hour crisis team is itself one of the NCI recommendations).
- The majority of the improvement appears to have come from patients being given an appointment within 7 days instead of one for a later date.

Benefits of project to date

- Comparison of the results showed an improvement from 50% to 73% of patients being followed up within 7 days.
- The crisis team were following up 77% of these patients.
- During this period the number of patients who were not seen within 7 days but were offered an appointment for a later date was reduced from 33% to 3%.
- These results have been presented to the CMHT and discussions took place around how to best follow up patients admitted for short term arranged admissions. A further audit cycle is planned for the near future.

'Up and About' in Care Homes

Background

In June 2011 the Care Inspectorate (formerly SCSWIS) and NHSScotland issued *Managing Falls and Fractures in Care Homes for Older People,* along with a falls awareness DVD. The resource aimed to help managers and staff to consider falls prevention and management in their care home and, where necessary, improve their approach to this. An evaluation of this resource has told us that where care homes have used it as intended (i.e. carrying out the self assessment then developing and implementing an improvement plan with the local health and social care team) significant reductions in falls have been achieved. However, the evaluation also highlighted that many care homes felt they did not have the time or local support to use the resource in this way. The National Falls Programme has therefore been working with care homes for older people and health and social care staff in three areas of Scotland (of which West Dunbartonshire is one) to tackle the problem of falls. The project was initially funded for 8 months from January 2014 but the National Team will continue until the end of June 2015.

Purpose of Project

Using the Model for Improvement including PDSA cycles, this project is testing a prototype approach to improvement in care homes which aims to introduce, improve and embed core practices to reduce and manage falls risk. This is being achieved through providing focused support to care home managers and staff to:

- Utilise the Care Inspectorate / NHSScotland self-assessment resource to best effect.
- Use the Model for Improvement.
- Gather and analyse data to understand and address the local causes and patterns of falls, and target improvement efforts.
- Provide training.
- Facilitate integrated working with the local health and social care team.
- Learn from each other and experts in the area of falls prevention and management.

The learning from Phase One will inform Phase Two - an improvement programme on a larger scale.

Conclusions

The West Dunbartonshire care homes that have made the most significant improvements have been using the Pillars for Success for falls and fractures. We look forward to continuing our improvement journey over the next few months.

Benefits of project to date

- Established a baseline of data to allow comparison of falls within and across care homes.
- Improved falls data collection and analysis.
- Reduced the number of falls in care homes.
- Reduced the number of falls resulting in injury.
- Improved awareness of falls; falls risk factors; and strategies to reduce falls across care home staff.
- Established a care homes network to provide ongoing support and advice.
- Identified gaps and areas of ongoing developmental need.
- Linked care homes into the 'Up and About' pathway (local and national).

Pilot of Namaste Care in West Dunbartonshire

Background

Namaste care was initially introduced in America by Joyce Simard and due to its success the approach has been adopted in a number of countries worldwide. At present there are only two care homes in Scotland who have recently piloted Namaste; they are in the early stages of implementation however have already reported positive outcomes for residents, staff and families. Namaste reflects the style of care of the hospice movement; this care focuses on the spirit within people allowing for a completely new approach to care within care homes. Once familiar with this style of care, staff are likely to adopt this approach with other residents, also benefiting those who do not have dementia. When the Namaste room is equipped and operating with trained staff, it should be sustainable with little external input and should not require any additional staff.

Namaste care was created to reduce distress and suffering whilst improving the care experience for people with advanced dementia and those caring for them. This is done by providing care which is completely person centred, through stimulating senses and providing calm environments. A room is equipped in the home to provide this care and one member of staff during each session is responsible to run this room.

Purpose of Project

To improve palliative and end of life care for people with dementia within care homes in West Dunbartonshire.

Methodology

The CHCP Palliative Nursing team worked closely with the Nursing Home staff and Dementia Specialist Nurse to introduce Namaste Care within the home. This pilot was run for one year and evaluated on a 3 monthly basis.

Benefits of project to date

- Namaste is now embedded in practice in Castle View Nursing Home.
- Many people with dementia have complex physical and mental health problems, these may also be life threatening, and this can lead to extreme emotional and physical distress.
- For family members and care staff, the impact of trying to support these people whilst watching them suffer such symptoms should not be underestimated.
- Namaste care aims to improve quality of life for residents; people receiving this style of care have started to speak after not talking for several months, improved behaviour has been reported and better symptom control.
- This not only has a positive impact on residents it also improves staff moral and family satisfaction of the level of care.

Releasing Time to Care (RTTC)

Purpose of Project

RTTC is a national programme, aimed at enhancing planning and delivery of patient care whilst making the best use of available resources

Background

Community Nursing RTTC commenced in WDCHCP in Dumbarton and Alexandria in April 2012. The project was led by Team leaders. A two day Training Programme was attended to gain an understanding of their role and the content of the RTTC Modules.

Methodology

There are nine modules in the RTTC Programme. The first three modules are the foundation modules which were completed with support from facilitators These consist of:-*The Well Organised Working Environment (WOWE*) which examines the Teams operational systems and processes is including improved management of supplies & stock levels using LEAN methodology. *Knowing How We are Doing (KHWD*) looks at how the Team functions to ensure that clinical & staff governance standards are met and that Patient and Staff satisfaction levels are assessed. *Patients Status at a Glance (PSAG*) looks at systems to promote continuity of patient care and risk management systems and processes. The "*Patient Perspective*" module is integral to all of these foundation modules, and therefore runs in tandem with various activities to ensure that the patient perspective is central to all discussions / change processes. The modules were led by DN Sisters

Benefits of project to date

- An agreed Team Vision has been developed in both Dumbarton & Alexandria and Clydebank, which has enhanced team building and team working.
- Standardised audits across the teams e.g. patient satisfaction
- Patient facing time collected locally prior to the national workload tool results.
- Protected time for staff to meet and review aspects of service delivery
- Enhanced team working
- Patient status at a glance boards utilised effectively in each team
- Staff developing 'standard care procedures' a process for setting, reviewing and auditing best practice in relation to specific nursing interventions.
- Acknowledgement of existing good practice in the management of off duty and in the daily allocation of visits
- A review of common missing data from referrals to the service, and local agreements to prompt extra questions that are not within the existing DN referral documentation i.e. – "is there a key safe box"; "does the patient have any pressure area damage / concerns".
- Team handover meetings and Team meetings are now more formalised which has improved communications & information sharing & in turn has increased continuity of care as handover reports take place without interruption.
- A Patient Experience Survey was completed in the three localities; this was a very beneficial audit as it evidenced a high standard of patient satisfaction with the DN service across the CHCP.
- A Staff Experience Survey was completed & evidenced that the majority of staff felt happy, supported and valued at work.
- Treatment room looked at waste appointments over a four week period. Indicated same offenders and GP practices would be informed to letter patients in attempt to minimise in the future.

Specialist Children's Services Case-Note Review – Acorn Centre

Purpose of Project
This was an audit carried out to ascertain the standard of record keeping.

Background:
- GMC/Royal Colleges' recommendations
- Poor standards of record keeping cited in Ombudsman's Reports for other services and SCS

Conclusions
The action plan sought improvement in the recording of Next of Kin information and the audit report provided a reminder to avoid jargon and abbreviations in the notes. In general the results of the audit were very good with some of the deficits already having been addressed by action plans. As services are transferred to the EMIS electronic patient record some of the issues raised are no longer be problematic as they are recorded automatically.

Benefits of project to date
- As a result of the audit the NHSGGC record keeping guidance was redistributed to staff with a one page 'aide-memoir' on the important points, along with a document developed by the CAMHS Practice Development Nurse which gives links to record keeping guidance for the various professional organisations working within SCS.
- A record template has been developed for use by CAMHS staff within the EMIS system.
- It was recommended that a record front sheet to address the recording of gender, next of kin and GP information be developed and that the use of the record keeping guidance for those professions not well versed in its contents be reinforced.
- West Dunbartonshire continues to maintain the good levels of compliance achieved.

PROTECTED LEARNING EVENTS

Shared learning event

The Annual CHCP Protected Learning Event (PLE) took place this year on the 27th November at the Beardmore Hotel Clydebank. The purpose of this event was to bring frontline staff together to review the Daniel Pelka Child Protection case in a multidisciplinary environment and to learn about the Post Diagnostic Support available to patients following a diagnosis of Dementia. The group also learned about local dementia initiatives supported by Alzheimer Scotland. In parallel we also provided sessions on communication and equalities for admin staff.

The session on Child Protection was designed to enable delegates to identify opportunities in West Dunbartonshire to do things differently in order to improve outcomes for children, responses could be themed into the following:

- Involve GPs more in Chronology.
- Improve communication between GPs, Social Workers, School Nurses and Teachers.
- Named individual work better.
- Joined-up IT systems.

The CHCP is working with GP practices and staff to improve Child Protection arrangements by support the use of the RCGP Safe Guarding Children Self Assessment through the CHCPs GP Clinical Effectiveness Programme.

Over 160 staff attended the event (43 [26%] of which were GPs). The event was evaluated and feedback proved to be very positive. Over 80% of respondents indicated the sessions they attended went well or very well, feedback was received indicating that 87% of respondents felt the arrangements were good or very good. Following the event feedback was received that a number of people were turned away from the event as they hadn't registered. Where possible delegates were accommodated on the day and the CHCP will endeavour to accommodate as many delegates as possible at future events. The CHCP is considering how it can improve the registration process and the management of unregistered delegates for future events.

Clinical Education Programme

In 2014 the CHCP developed a lunchtime education programme, delivering sessions for GPs and other clinical staff on key educational topics which were aligned to national and local priorities including:

- Adult Protection and Mental Health Act
- Death Certification and Bereavement Policy
- End of Life (including DNACPR)
- Diabetes

In addition to the one hour lunchtime programme, the session on the 18th September 2014 was extended to include a session on End of Life (including DNACPR). The opportunity to do this was as a result of this date being a previously agreed Protected Learning Time and was set aside in practice diaries. In 2015/16 the new HSCP will arrange for formal education sessions to be held on some PLT dates as a result of the successful session held in September 2014.

EXAMPLES OF AWARD RECOGNITION

Staff and services within West Dunbartonshire have always placed a premium on engaging with patients, carers and the wider communities that we serve. **West Dunbartonshire Link Up** ensures older people have access to a range of community health, social care and third sector services through a single point of access. This service was developed in response to feedback from older people and their carers; and specifically to the Reshaping Care for Older People programme. Older people, carers and local services are working jointly to help older people maintain their independence. The Link Up initiative - developed by the then CHCP and WD CVS – has won:

- The Working with Local Communities category of the 2014 Care Accolades Awards.
- The Self Management Project of the Year of the Health and Care Alliance Scotland Awards 2014.
- The Gold Award for the Local Matters category of the COSLA Excellence Awards 2015.

We aim to develop a workforce which feels positive to be part of the CHCP, feels listened to and valued and where all staff take responsibility to identify and address issues in their area of work in terms of quality, efficiency and effectiveness. Senior managers, lead professionals and staff in general within West Dunbartonshire have always recognised the value of supporting each other. The CHCP's and the Council's **Healthy Working Lives (HWL) Gold** Annual Review took place in August 2014, which confirmed that both had successfully maintained Gold Award status. This was the first joint assessment and necessitated a concerted effort from various staff and departmental teams across the Council and across the CHCP under the leadership of the CHCP's Health Improvement Team. The level of commitment evidenced by both organisations specifically in terms of planning, developing, implementing, monitoring activities in order to successfully execute the HWL award across both organisations was positively commented on by the assessor with the approach taken in West Dunbartonshire highlighted as good practice.

The NHS is going through a massive modernisation programme to ensure it is able to adapt and respond to the changing needs of the population we serve. Recognising and celebrating success and achievement is a vital part of showcasing the best of what the NHS is all about and encouraging others to aspire to greater levels of service, patient care and an effective health – and care - economy. At the **2014 NHSGGC Celebrating Success Staff Awards**, our CHCP commended the following local initiatives, teams and staff:

- Our local Palliative Care Programme - represented by Val McIver, Lynne McKnight and Pamela MacIntyre.
- Our Speech and Language Therapy Communication Link Person initiative - represented by Sheila Downie, Ros McCaughey and Victoria McIntosh.
- Our District Nursing Releasing Time to Care initiative - represented by Val McIver, Fiona Rodgers and Margaret MacLachlan.
- Our West Dunbartonshire Health Improvement Team.
- Janice Miller, our MSK Physiotherapy Manager for the Health Board area.

We are conscious that - as always - local progress and improvement is a product of the diligence and energy of a wider team of staff - well done to all involved.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 19th August 2015

Subject: Audit Arrangements

1. Purpose

1.1 To present proposals for audit arrangements for the West Dunbartonshire Health & Social Care Partnership Board.

2. Recommendation

2.1 The Partnership Board is recommended to:

- Approve the proposals for the establishment of an Audit Committee for the Partnership Board.
- Appoint Ros Micklem as Chair of the Audit Committee for her term of office as Vice-Chair of the Partnership Board.
- Direct the Chief Financial Officer to prepare Terms of Reference for the Audit Committee for consideration at its first meeting.
- Agree that internal audit service for the Partnership Board will be provided by West Dunbartonshire Council's Internal Audit Section, with Colin McDougall appointed as Chief Internal Auditor for the Partnership Board.
- Note that Audit Scotland has been appointed by the Accounts Commission to act as external auditor for the Partnership Board.
- Direct the Chief Financial Officer to make arrangements for the first meeting of the Audit Committee prior to the end of the calendar year.
- Direct the Chief Financial Officer to work with the appointed Chief Internal Auditor to prepare an operational agreement with respect to the internal audit service for consideration at the first meeting of the Audit Committee.
- Direct the Chief Internal Auditor to work with the Chief Financial Officer and the Chief Officer to prepare proposals for the development of a risk based internal audit plan for 2016-17, which would include the completion of a post integration report.

3. Background

3.1 Audit Scotland have emphasised that health and social care integration requires effective governance arrangements for the new joint bodies; and that a crucial element of governance is audit committee arrangements.

3.2 The Health Board has an established Audit Committee that is chaired by a Non-Executive Director of the Health Board (but not the Chair of the Health Board).

3.3 The Council has an established Audit and Performance Review Committee that is chaired by the Leader of the Opposition.

3.4 The Health & Social Care Partnership Board Financial Regulations reflect the recommendations of the national Integrated Resources Advisory Group confirms the responsibility of the Partnership Board to establish adequate and proportionate internal audit arrangements for review of the adequacy of the arrangements for risk management, governance and control of the delegated resources.

3.5 In approving the integration scheme that was submitted to the Scottish Government, the Council and the Health Board confirmed endorsed the principle that the new Partnership Board should establish a standing Audit Committee to focus on financial and internal audit on its behalf.

4. Main Issues

4.1 Given its responsbilities for budget expenditure, best practice within the Scottish Finance Manual dictates that an Audit Committee should be established to advise the Partnership Board on internal control (including corporate governance) and audit matters. Such an Audit Committee should:

- Be a formal sub-committee of the Partnership Board.
- Should be under the chair of voting member other than the Chair of the Partnership Board.
- Determine who will provide the internal audit service for the Partnership Board and appoint a Chief Internal Auditor.
- Confirm an external auditor, to be met at least once a year.
- Require the Chief Officer, Chief Financial Officer and the appointed Chief Internal Auditor to attend meetings (though not as members of the Audit Committee).
- Have written terms of reference.
- Have a clear programme of work (i.e. an internal audit plan) and arrange its meetings to ensure effective delivery of that programme.

4.2 The Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014 Guidance for Integration Financial Assurance confirms that it is for the Partnership Board to formally agree its audit arrangements and the membership of its Audit Committee, anticipating that the will be drawn from within the respective integration Joint Board. The Health Board and the Council also have a legitimate interest in being assured that the Partnership Board has agreed and implemented appropriate governance arrangements, including those for internal audit.

4.3 In approving the integration scheme for West Dunbartonshire that was then submitted to the Scottish Government, the Health Board and Council endorsed a number of expectations for the internal audit with respect to the Partnership Board. These have been updated and proposed as follows to the Partnership Board for adoption, i.e. that:

- The Partnership Board establish a standing Audit Committee to focus on financial and internal audit on behalf of the Partnership Board.

- The Audit Committee be composed of the voting members of the Partnership Board; and chaired by the Vice-Chair of the Partnership Board.
- The Chief Officer and Chief Financial Officer be required to attend meetings of the Audit Committee.
- As the Audit Committee will be responsible for overseeing the regularity of expenditure by Partnership Board, other non-voting members of the Partnership Board shall also have the right to attend. A schedule of meetings will be published for all Partnership Board members, and those non-voting members who confirm their intention to attend the meeting will be issued with papers for that meeting.
- The Audit Committee receive the formal submission of reports, findings and recommendations by the appointed Internal Audit service, external auditor, Audit Scotland and Inspectorate bodies.
- The Chief Financial Officer will nominate an Internal Audit Service, led by a named Chief Internal Auditor, to work on behalf of the Audit Committee. The appointed Chief Internal Auditor will be required to attend meetings of the Audit Committee.
- The Chief Financial Officer will prepare an Annual Governance Statement for the Audit Committee and the Partnership Board.
- The Audit Committee will meet quarterly, with a provision for additional meetings if required; and with meetings scheduled at regular intervals between the quarterly meetings of the Partnership Board.
- The minutes of the Audit Committee meetings will be routinely submitted to the Partnership Board.

4.4 The Chief Financial Officer will be responsible for providing assurance on the system of internal financial control to the Audit Committee on behalf of the Health Board and Council. In doing this, the Chief Financial Officer will be reliant on both the Health Board's and Council's systems of internal control to support compliance with both organisations' policies and promotes achievement of each organisation's aims and objectives, as well as those of the Partnership Board as expressed in its Strategic Plan.

4.5 The national Integrated Resources Advisory Group recommends that:

- The internal audit service should be provided by one of the internal audit teams from the Health Board or Local Authority.
- The Chief Internal Auditor from either of the Health Board or Local Authority undertake this role for the integration joint board in addition to their role as Chief Internal Auditor of their respective organisation.

4.6 Following discussions between the Chief Officer, the Chief Financial Officer, the Health Board Director of Finance and the Council Section 95 Officer it is proposed that internal audit service for the Partnership Board be provided by West Dunbartonshire Council's Internal Audit Section, with Colin McDougall (who is the Council's Chief Internal Auditor) appointed as Chief Internal Auditor for the Partnership Board. It is proposed that the Chief Financial Officer work with the appointed Chief Internal Auditor to prepare an operational agreement

with respect to the internal audit service for consideration at the first meeting of the Audit Committee.

4.7 It has been confirmed that:

- The Accounts Commission is responsible for appointing external auditors for Integration Joint Boards.
- In the first instance, the Accounts Commission has appointed Audit Scotland to undertake this role from such point as individual integration joint boards are established until the end of 2016/17.

It should be noted that Audit Scotland have separately begun a national performance audit looking at the integration of health and social care services; and are leading on an assessment of the progress made in implementing the reforms, working closely with the Care Inspectorate and Healthcare Improvement Scotland.

4.8 It has been confirmed that the Audit Scotland external audit team currently attached to West Dunbartonshire Council will similarly undertake that external audit role for the Partnership Board. It has been confirmed that members of that Audit Scotland external audit team will attend the meetings of the Partnership Board Audit Committee.

4.9 It is proposed that the Chief Financial Officer prepare Terms of Reference for the Audit Committee that reflect that span of responsibilities of the Partnership Board, i.e.:

- **The Strategic Plan.**
- **Financial plan underpinning the Strategic Plan.**
- **The operational delivery of those integrated services delegated to the Partnership Board (except for NHS acute hospital services).**
- **Relevant issues raised from the internal auditors of the Health Board, Council and the Partnership Board.**

4.10 The Chief Internal Auditor for the Partnership Board will report to the Chief Financial Officer and the Audit Committee on an annual risk-based audit plan, delivery of the plan and recommendations; and will provide an annual internal audit report, including the audit opinion.

4.11 The Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014 Guidance for Integration Financial Assurance acknowledges that the establishment of an Integration Joint Board audit committee will have implications for the ongoing work of the Health Board and Local Authority audit committees. The Chief Financial Officer will work with the internal auditors of the Health Board, Local Authority and the Partnership Board to ensure that there is clarity and consistency of appropriate scrutiny of the work of the Partnership Board and the Health & Social Care Partnership; and that the internal audit plans of the three audit committees provide necessary assurance to all three of the bodies. The Chief Internal Auditor will

ensure that the Partnership Board's annual internal audit plan and internal audit report are shared with the Health Board's Audit Committee and Council's Audit & Performance Review Committee through the reporting arrangements in those bodies for internal audit.

4.12 The Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014 Guidance for Integration Financial Assurance recommends that the three audit committees (Health Board, Local Authority and Integration Joint Board) are provided with a post integration report to evaluate the actual risk and financial performance against the pre-integration assumptions, performance on relevant integration milestones, identify lessons learned and assess whether the Integration Joint Board is on course to deliver the long-term benefits. It is proposed that such a post integration report is a joint undertaken by report by the Chief Internal Auditors of the Health Board, Council and the Partnership Board (the latter two being the same person fulfilling two distinct roles) as part of the 2016-17 internal audit plan for presentation initially to the Audit Committee and thereafter the full Partnership Board, the Health Board's Audit Committee and the Council's Audit & Performance Review Committee.

5. People Implications

5.1 As above, it is proposed that Colin McDougall be appointed as Chief Internal Auditor for the Partnership Board subject to review and agreement of the operational agreement.

6. Financial Implications

6.1 The Chief Financial Officer will be responsible for providing assurance on the system of internal financial control to the Audit Committee on behalf of the Health Board and Council. That system of internal financial control would be based on a framework of regular management information, Financial Regulations and Standing Financial Instructions, administrative procedures (including segregation of duties), management and supervision, and a system of delegation and accountability. In doing this, the Chief Financial Officer will be reliant on both the Health Board's and Council's systems of internal control to support compliance with both organisations' policies and promotes achievement of each organisation's aims and objectives, as well as those of the Partnership Board as expressed in its Strategic Plan.

6.2 The appointments of the Council's Internal Audit Section and Colin McDougall as Chief Internal Auditor for the Partnership Board would be subject to review and agreement of the operational agreement.

7. Professional Implications

7.1 The proposals here have been agreed with the Council Section 95 Officer and the Health Board Director of Finance. The Health Board Director of Finance and the Council Section 95 Officer will ensure that the Audit Committee is

provided with necessary technical and corporate support in relation to its remit.

7.2 The Chief Internal Auditor for the Partnership Board will report to the Chief Financial Officer and the Audit Committee on the approved annual risk-based audit plan; delivery of the audit plan and any recommendations; and will provide an annual internal audit report, including the audit opinion.

7.3 The Chief Internal Auditor will ensure that the Partnership Board's annual internal audit plan and internal audit report are shared with the Health Board's Audit Committee and Council's Audit & Performance Review Committee through the reporting arrangements in those bodies for internal audit.

8. Locality Implications

8.1 There are no locality implications associated with this report.

9. Risk Analysis

9.1 As stated above, Audit Scotland have emphasised that health and social care integration requires effective governance arrangements for the new joint bodies; and that a crucial element of governance is audit committee arrangements.

9.2 It is the responsibility of the Partnership Board to establish adequate and proportionate internal audit arrangements for review of the adequacy of the arrangements for risk management, governance and control of the delegated resources. The implementation of such arrangements by the Partnership Board will be subject to scrutiny.

10. Impact Assessments

10.1 None required

11. Consultation

11.1 These proposals have been shared with Audit Scotland, as the external auditors, and they have confirmed that they are appropriately based.

12. Strategic Assessment

12.1 Proper budgetary control and sound financial practice are cornerstones of good governance and support the Partnership Board and officers to pursue the strategic priorities of the HSCP Strategic Plan.

12.2 This report links to the strategic financial governance arrangements of both the Health Board and the Council.

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Date: 19th August 2015

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Appendices: None

Background Papers: Audit Scotland (2015) An overview of local government in Scotland 2015
http://www.auditscotland.gov.uk/docs/local/2015/nr_150305_local_government_overview.pdf

NHS Greater Glasgow & Clyde Health Board: Establishing a Health and Social Care Partnership for West Dunbartonshire (January 2015)

West Dunbartonshire Council: Establishing a Health and Social Care Partnership for West Dunbartonshire (February 2015)

HSCP Board Report (August 2015): Health & Social Care Partnership Board Financial Regulations

The Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014 Guidance for Integration Financial Assurance
http://www.gov.scot/Resource/0046/00465080.pdf

On Board: A Guide for Board Members of Public Bodies in Scotland
http://www.gov.scot/Resource/Doc/44473/0078499.doc

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 19th August 2015

Subject: Risk Management Policy & Strategy

1. Purpose

1.1 To present the Risk Management Strategy & Policy prepared for the new Health & Social Care Partnership.

2. Recommendation

2.1 The Partnership Board is recommended to:

1) Approve the Risk Management Policy & Strategy for the Health & Social Care Partnership; and

2) Direct the Chief Officer to prepare a draft strategic risk register for scrutiny at the first meeting of the Audit Committee prior to its being finalised and then presented to the subsequent meeting of the Partnership Board.

3. Background

3.1 Audit Scotland have emphasised that health and social care integration requires effective governance arrangements for the new joint bodies. Such governance arrangements include systems for managing risks.

3.2 The Health & Social Care Partnership Board Financial Regulations reflect the recommendations of the national Integrated Resources Advisory Group which confirms the responsibility of the Chief Officer to develop a local risk strategy and policy for approval by the Partnership Board (attached).

4. Main Issues

4.1 Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects. It is pro-active in understanding risk and uncertainty, it learns and builds upon existing good practice and is a continually evolving process that has an important role in ensuring that defensible and beneficial decisions are made.

4.2 The Integration Scheme for West Dunbartonshire confirms that the Health Board and the Council - along with the other local authorities in the Health Board area – had developed a model risk management policy and strategy to support integrated service delivery (except for NHS acute hospital services).

4.3 The attached local policy & strategy is both based on that model document and the local learning accumulated from the experience of the former Community Health & Care Partnership in having successfully developed and maintained an integrated strategic risk register.

4.4 The Integration Scheme confirms that a key element of the required risk management process is the preparation, scrutiny, approval and then annual review of the annual strategic risk register for the Health & Social Care Partnership. Subject to the approval of this local policy & strategy, an initial key action will be for the Chief Officer to draft such a strategic risk register for presentation at the first meeting of the Partnership Board's Audit Committee for scrutiny (subject to that proposal having been agreed by the Partnership Board separately and earlier at this meeting), before then bringing to the Partnership Board formally for approval.

5. People Implications

5.1 Risk management should be integrated into daily activities with everyone involved in identifying current and potential risks where they work. Individual staff have a responsibility to make every effort to be aware of situations which place them or others at risk, report identified hazards and implement safe working practices developed within their service areas.

5.2 This policy and strategy will be promoted and made readily accessible to Health & Social Care Partnership staff and will form the basis of any risk management training provided to them by the Council and Health Board.

6. Financial Implications

6.1 The Health Board's Director of Finance and the Council's Section 95 Officer will ensure that the Partnership Board and its Audit Committee is provided with the necessary technical and corporate support to develop, maintain and scrutinise strategic risk registers.

6.2 Financial decisions in respect of these risk management arrangements will rest with the Chief Financial Officer.

7. Professional Implications

7.1 This strategy and policy supports the regulatory frameworks within which health and social care professionals practice; and the established professional accountabilities that are currently in place within the NHS and local government. All health and social care professionals remain accountable for their individual clinical and care decisions.

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 As stated above, Audit Scotland have emphasised that health and social care integration requires effective governance arrangements for the new joint bodies. Such governance arrangements include systems for managing risks.

9.2 Risk management proactively reduces identified risks to an acceptable level by creating a culture founded upon assessment and prevention, rather than reaction and remedy. It plays a vital role supporting and informing decision-making in providing a safe and secure environment for service users, carers and staff. It should be embedded into all organisational processes and involve everyone in the organisation. Organisations that manage risk effectively and efficiently are more likely to achieve safe and effective care, and do so at lower overall cost.

9.3 It is the responsibility of Partnership Board to approve a local risk management policy & strategy, alongside the establishment of adequate and proportionate internal audit arrangements for review of the adequacy of the arrangements for risk management. The implementation of such arrangements by the Partnership Board will be subject to scrutiny.

10. Impact Assessments

10.1 None required

11. Consultation

11.1 This report was agreed with the Health Board Director of Finance and Council Section 95 Officer.

12. Strategic Assessment

12.1 The adoption of the attached Risk Management Strategy & Policy will prevent or mitigate the effects of loss or harm; and will increase success in the delivery of the Strategic Plan.

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Date: 19th August 2015

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Appendices:	West Dunbartonshire Health & Social Care partnership Risk Management Policy & Strategy
Background Papers:	Audit Scotland (2015) An overview of local government in Scotland 2015 http://www.auditscotland.gov.uk/docs/local/2015/nr_150305_local_government_overview.pdf HSCP Board Report (August 2015): Health & Social Care Partnership Board Financial Regulations The Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014 Guidance for Integration Financial Assurance http://www.gov.scot/Resource/0046/00465080.pdf
Wards Affected:	All

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership
Risk Management Policy & Strategy

CONTENTS

INTRODUCTION

1.1 *West Dunbartonshire Health & Social Care Partnership Board* is responsible for the strategic planning and reporting of a range of health and social care services delegated it by NHS Greater Glasgow & Clyde Health Board and West Dunbartonshire Council (described within its Integration Scheme). The Council and the Health Board discharge the operational delivery of those delegated services (except those related to the Health Board's Acute Division services most commonly associated with the emergency care pathway) through the partnership arrangement referred to as *West Dunbartonshire Health & Social Care Partnership*. The Health & Social Care Partnership Board is responsible for the operational oversight of West Dunbartonshire Health & Social Care Partnership.

1.2 The Partnership Board, the Council and the Health Board are committed to actively promoting an organisational culture that:

- Supports human rights and social justice.
- Values partnership working through example.
- Affirms the contribution of staff through the application of best practice, including learning and development.
- Is transparent and open to innovation, continuous learning and improvement.

1.3 The Health Board, the Council and the Partnership Board are committed to the Health & Social Care Partnership being an organisation in which staff delivering care:

- Practice in accordance with their professional standards, codes of conduct and organisational values.
- Are responsible for upholding professional and ethical standards in their practice and for continuous development and learning that should be applied to the benefit of the public.
- Ensure the best possible care and treatment experience for service users and families.
- Provide accurate information on quality of care and highlight areas of concern and risk as required.
- Work in partnership with management, service users, carers and other key stakeholders in the designing, monitoring and improvement of the quality of care and services.
- Speak up when they see practice that endangers the safety of patients or service users in line with local policies for public interest disclosure and regulatory requirements.
- Engage with colleagues, patients, service users, communities and partners to ensure that local needs and expectations for safe and high quality health and care services, improved wellbeing and wider outcomes are being met.

1.4 The Partnership Board, while having legal personality in its own right, has neither replaced nor assumed the rights or responsibilities of either the Health Board or the Council as the employers of the staff delivering integrated services; or for the operation of buildings or services under the operational remit of those staff. The Council and the Health Board will continue to indemnify, insure and accept responsibility for the staff that they each employ; their particular capital assets that integrated services are delivered from or with; and the respective services themselves that each has delegated to the Partnership Board. The existence of the Partnership Board does not change the current or future regulatory framework within which health and social care professionals practice; the established professional accountabilities that are currently in place within the NHS and local government. All health and social care professionals remain accountable for their individual clinical and care decisions.

1.5 The Council, the Health Board and the Partnership Board believes that appropriate application of good risk management will prevent or mitigate the effects of loss or harm and will increase success in the delivery of better clinical and financial outcomes, objectives, achievement of targets and fewer unexpected problems.

THE VISION

2.1 The West Dunbartonshire Health & Social Care Partnership Board's:

- Mission is to improve the health and wellbeing of West Dunbartonshire.
- Purpose is to plan for and ensure the delivery of high quality health and social care services to and with the communities of West Dunbartonshire.
- Core values are protection; improvement; efficiency; transparency; fairness; collaboration; respect; and compassion.

2.2 The risk management vision then is to support that mission, that purpose and those core values with appropriate and effective risk management practice will be embraced by the Health & Social Care Partnership Board and throughout the Health & Social Care Partnership as an enabler of success, whether:

- Delivering better outcomes for the people of West Dunbartonshire.
- Protecting the health, safety and well-being of everyone who engages with Health & Social Care Partnership services.
- For maximising opportunity, increasing performance, delivering innovation and best value.

Key benefits of effective risk management:

- Appropriate, defensible, timeous and best value decisions are made.
- Risk 'aware' not risk 'averse' decisions are based on a balanced appraisal of risk and enable acceptance of certain risks in order to achieve a particular goal or reward.
- High achievement of objectives and targets.
- High levels of morale and productivity.
- Better use and prioritisation of resources.
- High levels of user experience/ satisfaction with a consequent reduction in adverse incidents, claims and/ or litigation.
- A positive reputation established for the Health & Social Care Partnership.

2.3 In delivering this risk management vision, the Council, the Health Board and the Partnership Board will demonstrate a level of maturity where risk management is embedded and integrated in the decision making and operations of the Health & Social Care Partnership.

2.4 The fundamental measure of success for this vision will be how well the Partnership Board has been able to use its allocated resources to effectively deliver its Strategic Plan.

2.5 Effective communication of risk management information is essential to developing a consistent and effective approach to risk management. This policy and strategy will be promoted and made readily accessible to Health & Social Care Partnership staff and will form the basis of any risk management training provided to them by the Council and Health Board.

2.6 This Policy and Strategy (version 1.0) was approved by the Partnership Board at its meeting of 19th August 2015. It will be reviewed regularly to ensure that it reflects current standards; best practice and the requirements of the Partnership Board, Health Board and Council.

POLICY – THE APPROACH

3.1 The Partnership Board, the Council and the Health Board purposefully seeks to promote an environment that is risk 'aware' and strives to place risk management information at the heart of key decisions – and consequently take an effective approach to managing risk in a way that both address significant challenges and enable positive outcomes.

3.2 In normal circumstances the collective appetite/tolerance for risk is based on a combination of assessing estimates of consequence (also described as severity or outcome) and likelihood (frequency or probability) in the context of existing control measures.

Consequence Scoring		Likelihood Scoring	
1	Negligible	1	Rare
2	Minor	2	Unlikely
3	Moderate	3	Possible
4	Major	4	Likely
5	Catastrophic	5	Almost Certain

The magnitude or rating of a given risk is established using a two-dimensional grid or matrix, with consequence as one axis and likelihood as the other (Appendix 1). For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

- 1–3 Low risk.
- 4–6 Moderate risk.
- 8–12 High risk.
- 15–25 Extreme risk.

3.3 The Partnership Board, the Council and the Health Board promote the pursuit of opportunities that will benefit the delivery of the Health & Social Care Partnership Strategic Plan. Opportunity-related risk must be carefully evaluated in the context of the anticipated benefits for different service user groups and their anticipated periods of realisation.

3.4 The Partnership Board's Audit Committee will receive assurance reports (internal and external) not only on the adequacy but also the effectiveness of its risk management arrangements and will consequently value the contribution that risk management makes to the wider governance arrangements of the Partnership Board.

3.5 The Partnership Board, Council and Health Board - through the following risk management strategy - have established a Risk Management Framework, (which covers risk policy, procedure, process, systems, risk management roles and responsibilities).

STRATEGY - IMPLEMENTING THE POLICY

Introduction

4.1 The primary objectives of this strategy are to:

- Promote awareness of risk and define responsibility for managing risk within the Health & Social Care Partnership.
- Establish communication and sharing of risk information through all areas of the Health & Social Care Partnership.

- Initiate measures to reduce the exposure to risk and potential loss by the Health Board, Council and the Partnership Board.
- Establish standards and principles for the efficient management of risk, including regular monitoring, reporting and review.

4.2 This strategy takes a positive and holistic approach to risk management. The scope applies to all risks, whether relating to the clinical and care environment, employee safety and wellbeing, business risk, opportunities or threats.

4.3 *Strategic risks* represent the potential for the Partnership Board to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risk.

4.4 *Operational risks* represent the potential for impact (opportunity or threat) within or arising from the activites of an individual service area or team operating within the scope of the Health & Social Care Partnership's activities. The Chief Officer will have responsibility for managing operational risks as operational risks will be more 'front-line' in nature and the development of activities and controls to respond to these risks can be led by local managers and team leaders. Where a number of operational risks impact across multiple service areas or, because of interdependencies, require more strategic leadership, then these can be proposed for escalation to 'strategic risk' status for the Partnership Board.

4.5 All risks will be analysed consistently with an evaluation of risk based on likelihood (scored 1 to 5) multiplied by consequent impact (scored 1 to 5) as follows:

- 1–3 Low risk.
- 4–6 Moderate risk.
- 8–12 High risk.
- 15–25 Extreme risk.

4.6 All risks assessed as as extreme risk will be viewed as signficant and therefore subject to closer scrutiny by the Partnership Board's Audit Committee.

4.7 This document represents the risk management framework to be implemented across the Health & Social Care Partnership; and which will contribute to the wider governance arrangements, including those described within the West Dunbartonshire Health and Social Care Partnership Board Financial Regulations.

Risk management process

4.8 Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects. It is pro-active in understanding risk and uncertainty, it learns and builds upon existing good practice and is a continually evolving process that has an important role in ensuring that defensible and beneficial decisions are made.

4.9 Risk management practice should be embedded by the consistent application of the risk management process (shown in Appendix 2) across all areas of service delivery and business activities.

Application of good risk management

4.10 Standard procedures will be implemented across all areas of activity within the Health & Social Care Partnership in order to achieve consistent and effective implementation of good risk management.

4.11 Full implementation of the risk management process: this means that risk management information should (wherever possible) be used to guide major decisions in the same way that cost and benefit analysis is used.

4.12 Identification of risk using standard methodologies, and involving subject experts who have knowledge and experience of the activity or process under consideration.

4.13 Categorisation of risk under the headings below:

- Strategic Risks: such as risks that may arise from Political, Economical, Social, Technological, Legislative and Environmental factors that impact on the delivery of the Strategic Plan outcomes.
- Operational Risks: such as risks that may arise from or impact on Clinical Care and Treatment; Social Care; Customer Service; Employee Health, Safety & Well-being; Business Continuity/ Supply Chain; Information Security; and Asset Management.

4.14 An appropriate ownership of risk: specific risks will be owned by/ assigned to whoever is best placed to manage the risk and oversee the development of any new risk controls required.

4.15 Consistent application of the risk matrix here in to analyse risk in terms of likelihood of occurrence and potential impact, taking into account the effectiveness of risk control measures in place.

4.16 Consistent response to risk that is proportionate to the level of risk: this means that risk may be terminated; transferred elsewhere (ie to another partner or third party); tolerated as it is; or, treated with cost effective measures to bring it to a level where it is acceptable or tolerable for the Partnership Board in keeping with its appetite/ tolerance for risk. In the case of opportunities, the Partnership Board may 'take' an informed risk in terms of tolerating it if the opportunity is judged to be (1) worthwhile pursuing and (2) the Partnership Board is confident in the Health & Social Care Partnerhip's ability to achieve the benefits and manage/ contain the associated risk.

4.17 Implementation and maintenance of risk registers as a means of collating risk information in a consistent format allowing comparison of risk evaluations, informed decision-making in relation to prioritising resources and ease of access to information for risk reporting.

4.18 Reporting of strategic risks and key operational risks (within a strategic risk register) will be presented to the Partnership Board's Audit Committee for scrutiny and Partnership Board for approval on an annual basis.

4.19 Operation of a procedure for movement of risks between strategic and operational risk registers that will be facilitated by the Chief Financial Officer of the Health & Social Care Partnership.

4.20 Routine reporting of risk information within and across teams and a commitment to a 'lessons learned' culture that seeks to learn from both good and poor experience in order to replicate good practice and reduce adverse events and associated complaints and claims.

LEADERSHIP AND ACCOUNTABILITY

Health & Social Care Partnership Board

5.1 Members of the Partnership Board are responsible for:

- Oversight of the these risk management arrangements.

- Receipt and review of reports on strategic risks and any key operational risks that are formally brought to their attention.
- Ensuring they are aware of any risks linked to formal reports and recommendations from the Chief Officer and other officers of the Health & Social Care Partnership.

5.2 Strategic risk registers will be presented to the Partnership Board's Audit Committee for scrutiny and the Health & Social Care Partnership Board for approval on an annual basis

Chief Officer

5.3 The Chief Officer is responsible for ensuring that suitable and effective arrangements are in place to manage the risks relating to the Health & Social Care Partnership.

5.4 The Chief Officer will prepare an annual strategic risk register that will identify, assess and prioritise risks related to the preparation and delivery of the Strategic Plan; and identify and describe processes for mitigating those risks. This will then be presented to the Partnership Board's Audit Committee for scrutiny and the Partnership Board for approval on an annual basis; and then shared with the Council and Health Board.

5.5 The Chief Officer will ensure that the approved strategic risk register is provided to both of the Council and the Health Board to enable them to take account of its content as part of their overall risk management arrangements. The Chief Officer will formally review the risk register on a six monthly basis. The Chief Officer is responsible for drawing to the attention of the Audit Committee, the Partnership Board, Council and Health Board any substantive developments in-year that lead to a substantial change to the strategic risk register in-year.

Chief Financial Officer

5.6 The Chief Financial Officer is responsible for promoting arrangements to identify and manage key business risks, risk mitigation and insurance.

Health & Social Care Partnership Senior Management Team

5.7 Members of the Senior Management Team are responsible for:

- Supporting the Chief Officer and Chief Financial Officer in fulfilling their responsibilities.
- Receipt and review of regular risk reports on strategic, shared and key operational risks and escalating any matters of concern to the Chief Officer.
- Ensuring that the standard procedures set out in this strategy are actively promoted across their teams and within their areas of responsibility.

Individual Risk Owners

5.8 It is the responsibility of each risk owner to ensure that:

- Risks assigned to them are analysed in keeping with the agreed risk matrix.
- Data on which risk evaluations are based are robust and reliable so far as possible.
- Risks are defined clearly to make explicit the scope of the challenge, opportunity or hazard and the consequences that may arise.
- Risk is reviewed not only in terms of likelihood and impact of occurrence, but takes account of any changes in context that may affect the risk.
- Controls in place to manage the risk are proportionate to the context and level of risk.

All staff working within the Health & Social Care Partnership

5.9 Risk management should be integrated into daily activities with everyone involved in identifying current and potential risks where they work. Individuals have a responsibility to make every effort to be aware of situations which place them or others at risk, report identified hazards and implement safe working practices developed within their service areas. This approach requires everyone to understand:

- The risks that relate to their roles and activities.
- How their actions relate to their own, their services users and public safety.
- Their accountability for particular risks and how they can manage them.
- The importance of flagging up incidents and/ or near misses to allow lessons to be learned and contribute to ongoing improvement of risk management arrangements.
- That good risk management should be a key part of the Health & Social Care Partnership's culture.

Health Board and Council

5.10 The Health Board's Director of Finance and the Council's Section 95 Officer will ensure that the Partnership Board and its Audit Committee are provided with the necessary technical and corporate support to develop, maintain and scrutinise strategic risk registers.

5.11 The Health Board or the Council retain the rights and responsibilities of being the employers of the staff delivering integrated services; or for the operation of buildings or services under the operational remit of those staff. The Council and the Health Board will ensure that staff working within the Health & Social Care Partnership have the appropriate skills and knowledge to provide the appropriate standard of care. The Chief Officer has delegated responsibilities, through the Chief Executives of the Council and the Health Board, for the professional standards of staff working within the Health & Social Care Partnership. The Chief Officer, relevant lead health professionals and the Council Chief Social Work Officer will work together to ensure appropriate professional standards and leadership.

5.12 The Council and the Health Board continue to indemnify, insure and accept responsibility for the staff that they each employ; their particular capital assets that integrated services are delivered from or with; and the respective services themselves that each has delegated to the Partnership Board. Liabilities arising from decisions taken by the Partnership Board are equally shared between the Council and the Health Board.

5.13 The Council's Chief Social Work Officer will provide appropriate professional advice to the Chief Officer and the Partnership Board in relation to statutory social work duties and make certain decisions in terms of the Social Work (Scotland) Act 1968.

5.14 The Health Board Chief Executive, as the accountable officer, is responsible for clinical governance, quality, patient safety and engagement, supported by the Health Board's professional advisers. The Health Board's Medical Director is responsible for the systems which support the delivery of clinical governance and medicines governance. The Chief Officer will be supported by and receive appropriate professional advice from professional leads nominated by the Health Board who relate to and are supported by the Health Board's Medical Director and Director of Nursing.

5.15 The Council and Health Board will take account of the strategic risk register and relevant risk reports to keep their own organisations updated on the management of the risks, highlighting any local risks that might impact on the wider organisation.

Senior Information Risk Owner

5.16 Responsibility for this specific role will remain within the Council and the Health Board.

RESOURCING

Resourcing the risk management framework

6.1 The Health Board's Director of Finance and the Council's Section 95 Officer will ensure that the Health & Social Care Partnership Board and its Audit Committee is provided with the necessary technical and corporate support to develop, maintain and scrutinise strategic risk registers.

6.2 Much of the work on developing and leading the ongoing implementation of the risk Management ramework will be undertaken as part of routine activity within the Health & Social Care Partnership.

6.3 Where risks impact on a specifically on either the Council or Health Board and new risk control measures require to be developed and funded, it is expected that the costs will be borne by that organisation.

6.4 Financial decisions in respect of the these risk management arrangements will rest with the Chief Financial Officer.

Risk management training and development opportunities

6.5 To implement effectively this policy and strategy, it is essential for staff to have the competence and capacity for managing risk and handling risk judgements with confidence, to focus on learning from events and past experience in relation to what has worked well or could have been managed better, and to focus on identifying malfunctioning 'systems' rather than people.

6.6 Training is important and is essential in embedding a positive risk management culture and in developing risk management maturity. The Senior Management Team will regularly review risk management training and development needs and source the relevant training and development opportunities required from the Council and Health Board.

6.7 Wherever possible the Chief Financial Officer will ensure that any locally identified risk management training and education costs will be kept to a minimum, with the majority of risk-related courses/ training being delivered through resources available from the Council and Health Board corporately (notably their dedicated risk managers/ risk management specialists).

MONITORING

7.1 The Health & Social Care Partnership operates in a dynamic and challenging environment. A suitable system is required to ensure risks are monitored for change in context and scoring so that appropriate response is made.

7.2 The Chief Officer will jointly prepare an annual strategic risk register that will identify, assess and prioritise risks related to the preparation and delivery of the Strategic Plan; and identify and describe processes for mitigating those risks.

7.3 Key risk indicators (KRIs) will be identified and linked where appropriate to specific risks to provide assurance on the performance of certain control measures. For example, specific clinical incident data can provide assurance that risks associated with the delivery of clinical care are controlled, or budget monitoring performance indicators can provide assurance that key financial risks are under control. The performance data linked to the Strategic Plan will also inform the identification of new risks or highlight where existing risks require more attention.

7.4 The strategic risk register will be presented to the Partnership Board's Audit Committee for scrutiny and the Health & Social Care Partnership Board for approval on an annual basis; and then shared with the Council and Health Board.

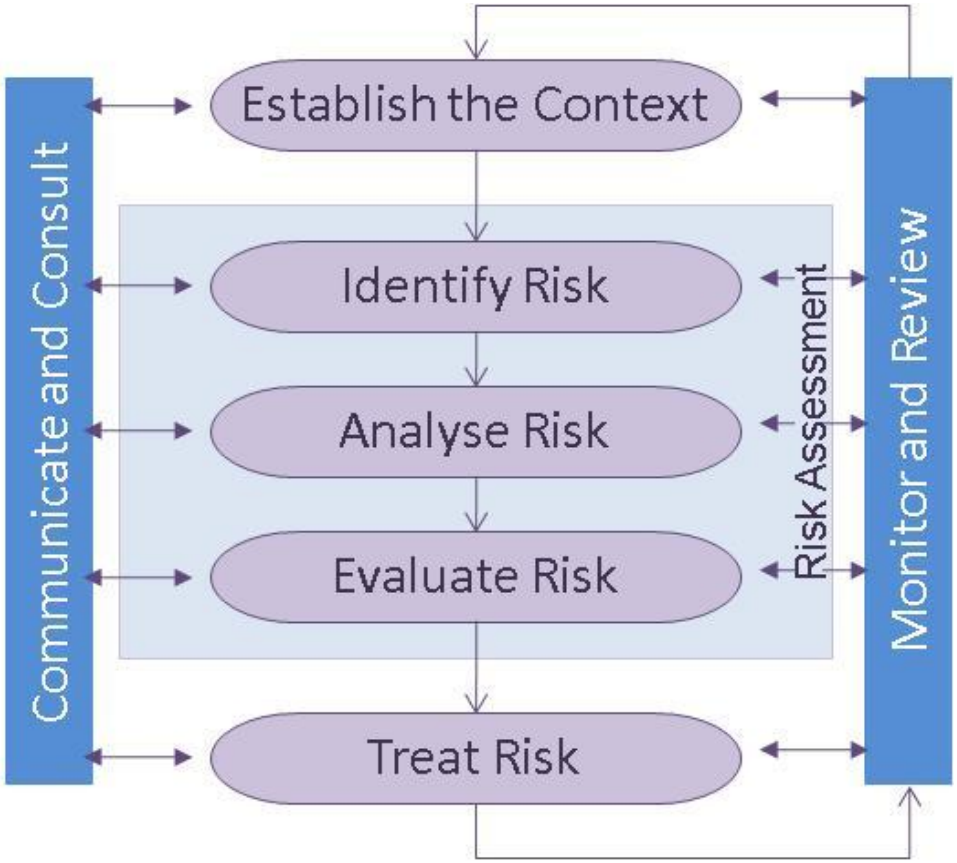
7.5 The Chief Officer will ensure that the approved strategic risk register is provided to both of the Council and the Health Board to enable them to take account of its content as part of their overall risk management arrangements. The Chief Officer will formally review the risk register on a six monthly basis. The Chief Officer is responsible for drawing to the attention of the Audit Committee, the Partnership Board, Council and Health Board any substantive developments in-year that lead to a substantial change to the strategic risk register in-year.

7.6 The Chief Officer and Chief Financial Officer will reviewing the these risk management arrangements on a regular basis to provide assurance to the Partnership Board and its Audit Committee, the Council and the Health Board. Such a 'Plan/ Do/ Study/ Act review cycle that will shape future risk management priorities and activitie; inform subsequent revisions of this policy and strategy; and drive continuous improvement in risk management across the Health & Social Care Partnership.

	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1–3	Low risk
4–6	Moderate risk
8–12	High risk
15–25	Extreme risk


Establish the Context
Identify Risk
Analyse Risk
Evaluate Risk
Treat Risk
Risk Assessment
Communicate and Consult
Monitor and Review

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 19 August 2015

Subject: Proposed Relocation of Clydebank Older Adult Continuing Care Dementia Beds from Gartnavel Royal Hospital to the Dumbarton Joint Hospital

1. Purpose

1.1 To inform the HSCP Board of the proposal to relocate four Older Adult Continuing Care Beds currently within Gartnavel Royal Hospital to Glenarn Ward based at the Dumbarton Joint Hospital.

2. Recommendations

2.1 To agree the proposal to relocate of 4 Older Continuing Care Beds from Gartnavel Royal to Dumbarton Joint Hospital.

3. Background

3.1 The provision of Older Adult Continuing Care Beds for West Dunbartonshire is located in 2 Hospital Sites, Gartnavel Royal Hospital and The Dumbarton Joint Hospital within Glenarn Ward.

3.2 Clydebank Elderly Mentally ill population currently requires access to four Older Adult Continuing Care Beds at Gartnavel Royal Hospital.

3.3 Dumbarton and Alexandria currently has 12 Older Adult Continuing Care Beds in Glenarn Ward at the Dumbarton Joint Hospital.

3.4 Over the last 4 years Older Adult Psychiatry Services within West Dumbarton have seen significant development and investment which have resulted increased access to out patient clinics , increased access to post diagnostic support , the development of a community Older Peoples Resource Centre and the development of Dementia Cafes .

4. Main Issues

4.1 The unit cost per bed in Glenarn Ward is expensive in comparison with the unit cost per bed across NHS GG&C. The relocation of an additional 4 Gartnavel Royal beds would see the bed compliment increasing from 12 to 16 beds, bringing the unit cost per bed in line with NHS GG&C, thus ensuring the sustainability of the ward on the Dumbarton Joint Hospital site

4.2 The increase in capacity from 12 to 16 beds can be achieved within the current ward area requiring only modest adaptations to underpin the change

in ward capacity. A capacity of 16 beds is consistent with meeting historic and current bed use levels which have normally been slightly lower than that level.

4.3 The relocation of beds would consolidate all Continuing Care beds for older people with dementia within the West Dunbartonshire boundary.

4.4 This would facilitate better clinical cross cover arrangements and enabling all patients and clients access to the full range of services such as the Primary Care Dementia Team, Post diagnostic support, increased carers support from Carers of West Dunbartonshire and further education and peer support from the Dementia Café.

4.5 The proposals above are consistent with the principles set out in:

- The Clyde Modernising Mental Health Strategy which recognised the provision of continuing care beds in local areas whenever possible
- The Vale vision which saw the continued provision of Continuing and Acute Care beds within West Dunbartonshire and recognised the need to enhance the long term sustainability of these inpatient services

4.6 We have also started to explore the opportunity of consolidating the acute OPMH beds for the Clydebank area currently based at Gartnavel alongside those for Dumbarton currently at the Vale.

5. People Implications

5.1 Nil

6. Financial Implications

6.1 There are no financial implications to the HSPC however a small capital cost will be required to undertake some minor works within Glenarn Ward; this would be met by NHS GG&C.

7. Professional Implications

7.1 Minor changes to Consultant Psychiatrist's job plans.

8. Locality Implications

8.1 Nil

9. Risk Analysis

9.1 Not relocating beds from Gartnavel Royal to Dumbarton may result in a challenge to the long term sustainability and retention of inpatient beds locally within the boundary of West Dunbartonshire.

10. Impact Assessments

10.1 Nil

11. Consultation

11.1 The proposals set out in this report will require appropriate engagement to be undertaken with users and carers and a range of stakeholders .The Old age clinical teams have been fully involved the planning of this and are supportive of the transfer of beds. Existing Clydebank EMI patients would continue to receive their inpatient care in Gartnavel Hospital with only new admissions moving to Glenarn Ward in December 2015.

12. Strategic Assessment

12.1 By having all Continuing Care beds on site will enable better clinical cross cover and full assess to the full range of supports for patients and carers. This is consistent with the HSPC Strategic Plan 2015-16

Author: **John Russell Head of Mental Health, Addictions and Learning Disability**

Date: **27 July 2015**

Person to Contact: **John Russell Head of Mental Health, Addictions and Learning Disability**

Appendices: **Nil**

Background Papers: **Nil**

Wards Affected: **All Clydebank Wards**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 19th August 2015

Subject: Care Inspectorate Reports for Older People's Care Homes Operated by the Independent Sector in West Dunbartonshire

1. Purpose

1.1 To provide a routine up-date on the most recent Care Inspectorate assessments for three independent sector residential older peoples' Care Homes within West Dunbartonshire.

2. Recommendations

2.1 The Partnership Board is recommended to note the content of this report.

3. Background

3.1 Care Inspectorate inspections focus on any combination of the four thematic areas: quality of care and support; environment; staffing; and management & leadership.

3.2 Any care home which has been awarded Grade 2 (i.e. weak) or less and/ or have requirements placed upon them will usually be inspected again within the following twelve weeks. These follow-up visits present the opportunity to demonstrate progress on the improvement action plan agreed and to have an improved grade awarded if merited.

3.3 The Health and Social Care Partnership Quality Assurance Section monitor the independent sector care homes located within West Dunbartonshire in line with the terms of the National Care Home Contract; and arrange monitoring visits to ensure continued progress is being maintained in relation to agreed improvement plans. In addition, the Health and Social Care Partnership works with independent sector providers to maintain their awareness of new developments and provide opportunities to share good practice/learning via correspondence and regular care home provider meetings.

3.4 The independent sector Care Homes reported within this report are:

- Strathleven Care Home
- Castle View Nursing Home
- Clyde Court Care Home

Copies of the inspection reports can be accessed on the Care Inspectorate web-site: www.scswis.com.

4. Main Issues

Strathleven Care Home

4.1 Strathleven Care Home is owned and managed by Pelan Limited.

4.2 The care home was inspected on 19th January 2015 and the report published on 30th January 2015. The following grades were awarded:

- For the theme of *Care and Support* – Grade 5/Very Good.
- For the theme of *Environment* – Grade 4/Good.
- For the theme of *Staffing* – Grade 5/Very Good.
- For the theme of *Management and Leadership* – Grade 5/Very Good.

4.3 There were no requirements detailed in the inspection report.

Castle View Nursing Home

4.4 Castle View Nursing Home is owned and managed by HC-One Limited.

4.5 The care home was inspected on 3rd March 2015 and the report published on 26th March 2015. The following grades were awarded:

- For the theme of *Care and Support* – Grade 5/Very Good.
- For the theme of *Environment* – Grade 4/Good.
- For the theme of *Staffing* – Grade 4/Good.
- For the theme of *Management and Leadership* – Grade 4/Good.

4.6 There were no requirements detailed in the inspection report.

Clyde Court Care Home

4.7 Clyde Court Care Home is owned and managed by Four Seasons (No 9) Limited.

4.8 The care home was inspected on 27th April 2015 and the report published on 20th May 2015. The following grades were awarded:

- For the theme of *Care and Support* – Grade 3/Adequate.
- For the theme of *Environment* – Grade 3/Adequate.
- For the theme of *Staffing* – Grade 3/Adequate.
- For the theme of *Management and Leadership* – Grade 3/Adequate.

4.9 The inspection report detailed two requirements to be addressed:

- The provider must ensure that measures are put in place to ensure that high levels of cleanliness are maintained and best practice regarding the control of infection adhered to. In order to do this they have to audit the

cleanliness of the environment the outcomes to inform an action plan to address the issues identified; residents to have the opportunity to clean their hands prior to mealtimes; residents toiletries, toothbrushes, hairbrushes and razors maintained and stored in a hygienic and safe manner; staff to adhere to best practice guidance regarding the storage of continence aids and that food and drinks for residents use are managed and stored in line with best practice for food safety. This requirement is to be completed by 27th October 2015; at the time of submitting this report the Health and Social Care Partnership had been reassured that it will be completed within the timescale given.

- The provider must ensure that measures to protect residents and minimise the risk of falls are fully implemented. This is with specific reference to seeking advice from healthcare professionals regarding the support for residents with a high risk of falling and ensures this is evidenced and to identify strategies to minimise the risk of falls are effectively implemented, this to include the appropriate use of equipment and supervision of residents at risk. This requirement is to be completed by 27th October 2015; at the time of submitting this report the Health and Social Care Partnership had been reassured that it will be completed within the timescale given.

4.10 A comprehensive action plan was devised by Clyde Court Care Home and shared with the Health and Social Care Partnership Quality Assurance team to address the requirements in the inspection report. In addition to that plan, the Quality Assurance team having been visiting the Care Home to view the remedial work undertaken by the Care Home and confirm the corrective actions are carried out appropriately within agreed timescales.

4.11 The table below summarizes the grades between the last two inspections for the Care Homes above**:**

Care Home	**Previous Grades**						**Current Grades**					
	1	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**
				20 November 2013							**10 October 2014**	
Strathleven Care Home												
• Care & Support				✓							✓	
• Environment				✓						✓		
• Staffing				✓							✓	
• Management & Leadership				✓							✓	
				10 October 2014							**03 March 2015**	
Castle View Nursing Home												
• Care & Support				✓							✓	
• Environment			✓							✓		
• Staffing				✓						✓		
• Management & Leadership				✓						✓		
				13 October 2014							**27 April 20015**	
Clyde Court Care Home												
• Care & Support		✓							✓			
• Environment		✓							✓			
• Staffing		✓							✓			
• Management & Leadership		✓							✓			

5. People Implications

5.1 There are no people implications associated with this report.

6. Financial Implications

6.1 The National Care Home Contract provides an additional quality payment, by the Council, to Care Homes if the Care Inspectorate Inspection report awards grade of 5/Very Good or 6/Excellent in the Quality of Care and Support thematic area. There is a second additional quality payment if the high grade in Quality of Care and Support thematic area is coupled with a grading of a 5/Very Good or 6/Excellent in any of the other three thematic areas.

6.2 The National Care Home Contract also accounts for providers receiving low grades of 1/Unsatisfactory or 2/Weak in the Care Inspectorate Inspection report. If either of these grades are awarded it may trigger the withdrawal of the quality funding component, resulting in a reduction of £20 per resident per week from the weekly fee payable.

6.3 The Inspection Report for Strathleven Care Home has financial implications for the Partnership Board. As they received the grade of 5/Very Good for the Quality of Care and Support thematic area coupled with the grading of 5/Very Good in two of the other three thematic areas in their inspection report they will be paid the enhanced weekly rate for every resident Health and Social Care Partnership has placed in the home.

6.4 Castle View Nursing Home also received the additional quality payment due to the grade of 5/Very Good in Quality of Care and Support thematic area and a 5/Very Good in two of the other three thematic areas from their inspection of February 2014. Their inspection of October 2015 resulted in the grade of 4/Good being awarded for all four thematic areas. In line with the National Care Home Contract, the service was given the opportunity to correct the grades awarded. If in their next inspection the grades remained at the same level or lower, the additional quality payment was to be removed.

The grades awarded to Castle View Nursing Home in this most recent inspection are an improvement but will result in the removal of the second additional quality payment, as detailed in 6.1. They will now only receive the single additional quality payment.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

8.1 There are no relevant locality implications associated with this report.

9. Risk Analysis

9.1 Grades awarded to a service after a Care Inspectorate inspection are an important performance indicator for registered services. For any service assessed by the Care Inspectorate, failure to meet requirements within the time-scales set out could result in a reduction in grading or enforcement action. Consistently poor grades awarded to any independent sector Care Home would be of concern to the Partnership Board, particularly in relation to the continued placement of older people in such establishments.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The Strategic Plan 2015-16 emphasises the importance of quality assurance amongst independent sector providers of care; and the Partnership Board's commitment to work with independent sector providers within an agreed assurance framework.

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Date: 19th August 2015

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Appendices: None

Background Papers: All the inspection reports can be accessed from http://www.scswis.com/index.php?option=com_content&task=view&id=7909&Itemid=727

Wards Affected: All.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 19th August 2015

Subject: Care Inspectorate Reports for Older People's Residential and Day Care Services Operated by West Dunbartonshire Council.

1. Purpose

1.1 To provide information regarding the most recent inspection reports for three of the Council's own Older People's Residential Care Home and Day Care Services.

2. Recommendations

2.1 The Partnership Board is recommended to note the content of this report and the work undertaken to ensure grades awarded reflect the quality levels expected by it.

3. Background

3.1 Care Inspectorate inspections focus on any combination of four thematic areas. These themes are: quality of care and support, environment, staffing and management and leadership.

3.2 The service(s) covered in this Partnership Board report are:

- Dalreoch Day Centre
- Boquhanran House
- Mount Pleasant
- Dalreoch House

3.3 Copies of inspection reports for all services can be accessed on the Care Inspectorate website: www.scswis.com.

4. Main Issues

4.1 Dalreoch Day Care Centre

Dalreoch Day Care Centre was inspected on 16th December 2014. The Inspector commented that the staff team have created a warm and welcoming atmosphere for those who attend the service. Existing service users are involved in helping new people settle into the service making sure they feel welcomed and integrated.

4.2 The Inspection focussed on four thematic areas with the following grades Awarded:

- For Care and Support - Grade 4 Good
- For Environment – Grade 4 Good
- For Staffing – Grade 4 Good
- For Leadership and Management – Grade 4 Good

4.3 There were no requirements arising from this inspection.

4.4 The table below sets out the movement in grades for this day centre over the last two inspections.

Service	**Previous Grades 14th March 2014**		
Dalreoch Day Centre	**Quality Statements**	**Grades Awarded**	**Overall Grade**
Care & Support	1 3	4 5	**4**
Environment	1 2	4 5	**4**
Staffing	1 3	4 5	**4**
Management & Leadership	1 4	4 4	**4**

Service	**Current Grades 16th December 2014**		
Dalreoch Day Centre	**Quality Statements**	**Grades Awarded**	**Overall Grade**
Care & Support	1 3	4 5	**4**
Environment	1 2	4 4	**4**
Staffing	1 3	5 4	**4**
Management & Leadership	1 4	4 4	**4**

4.5 <u>Boquhanran House</u>

Boquhanran House was inspected on the 28th January 2015 and on the 28th May 2015. The Inspector commented that many improvements have been made meaning that there has been a number of positive outcomes for residents including how support and care is delivered, record keeping, staff being given clear guidance and support to fulfil their role and overall improved management of the service.

The service has made a number of improvements across key areas such as the environment and involving staff, residents and relatives with the on-going

development of the service. Staff within the service have worked on (through using the new care plans) identifying outcomes with each resident and were looking at ways in which these could be met. Staff are more motivated due to good supports and clear direction given by the management team.

4.6 The inspection focussed on four thematic areas, with the following grades awarded.

- For Care and Support – Grade 4 Good
- For Environment – Grade 4 Good
- For Staffing – Grade 4 Good
- For Management and Leadership – Grade 5 Very Good

4.7 There were no requirements arising from this inspection.

4.8 The table below sets out the movement in grades for this care home over the last three inspections.

Service	**Current Grades 2nd July 2014**		
Boquhanran House	**Quality Statement**	**Grade**	**Overall Grade**
Care & Support	1 3	3 3	**3**
Environment	1 2	3 3	**3**
Staffing	1 3	3 3	**3**
Management & Leadership	1 4	3 3	**3**

Service	**Previous Grades 28th January 2015**		
Boquhanran House	**Quality Statement**	**Grade**	**Overall Grade**
Care & Support	1 3	4 4	**4**
Environment	1 2	4 3	**3**
Staffing	1 3	4 4	**4**
Management & Leadership	1 4	4 4	**4**

Service	**Current Grades 28th May 2015**		
Boquhanran House	**Quality Statement**	**Grade**	**Overall Grade**
Care & Support	1 3	4 4	**4**
Environment	2 3	4 4	**4**
Staffing	1 3	4 4	**4**
Management & Leadership	2 4	5 5	**5**

4.9 Mount Pleasant

Mount Pleasant was inspected on 12th February 2015. The inspector commented that the home provides lots of opportunities for residents and relatives to assess the quality of care and support. Staff are well thought of by residents and relatives we spoke with. The home is welcoming and relaxed.

4.10 The inspection focussed on four thematic areas, with the following grades awarded.

- For Care and Support – Grade 4 Good
- For Environment – Grade 4 Good
- For Staffing – Grade 5 Very Good
- For Management and Leadership – Grade 4 Good

4.11 There were no requirements arising from this inspection.

4.12 The table below sets out the movement in grades for this care home over the last two inspections.

Service	**Previous Grades 9th October 2014**		
Mount Pleasant	**Quality Statement**	**Grade**	**Overall Grade**
Care & Support	1 3	4 3	**3**
Environment	1 2	4 4	**4**
Staffing	1 3	4 4	**4**
Management & Leadership	1 4	4 3	**3**

Service	**Current Grades 12th February 2015**		
Mount Pleasant	**Quality Statement**	**Grade**	**Overall Grade**
Care & Support	1 3	5 4	**4**
Environment	1 2	5 4	**4**
Staffing	1 3	5 5	**5**
Management & Leadership	1 4	5 4	**4**

4.13 Dalreoch House

Dalreoch House was inspected on 21st May 2015. The inspector commented that this is a service which continues to develop under effective leadership. The range of activities on offer to residents has improved and staff are actively engaged in promoting person centred working to ensure the assessed needs and individual stated preferences of residents is being met.

This service has a vision of how it can further improve by effective engagement with resident's and relatives involving them in all aspects of service development and supporting the professional development of staff through leadership and other training.

4.14 The inspection focussed on four thematic areas, with the following grades awarded.

- For Care and Support – Grade 4 Good
- For Environment – Grade 4 Good
- For Staffing – Grade 5 Very Good
- For Management and Leadership – Grade 5 Very Good

4.15 There were no requirements arising from this inspection.

4.16 The table below sets out the movement in grades for this care home over the last two inspections.

Service	**Previous Grades 30th July 2014**		
Dalreoch House	**Quality Statement**	**Grade**	**Overall Grade**
Care & Support	1 3	4 4	**4**
Environment	1 2	4 4	**4**
Staffing	1 3	4 4	**4**
Management & Leadership	1 4	4 4	**4**

Service	**Current Grades 9th July 2015**		
Dalreoch House	**Quality Statement**	**Grade**	**Overall Grade**
Care & Support	1 5	5 4	**4**
Environment	2 3	5 4	**4**
Staffing	2 3	5 5	**5**
Management & Leadership	2 4	5 5	**5**

4.17 The table below summarises the movement in grades for the services over their last two inspections.

Service	Previous Grades						Current Grades					
	1	2	3	4	5	6	1	2	3	4	5	6
Dalreoch Day Centre	**14th March 2014**						**16th December 2014**					
• Care & Support • Environment • Staff • Management & Leadership				✓ ✓ ✓ ✓						✓ ✓ ✓ ✓		
Boquhanran House	**28th January 2015**						**28th May 2015**					
• Care & Support • Environment • Staff • Management & Leadership			✓	✓ ✓ ✓						✓ ✓ ✓	✓	
Mount Pleasant	**9th October 2014**						**12th February 2015**					
• Care & Support • Environment • Staff • Management & Leadership			✓ ✓	 ✓ ✓						✓ ✓ ✓	✓	
Dalreoch	**30th July 2014**						**9th July 2015**					
• Care & Support • Environment • Staff • Management & Leadership				✓ ✓ ✓ ✓						✓ ✓	✓ ✓	

5. People Implications

5.1 There are no people implications associated with this report.

6. Financial Implications

6.1 There are no financial implications associated with this report.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

8.1 There are no locality implications associated with this report.

9. Risk Analysis

9.1 For any services inspected, failure to meet requirements within the time-scales set out in their inspection report could result in a reduction in grading or enforcement action. This may have an impact on our ability to continue to deliver the service.

10. Impact Assessments

10.1 Not required for this report.

11. Consultation

11.1 Not required for this report

12. Strategic Assessment

12.1 The Strategic Plan 2015/16 emphasises the Partnership Board's commitment to providing high quality and appropriate care for older people; and providing quality assurance across all services

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Date: **19 August 2015**

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Appendices: **None**

Background Papers: **None**

Wards Affected: **All**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 19th August 2015

Subject: Care Inspectorate Reports for Children & Young People's Services operated by West Dunbartonshire Council

1. Purpose

1.1 To provide information regarding the most recent inspection reports for the Throughcare & Aftercare Service and Craigellachie Children's Unit.

2. Recommendations

2.1 The Partnership Board is recommended to note the content of this report and the work undertaken to ensure grades awarded reflect the quality levels expected by it.

3. Background

3.1 Care Inspectorate inspections focus on any combination of four thematic areas. These themes are: quality of care and support, environment, staffing and management and leadership.

3.2 The service(s) covered in this Partnership Board report are:

- Throughcare & Aftercare Service.
- Craigellachie Children's House.

3.3 Copies of inspection reports for all services can be accessed on the Care Inspectorate website: www.scswis.com.

4. Main Issues

4.1 Throughcare & Aftercare Service

The Throughcare & Aftercare service was inspected on 27th March 2015 and the subsequent report was published in June 2015. The following grades were awarded:

For the theme of

- *Quality of Care and Support* – Grade 6/Excellent.
- *Quality of Staffing* – Grade 6/Excellent.
- *Quality of Management and Leadership* – Grade 6/Excellent.

4.2 Due to the service receiving grade 6/excellent for all 3 areas there were no requirements and no recommendations.

4.3 The inspector concluded:

"The service works well to meet the needs of those who use it. The ethos of the staff team led by its experienced manager has meant that it continues to seek to develop innovative practice in concert with other partner agencies. Efforts should be made to sustain the quality of practice evidenced in this inspection".

4.4 As the table below demonstrates all grades show an improvement from the previous inspection (February 2014) and reflect the excellent standards of care offered to our young people.

4.5 The table below sets out the movement in grades for the services over the last two inspections

Throughcare & Aftercare Service	**Previous Grades**						**Current Grades**					
	1	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**
	Feb 2014						Mar 2015					
• Care & support • Staff • Management & Leadership					✓ ✓ ✓							✓ ✓ ✓

Craigellachie Children's Unit

4.6 Craigellachie Children's Unit was inspected on 11th and 17th December 2014 and the report was published in February 2015. The following grades were awarded:

For the theme of

- *Care and Support* – Grade 5/Very Good
- *Quality of Environment* – Grade 5/Very Good
- *Quality of Staffing* – Grade 5/Very Good.
- *Quality of Management and Leadership* – Grade 5/Very Good.

4.7 For this report there were no requirements and only 2 recommendations. One recommendation was to have a visitor's book in place and this was rectified at the time of inspection report (February 2015). The other recommendation was to ensure that the staff team had time to meet together to discuss issues, and reflect on the service needs and child care practice. Since the publication of the report there have been regular staff team meetings and a team building day is planned for September/October of this year.

4.8 The inspector noted in her report, how she had observed young people laugh and joke with staff in a positive and relaxed manner. She also recorded that

overall young people were happy with the quality of care and support provided to them by staff at the Craigellachie Unit.

4.9 All grades remain consistent with previous inspections, and reflect the high standards of care offered to our young people within the Craigellachie Unit.

4.10 The table below sets out the grades for the services over the last two inspections**:**

Home	**Previous Grades**						**Current Grades**					
Craigellachie Children's Unit	**1**	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**
	Feb 2014						Nov 2014					
• Care & support • Environment • Staff • Management & Leadership					✓ ✓ ✓ ✓						✓ ✓ ✓ ✓	

5. People Implications

5.1 There are no people implications associated with this report.

6. Financial Implications

6.1 There are no financial implications associated with this report.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

8.1 There are no locality implications associated with this report.

9. Risk Analysis

9.1 For any services inspected, failure to meet requirements within the time-scales set out in their inspection report could result in a reduction in grading or enforcement action. This may have an impact on our ability to continue to deliver the service.

10. Impact Assessments

10.1 Not required for this report.

11. Consultation

11.1 Not required for this report

12. Strategic Assessment

12.1 The Strategic Plan 2015/16 emphasises the Partnership Board's commitment to providing high quality and appropriate care for children and young people; and providing quality assurance across all services

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Date: **19 August 2015**

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Appendices: **None**

Background Papers: **None**

Wards Affected: **All**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 19th August 2015

Subject: Healthcare Improvement Scotland Consultation - Building a comprehensive approach to reviewing the quality of care

1. Purpose

1.1 To bring attention to the Healthcare Improvement Scotland consultation *Building a comprehensive approach to reviewing the quality of care*; and to present the proposed response for submission by the Health & Social Care Partnership.

2. Recommendation

2.1 The Partnership Board is recommended to approve the attached draft as the HSCP response to the consultation.

3. Background

3.1 The Integration Scheme for West Dunbartonshire emphasises the importance of effective clinical and care governance across Health & Social Care Partnership services.

3.2 Healthcare Improvement Scotland (HIS) is the national healthcare improvement organisation for Scotland and part of NHSScotland.

3.3 HIS is currently consulting upon proposals for a new model for how it will review the quality of care (executive summary attached). This consultation document sets out:

- A new framework to assess and improve the quality of care that can be used locally and nationally.
- The establishment of more comprehensive assessments of the quality of care, considering domains of leadership, governance, workforce, improvement infrastructure as well as person-centred, safety and effectiveness.
- Independent and objective external assessments of the sustainability of care.
- An increased emphasis on local systems of scrutiny and assurance with service providers using the framework to assess the quality of care.

3.4 The deadline for the response is the 30th September 2015.

4. Main Issues

4.1 The attached response to the consultation questions has been prepared on behalf of West Dunbartonshire Health & Social Care Partnership.

4.2 The response emphasises that:

- West Dunbartonshire Health & Social Care Partnership is strongly committed to robust quality assurance and understands the important contribution that external inspection has to that process – not least to provide reassurance to the public and other stakeholders in terms of the care we and our staff are responsible for providing on a day and daily basis.

- The proposals being consulted upon by HIS are laudable and that we very much agree that there is value in a refreshed inspection framework for health and social care.

- However, in order to be deliverable and effective – and indeed to enjoy the confidence of the staff actually delivering and managing services – such a framework needs to be clearer; proportionate and joined-up across inspection bodies.

5. People Implications

5.1 There are no people implications associated with this report.

6. Financial Implications

6.1 There are no financial implications associated with this report.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

8.1 There are no locality implications associated with this report.

9. Risk Analysis

9.1 West Dunbartonshire Health & Social Care Partnership is strongly committed to robust quality assurance and understands the important contribution that external inspection has to that process – not least to provide reassurance to the public and other stakeholders in terms of the care we and our staff are responsible for providing on a day and daily basis.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 The Partnership Board's appointed professional advisers were consulted on the preparation of this response.

12. Strategic Assessment

12.1 The Strategic Plan recognises that effective clinical and care governance arrangements need to be in place to support the delivery of safe, effective and person-centred health and social care services within integrated services.

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Date: 19th August 2015

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Appendices: Healthcare Improvement Scotland Consultation: Building a comprehensive approach to reviewing the quality of care – Executive Summary

Proposed West Dunbartonshire Health & Social Care Partnership Response to Healthcare Improvement Scotland Consultation

Background Papers: Healthcare Improvement Scotland Consultation: Building a comprehensive approach to reviewing the quality of care: http://healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_reviews/qoc_reviews_consultation.aspx

Wards Affected: All

Healthcare Improvement Scotland

NHS SCOTLAND

Building a comprehensive approach to reviewing the quality of care: *Supporting the delivery of sustainable high quality services*

A consultation paper: executive summary

July 2015

A new model for reviewing the quality of care

The consultation paper describes proposals for a new model of reviewing the quality of care in Scotland.

We want your views on the new model, and how it could be improved, so that care is consistently delivered to a high quality and can continue to deliver high quality care in the future. Your comments, and those provided to us at discussion meetings to be held this summer (more detail on page 8), will be used to inform the final recommendations for the new model.

The consultation paper sets out several significant changes to the way the quality of care is currently reviewed:

- a **new framework to assess and improve the quality of care** that can be used locally and nationally
- the establishment of **more comprehensive assessments of the quality of care**, considering domains of leadership, governance, workforce, improvement infrastructure as well as person-centred, safety and effectiveness
- independent and objective external **assessments of the sustainability of care**, and
- an **increased emphasis on local systems of scrutiny and assurance** with service providers using the framework to assess the quality of care.

The new model builds on the strengths of the current scrutiny system, and is based on the five key principles for the use of external scrutiny: independence, public focus, proportionality, transparency and accountability.

Under the new model, scrutiny will be proportionate to the risk identified and will recognise the differences in service providers' size, complexity and capacity to respond. Scrutiny will provide public assurance, focus on identifying and supporting areas for improvement, and will share good practice more widely for others to learn from. We will also apply the learning from the new way that the care of older people in acute hospitals is being inspected.

A more flexible approach to scrutiny based on a quality framework

We propose a more flexible approach to scrutiny that can be used to assess the quality of care provided at different levels, such as within a particular healthcare facility; across a whole organisation or system; along a patient journey through different care providers; as a thematic assessment across a range of services or issues at a national level; and for investigating serious issues where required.

The new approach will assess the essential components of high quality care, using a consistent quality framework. The proposed quality framework is part of this consultation and provides guidance on what 'good' quality care might look like. The framework also includes person-focused outcomes to help people using services to understand what they can expect and for providers to know what is expected of them.

The framework could be used to support scrutiny and assurance at both local and national levels. It is based on seven domains: person-centred care, safety, effectiveness, leadership, governance, workforce and quality improvement. Culture and sustainability of services (whether they can continue to deliver high quality care in the future) will run through all of the seven domains.

The following table highlights the main differences between how healthcare services in Scotland are currently scrutinised and the proposed new approach to scrutiny and assurance which is set out in the consultation paper.

Current approach	Proposed approach
Focused topic-based external scrutiny that does not always reflect what is taking place at an organisational level in terms of strategic intent, sustainability, competing priorities or local context.	More comprehensive quality framework that is locally owned and against which improvement can be externally assessed.
Focus on unannounced inspections at frontline at a point in time.	Unannounced inspections part of a larger system of scrutiny which encompasses other factors which impinge on the quality of care. An open and transparent approach to discussing progress, challenges and areas for improvement with providers and supporting them to find solutions.
Separate approaches between scrutiny and improvement to measurement.	Unified and consistent set of measures underpinned by the quality framework.
Links between scrutiny and improvement activities tend to be made on a project or programme basis which can lead to inconsistency.	Tailored, practical, timely and relevant improvement support following scrutiny Systematically linking our scrutiny activities with existing or planned improvement work (for example, care of older people in acute hospitals inspections linked to associated improvement work).
Diverse range of scrutiny activities with a large focus on hospital services.	More coherent set of scrutiny activities linked to 2020 vision for health and social care across scrutiny bodies within a sensibly planned and proportionate scrutiny programme. Undertaking thematic reviews of services which cut across several providers or services and focus on the pathway of care, for example, reviews of pre-hospital care, child and adolescent mental health services or services for those with learning disabilities. This will help provide comprehensive insight, shared learning and opportunities for improvement.
Lack of clarity around the overall quality of care at a system or organisational level.	More comprehensive assessments of the quality of care at different levels of the system, encompassing leadership and governance. The proposed framework includes potential person-focused outcomes to help patients or service users understand what they can consistently expect, and for providers to know what's expected of them.

Current approach	Proposed approach
Ad hoc investigations triggered by 'red lights'.	Earlier intervention and scrutiny at 'amber' point, with increased focus on local leadership inviting external 'diagnostic support'.
Separate approaches to scrutiny by external agencies.	Stronger collaboration between bodies underpinned by greater sharing of intelligence and leadership by the agency with the most appropriate skills and expertise for the subject matter.
Insufficient clarity and resources for tailored support and follow up of scrutiny recommendations.	A more tailored approach to support, with emphasis on support being practical, relevant and timely.
Service sustainability not seen as an integral part of the external scrutiny of the quality of care.	Service sustainability seen as an integral part of the assessment of the quality of care in order to support service change in the face of imminent and future challenges of population ageing, technological advances, public expectations and funding constraints.
Starting to share intelligence between scrutiny bodies to inform current scrutiny activities.	Systematic sharing of intelligence between different scrutiny bodies in Scotland. This will help us to anticipate problems earlier and offer more timely intervention and support.

Consultation questions

The questions we are seeking your views on are:

Question 1	The paper describes a number of principles that are guiding our approach; an approach that: • drives improvement • is person-centred • is open and honest • is fair, transparent and risk based • is flexible • is developed in partnership • is owned by all those involved • is proportionate and practical, and • is adaptable for a variety of care settings. Do you agree with the principles that guide our approach?
Question 2	The quality framework is based on seven domains of person-centred care, safety, effectiveness, leadership, governance, workforce and quality improvement. Do you think these are the right core domains, and will the supporting detail within the quality framework support the assessment and improvement of quality care?
Question 3	How reasonable or practical is it to assess care against the domains and categories set out in the quality framework?
Question 4	Should the quality framework form a set of standards that must be met or remain a guide of best practice?
Question 5	Would it be helpful to also develop a set of consistent Key Quality Indicators against the quality framework domains for use locally and nationally?
Question 6	Do you think culture underpins the domains within the quality framework and how might culture be assessed?

Question 7	The paper proposes that our new approach scrutinises across different levels of an organisation or system of care. This would be reflected at three broad levels: • services and systems provided across a provider area, including interfaces between services, for example the interface between health and social care (**macro level**) • across particular services such as care of older people, accident and emergency or primary care services (**meso level**), and • at ward level, within a community setting, or any other setting with direct interaction between a care professional and the patient, service user or carer (**micro level**). Do you think external scrutiny should focus on these three broad levels across an organisation or system of care?
Question 8	Do you think the new approach to scrutiny should include the four dimensions of: • Thematic Quality of Care Reviews • Organisational Quality of Care Reviews • Service Level Reviews • Point-of-Care Reviews or Inspections?
Question 9	Would it be helpful to include making recommendations for service sustainability as part of the new approach?
Question 10	Will the proposals set out in the consultation document support the further integration of health and social care?
Question 11	Do you feel that care will be safer and better for people as a result of the proposed changes?

Consultation response form

A response form containing all of the consultation questions is available at www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_reviews.aspx

We welcome responses from all organisations and individuals. Please send your response to this consultation by Wednesday 30 September 2015 to: hcis.QoCR@nhs.net, or by post to the address on the form.

We are also holding regional discussion groups over the summer where you can find out more and give us your views:

17 July: Edinburgh, Apex International Hotel
24 August: Elgin, Eight Acres Hotel
1 September: Glasgow, Beardmore Hotel & Conference Centre

Each group is 9:45am–2:15pm. Lunch and refreshments will be provided.
Please contact us at hcis.QoCR@nhs.net to confirm your place.

We look forward to receiving your comments.

Healthcare Improvement Scotland

www.healthcareimprovementscotland.org

Edinburgh Office: Gyle Square | 1 South Gyle Crescent | Edinburgh | EH12 9EB
Telephone: 0131 623 4300

Glasgow Office: Delta House | 50 West Nile Street | Glasgow | G1 2NP
Telephone: 0141 225 6999

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.

HEI Healthcare Environment Inspectorate
Ensuring your hospital is safe and clean

scottish health council
making sure your voice counts

Scottish Health Technologies Group

SIGN
Scottish Intercollegiate Guidelines Network

Scottish Medicines Consortium

You can read and download this document from our website. We are happy to consider requests for other languages or formats. Please contact our Equality and Diversity Advisor on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net

Building a comprehensive approach to reviewing the quality of care: *Supporting the delivery of sustainable high quality services*

Consultation response form

About you

My name	Soumen Sengupta			
Job title (if applicable)	Head of Strategy, Planning and Health Improvement			
Organisation name (if applicable)	West Dunbartonshire Health and Social Care Partnership			
Email address (if applicable)	Soumen.Sengupta@ggc.scot.nhs.uk			
I am responding as: (mark 'x' where relevant)	Member of the public		Carer	
	Healthcare professional	x	Social care professional	x
	Voluntary /community sector representative		Other stakeholder	

Please return this form by **Wednesday 30 September 2015** to: hcis.QoCR@nhs.net
If you would prefer to write to us then please send your response to:

Quality of Care Review Team
Scrutiny and Assurance Directorate
Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Using your Personal Information
Personal information which you supply to us will be used for the purposes of processing your attendance at our consultation events and providing you with feedback following the close of consultation in September. Further information on how we manage personal information can be found on:
http://www.healthcareimprovementscotland.org/footernav/respecting_your_privacy.aspx

Consultation questions

Question 1: The paper describes a number of principles that are guiding our approach; an approach that: • drives improvement • is person-centred • is open and honest • is fair, transparent and risk based • is flexible • is developed in partnership • is owned by all those involved • is proportionate and practical, and • is adaptable for a variety of care settings. Do you agree with the principles that guide our approach?	We would support each of these principles individually – and give credit to HIS for its ambition of delivering them collectively. However, we are not entirely convinced that the all of these principles are clearly and equally embedded across the domains and categories as currently articulated by HIS – and so would hope that would be addressed following the conclusion of this consultation. Specifically: • With regard to the principles of flexibility, proportionality and ownership we feel these are somewhat at odds with the degree of structure and prescriptiveness expressed throughout the framework itself. • With regard to the principle of partnership, we would have hoped that given the new commitment to joint agency inspection that any such principles (and indeed this overall approach) would have been developed across and relate to all of the regulatory bodies with a responsibility for health and social care quality in Scotland.
Question 2: The quality framework is based on seven domains of person-centred care, safety, effectiveness, leadership, governance, workforce and quality improvement. Do you think these are the right core domains, and will the supporting detail within the quality framework support the assessment and improvement of quality care?	We would agree with the seven individual domains as proposed, not least as they reflect themes evident across other established scrutiny and evaluation frameworks. However, the supporting detail within the quality framework is itself: • Unclear about the extent of local flexibility and local scrutiny – and somewhat at odds with the degree of structure and prescriptiveness expressed throughout. • Somewhat out of date with respect to the new Health & Social Care Partnership and their Integration Authorities (e.g. by referring to social care partners and partner agencies). • Unclear about the status of measuring quality of social care provision – not least as that falls within the remit of

	the Care Inspectorate and its recently consulted upon Care Quality Standards.
Question 3: How reasonable or practical is it to assess care against the domains and categories set out in the quality framework?	The quality framework sets an entirely laudable but somewhat idealised benchmark. As such, we are not entirely convinced that the approach to as articulated is as yet either reasonable nor practical in terms of the bureaucratic burden it would place on the staff working within and responsible for the services being assessed – and so would hope that would be addressed following the conclusion of this consultation. Specifically: • There is also arguably a tension between the differing aspirations of certain principles – most notably how a framework as comprehensive and structured as the one proposed is also simultaneously flexible and can be locally "owned". • The practical complexity of assessing 50 defined categories, potentially with related Key Quality Indicators, alone presents challenges. • It is also unclear how these would dovetail with the assessment of services and integrated Partnerships by the Care Inspectorate with respect to its recently consulted upon Care Quality Standards – and that is before consideration of the cumulative impact of assessment that integrated Partnerships would have to manage and resource in response to the differing standards and expectations of both HIS and the Care Inspectorate (the "joint" inspection indicators notwithstanding).
Question 4: Should the quality framework form a set of standards that must be met or remain a guide of best practice?	In its current guise the quality framework is: • Too excessive in totality to reasonably or practically form a set of standards that must be met. • Too cumbersome to provide meaningful Best Practice Guidance, not least given the already crowded "support and improvement" environment in which Health and Social Care Partnerships are having to operate. However, it would be useful and reasonable to identify a

	more focused and limited sub-set of mandatory standards – provided that: • These were also shared by the Care Inspectorate with regards to its Care Quality Standards. • With regards to the new Health & Social Care Partnerships, Integration Authorities and (indeed) Community Planning Partnerships, formed the basis for the joint inspection standards. • Clearly replaced - at the very least - the same number of existing standards as applied by both HIS and the Care Inspectorate.
Question 5: Would it be helpful to also develop a set of consistent Key Quality Indicators against the quality framework domains for use locally and nationally?	Yes – provided that such Key Quality Standards are: • Based on a more focused and limited sub-set of mandatory standards (as per our response to Q4) that are shared by the Care Inspectorate. • Related directly to national health and wellbeing outcomes and the national outcomes for children.
Question 6: Do you think culture underpins the domains within the quality framework and how might culture be assessed?	The importance of "culture" is certainly implied across all of the domains – but not necessarily in a helpful manner, given that "culture" is notoriously to define and difficult to assess in an objective manner (as this question itself acknowledges). HIS – and indeed Care Inspectorate – should refrain from placing an undue emphasis on "culture" until such time as they can clearly define it in a meaningful fashion; and are more confidently able to propose an objective and consistently applied approach to assessing it.
Question 7: The paper proposes that our new approach scrutinises across different levels of an organisation or system of care. This would be reflected at three broad levels: • services and systems provided across a provider	We are not entirely convinced that the approach as articulated is as yet either reasonable nor practical in terms of the bureaucratic burden it would place on the staff working within and responsible for the services being assessed – and so would hope that would be addressed following the conclusion of this consultation and further in-depth thought. Specifically it creates the risk of an overly complex – and labyrinthine – inspection industry, not least because: • The levels as proposed arguably create artificial

area, including interfaces between services, for example the interface between health and social care **(macro level)** • across particular services such as care of older people, accident and emergency or primary care services **(meso level)**, and • at ward level, within a community setting, or any other setting with direct interaction between a care professional and the patient, service user or carer **(micro level)**. Do you think external scrutiny should focus on these three broad levels across an organisation or system of care?	distinctions with respect to how integrated health and social care partnerships are developing – which would be further complicated by the fact that differing ranges of services have been integrated within different integration authorities across the country. • It is also unclear how this approach would dovetail with the assessment of services and integrated Partnerships by the Care Inspectorate with respect to its recently consulted upon Care Quality Standards – and that is before consideration of the cumulative impact of assessment that integrated Partnerships would have to manage and resource in response to the differing standards and expectations of both HIS and the Care Inspectorate (the "joint" inspection indicators notwithstanding).
Question 8: Do you think the new approach to scrutiny should include the four dimensions of: • Thematic Quality of Care Reviews • Organisational Quality of Care Reviews • Service Level Reviews, and • Point-of-Care Reviews or inspections?	We are not entirely convinced that the approach as articulated is as yet either reasonable nor practical in terms of the bureaucratic burden it would place on the staff working within and responsible for the services being assessed – and so would hope that would be addressed following the conclusion of this consultation and further in-depth thought. Specifically it adds to the risk of an overly complex – and labyrinthine – inspection industry, not least because: • The levels as proposed arguably create artificial distinctions with respect to how integrated health and social care partnerships are developing – which would be further complicated by the fact that differing ranges of services have been integrated within different integration authorities across the country. • It is also unclear how this approach would dovetail with the assessment of services and integrated Partnerships by the Care Inspectorate with respect to its recently

	consulted upon Care Quality Standards – and that is before consideration of the cumulative impact of assessment that integrated Partnerships would have to manage and resource in response to the differing standards and expectations of both HIS and the Care Inspectorate (the "joint" inspection indicators notwithstanding).
Question 9: Would it be helpful to include making recommendations for service sustainability as part of the new approach?	There would be merit in reports noting challenges to service sustainability (e.g. ability to recruit sufficient numbers of qualified staff). However, we are unconvinced of the merit of any such issues then being framed as recommendations - as such recommendations would inevitably be contestable and in many cases would be a matter of legitimate political policy and external funding allocations (whether at national or local level).
Question 10: Will the proposals set out in the consultation document support the further integration of health and social care?	Frustratingly no – even though clearly the intent is there within HIS; and because enabling appropriate and effective health and social care integration is Health & Social Care Partnership's raison d'etre. Our concern is that in its current guise, these proposals adds to the risk of an overly complex – and labyrinthine – inspection industry and the already crowded "support and improvement" environment in which Health and Social Care Partnerships are having to operate and in which integration authorities will be making decisions.
Question 11: Do you feel that care will be safer and better for people as a result of the proposed changes?	Disappointingly no – even though clearly the intent is there within HIS; and because our priority is to provide safe and effective services for our communities. Our concern is that in its current guise, these proposals adds to the risk of an overly complex – and labyrinthine – inspection industry and the already crowded "support and improvement" environment in which Health and Social Care Partnerships are having to operate and in which integration authorities will be making decisions.

Any other comments?

West Dunbartonshire Health & Social Care Partnership is strongly committed to robust quality assurance and understands the important contribution that external inspection has to that process – not least to provide reassurance to the public and other stakeholders in terms of the care we and our staff are responsible for providing on a day and daily basis.

As we have set out within this response, the intent is laudable – and we very much agree that there is value in a refreshed inspection framework for health and social care. However, in order to be deliverable and effective – and indeed to enjoy the confidence of the staff actually delivering and managing services – such a framework needs to be clearer; proportionate and joined-up across inspection bodies.

As such, we offer these responses as a constructive partner, and very much look forward to the outcomes of the consultative process.

Thank you for your response.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 19th August 2015

Subject: Financial Report 2015/16 as at Period 3 (30th June 2015)

1. Purpose

1.1 The purpose of the report is to provide the Partnership Board with an update on the financial performance and capital work progress of the West Dunbartonshire Health & Social Care Partnership for the period to 30th June 2015 (Period 3).

2. Recommendations

2.1 The Partnership Board is recommended to note:

- The contents of the report showing a forecast full year adverse revenue variance of £0.727m (0.54%) and £0.546m for the period from 1st July 2015.
- The key requirement for the senior management team to develop a recovery plan to address the projected overspend.
- That elements of corrective actions are already in place as described within the report.
- The current position regarding capital work progress on projects.

2.2 The Partnership Board is recommended to approve Social Care budget virements of £0.883m as described under section 3.4 of this report.

3. Background

Health Board Allocation

3.1 At the meeting of Health Board on 23rd June 2015, NHS Board Members agreed the revenue estimates for 2015/16, including a total net West Dunbartonshire Health & Social Care Partnership budget of £74.970m.

3.2 Since then the following budget adjustments have taken place revising the budget to £75.529m (overleaf).

Budget Agreed by the Health Board 23rd June 2015	£74.970m
Additional Allocations of:	
GP prescribing	£0.521m
SGHD Health Improvement Programmes	£0.143m
SGHD – Child & Adolescent Mental Health	£0.157m
Acute Services – Specialist care package	£0.050m
Resource Allocation Model – District Nursing	£0.008m
Deduction of Allocations:	
Acute Geriatrician consultant Sessions	(£0.025m)
Hosted GC HSCP: Specialist Child Service (Paediatric Redesign and CAMHs Medical Pays)	(£0.296m)
Revised Budget	**£75.529m**

Council Allocation

3.3 At the meeting of West Dunbartonshire Council on 4th February 2015, Members agreed the revenue estimates for 2015/2016, including a total net West Dunbartonshire Health & Social Care Partnership budget of £61.321m.

3.4 Since then the following budget adjustments have taken place revising the budget to £60.414m.

Budget Agreed by Council 6th February 2014	£61.321m
Additional Allocations of:	
Reduced Savings target for Training	£0.014m
Deduction of Allocations:	
Corporate Savings target – Trade Union review	(£0.012m)
Corporate Savings target – Clerical and admin	(£0.026m)
Deductions due to Virement:	
To Education – Day Placements	(£0.782m)
To Education – Residential Transport	(£0.101m)
Revised Budget	**£60.414m**

4. Main Issues

Summary Position

4.1 The West Dunbartonshire Health & Social Care Partnership revenue position is reporting for the period 1st April to 30th June 2015 an overspend of £180,900 (0.56%).

4.2 The Partnership's NHS Health budget is reporting a net underspend of £3,900 (0.02%) and the Social Care budget is reporting a net overspend of £184,800 (1.27%) for the period 1st April to 30 June 2015.

4.3 The summary position is reported within the following table and the significant variances affecting the overall position reported above are highlighted within section 4.5 and 4.6 of this report.

	Annual Budget	YTD Budget	YTD Actuals	Variance	Variance	Forecast	Variance	Forecast
	£000's	£000's	£000's	£000's	%	Full Year	%	9 months
Health Care	75,528.6	17,807.0	17,803.1	3.9	0.02%	15.6	0.02%	11.7
Social Care	60,408.0	14,530.3	14,715.0	(184.8)	-1.27%	(743.0)	-1.23%	(557.3)
Total Net Expenditure	**£135,936.6**	**£32,337.3**	**£32,518.1**	**£(180.9)**	**-0.56%**	**£(727.4)**	**-0.54%**	**£(545.6)**

Members should note that NHS Health financial convention of reporting overspends as negative variances (-) and underspends as positive variances (+) has been adopted for all financial tables within the report.

4.4 Additional detailed breakdown of individual costs at care group level are reported in Appendix 1 and 2 of this report.

Significant Variances – Health Services

4.5 The net underspend position is £3,900. The key areas are:

- **Addictions – Community Services** is reporting an underspend of £26,200 mainly due to vacancy slippage and workforce planning as part of a service redesign review.

- **Health & Community Care** reported an underspend of £1,900. The main areas of pressure are Equipu (£35,400) and has been offset by an underspend within Nursing and Rehabilitation Pays.

- **Learning Disability – Community is reporting** an underspend of £34,000. This is mainly due vacancies as a result of the ongoing service redesign plans which are currently underway.

- **Mental Health – Adult Community Services** is reporting an underspend of £27,600. This is mainly due vacancy slippage and workforce planning as part of a service redesign review.

- **Other Services is** reporting an overspend of £85,100 mainly due to a review of anticipated service pressures within the financial year.

- **GP Prescribing for Partnerships in 2015/16**

  The reported GP Prescribing result is based on the actual result for the month to 30th April 2015 extrapolated to 30th June 2015. The total result across all Partnerships for April is 1.2% over budget.

  West Dunbartonshire Health & Social Care Partnership is reporting a £185k (4.26%) over spend as at 30th June 2015 based on April dispensing costs, however, under the risk sharing arrangement the over spend has been adjusted to report a cost neutral position.

  As GP Prescribing is extremely volatile, there continues to be an element of financial risk and this will continue to be carefully monitored throughout 2015/16. Variances specific to West Dunbartonshire Health & Social Care Partnership are currently being investigated by Prescribing Advisors.

  <u>Significant Variances - Social Care Services</u>

4.6 The net overspend position is £184,800. The key areas are:

- **Childcare - Community Placements** is reporting a year to date overspend of £25,000. This is due to a higher than budgeted number of children in fostering combined with the need to use higher costing external fostering agencies due to lack of availability in foster parents. In addition adoption arrangement costs are also higher due to fees requiring to be paid to other local authorities in respect of requiring adoptive parents from other areas.

  The ongoing fostering recruitment campaign will increase own foster parents but will not fully alleviate the pressure on this service. Placements are being reviewed regularly to identify where there is scope to move from External to own foster parents.

  If current levels of activity continue then it is unlikely that this budget line can be contained however it is still early in the financial year and demand may vary. At this stage the forecast overspend is £104,000 and is subject to ongoing review.

- **Children's Residential Schools** is reporting a year to date overspend of £38,000 due to residential placements of two children more than anticipated in the budget. The Residential school placements are demand led and as a result the overspend is likely to continue for the remainder of the financial year unless there are unexpected leavers.

  At this stage the forecast overspend is £150,000 and is subject to ongoing monitoring and review.

- **Residential Accommodation for Elderly** is reporting a year to date overspend of £36,000 due to staff absence cost pressures.

  Robust absence management controls are ongoing in the monitoring of sickness levels. The implementation of improved procedures require management authorisation as part of the assessment process. Staff rotas are also being reviewed to ensure maximum utilisation of staff where absence levels drop further. It is anticipated that it may be possible to bring this overspend back in line with budget. At this stage however the forecast overspend is £251,000 and is subject to ongoing monitoring and review.

- **Sheltered Housing** is reporting a year to date underspend of £18,000 within employee costs mainly due to staff turnover and reduction in absence and overtime cover.

  Peripatetic staff are now being employed to make the service more flexible.

  The underspend is forecast to continue and is projected at £60,000 for the full year and which will partially offset other service pressures within the Health & Social Care Partnership.

- **Physical Disability** is reporting a year to date overspend of £32,000 due to an increase in the number of clients within residential accommodation and an increase in clients with direct payments. In addition the anticipated savings on respite are unlikely to be achieved**.**

  Clients agreed packages of care are reviewed regularly to ensure that service adapts to clients capabilities. Where possible service provision is geared towards enabling clients to develop their own capacity to be more independent and therefore reduce levels of support over time.

  At this stage the forecast overspend is £127,000 and is subject to ongoing monitoring and review.

- **Homecare** is reporting a year to date overspend of £107,000 partly due to higher than estimated overtime and agency usage to cover for sickness and vacancies. Income is also showing an adverse situation due to number of clients paying a contributions lower than budgeted

  A bank of supply staff were recruited and trained in June and are now being utilised together with a rolling program of recruitment commencing to mitigate staff turnover gaps. This will increase the capacity and flexibility of in house hours and reduce the need for overtime / agency staff. In relation to income; homecare care organisers are reviewing clients who are not currently on a charge in order to ensure maximum income levels are achieved and reduce the current projected under recovery.

  It is anticipated that the use of supply staff, when firmly established, will begin to reduce the cost pressure and achieve spend in line with budget. In relation

to income, it is anticipated that the current focus on maximizing charging should bring this income closer to budget but due to the large under recovery it is not likely to fully bridge the income gap in this financial year.

At this stage the forecast overspend is £429,000 and is subject to ongoing monitoring and review.

- **Addictions Services** is reporting a year to date underspend of £15,000 due to reduced need for Housing Support.

  The underspend is forecast at £60,000 by year end which will offset service pressures within the overall Health & Social Care Partnership.

- **Other Services** (including Health & Social Care Partnership HQ) is reporting a year to date underspend of £54,000 mainly due to anticipated burden built into budgets for some specific clients with no in year requirement due to change in clients' circumstances.

  The underspend is forecast at £216,000 by year end which will offset service pressures within the overall Health & Social Care Partnership.

Savings Performance to Date – Health

4.7 From within NHSGG&C Partnerships overall savings plan, West Dunbartonshire Health & Social Care Partnership was allocated a local savings target of £0.630m against its directly managed services.

4.8 At this stage the total unachieved savings to date is reported at £19,800. The main area of unachieved savings is reported within Children's Community Services and is subject to internal discussions with service leads.

4.9 At this stage plans are in place to deliver the full savings requirement within 2015/16 in line with the savings targets set.

Savings Performance to Date – Social Care

4.10 From within West Dunbartonshire Council, the savings target allocated to West Dunbartonshire Health & Social Care Partnership was £1.47m against the its Social Care services.

4.11 At this stage the total unachieved savings to date is reported at £25,000 within the Respite Placements plan. A review of alternative placements is being undertaken to find alternative local placements at lower cost. The position is under review whilst noting the delivery of the savings will be challenging to deliver within this financial year.

4.12 At this stage plans are in place to deliver all other planned savings in line with the approved savings plan for 2015/16.

Financial Challenges and Assumptions

4.13 The main challenges to be faced in 2015/16 are as follows:

- The Social Care services budget remains under pressure, mainly due to the increased level of demands for services. It is anticipated that the actions outlined within section 4.6 will help mitigate an element of the budget pressures outlined in this report.

- There continues to be an inherent risk surrounding GP Prescribing and this will continue to be carefully monitored throughout this financial year. Further details on the Health & Social Care Partnership's financial performance will be provided routinely.

- The Health & Social Care Partnership is reporting a £180,900 overspend to the 30th June 2015. The Health & Social Care Partnership is planning forward to achieve the required level of in-year savings and deliver a balanced position against budget for the current financial year. The position will be monitored carefully over the remaining months of this financial year, and in particular the actual performance of the in year challenges reported under section 4 of this report.

- The Chief Officer continues to manage and review the budget across all service areas in conjunction with the senior management team and will put recovery plans in place to address areas of significant overspend reported under section 4.6 of this report.

2015/16 Capital Expenditure

4.14 The progress to date of the individual "live" schemes funded within the Health & Social Care Partnership is as follows.

4.15 On 23rd June 2015 the Scottish Government announced that a new £19 million **Clydebank Health & Care Centre** will be funded through its non-profit distributing (NPD) programme using the HUB model of Design Build, Finance and Maintain (DBFM) . The Health Board - with input from the Health & Social Care Partnership's Senior Management Team - has now appointed architects for the project and developed a draft programme for key stages, with completion of an outline business case currently scheduled for February/March 2016.

4.16 The design and construction of replacement elderly care homes and day care centres in Dumbarton and Clydebank areas continue to progress.

Dumbarton - Enabling works will continue until mid-August 2015 consisting of asbestos removal and demolition of Crosslet House, permanent diversion of right of way through the site, removal of Japanese Knotweed and the completion of the tree removal. Main construction is now due to start on the site in mid-August, under the auspices of the current Letter of Agreement

(LOI) with an expected completion date of January 2017. The Financial Close has been delayed to allow due diligence to be undertaken on the design proposals and construction costs. Because the early works are being undertaken under a Letter of Intent (LOI) this has meant no detriment to the Programme. Financial Close has to be achieved by 24th August in order for the building to be handed over to the Council in January 2017. The slippage has been caused by a delay in the main construction programme from when the financial year spend estimates were made.

Clydebank - Availability of the site was being progressed through the development agreement between WDC and Clydebank Regeneration Ltd (CRL) which was successfully concluded in July 2015. HUB West Scotland have been decoupled from the procurement process in order for the project to be procured through a more efficient framework and options for the procurement of the care home are currently being assessed with a recommendation due to be made to the Project Board in Mid August. Construction is expected to begin in July 2016 with a completion date of September 2017.

4.17 **Service Redesign Bruce Street -** Work is ongoing to establish a new disability learning facility as a replacement for Auchentoshan. The final overspend anticipated is £55,000 due to works instructed to tackle unforeseen onsite issues primarily during the last few weeks on site. The Council was unable to mitigate the potential overspend by value engineering / savings, as all materials were ordered, and the majority of works undertaken prior to the additional works being instructed. The final account is now concluded and the Practical Completion for the Centre was issued on 10th October 2014. The Client has taken possession and the Centre is now open to the various users.

4.18 The summary capital expenditure position is reported within the following table and the significant variances affecting the overall position reported above are highlighted within Appendix 3 and 4 of this report.

Budget Details	Project Life Financials					
	Budget	Spend to Date		Forecast Spend	Forecast Variance	
	£000	£000	%	£000	£000	%
TOTAL PROJECTS AT RED STATUS						
Project Life Financials						
HSCP	23,364	1,488	6%	23,419	55	0%
Current Year Financials						
HSCP	7,385	66	1%	4,940	(2,445)	-33%

5. People Implications

5.1 None.

6. Financial Implications

6.1 Other than the financial position noted above, there are no financial implications of the budgetary control report.

7. Professional Implications

7.1 None

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 The main financial risks to the ongoing financial position relate to currently unforeseen costs and issues arising between now and the financial year-end. Any significant issues will be reported to future Partnership Board meetings.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 This report was agreed with the Health Board Director of Finance and Council's Section 95 Officer.

12. Strategic Assessment

12.1 Proper budgetary control and sound financial practice are cornerstones of good governance and support the Partnership Board and officers to pursue the strategic priorities of the Strategic Plan.

12.2 This report links to the strategic financial governance arrangements of both parent organisations.

Jeanne Middleton – Chief Financial Officer

Date: 19th August 2015

Person to Contact: Jeanne Middleton – Chief Financial Officer, Garshake Road, Dumbarton, G82 3PU, Telephone: 01389 737311
e-mail jeanne.middleton@ggc.scot.nhs.uk

Appendices: Appendix 1 - Health Financial Statement (P3 Budget report)
Appendix 2 - Social Care Financial Statement (P3 BCR)
Appendix 3 & 4 - General Service Capital Programme

Background Papers: None

Wards Affected: All

Appendix 1

Health Budget Report – Period 3 (as at 30 June 2015)

Care Group	Annual Budget £'000	Cumulative Budget £'000	Cumulative Actuals £'000	Cumulative Variance £'000
Addictions - Community	1,966.4	324.7	298.5	26.2
Adult Community Services	11,113.5	2,623.9	2,622.0	1.9
Wd Integrated Care Fund	1,584.3	126.6	126.6	0.0
Child Services - Specialist	1,898.6	474.6	479.9	(5.3)
Child Services - Community	2,410.3	616.6	628.5	(11.9)
Fhs - Prescribing	17,776.3	4,531.0	4,531.0	0.0
Fhs - Gms	11,533.0	2,874.2	2,874.2	0.0
Fhs - Other	11,185.6	2,603.0	2,603.0	0.0
Hosted Services	858.0	193.2	187.6	5.5
Learn Dis - Community	601.5	150.4	116.4	34.0
Men Health - Adult Inpatient	0.0	0.0	(0.2)	0.2
Men Health - Adult Community	4,611.3	1,149.4	1,121.8	27.6
Men Health - Elderly Services	3,256.7	813.1	808.7	4.3
Other Services	3,005.0	619.3	704.4	(85.1)
Planning & Health Improvement	1,009.2	218.0	211.7	6.4
Resource Transfer - Local Auth	7,767.5	1,941.9	1,941.9	0.0
Expenditure	80,577.2	19,259.9	19,256.0	3.8
Addictions - Community	(95.3)	0.0	0.0	0.0
Adult Community Services	(489.1)	(223.7)	(223.7)	0.0
Child Services - Specialist	(827.6)	(139.3)	(139.3)	0.0
Child Services - Community	(259.9)	(118.8)	(118.8)	0.0
Fhs - Other	(974.4)	(251.9)	(251.9)	0.0
Learn Dis - Community	(320.0)	(80.0)	(80.0)	0.0
Men Health - Adult Community	(1,072.3)	(216.3)	(216.3)	0.0
Men Health - Elderly Services	(182.6)	(45.6)	(45.6)	0.0
Other Services	(628.2)	(312.5)	(312.5)	0.0
Planning & Health Improvement	(20.0)	(20.0)	(20.0)	0.0
Resource Transfer - Local Auth	(179.2)	(44.8)	(44.8)	0.0
Income	(5,048.6)	(1,452.9)	(1,452.9)	0.0
West Dunbartonshire HSCP	**75,528.6**	**17,807.0**	**17,803.1**	**3.8**

WEST DUNBARTONSHIRE COUNCIL
REVENUE BUDGETARY CONTROL 2015/2016
HSCP SUMMARY

Appendix 2

MONTH END DATE **30 June 2015**

PERIOD **3**

Actual Outturn 2014/15	Departmental / Subjective Summary	YTD Budget 2015/16	Spend to Date 2015/16	YTD Variance	Total Budget 2015/16	Forecast Spend 2015/16	Forecast Variance YTD
£000		£000	£000		£000	£000	£000
1,002	Strategy, Planning & Health Improvement	227	222	(5)	1,193	1,172	(21)
3,580	Residential Accommodation for Young People	794	797	3	3,071	3,083	12
2,876	Community Placements	721	745	25	2,856	2,960	104
1,880	Residential Schools	221	259	38	846	996	150
3,945	Childcare Operations	792	793	2	4,037	4,043	6
3,951	Other Services - Young People	760	763	3	3,951	3,963	12
6,076	WDC Residential Accom for Older People	1,592	1,655	63	5,745	5,996	251
6,531	External Residental for Older People	2,901	2,901	0	6,916	6,916	0
1,390	Sheltered Housing	378	360	(18)	1,448	1,377	(71)
1,107	Day Centres Older People	228	237	9	1,040	1,075	35
90	Meals on Wheels	9	10	2	81	87	6
278	Community Alarms	19	13	(6)	146	122	(24)
3,046	Community Health Operations	622	625	3	2,721	2,734	13
9,476	Residential Learning Disability	1,600	1,598	(2)	9,634	9,628	(6)
2,065	Physical Disability	395	427	32	1,968	2,095	127
1,478	Day Centres Learning Disability	271	265	(6)	1,572	1,550	(22)
245	HSCP HQ	97	43	(54)	433	217	(216)
1,603	Mental Health	421	425	5	2,066	2,084	18
9,878	Homecare	2,202	2,309	107	9,853	10,282	429
0	Other Specific Services	0	0	0	0	0	0
1,049	Addiction Services	283	268	(15)	1,231	1,171	(60)
(100)	Older Peoples Change Fund	0	0	0	(400)	(400)	0
61,446	**Total Net Expenditure**	**14,530**	**14,715**	**185**	**60,408**	**61,151**	**743**
£000	**Subjective Summary**	£000	£000	£000	£000	£000	£000
36,934	Employee	7,703	7,808	105	36,582	37,002	420
977	Property	160	161	2	957	963	6
1,431	Transport and Plant	92	95	3	1,177	1,198	21
1,228	Supplies, Services and Admin	187	190	3	1,131	1,142	11
36,674	Payments to Other Bodies	6,829	6,832	3	36,587	36,596	9
1,345	Other	436	463	28	1,450	1,560	110
78,589	**Gross Expenditure**	**15,406**	**15,549**	**143**	**77,884**	**78,461**	**577**
(17,143)	**Income**	**(876)**	**(834)**	42	**(17,476)**	**(17,310)**	166
61,446	**Net Expenditure**	**14,530**	**14,715**	**185**	**60,408**	**61,151**	**743**

WEST DUNBARTONSHIRE COUNCIL **APPENDIX 3**
GENERAL SERVICES CAPITAL PROGRAMME
ANALYSIS OF PROJECTS AT RED ALERT STATUS

MONTH END DATE **30 June 2015**

PERIOD **3**

Budget Details	Project Life Financials					
	Budget	Spend to Date		Forecast Spend	Forecast Variance	
	£000	£000	%	£000	£000	%
Service Redesign Bruce Street (David Elliot)						
Project Life Financials	712	750	105%	767	55	8%
Current Year Financials	14	52	369%	69	55	393%
Project Description	This budget is to establish a new disability learning facility as a replacement for Auchentoshan					
Project Lifecycle	Planned End Date		14-Sep-14	Forecast End Date		31-Mar-16

Main Issues / Reason for Variance

Final overspend anticipated to be £55k due to works instructed to tackle unforeseen onsite issues primarily during the last few weeks on site.

Mitigating Action

WDC was unable to mitigate the potential overspend by value engineering / savings, as all materials were ordered, and the majority of works undertaken prior to the additional works being instructed. Final account is now concluded.

Anticipated Outcome

Practical Completion for the Centre was issued on 10 October 2014. The Client has taken possession and the Centre is now open to the various users.

Replace Elderly Care Homes / Daycare Centres (Chris McNeill)

Project Life Financials	22,652	739	3%	22,652	0	0%
Current Year Financials	7,371	15	0%	4,871	(2,500)	-34%

Project Description	Design and construction of replacement elderly care homes and day care centres in Dumbarton and Clydebank areas			
Project Lifecycle	Planned End Date	11-Dec-15	Forecast End Date	30-Sep-18

Main Issues / Reason for Variance

General - The total affordability cap of the home in Dumbarton has been confirmed as £13.1m leaving £9.5m available for the Clydebank home. Due diligence and value engineering during the Stage 2 towards Financial Close in August 2015 will seek to achieve a final cost below this figure

Dumbarton - Enabling works will continue until mid-August 2015 consisting of asbestos removal and demolition of Crosslet House, permanent diversion of right of way through the site, removal of Japanese Knotweed and the completion of the tree removal. Main construction is now due to start on the site in mid-August, under the auspicies of the current Letter of Agreement (LOI) with an expected completion date of January 2017. The Financial Close has been delayed to allow due diligence to be undertaken on the design proposals and construction costs. Because the early works are being undertaken under a Letter of Intent (LOI) this has meant no detriment to the Programme. Financial Close has to be achieved by 24th August in order for the building to be handed over to the Council in January 2017. The slippage has been caused by a delay in the main construction programme from when the financial year spend estimates were made.

Clydebank - Availability of the site was being progressed through the development agreement between WDC and Clydebank Regeneration Ltd (CRL) which was successfully concluded in July 2015. HUBWest Scotland have been decoupled from the procurement process in order for the project to be procured through a more efficient framework and options for the procurement of the care home are currently being assessed with a recommendation due to be made to the Project Board in Mid August. Construction is expected to begin in July 2016 with a completion date of September 2017.

Mitigating Action

Dumbarton - Daily dialogue with HubWest Scotland and main contractors to ensure that costs are maintained within the affordability cap and dates are adhered to.

Clydebank - WDC will continue to liaise with CRL to ensure that site preparation works continue to proceed in line with project timescale and Masterplan development and within available budget.

Anticipated Outcome

Dumbarton - Development will proceed in accordance with agreed timescale and budget.

Clydebank - Development will proceed in tandem with development of new health centre and in the context of the Queens Quay masterplan and infrastrucure projects.

HSCP Overall Capital Summary

WEST DUNBARTONSHIRE COUNCIL
GENERAL SERVICES CAPITAL PROGRAMME
OVERALL PROGRAMME SUMMARY

APPENDIX _4_

MONTH END DATE 30 June 2015

PERIOD 3

Project Status Analysis	Project Life Status Analysis				Current Year Project Status Analysis			
	Number of Projects at RAG Status	% Projects at RAG Status	Spend to Date £000	% Project Spend at RAG Status	Number of Projects at RAG Status	% Projects at RAG Status	Spend to Date £000	% Project Spend at RAG Status
Red								
Projects are forecast to be overspent and/or experience material delay to completion	2	67%	1,488	76%	2	67%	66	80%
Amber								
Projects are either at risk of being overspent and/or delay in completion (although this is unquantifiable at present) or the project has any issues that require to be reported at this time	0	0%	0	0%	0	0%	0	0%
Green								
Projects are on target both in relation to overall budget and the forecast stages in the project life cycle and no issues are anticipated at this time	1	33%	473	24%	1	33%	16	20%
TOTAL EXPENDITURE	**3**	**100%**	**1,962**	**100%**	**3**	**100%**	**83**	**100%**

Project Status Analysis	Project Life Financials				Current Year Financials					
	Budget £000	Spend to Date £000	Forecast Spend £000	Forecast Variance £000	Budget £000	Spend to Date £000	Forecast Spend £000	Forecast Variance £000	Re-Phasing £000	Over/ (Under) £000
Red										
Projects are forecast to be overspent and/or significant delay to completion	23,364	1,488	23,419	55	7,385	66	4,940	(2,445)	(2,500)	55
Amber										
Projects are either at risk of being overspent and/or delay in completion (although this is unquantifiable at present) or the project has any issues that require to be reported at this time	0	0	0	0	0	0	0	0	0	0
Green										
Projects are on target both in relation to overall budget and the forecast stages in the project life cycle and no issues are anticipated at this time	1,201	473	1,123	(78)	661	16	666	5	0	5
TOTAL EXPENDITURE	**24,565**	**1,962**	**24,542**	**(23)**	**8,046**	**83**	**5,606**	**(2,440)**	**(2,500)**	**60**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 19th August 2015

Subject: Financial Regulations

1. Purpose

1.1 To seek the Partnership Board's approval for its Financial Regulations.

2. Recommendations

2.1 It is recommended that the Partnership Board approves the attached Financial Regulations.

3. Background

3.1 The Financial Regulations are a key component of the Partnership Board's governance arrangements. They set out the expectations on and the responsibilities of the Partnership Board and senior officers in relation to the proper administration of the Partnership Board's finances, as well as the internal audit arrangements that the Partnership Board will have to put in place.

4. Main issues

4.1 The proposed Financial Regulations for the Partnership Board are attached. These provide a framework for the Partnership Board and senior officers to ensure proper administration of the Partnership Board's finances.

4.2 The regulations are based on the model regualtions developed jointly by the national health and social care Technical Finance Working Group to help ensure a consistent approach whilst allowing scope for local variations within each integration authority.

4.3 The Financial Regulations of the Partnership Board will not supersede those of West Dunbartonshire Council or the Standing Financial Instructions of NHS Greater Glasgow & Clyde Health Board: it is an overarching document which will operate alongside both those organisation's regulations.

4.4 The Technical Finance Working Group is aware of the following outstanding issue which is subject to national guidance:

- Formal documentation of accounting treatment, the format of accounts (including structure of notes and content of accounts), and the treatment of support services – Scottish Government advice is that integration authorities will need to produce accounts for 2015/16 irrespective of the date of

commencement in the Strategic Plan. It is anticipated that these issues will covered in the finalised guidance. It should be noted that with the Partnership Board having approved its Strategic Plan at its inaugural meeting, the integration start day for the West Dunbartonshire integration arrangements was the 1st July 2015. The approved Strategic Plan detailed both the full year's financial position and the budget for the nine month period from the 1st of July 2015.

4.5 Those papers which will be submitted to the HSCP Board in due course include:

- Proposals for Internal Audit arrangements (see Item 05)
- Risk Management Policy & Strategy (see Item 06)
- A financial governance system for the proper use of delegated resources
- Statement of Internal Control – Governance Statement & Financial Assurance
- Business Continuity
- Reserves Strategy – we can now formulate a reserves strategy on the basis of the above provisional assessment that integration joint boards will have the status of a local government body.

5. People Implications

5.1 None

6. Financial Implications

6.1 The Financial Regulations are a key component of the Partnership Board's governance arrangements. They set out the expectations on and the responsibilities of the Partnership Board and senior officers in relation to the proper administration of the Partnership Board's finances, as well as the internal audit arrangements that the Partnership Board will have to put in place.

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7. Professional Implications

7.1 None

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 Approval of the attached Financial Regulations will ensure the Partnership Board complies with the requirements of Section 95 of the Local Government (Scotland) Act 1973, which states that relevant authorities "shall make arrangements for the proper administration of their financial affairs and shall

secure that the proper officer of the authority has responsibility for the administration of those affairs."

9.2 The Health Boards Standing Financial Instructions and the Council's Standing orders are currently in place and Health & Social Care Partnership Scheme of Delegations to the Chief Officer are currently in place.

10. Impact Assessments

10.1 None

11. Consultation

11.1 This report was prepared in conjunction with Health and Council Colleagues and was agreed with the Health Board Director of Finance and Council's Section 95 Officer.

12. Strategic Assessment

12.1 Proper budgetary control and sound financial practice are cornerstones of good governance and support the Partnership Board and officers to pursue the strategic priorities of the Strategic Plan.

12.2 This report links to the strategic financial governance arrangements of both the Health Board and the Council

Jeanne Middleton - Chief Financial Officer

Date: 19th August 2015

Person to Contact: Jeanne Middleton – Chief Financial Officer
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Appendices: West Dunbartonshire Health & Social Care Partnership Board Financial Regulations

Background Papers: None

Wards Affected: All

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board

Financial Regulations

CONTENTS

The Health & Social Care Partnership Board positively promotes the principles of sound corporate governance within all areas of its affairs. These Financial Regulations are an essential component of the governance of the Health & Social Care Partnership Board.

WHAT THE REGULATIONS COVER

1.1 West Dunbartonshire Health & Social Care Partnership Board is responsible for the strategic planning and reporting of a range of health and social care services delegated it by NHS Greater Glasgow & Clyde Health Board and West Dunbartonshire Council (described in full within its approved Integration Scheme). The Council and the Health Board discharge the operational delivery of those delegated services (except those related to the Health Board's Acute Division services most commonly associated with the emergency care pathway) through the partnership arrangement referred to as West Dunbartonshire Health & Social Care Partnership. The Health & Social Care Partnership Board is responsible for the operational oversight of West Dunbartonshire Health & Social Care Partnership.

1.2 The West Dunbartonshire Health & Social Care Partnership Board's:

- Mission is to improve the health and wellbeing of West Dunbartonshire.
- Purpose is to plan for and ensure the delivery of high quality health and social care services to and with the communities of West Dunbartonshire.
- Core values are protection; improvement; efficiency; transparency; fairness; collaboration; respect; and compassion.

1.3 The Partnership Board is a legal entity in its own right created by Parliamentary Order, following ministerial approval of the Integration Scheme. It is accountable for the stewardship of public funds and is expected to operate under public sector best practice governance arrangements, proportionate to its transactions and responsibilities. Stewardship is a major function of management and, therefore, a responsibility placed upon the appointed members and officers of the Partnership Board.

1.4 These financial regulations should be read in conjunction with the Standing Financial Instructions of NHS Greater Glasgow and Clyde Health Board; relevant policies of West Dunbartonshire Council.

1.5 The Regulations set out the respective responsibilities of the Chief Officer and the Chief Financial Officer of the Partnership Board.

1.6 It will be the duty of the Chief Officer assisted by the Chief Financial Officer to ensure that these Regulations are made known to the appropriate persons within the Partnership Board; and to ensure that they are adhered to.

1.7 If is believed that anyone has broken, or may break, these Regulations, this must be reported immediately to the Chief Financial Officer, who may then discuss the matter with the Chief Officer, Health Board Chief Executive, Council Chief Executive, Health Board Director of Finance or Council 95 Officer as appropriate to decide what action to take.

1.8 These Regulations will be the subject of regular review by the Chief Financial Officer in consultation with the Health Board Director of Finance and the Council Section 95 Officer; and where necessary, subsequent adjustments will be submitted to the Partnership Board for approval.

FINANCIAL MANAGEMENT AND PERFORMANCE

2.1 The Integration Scheme sets out the detail of the integration arrangement agreed between NHS Greater Glasgow and Clyde Health Board and West Dunbartonshire Council. In relation to financial management it specifies:

- The financial management arrangements including treatment of budget variances.
- Reporting arrangements between the Partnership Board, the Health Board and the Council.
- The method for determining the resources to be made available by the Health Board and the Council.
- The functions which are delegated to the Partnership Board by the Health Board and the Council.

Responsibilities of the Chief Officer

2.2 The Chief Officer is the accountable officer of the Partnership Board in all matters except finance.

2.3 The Chief Officer will discharge their duties in respect of the delegated resources by:

- Ensuring that the Strategic Plan meets the requirement for economy, efficiency and effectiveness.
- Giving directions to the Health Board and the Council that are designed to ensure resources are spent in accordance with the plan; it is the responsibility of the Chief Officer to ensure that the provisions of the directions enable them to discharge their responsibilities in this respect within available resources.

2.4 The Chief Officer will also holds an operational role in the Health Board and the Council for the management of the delegated services (except for the management of NHS acute hospital services which is retained within the Health Board) through the partnership arrangement referred to as West Dunbartonshire Health & Social Care Partnership. The Health & Social Care Partnership Board is responsible for the operational oversight of West Dunbartonshire Health & Social Care Partnership.

2.5 In this operational role the Chief Officer has no “accountable officer” status but is:

- Accountable to the Health Board Chief Executive for financial management of the operational budget.
- Accountable to the Section 95 Officer of the Council for financial management of the operational budget.
- Accountable to the Health Board Chief Executive and the Council Chief Executive for ensuring that integrated service delivery is conducted within the operational service delivery framework established by the Health Board and Council for their respective functions, ensuring both those organisations can also their discharge their governance responsibilities.

Responsibilities of the Chief Financial Officer

2.6 The Chief Financial Officer is the accountable officer for financial management and administration of the Partnership Board. The Chief Financial Officer will be line managed by the Chief Officer, and professionally supervised and formally supported by the Council Section 95 Officer and the Health Board Director of Finance.

2.7 The Chief Financial Officer will discharge their duties in respect of the delegated resources by:

- Establishing financial governance systems for the proper use of the delegated resources.
- Ensuring that the Strategic Plan meets the requirement for best value in the use of the Partnership Board's resources.

Responsibilities of the Health Board Accountable Officer, Health Board Director of Finance and Council Section 95 Officer

2.8 The Health Board Accountable Officer and the Council Section 95 Officer are responsible for providing the Partnership Board with assurance that its delegated resources are appropriately robust to allow it to carry out its delegated services and functions, both prior to the approval of its Strategic Plans and at the start of each financial year. They are also responsible for assuring their respective organisations of that resources are being used in accordance with the Strategic Plan; and of the systems and monitoring arrangements for financial performance management in compliance with the Integration Scheme.

2.9 The Health Board Director of Finance and the Council Section 95 Officer will provide specific advice and professional support to the Chief Officer and Chief Financial Officer to support the production of the Strategic Plan; and to provide support to the Partnership Board to ensure that adequate systems of internal control are established and maintained.

FINANCIAL PLANNING

Strategic Plan and Integrated Budget

3.1 In accordance with its Integration Scheme, the Health & Social Care Partnership Board is responsible for the production, approval and monitoring of a Strategic Plan for those integrated services delegated to it. The resources within scope of the Strategic Plan are:

- The payment made by the Council to the Partnership Board in respect of all of the functions delegated by Council to the Partnership Board.
- The payment made by the Health Board to the Partnership Board in respect of all of the functions delegated by Health Board to the Partnership Board.
- The amount set aside by the Health Board to the Partnership Board in respect of NHS acute hospital services for the West Dunbartonshire population.

3.2 The Health Board and Council will provide indicative three year rolling funding allocations to the Partnership Board to support its strategic planning process.

Such indicative allocations will remain subject to annual approval by both organisations.

3.3 The Chief Officer and the Chief Financial Officer will develop a business case for the integrated budget based on the Strategic Plan and present it to the Health Board and Council for consideration and agreement as part of each organisation's annual budget setting process. The business case will be evidence-based, with full transparency on its assumptions and take account of:

- **Activity Changes**. The impact on resources in respect of increased demand (e.g. demographic pressures and increased prevalence of long term conditions) and for other planned activity changes.
- **Cost Inflation**. Pay and supplies cost increases.
- **Efficiencies**. All savings (including increased income opportunities and service rationalisations/cessations) should be agreed between the Partnership Board, the Council and the Health Board as part of the annual rolling financial planning process to ensure transparency.
- **Performance on outcomes**. The potential impact of efficiencies on agreed outcomes must be clearly stated and open to challenge by the Council and the Health Board.
- **Legal requirements**. Legislation may entail expenditure commitments that should be taken into amount in adjusting the payment.
- **Transfers to/from the notional budget for hospital services** set out in the Strategic Plan.
- **Adjustments to address equity**. The Council and the Health Board may choose to adjust contributions to smooth the variation in weighted capita resource allocations across partnerships. Information to support this will be provided by ISD and ASD.

3.4 The Strategic Plan will determine the allocation of resources with respect to operational delivery of integrated services. Strategic Plans will take account of all resources available to the Chief Officer, including capital assets owned by the Health Board on behalf of Scottish Ministers, and the Council.

Limits on Expenditure

3.5 No expenditure will be incurred by the Partnership Board unless it has been included within the approved integrated budget and Strategic Plan except:

- Where additional funding has been approved by the Health Board and/or Council; and the integrated budget and Strategic Plan has been updated appropriately.
- Where a supplementary budget has been approved by the Partnership Board.
- In emergency situations in terms of any scheme of delegation.
- Is provided in paragraph 3.5 below (Virement).

3.6 Virement is defined by CIPFA as "the transfer of an under-spend on one budget head to finance additional spending on another budget head in accordance with the Financial Regulations". In effect virement is the transfer of budget from one main budget heading (e.g. employee costs, supplies and services) to another; or a transfer of budget from one service to another. Where resources are transferred between the two operational arms of the integrated budget this will require in-year balancing adjustments to the allocations from the Partnership

Board to the Council and the Health Board, i.e. a reduction in the allocation to the body with the under-spend and a corresponding increase in the allocation to the body with the overspend.

3.7 Virements require approval by the Chief Financial Officer and the Partnership Board; and they will be permitted subject to any Scheme of Delegation of the Partnership Board as follows:

- Virement must not create additional overall budget liability. One off savings or additional income should not be used to support recurring expenditure or to create future commitments including full year effects of decisions made part way through a year.
- The Chief Officer will not be permitted to vire between the integrated budget and those budgets that are managed by the Chief Officer, but are outwith the scope of the Strategic Plan, unless agreed by the Council and the Health Board.

Budgetary Control

3.8 It is the responsibility of the Chief Officer and Chief Financial Officer to report regularly and timeously on all budgetary control measures, comparing projected outturn with the approved financial plan, to the Partnership Board and other bodies as designated by the Health Board and Council.

3.9 The Health Board Director of Finance and the Council Section 95 Officer will, along with Chief Financial Officer, put in place a system of budgetary control which will provide the Chief Officer with management accounting information for both arms of the operational budget and for the Partnership Board in aggregate.

3.10 It is the responsibility of the Chief Financial Officer, in consultation with the Health Board Director of Finance and the Council Section 95 Officer to agree a consistent basis and timetable for the preparation and reporting of management accounting information.

3.11 The Integration Scheme specifies how in year over-spends or under-spends will be treated. Where it appears that any heading of income or expenditure may vary significantly from the Financial Plan, it will be the duty of the Chief Officer and the Chief Financial Officer, in conjunction with the Health Board Director of Finance and the Council Section 95 Officer to report in accordance with the appropriate method established for that purpose by the Partnership Board, Health Board and Council, the details of the variance and any remedial action required.

Reports to the Partnership Board

3.12 All reports to the Partnership Board and sub-committees thereof must specifically identify the extent of any financial implications. These must have been discussed and agreed with the Chief Financial Officer prior to lodging of reports.

LEGALITY OF EXPENDITURE

4.1 It will be the duty of the Chief Officer to ensure that no expenditure is incurred, or include within the Strategic Financial Plan unless it is within the power of the

Partnership Board as per the Integration Scheme. In cases of doubt the Chief Officer should consult the respective legal advisers of the Health Board and Council before incurring expenditure. The legality of expenditure on new service developments, initial contributions to other organisations and responses to emergency situations which require expenditure must be clarified prior to being incurred and with reference to Schemes of Delegation.

REVIEWING THE FINANCIAL REGULATIONS

5.1 The Partnership Board will consider and approve any alterations to these Financial Regulations. The Partnership Board may also withdraw these financial regulations. If so, this will come into force from the first working day after the end of the Partnership Board meeting at which the change or withdrawal was approved.

RESERVES

6.1 Legislation, under Section 106 of the Local Government (Scotland) Act 1973 as amended, empowers the Partnership Board to hold reserves which should be accounted for in the financial accounts and records of the Partnership Board.

6.2 The Partnership Board will develop a reserves policy and a reserves strategy which will include the level of reserves required and their purpose. This will be agreed as part of the annual budget setting process and will be reflected in the Strategic Plan.

VAT

7.1 HM Revenues & Customs (HMRC) has confirmed that there is no requirement to have a separate VAT registration for the Partnership Board, as it will not be delivering any services within the scope of VAT. This situation should be kept under review by the Chief Financial Officer should the operational activities of the Partnership Board change and a need to register be established. HMRC guidance applies to Scotland, will allow a VAT neutral outcome.

PROCUREMENT OF SERVICES

8.1 Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014/285 provides that the Partnership Board may enter into a contract with any other person in relation to the provision of goods and services to the Partnership Board for the purpose of carrying out the functions conferred in it by the Act. The Partnership Board should take advice from the Chief Financial Officer when considering any such direct procurement exercise.

8.2 As a result of specific VAT and accounting issues associated with Partnership Board contracting directly for the provision of goods and services, the Chief Officer is required to consult with the Health Board Director of Finance, the Council's Section 95 Officer and the Chief Financial Officer prior to any direct procurement exercise being undertaken.

FINANCIAL REPORTING

Accounting Procedures and Records

9.1 All accounting procedures and records of the Partnership Board will be as specified in applicable legislation and regulations. Financial Statements will be prepared following the Code of Practice on Local Authority Accounting in the UK. Statements will be signed as specified in regulations made under Section 105 of the Local Government (Scotland) Act 1973.

9.2 The financial statements must be completed to meet the audit and publication timetable specified in regulations made under section 105 of the Local Government (Scotland) Act 1973. It is the primary responsibility of the Chief Financial Officer to meet these targets; and of the Chief Officer to provide any relevant information to ensure that the Health Board and Council meet their respective statutory audit and publication requirements for their individual and group financial statements. The Chief Financial Officer will agree the financial statements timetable with the external auditors of the Partnership Board, Health Board and Council.

INTERNAL AUDIT

10.1 It is the responsibility of the Partnership Board to establish adequate and proportionate internal audit arrangements for review of the adequacy of the arrangements for risk management, governance and control of the delegated resources; and which are consistent with good practice governance standards in the public sector. This will include determining who will provide the internal audit service for Partnership Board and appointing a Chief Internal Auditor.

10.2 The internal audit service should be provided by one of the internal audit teams from the Health Board or Local Authority.

10.3 The Chief Internal Auditor from either the Health Board or Council will be appointed to undertake this role for the Partnership Board in addition to their role as Chief Internal Auditor of their respective Authority.

10.4 The appointed Internal Audit Service will undertake their work in compliance with the Public Sector Internal Audit Standards.

10.5 The Partnership Board will establish a standing Audit Committee to focus on financial and internal audit on behalf of the Partnership Board. It will be the responsibility of the Partnership Board to agree the membership having regard to the agreed remit, skills and good practice for a public sector audit committees. It is anticipated that voting members of the Partnership Board will serve in this capacity. The Chief Officer, Chief Financial Officer and appointed Chief Internal Auditor will be required to attend meetings of the Audit Committee.

10.6 Before the start of each financial year, the Chief Internal Auditor will consult with the Chief Officer and Chief Financial Officer in the preparation of a strategic and risk-based audit plan, which the Chief Internal Auditor will then submit to the Audit Committee at the start of the financial year. The scope of interest of such internal audit plans will be:

- The Strategic Plan.
- Financial Plan underpinning the Strategic Plan.
- The operational delivery of those integrated services delegated to the Partnership Board (except for NHS acute hospital services).
- Relevant issues raised from the internal auditors of the Health Board, Council and the Partnership Board.

10.7 The Chief Internal Auditor for the Partnership Board will report to the Chief Financial Officer and the Audit Committee on the approved annual risk-based audit plan; delivery of the audit plan and any recommendations; and will provide an annual internal audit report, including the audit opinion.

10.8 The Chief Financial Officer will work with the internal auditors of the Health Board, Local Authority and the Partnership Board to ensure that there is clarity and consistency of appropriate scrutiny of the work of the Partnership Board and the Health & Social Care Partnership; and that the internal audit plans of the three audit committees provide necessary assurance to all three of the bodies.

10.9 The Chief Internal Auditor will ensure that the Partnership Board's annual internal audit plan and internal audit report are shared with the Health Board's Audit Committee and Council's Audit & Performance Review Committee through the reporting arrangements in those bodies for internal audit.

10.10 Reports on each internal audit engagement will be submitted to the Chief Officer and Chief Financial Officer.

EXTERNAL AUDIT

11.1 The Accounts Commission will appoint the External Auditors to the Partnership Board as specified under Section 13 of the legislation.

RISK MANAGEMENT AND INSURANCE

Responsibility for Insurance and Risk

12.1 The Partnership Board, while having legal personality in its own right, has neither replaced nor assumed the rights or responsibilities of either the Health Board or the Council as the employers of the staff delivering integrated services; or for the operation of buildings or services under the operational remit of those staff. The Council and the Health Board will continue to indemnify, insure and accept responsibility for the staff that they each employ; their particular capital assets that integrated services are delivered from or with; and the respective services

themselves that each has delegated to the Partnership Board.

12.2 The Partnership Board will make appropriate insurance arrangements for all activities of the Partnership Board in accordance with its locally approved risk management policy and strategy. The Chief Financial Officer will arrange, taking such specialist advice as may be necessary, that adequate insurance cover is obtained for all normal insurable risks arising from the activities of the Partnership Board and for which it is the general custom to insure. This will include the provision of appropriate insurance in respect of voting members of the Partnership Board acting in a decision making capacity. The Chief Officer and the Chief Finance Officer will put in place appropriate procedures for the notification and handling of any insurance claims made against the Partnership Board.

Risk Management

12.3 The Chief Officer will be responsible for developing and implementing the Partnership Board's approved risk management policy and strategy. This will include arrangements for maintaining and reporting on a strategic risk register that will identify, assess and prioritise risks related to the preparation and delivery of the Strategic Plan; and identify and describe processes for mitigating those risks. This will then be presented to the Partnership Board's Audit Committee for scrutiny and the Health & Social Care Partnership Board for approval on an annual basis; and then shared with the Council and Health Board.

12.4 The Health Board and Council will continue to identify and manage within their own risk management arrangements any risks they have retained under the Integration Scheme. The NHS Board and Council will continue to report on the management of such risks, alongside the impacts of the integration arrangements.

12.5 The Health Board Director of Finance and the Council Section 95 Officer will ensure that the Partnership Board's Audit Committee, Chief Officer and Chief Financial Officer have access to professional support and advice in respect of risk management.

ECONOMY, EFFICIENCY AND EFFECTIVENESS (BEST VALUE)

13.1 The Chief Officer will ensure that arrangements are in place to maintain control and clear public accountability over the public funds delegated to the Partnership Board. The Partnership Board has a duty to put in place proper arrangements for securing Best Value in the use of resources and delivery of services.

13.2 It will be the responsibility of the Chief Officer to deliver the arrangements put in place to secure Best Value. This will be incorporated into the process of strategic planning, in order to establish the systematic identification of priorities; and the implementation of the Strategic Plan with respect to services delivered within the Health and Social Care Partnership so as to realise Best Value.