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, 18 November 2015 at 2.00 p.m.

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

Non-Voting Members: Keith Redpath, Chief Officer; Jeanne Middleton, Chief Finance Officer; 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; Barbara Barnes, Co-Chair, Public Engagement Forum/Chair of the Local Engagement Network (Dumbarton and Alexandria area); Dr Neil Mackay, Chair of Locality Core Group for the Alexandria & Dumbarton area; Janice Miller, MSK Physiotherapy Manager as the Lead Allied Health Professional for the Health & Social Care Partnership; Diana McCrone, as NHS Staff Side Co-Chair of the Health & Social Care Partnership Joint Staff Forum and Peter O'Neill, UNISON, Staff Side Co-Chair of Health & Social Care Partnership's Joint Staff Forum.

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

Apologies: Apologies for absence were intimated on behalf of Mr Allan Macleod (voting member), Anne McDougall, Co-Chair, Public Engagement Forum/Chair of the Local Engagement Network (Clydebank area) and Dr Martin Perry, Consultant/Clinical Lead at the Vale of Leven Hospital

Councillor Gail Casey in the Chair

CHAIR'S REMARKS

The Chair, Councillor Casey, informed the Partnership of the staff achievements celebrated at the NHS Greater Glasgow and Clyde 'Celebrating Success Awards Ceremony' held on 16 November 2015 and congratulated the West Dunbartonshire Health & Social Care Partnership local winners recognised at the event as undernoted:-

- The Young People in Mind Team: Brenda Kelly, Louise Grant, Emma Marshall, Karen Ferguson & Janice Murphy

- Leadership of Acquired Brain Injury Team: Angela Sprott

- The Work Connect Initiative: Ingram Wilson and Lorraine Davin

- Heather Irving for her work enabling local quality improvement

- Community Older People's Team: Mary-Angela McKenna, Caroline Thomson, Linda Young, Helen Faye and Hazel Kelly

It was noted that the Care at Home Pharmacy initiative, represented by Pamela McIntyre, Lynne Meldrum and Richard Heard, had won the Health Board wide Improving Health category.

It was also noted that the event marked the end of Andrew Robertson's tenure as Chairman of the Health Board therefore the Partnership Board recorded its thanks to Dr Robertson for his tremendous achievements in the role and expressed best wishes for the future.

Thereafter, the Chair drew attention to further national recognition received by staff in recent weeks, as undernoted:-

- Integrated Palliative Care Programme winning the Integration category at the Scottish Herald Society Awards

- Youth Mentoring Scheme winning two categories at the Scottish Mentoring Network Awards – for Justice Project of the Year and Exceptional Contribution Award for Ronnie Rearden one of the Partnership's local mentors

- Pamela McIntyre, Lead Pharmacist, who was recognised with the Leading and Managing for Quality Award at the Scottish Health Awards

Thereafter, the Committee congratulated all nominees, winners and their teams on their continued commitment and contributions to providing high quality services on behalf of the Partnership.

DECLARATIONS OF INTEREST

Councillor Rooney declared a financial interest of his spouse in the item under the heading 'Quality Assurance in West Dunbartonshire Care Homes', his spouse being a member of staff at a care home in West Dunbartonshire, and intimated that he proposed to take part in the discussion on this item.

Barbara Barnes declared a non-financial interest in the item under the heading 'Quality Assurance in West Dunbartonshire Care Homes', being an inspection volunteer for the Care Inspectorate, and intimated that she proposed to take part in the discussion on this item.

MINUTES OF PREVIOUS MEETING

The Minutes of Meeting of West Dunbartonshire Health & Social Care Partnership Board held on 19 August 2015 was submitted and approved as a correct record subject to the inclusion of Barbara Barnes in the sederunt for the meeting.

MEMBERSHIP OF THE PARTNERSHIP BOARD

A report was submitted by the Chief Officer seeking approval for nominations of individuals as non-voting members of the Partnership Board.

Having heard the Chair, Councillor Casey, the Partnership Board agreed:-

(1) to appoint the nominated non-voting members of the Partnership Board including confirming the designated professional advisors as detailed in the report;

(2) to note that Lindsay Lockhart, Chair of Carers of West Dunbartonshire had recently stood down as the non-voting member on the Partnership Board due to appointment of a new job;

(3) to note that Helen Turley had announced her retirement from the Council and would be standing down from the Partnership Board with respect to her role as Chief Housing Officer;

(4) to wish both members well for the future and to thank them for their contribution to the Partnership Board to date; and

(5) that successors for both non-voting member representative roles would be sought and thereafter a further report would be brought to a future meeting once representatives had been identified for nomination by the Chief Officer.

KINSHIP CARE - INTERIM POLICY

A report was submitted by the Head of Children's Health, Care and Criminal Justice Services seeking approval of the Interim Kinship Care Policy.

Having heard the Head of Children's Health, Care and Criminal Justice and the Chief Finance Officer in further explanation of the report and in answer to Members questions, the Partnership Board agreed:-

(1) to note the contents of this cover report in respect of the approach to supporting kinship carers;

(2) to approve the Interim Policy in respect of Kinship Care as appended to the report;

(3) to approve the movement to new payments, to be back dated to 1 October 2015 to meet the Scottish Government's requirement; and

(4) to request further updates once the new duties from the Children and Young People (Scotland) Act 2014 come into effect in April 2016.

WEST DUNBARTONSHIRE CHCP
YEAR-END PERFORMANCE REPORT 2014/15

A report was submitted by the Head of Strategy, Planning and Health Improvement providing the final summary of performance by the former West Dunbartonshire Community Health & Care Partnership (including complaints management overview).

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

(1) to note the concerns in relation to performance against targets set and that future reports on performance would include more detailed analysis with an in-depth focus on areas of particular interest; and

(2) to otherwise note the terms of the report.

ANNUAL CHIEF SOCIAL WORK OFFICER'S REPORT 2015

A report was submitted by the Chief Social Work Officer presenting the West Dunbartonshire Annual Chief Social Work Officer's Report for the period July 2014 to June 2015.

Having heard the Chief Social Work Officer in further explanation of the report and in answer to Members questions, the Partnership Board agreed:-

(1) to note that the Chief Social Work Officer would make the report widely available within the HSCP, Council and externally as appropriate;

(2) that all members of the Health & Social Care Partnership would be invited to attend the planned Elected Members Briefing Session on the role and function of the Public Protection Chief Officers Group scheduled to be held on Wednesday, 13 January 2016 to raise the profile, awareness and understanding of this group across the Council; and

(3) otherwise to note the contents of the report and associated appendices.

CRIMINAL JUSTICE SOCIAL WORK ANNUAL REPORT 2014-15

A report was submitted by the Head of Children's Health, Care and Criminal Justice Services advising of the annual report submitted to the North Strathclyde Community Justice Authority with regard to the work undertaken by Criminal Justice Social in 2014-2015.

Having heard the Chief Officer and the Head of Children's Health, Care and Criminal Justice in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note the concerns in relation to diminishing funding value when set against operational costs and the work currently being undertaken by the Scottish Government to revise the overall level of grant available and the formula determining grant allocation; and

(2) to otherwise note the contents of the report.

WORKFORCE AND ORGANISATIONAL DEVELOPMENT STRATEGY 2015-2018 & SUPPORT PLAN 2015-2016

A report was submitted by the Head of People and Change presenting the Health & Social Care Partnership's Workforce and Organisational Development Strategy 2015-2018 & Support Plan 2015-2016.

Having heard the Head of People and Change in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to endorse the Workforce and Organisational Development Strategy 2015-2018 & Support Plan 2015-2016; and

(2) a request that grade analysis by gender would be included in future reports on workforce and organisational development.

STRATEGIC RISK REGISTER

A report was submitted by the Head of Strategy, Planning and Health presenting the first Strategic Risk Register for the Health & Social Care Partnership.

Having heard the Chair, Councillor Casey, the Partnership Board agreed to approve the Strategic Risk Register for the Partnership.

WINTER PLAN 2015-16

A report was submitted by the Head of Community Health and Care Services presenting the Health & Social Care Partnership Winter Plan for 2015/16.

Having heard the Head of Community Health and Care Services in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to approve the Winter Plan 2015/16 as appended to the report;

(2) to note that, in response to concerns relating to local press reports on a significant increase in winter deaths last winter, an analysis of winter deaths for 2014/15 would be provided to members of the Partnership Board when available from the Director of Public Health for Greater Glasgow and Clyde; and

(3) to note the work undertaken to produce an unscheduled care plan with a particular focus on the winter period for the Partnership area.

QUALITY ASSURANCE IN WEST DUNBARTONSHIRE CARE HOMES

A report was submitted by the Head of Community Health and Care Services providing an overview of the measures taken by the Health & Social Care Partnership to ensure that the care provided to its residents in both local authority and independent sector care homes is monitored and improved.

Having heard the Head of Community Health and Care Services in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to note the terms of the report.

NHSGGC MUSCULOSKELETAL PHYSIOTHERAPY – DELIVERY AND DEVELOPMENT

A report was submitted by the Musculoskeletal Physiotherapy Manager providing an overview of the Musculoskeletal (MSK) Physiotherapy Service and the actions being taken in relation to the March 2016 national target of 90% of MSK patients to be seen within four weeks.

Having heard the Chief Officer, the Head of Strategy, Planning and Health Improvement and the MSK Physiotherapy Manager in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to note the terms of report.

FINANCIAL REPORT 2015/16 AS AT PERIOD 6 (30 SEPTEMBER 2015)

A report was submitted by the Chief Financial Officer providing an update on:-

(a) the financial performance and capital work progress of the WD Health & Social Care Partnership for the period to 30 September 2015 (Period 6); and

(b) the financial planning process for both health care and social care for 2016/17.

Having heard the Finance Officer in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to approve health care budget virements of £0.024 million and Social Care budget virements of £0.101 million as detailed in the report;

(2) to note the added complexity of reporting the financial performance of both the Community Health & Care Partnership (CHCP) and Health & Social Care Partnership (HSCP) due to the in-year establishment of the formal arrangements;

(3) to note the contents of the report showing a forecast full year adverse revenue variance of £0.667m (0.49%) and £0.487m for the period from 1st July 2015, highlighting a favourable movement of £59,000 when compared to the previous reporting period forecast overspend of £0.523m;

(4) to note the key requirement for the HSCP Senior Management Team to implement a recovery plan to address the projected overspends;

(5) to note that elements of corrective actions were already in place as described within the report;

(6) to note that requirement to report the financial performance of Health Board Acute Services Set Aside notional budget; and Hosted services covering both Health Board Acute Services and Council Housing services; and

(7) to note the current position regarding capital work progress on projects.

MINUTES OF MEETING OF THE H&SCP AUDIT COMMITTEE

The draft Minutes of Meeting of the West Dunbartonshire H&SCP Audit Committee held on Wednesday, 30 September 2015 were submitted and noted.

MINUTES OF MEETING OF THE H&SCP JOINT STAFF FORUM

The draft Minutes of Meeting of the West Dunbartonshire H&SCP Joint Staff Forum held on 28 October 2015 were submitted and noted.

PROPOSED CHANGE OF SCHEDULED MEETING OF PARTNERSHIP BOARD

Having heard the Chair, Councillor Casey, Members agreed to a change of date for the meeting of the Partnership Board from Wednesday, 18 May 2016 at 2.00 p.m. to Wednesday, 25 May 2016 at 10.00 a.m. subject to the Committee Officer checking availability with voting members of the Partnership.

EXCLUSION OF PRESS AND PUBLIC

Having heard the legal officer, the Partnership approved the following resolution:-

"In terms of Section 50 (A) of the Local Government (Scotland) Act, 1973 that the press and public be excluded from the remainder of the meeting as the following items of business involve the likely disclosure of exempt information as defined in Paragraphs 1 and 3 of Part 1 of Schedule 7A to the Act."

Note:- Councillor Rooney (voting member) and Jeanne Middleton, Dr Kevin Fellows, Selina Ross, Dr Neil Mackay and Janice Miller (non-voting members) and all officers with the exception of Chris McNeill left the meeting at this point in the proceedings.

DECLARATION OF INTEREST

Councillor McColl declared a non-financial interest in the undernoted item of business and left the meeting at this point.

SOCIAL WORK COMPLAINTS REVIEW SUB-COMMITTEE - 8 OCTOBER 2015

A report was submitted by the Head of Legal, Democratic and Regulatory Services advising of a complaint heard by the Social Work Complaints Review Sub-Committee.

Having heard the Chief Officer and the Head of Community Health and Care Services in further explanation of the report and in answer to Members' questions, the Partnership agreed:-

(1) to approve the recommendation contained in the Minutes of Meeting of the Social Work Complaints Review Sub-Committee held on 8 October 2015; and

(2) to note the findings of the Sub-Committee.

The meeting closed at 4.24 p.m.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 17th February 2016

Subject: Membership of the Partnership Board

1. Purpose

1.1 To nominate individuals to be non-voting members of the Partnership Board.

2. Recommendation

2.1 The voting members of the Partnership Board are recommended to appoint the nominated non-voting members of the Partnership Board.

3. Background

3.1 The constitution of the Health & Social Care Partnership Board is established through the Public Bodies (Joint Working) (Scotland) Act 2014.

3.2 As confirmed within the approved Integration Scheme for West Dunbartonshire, it has been agreed that:

- The Council would formally identify three representatives to be voting members on the Partnership Board, to serve for a period of three years.
- The Health Board would formally identify three representatives to be voting members on the Partnership Board, to serve for a period of three years. The Health Board retains the discretion to replace its nominated members on the Integration Joint Board.
- The term of office of the chair and vice chair will be three years. The first chair of the Partnership Board was nominated by the Council; and the first vice-chair was be nominated by the Health Board. As required by the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014, the parties will alternate nominating the chair and vice-chair.

3.3 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 states that when an integration joint board is established it must include the following non-voting members:

- The chief officer of the integration joint board.
- The proper officer of the integration joint board appointed under section 95 of the Local Government (Scotland) Act 1973(1).
- The following professional advisors:
- The chief social work officer of the local authority.
- A registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978(2).

- A registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract.
- A registered medical practitioner employed by the Health Board and not providing primary medical services.

- At least one member in respect of each of the groups:

  - Staff of the constituent authorities engaged in the provision of services provided under integration functions.
  - Third sector bodies carrying out activities related to health or social care in the area of the local authority.
  - Service users residing in the area of the local authority.
  - Persons providing unpaid care in the area of the local authority.

3.4 Integration joint boards are also to incorporate representation from each of their area's agreed localities as detailed within their first year Strategic Plan.

3.5 Given the delegations of the Integration Scheme, an additional two professional advisors were approved by the voting members for inclusion as non-voting members on the Partnership Board:

- A registered Allied Health Professional who is employed by the Health Board.
- The chief housing officer of the Council.

3.6 In clarifying the latter, this would be a senior and appropriately qualified housing professional employed by the Council in its role as strategic housing authority.

3.7 As confirmed within the Integration Scheme, the individuals to be appointed as non-voting members with respect to each of the above categories were and are to be formally determined by the Partnership Board's voting members.

3.8 At its meeting of the 18th November 2015, the Partnership Board was informed that two non-voting members were stepping down from the Partnership Board; and so the Chief Officer would bring a follow-up report to the Partnership Board at the earliest opportunity with nominations for the following:

- A member is respect of persons providing unpaid care in the area of the local authority.
- A senior and appropriately qualified housing professional employed by the Council in its role as strategic housing authority.

4. Main Issues

4.1 The following individuals are currently appointed to the Partnership Board:

<u>The voting members from the elected members of the Council</u>

- Gail Casey (to be Chair).

- Martin Rooney.
- Jonathan McColl.

The voting members from the non-executive directors of the Health Board

- Ros Micklem (to be Vice-Chair).
- Heather Cameron.
- Allan Macleod.

Non-voting members

- Keith Redpath – as the Chief Officer of the Partnership Board.
- Jeanne Middleton – as Chief Financial Officer of the Partnership Board.
- Professional Advisors to the Partnership Board:

    - Jackie Irvine – as the Chief Social Work Officer of the Council.
    - Kevin Fellows – as Clinical Director for the Health & Social Care
    - Partnership.
    - Wilma Hepburn – as the Professional Nurse Advisor to the Health & Social Care Partnership.
    - Partnership.
    - Martin Perry (Consultant/Clinical Lead at the Vale of Leven Hospital) – as the registered medical practitioner employed by the Health Board and not providing primary medical services.
    - Janice Miller (MSK Physiotherapy Manager) – as the Lead Allied Health Professional for the Health & Social Care Partnership.

- Alison Wilding (GP) – as Chair of the HSCP's Locality Group for the Clydebank area.
- Neil Mackay (GP) – as the Chair of the HSCP's Locality Group for the Alexandria & Dumbarton area.
- Selina Ross - as Chief Officer of West Dunbartonshire CVS (Third Sector Interface).
- Diana McCrone – as NHS Staff Side Co-Chair of HSCP's Joint Staff Forum.
- Peter O'Neil – as Council Staff Side Co-Chair of HSCP's Joint Staff Forum.Barbara Barnes – as Co-Chair of the West Dunbartonshire HSCP Public Engagement Forum and as Chair of the HSCP's Local Engagement Network for the Alexandria & Dumbarton area.
- Anne McDougall– as Co-Chair of the West Dunbartonshire HSCP Public Engagement Forum and as Chair of the HSCP's Local Engagement Network for the Clydebank area.

4.2 Following discussions and necessary processes, the following individuals are recommended to the Partnership Board to appoint as non-voting members:

- Kim McNab – Service Manager for Carers of West Dunbartonshire.
- John Kerr – Service Manager, Housing Strategy & Development at the local authority.

5. People Implications

5.1 The non-voting membership already includes staff side/trade union representation from the NHS and the Council.

6. Financial Implications

6.1 The non-voting membership already includes the Chief Financial Officer of the Health & Social Care Partnership.

7. Professional Implications

7.1 The non-voting members recommended include the professional advisor for housing.

8. Locality Implications

8.1 The non-voting membership already includes the chairs of the locality groups.

9. Risk Analysis

9.1 The Council and the Health Board are obliged to ensure that the constitution of the Partnership Board is as prescribed in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

9.2 The voting members of the Partnership Board are obliged to appoint non-voting members as per the approved Integration Scheme for West Dunbartonshire.

10. Impact Assessments

10.1 Not applicable.

11. Consultation

11.1 Not applicable.

12. Strategic Assessment

12.1 Not applicable.

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Date: 4th February 2016

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Appendices: None

Background Papers: The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014

HSCP Board Report (November 2015): Membership of the Partnership Board

HSCP Board Report (July 2015): Membership of the Partnership Board

HSCP Board Report (July 2015): Integration Scheme

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

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 17 February 2016

Subject: Integrated Care Fund Mid Year Report

1. Purpose

1.1 To provide the Board with an update on the use of the Integrated Care Fund (ICF) for the first half of the 2015-16 financial year.

2. Recommendations

2.1 The Committee is asked to note the report.

3. Background

3.1 In April 2015 Partnerships were advised of the requirements for the new Integrated Care Fund. The fund builds on the work of the Change Fund for Older People and seeks the development of further work for people of all ages with long term conditions and multi-morbidity.

3.2 The financial allocation was therefore raised from £1.02m to £1.99m with funding confirmed for 3 years. The half yearly report for the Scottish Government is attached at Appendix 1. The report describes the investment, work streams and indicators of progress. Whilst there has been significant restructuring of our working methods, sustained investment will be required to continue with these changes.

4. Main Issues

4.1 Specific consultation which was undertaken in response to the national guidance for local partnerships found clear support supporting people to stay at home by:

- Providing reablement and rehabilitation for home care clients.
- Providing a home based pharmacy service.
- Providing support to carers including peer support.
- Nursing support for anticipatory care planning.
- Providing additional respite provision and co-ordination through the respite booking bureau.
- Providing a primary care dementia service.
- Providing additional support for hospital discharge and rehabilitation.

4.2 In relation to what new services would contribute to older or multi morbid patients being able to stay at home for longer, clear support was voiced for:

- Promoting self management and providing support.
- Enabling seamless patient/ carers centred services.
- Anticipatory care management of health and social care needs.
- Integrated approach to housing and health care including the development of accessible housing for older people and people with a disability.
- Support service designed around the needs of people with multiple health care issues including easier access to information and navigation to other supports.

4.3 In relation to the themes required within the local Integrated Care Fund Plan to meet the national principles set for the programme, there was clear support for

- Chronic Obstructive Pulmonary Disease (COPD), Dementia and Diabetes being the top long term conditions to address.
- Investment was seen to be required in relation to focussed primary care provision and specialist nurses who can respond quickly and who have good links into hospital specialist consultants.
- A focus on primary prevention in relation to smoking, obesity including access to healthy food and healthy meals for children and families was suggested.
- A focus on self management and independence and confidence and maintaining people at home safely.

4.4 The programme includes patient identification by General Practice of patients identified as presenting with additional risk. These patients present with multiple long term conditions such as COPD or have risks associated with ageing. A total of 1634 patients are currently being monitored within the scheme.

These patients are assessed and care managed by a range of funded staff including:

- Additional Community Nurses
- Pharmacists
- COPD Specialist Nurses
- Palliative Care Nurses
- Additional Occupational Therapy, Physiotherapy
- Home Care Services including short term home based respite

4.5 Risk and management plans are in place for these patients aimed at monitoring them at home and avoiding admission if possible.

4.6 In addition the programme involves carers' organisations and other 3rd Sector partners in developing self management and peer support programmes.

4.7 Outcomes are being analysed with partners in Scottish Government (Summary Report from ISD, Appendix 2) and using monthly data (see appendix 3).

4.8 It was also recognised that there was a need to continue to support the integration agenda across health and social care, working with the CHCP and then HSCP to understand and make best use of resources within the community and across with NHS acute/ secondary care.

4.9 The Integrated Care Fund plan has adopted those key work streams undertaken as part of Older People Change Fund programme which have been identified as being are directly transferable to a broader age group that (like older people) demonstrate high levels of health and social care need as a result of multi morbidity and inequalities. The actions reflect a collective commitment to:

- Optimal outcomes for individual service users.
- A client-centred approach appropriate to individual needs through an emphasis on informed self-care, co-production and personalisation of services.
- Effective and safe services that draw upon the best available evidence and local feedback from service users.
- Equalities-sensitive practice.
- Acceptability of service provision informed through constructive engagement with local stakeholders – including staff, community groups and elected representatives.
- Affordable and efficient services that continue to be reflective of the relative demands across the West Dunbartonshire population as a whole.

5. People Implications

5.1 Investment in additional staff has been necessary to build on the work of our core teams, and core staff have adapted their work roles to address these priorities.

6. Financial Implications

6.1 None.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 Although the work streams are delivered across the authority, locality groups review and prioritise the activities associated with the plan.

9. Risk Analysis

9.1 None.

10. Impact Assessments

10.1 Monitoring of expected outcomes against actual is undertaken monthly.

11. Consultation

11.1 Consultation with Locality Groups and with the ICF Reference Group for next years funding will commence in January.

12. Strategic Assessment

12.1 The ICF forms part of the IJB Strategic Plan.

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Date: 8 February 2015

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Appendices: **Appendix 1** - Integrated Care Fund 2015/16 - Mid-Year Financial Summary and Progress towards ICF Outcomes
Appendix 2 - Overview of Anticipatory Care Plans in WD H&SCP
Appendix 3 - WDC Older People's Summary and detailed report - November 2015

Background Papers: None

Wards Affected: All

Appendix 1

INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16

Integrated Care Fund – 2015/16 – Mid-Year Financial Summary

(West Dunbartonshire HSCP) –(£1.99m)

	Allocation for 2015/16	**Spend - April to September 2015**	**Forecast Spend – October to End March 2015**	**Projected Over/Underspends**
Preventative and Anticipatory Care	521	230	291	0
Proactive Care and Support at Home	570	210	360	0
Care at Times of Transition	340	204	136	0
Unscheduled Care	474	198	276	0
Performance Management	85	38	47	0
Total ICF spend to date- 2015/16	£1,990,000	**£880k**	**£1.11m**	**0**

Integrated Care Fund – 2015/16 – Progress towards ICF Outcomes

WORK STREAM ACTIVITY OR PROJECT	OUTCOMES FOR 2015/16	PROGRESS TOWARDS OUTCOMES FOR 2015/16	SOURCE OF DATA USED TO MONITOR PROGRESS	ACTION TAKEN IN RELATION TO UNDER PERFORMANCE
Preventative and Anticipatory Care	Develop Case Finding Anticipatory Care Planning Supported Self Care Developing Community Supports and Capacity (3rd Sector) Health Improvement (eg Smoking Cessation, Physical Activity, Pulmonary Rehab, Cardiac Rehab)	Case finding and ACP in place. Key self care programmes in place. Work ongoing with Independent sector organisations with enhanced interventions including Health Improvement activities.	Internal monitoring in place Ie Nos of patients identified, no of ACPs undertaken no of interventions Monitoring AE attendances and unscheduled care activity.	NA
Proactive Care and Support at Home	Assessment Case Management Supported Self Care Carer's Support Equipment and Adaptations Care at Home Reablement and Rehabilitation Medicines Management Structured work with Care Homes Develop House of Care model	Case management in place. Re-ablement continuing Medicines management in place Partnership with Scottish Care ongoing Supported self care models being developed	No of patients in the programme No off patients receiving intervention No of clients reabled and outcomes	NA

Care at Times of Transition	Case Management Medicines Management Information and Support Discharge Support Multi-disciplinary Reviews	Carers involved in transitions Clients in receipt of pharmacy care at home	Client numbers	NA
Unscheduled Care	Anticipatory Care Case Management Access to Respite and Nurse led beds Same Day Discharge Supported Discharge Medicines Management Enhanced E-Kis recording including Social Care End of Life Care	Admission avoidance activity in place ACP and e-KIS in place	Bed days Unscheduled care aattndances and admissions	NA
Performance Management	Development and process for Key Indicators	Internal audit team undertaking review of KPIs	NA	NA

INTEGRATED CARE FUND – MID YEAR REPORTING TEMPLATE 2015/16

Integrated Care Fund - Indicators of progress

Question	Comment
How has ICF funding allowed links to be established with wider Community Planning activity?	The Integrated Care Fund has been managed and developed through the Community Planning Delivery and Implementation Group (DIG), since 2010, with representation from the Health and Social Care Partnership, third and independent sectors including carers' representatives and service user representatives. The Health and Social Care Partnership (HSCP) (July 2015) cements together both NHS and local authority responsibilities for community-based health and social care services within a single, integrated structure; previously housed within the CHCP established in 2010. This approach was established with the Older People's Change Fund and with the Early Years Collaborative and as such focuses all of our local activity within a single structure representing a community planning in practice model of delivery.
What progress has been made linking ICF activity to work being taken forward through Strategic Commissioning more broadly?	The local partnership approach outlined above has been developed further to create a Market Facilitation Consortium model of commissioning across all of our health and social care services from across the statutory, independent and third sector to make the best use of the significant resources invested across our communities. The approach provides third and independent sector partners, alongside procurement specialists, access to the same information and data used within statutory services; providing opportunities for service delivery where there is an agreed and identifiable need for services based on demographic and neighbourhood analysis. Partners across sectors are then working in an innovative and collaborative approach which as a result is responsive, flexible and accountable to local people within their own localities. This approach ensures that the partnership, as a whole, effectively uses the Integrated Care Fund alongside other funding streams available to the HSCP and wider partners. The HSCP Strategic Plan has been agreed within the HSCP Integrated Joint Board following consultation across all partners and within the community. The delivery model for the Plan is a partnership between West Dunbartonshire CVS, Scottish Care and West Dunbartonshire Health and Social Care Partnership (HSCP) who have already hosted a Commissioning Services for Older Adults Workshop, and plans are in place to facilitate a series of workshops with partners across care groups including adults' services and children and young people's services.
How has ICF funding	As outlined above the Market Facilitation Consortium model aims to deliver better outcomes for those with long

strengthened localities including input from Third Sector, Carers and Service Users	term conditions and those with multi-morbidities by improving preventative and anticipatory care and making best use of our community resources; measuring our impact with the national health and well-being indicators. The opportunities for effective partnership exists within the Integrated Care Fund DIG as well as within the Consortium Market Facilitation model as outlined above. The approach provides third and independent sector partners access to the same information and data used within statutory services; providing opportunities for service delivery where there is an agreed and identifiable need for services based on demographic and neighbourhood analysis. Partners across sectors are then working in an innovative and collaborative approach which as a result is responsive, flexible and accountable to local people within their own localities.
What evidence (if any) is available to the partnership that ICF investments are sustainable	As with the Change Fund and the Early Years Collaborative, our partnership to deliver the Integrated Care Fund is based on investment for change within services rather than project based workstreams to ensure that practice changes are sustainable and future proof as far as possible. However with an increasingly challenging financial envelope across the public sector there is a requirement for a wider review of our investments across all partners; mapped to an analysis of spend and linked to outcomes for patients and clients, as per the commissioning approach outlined above.
Where applicable - what progress has been made in implementing the National Action Plan for Multi-Morbidity	Within the HSCP, West Dunbartonshire has a well-established Long Term Conditions Working Group; representation from clinicians, pharmacists and nursing staff as well as social care practitioners. The work of this group is informed by analysis of health and social care demographic and prevalence data as well as more innovative models of delivery such as social prescribing with the third sector, medicines prompting with care at home and volunteer foot care services with podiatry services. As community health and social care teams have been integrated since 2010, shared assessment practice and the delivery of integrated care are already embedded across community health and care adult and older people's teams; including within an integrated, and award winning, out of hours care at home/district nursing service linked to out of hours GPs.

Overview of:
Evaluation of Anticipatory Care Plans in West Dunbartonshire Community Health and Care Partnership (WDCHCP)

This gives a brief overview of the technical paper produced by ISD. This is not intended to replace the summary paper to be prepared by WDCHCP. It is intended to highlight key features of the evaluation for discussion purposes.

Background

ISD has been working with WDCHCP since 2014 around the ACP methodology that WDCHCP implemented in 2012. The intention was to see if ACP's have had an impact on health measures such as hospital admissions.

Two cohorts were identified with a SPARRA score of 60-100 and of 40-60 to be used in comparison with the general population in WDCHCP and around Scotland to see if change has happened.

Change

The following are the changes that can be seen in the data:

- For number of Emergency admissions for both cohorts there is a downward direction change that concurs with the ACP introduction
- Bed days takes a little longer but again there is a change of direction downwards
- For A&E there is also a downward change in direction but this is less pronounced and could be due to other factors
- Prescriptions show variation and a longer trend might illicit change, this could be down to Medication Reviews rather than ACPs
- When looking at the costs it is important to note that a shift is expected with social care costs increasing before health care reduces; see the following table.

Table 1 – Summary of Costs with Adjusted and Predicted

	2010/11	2011/12	2012/13
Health Care	£3,277,142	£5,693,199	£6,412,693

	2013/14	Diff to Predicted
Actual	£3,681,379	£4,581,850
Adjusted	£4,311,716	£3,951,514
Predicted	£8,263,229	

	2010/11	2011/12	2012/13
Social Care	£3,747,092*	£3,877,299	£4,381,334

Actual	£4,324,628	£311,522
Adjusted	£5,065,104	-£428,954
Predicted	£4,636,150	

* Estimated

The table above shows the overall Health and Social Care costs for the four years. They show an increase then decrease in Health Care costs and a steady increase for Social Care Costs.

The Adjusted figures take into account the drop in numbers for the 2013/14 year and the Predicted figures estimate the cost based on the previous three year trend.

The difference to the actual for the Adjusted and Predicted show:

- An estimated saving of +£4 to +£5 million in costs in health
- A change of -£0.5 to +£0.5 million in social care costs

These figures have been adjusted to one significant figure for illustration purposes.

Conclusion

There is a reduction in the percentage of patients having at least one EA; a reduction in the rate of EA and emergency bed days. There is a slowing increase in prescribing activity in P1, and a decrease in prescribing activity in P2. The cost saving with estimates shows a potential saving based on ACP methodology.

At the same time, the P1 and P2 patients received a combination of different types of social care eg contact with the Older People Team, support from telecare alarm and telecare sensors, and Day Care and Overnight Care.

Older People's Bed Days Lost to Delayed Discharge Monthy Monitoring Report - November 2015

Bed Days Lost to Delayed Discharge (inc AWIs) - Acute

(patients aged 65 & over on day of admission)

							2015/16										2015/16			2015/16	
CH(C)P	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	Apr Actual	May Actual	June Actual	July Actual	Aug Actual	Sept Actual	Oct Actual	Nov Actual	Nov 50% Target	Nov 75% Indicator	Cumulative Actual 2015/16	Cumulative 50% Target	Cumulative 75% Indicator	2015/16 Yr End Forecast	2015/16 Yr End Target
West Dunbartonshire	7,638	8,644	8611	6050	4925	5,802	396	284	230	263	242	157	219	187	318	159	1,978	2,546	1,273	3072	3819
GGC(All above areas)	**7,638**	**8,644**	**8,611**	**6,050**	**4,925**	**5,802**	**396**	**284**	**230**	**263**	**242**	**157**	**219**	**187**	**318**	**159**	**1,978**	**2,546**	**1,273**	**35004**	**3819**

Bed Days Lost to Delayed Discharge for AWIs - Acute

(patients aged 65 & over on day of admission)

							2015/16										2015/16			2015/16	
CH(C)P	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	Apr Actual	May Actual	June Actual	July Actual	Aug Actual	Sept Actual	Oct Actual	Nov Actual	Nov 50% Target	Nov 75% Indicator	Cumulative Actual 2015/16	Cumulative 50% Target	Cumulative 75% Indicator	2015/16 Yr End Forecast	2015/16 Yr End Target
West Dunbartonshire	931	3,160	1798	1,872	1547	2,127	124	93	111	137	120	82	153	128	39	19	948	310	155	1404	466

AWI identified by code "51X"
Edison extract as at 29th December 2015

Older People's Monthly Monitoring Template - November 2015/16

The purpose of this report is to provide a monthly performance update against the suite of key performance indicators identified in each of NHS Greater Glasgow and Clyde's six Change Fund Plans

Appendix 3

WEST DUNBARTONSHIRE HSCP

Ref No	Performance Measures	2009/10 Baseline	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Actual	2015/16 Apr	May	June	July	Aug	Sept	Oct	Nov	Nov 50% Target	Nov 75% Indicator	2015/16 Cumulative Actual	Cumulative 50% Target	Cumulative 75% Indicator
1	Number of acute bed days lost to delayed discharges (inc AWI)	7,638	8,644	8,611	6,050	4,925	5,802	396	284	230	263	242	157	219	187	318	159	1,978	2,546	1,273
2	Number of acute bed days lost to delayed discharges for Adults With Incapacity	931	3,160	1,798	1,872	1,547	2,127	124	93	111	137	120	82	153	128	39	19	948	310	155
3	Number of acute delayed discharges (within period)							34	30	26	24	20	15	17	15					
	Delayed Discharges (at census)	N/A	N/A	N/A	N/A	N/A	N/A	7	4	3	6	4	3	6	8					
	Delayed Discharge > 14 days	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	0					
	Delayed Discharge < 3 days (72 hours)	N/A	N/A	N/A	N/A	N/A	N/A	n/a	2	0	2	1	0	1	0					
	Delayed Discharge > 14 days exception codes	N/A	N/A	N/A	N/A	N/A	N/A	7	2	3	4	3	3	5	7					
	Delayed Discharge < 3 days (72 hours) exception codes	N/A	N/A	N/A	N/A	N/A	N/A	n/a	0	0	0	0	0	0	1					
5	Unplanned acute bed days (65 +)	51,046	53,002	55,176	51,748	45,641	49,327	3,475	3,303	3,025	3,125	3,168	2,787	2,941	3,786			25,610		
	Unplanned acute bed days 65 + rate / 1,000 pop	3,458	3,567	3,681	3,389	2,942	3,179	221	210	192	199	201	177	187	241			1,627		
6	Unplanned acute bed days (75 +)	37,966	38,840	41,615	39,314	33,094	36,630	2,489	2,399	2,085	2,278	2,347	2,129	2,273	2,912			18,912		
	Unplanned acute bed days 75 + rate / 1,000 pop	5,582	5,687	6,054	5,712	4,827	5,343	356	343	298	326	336	305	325	417			2,707		
7	Number of emergency admissions 65+	3,947	4,253	4,482	4,398	3,973	4,372	335	321	330	340	305	253	290	352			2,526		
	Emergency admissions 65+ Rate /1,000 pop	267	286	299	288	256	282	21	20	21	22	19	16	18	22			160		
8	Number of unplanned admissions by SIMD:																			
	SIMD Quintile 1	521	579	640	588	588	515	48	30	40	44	58	29	35	45			329		
	SIMD Quintile 2	1057	1,096	1,121	1,079	1,079	1,332	96	98	90	115	90	90	78	116			773		
	SIMD Quintile 3	1501	1,582	1,655	1,642	1,418	1,675	122	147	127	119	104	91	110	127			947		
	SIMD Quintile 4	769	855	950	995	785	718	54	40	61	45	45	38	62	57			402		
	SIMD Quintile 5	99	139	103	83	94	132	15	6	12	17	8	5	5	7			75		
9	Reduction in ALOS delay for AWI patients	98	122																	
10	Number of EMI delayed discharges	17	6	63	47	33	37	4	5	1	1	0	1	5	1			18		
11	Number of bed days lost to EMI delayed discharges	1,140	730	1,514	611	710	522	87	36	3	26	0	8	25	12			197		
12	Number of people in care home placements in the month	449	N/A	505	533	563	535	542	549	564	552	565	565	551	552			551	Data Only	
13	% of people aged 65 years+ admitted twice or more, as an emergency, who have not had an assessment	0	N/A	37.52%	34.16%	41%	39.2%	39.2%	39.2% (prov)	29.4%	29.4% (prov)	29.4% (prov)	29.4% (prov)	35.4% (prov)	35.4%			35.4%	40%	
14	Number of patients in anticipatory care programmes	N/A	N/A	N/A	N/A	1,024	1,645		1,601			1,634			Report Qtrly			1,634	1,200	
15	% of people aged 65 years+ with intensive care needs receiving care at home.	0	N/A	42.8%	42.4%	40.8%	39.3%	40.2%	40.2% (prov)	38% (prov)	38.5% (prov)	38.0% (prov)	38.0% (prov)	38.6% (prov)	38.5%			38.6%	53%	
16	Number of new admissions to care homes (65 years+)	N/A	N/A	197	210	198	186	17	15	17	9	17	18	11	15			104	Data Only	

Source: All Delayed Discharge measures (except censuspositions) are calculated using a monthly EDISON extract supplied by Partnership Information Team
Census position for delayed discharged is taken from the Performance Sharepoint site
All Emergency Admission/Emergency Bed Days measures are calculated using a PAS extract supplied by the Acute Information Team
All EMI Admissions/LOS measures use a monthly extract supplied by the Partnership Information Team
A&E attendances are calculated from the ISD A&E datamart
Populations for calculations of rates use the GRO(S) mid year estimates.
New boundary area for NHS GGC from 1st April 2014. All of East Renfrewshire CH(C)P now included.

Notes: Figures are provisional and subject to change
Postcodes are matched to HBRES, council and SIMD lookup files and any errors in postcoded PAS data may lead to slight errors in linkage

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 17th February 2016

Subject: NHS Greater Glasgow & Clyde
- Developing GP Services: Engaging and Listening Consultation

1. Purpose

1.1 To present the NHS Greater Glasgow & Clyde Health Board's *Developing GP Services: Engaging and Listening* consultation process.

2. Recommendations

2.1 The Partnership Board is recommended to note the *Developing GP Services: Engaging and Listening* consultation process and the West Dunbartonshire Health & Social Care Partnership's facilitated submission to it.

3. Background

3.1 At its August 2015 meeting, the Partnership Board endorsed the Health Board's Clinical Services Strategy, with its key aims 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 developing and approving that Strategy, the Health Board's intention has been to continue to engage with stakeholders. This include engaging with each of the new Integration Joint Boards within the Greater Glasgow & Clyde area as they are each established on the

refresh of the Health Board's Primary Care Strategy and the further development of primary and community services.

4.4 The Health & Social Care Partnership's Strategic Plan 2015-16 recognises that access to and the development of primary medical services is a key consideration in improving the delivery of services; and the importance of ensuring patients are at the heart of how these are designed and provided. Patients should have increased confidence that the care delivered by all parts of primary care is safe, effective and person centred. This requires a culture of ongoing review of decisions taken, and interventions made, as well as encouraging comment and input from patients and the wider public.

4.5 In September 2015, the Health Board produced *Developing GP Services: Engaging and Listening* which considered the development of the direction for GP services for the Health Board area within the context of the Scottish Government's 2020 Vision. The paper and its attendant consultation exercise are attached (Appendix 1). This paper was developed through the Health Board's Primary Care Steering Group which brings together representatives of all of the GP, Dental, Pharmacy and Optometric Contractors and Clinical, Managerial and Planning Leads from Partnerships and across the Health Board area.

4.6 As part of the Health's Board consultation process, West Dunbartonshire Health & Social Care Partnership disseminated the paper within its two localities – Clydebank and Alexandria/Dumbarton - to encourage stakeholders to contribute views directly into the Health Board process. The Partnership also organised a number of engagement events – one set with local General Practitioners and the other set with patients/community representatives – the feedback of which has been captured within a short report that was submitted into the Health Board process as requested of all Partnerships (attached – Appendix 2).

5. People Implications

5.1 The Health Board's Clinical Services Strategy recognises the importance of supporting the workforce to meet future changes; and that effective implementation will require strong clinical leadership and commitment as well as a significant cultural shift – both from staff employed by and managed within the Health Board; and from NHS external contractors, including GPs and their staff within their practices.

6. Financial Implications

6.1 The Health Board's Clinical Service's Strategy recognises that that the NHS is facing a period of rising demand resultant from demographic pressures at the same time as facing a period of significant financial constraint.

7. Professional Implications

7.1 *Developing GP Services: Engaging and Listening* was developed through the Health Board's Primary Care Steering Group which brings together representatives of all of the GP, Dental, Pharmacy and Optometric Contractors and Clinical, Managerial and Planning Leads from Partnerships and across the Health Board area.

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.

8.2 As part of the Health Board's *Developing GP Services: Engaging and Listening* consultation process, West Dunbartonshire Health & Social Care Partnership disseminated the paper within its two localities – Clydebank and Alexandria/Dumbarton - to encourage stakeholders to contribute views directly into the Health Board process. The Partnership also engaged directly with local General Practitioners, with that feedback capture in the Appendix 2 report provided here.

9. Risk Analysis

9.1 *Developing GP Services: Engaging and Listening* recognises that everyone having access to a family doctor (GP) is one of the great strengths of the NHS; but that the service is under severe strain as demand for GP services is rising and the number of people choosing to become a GP is not enough to keep pace.

9.2 The Cabinet Secretary for Health and Wellbeing confirmed in October 2015 of the Scottish Government's intention to dismantle the Quality and Outcome Framework (QOF) and introduce transitional arrangements for quality in 2016/17 in preparation for a new Scottish General Medical Services (GMS) contract with GPs in 2017. As outlined in the attached correspondence (Appendix 3), the most significant part of the negotiation has been taking the first steps to develop a flexible and non-bureaucratic framework that ensures quality and delivery of outcomes; and encourages a greater degree of multi-disciplinary leadership in the context of health and social care integration. The outputs of this Health Board engagement and consultation process should then constructively inform these new contractual negotiations and arrangements at a national level.

10. Impact Assessments

10.1 None required for this report.

11. Consultation

11.1 As part of the Health's Board consultation process West Dunbartonshire Health & Social Care Partnership the Partnership engaged with local patients/community representatives, with that feedback capture in the Appendix 2 report provided here.

12. Strategic Assessment

12.1 The Health & Social Care Partnership's Strategic Plan 2015-16 recognises that access to and the development of primary medical services is a key consideration in improving the delivery of services.

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Date: 28th January 2016

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Appendices:

(1) Developing GP Services: Engaging and Listening

(2) Developing GP Services: Engagement & Listening - West Dunbartonshire Health & Social Care Partnership Facilitated Submission

(3) GMS Contract Correspondence from Scottish Government (December 2015)

Background Papers: HSCP Board Report (August 2015): NHSGGC Clinical Services Strategy 2015

Wards Affected: All

NHS Greater Glasgow and Clyde

Appendix 1

Developing GP Services: engaging and listening

1. Introduction

This short paper launches our programme to engage a wide range of interests in developing a direction for GP services in NHS Greater Glasgow and Clyde. We are launching this programme to engage with and listen to a wide range of opinions about GP services and how these services need to change.

General Practice, with registered patient lists, everyone having access to a family doctor, delivering continuity of care, is one of the great strengths of the NHS, but it is under severe strain. Demand is rising; the number of people choosing to become a GP is not keeping pace with the growth in funded training posts. The traditional divide between primary care, community services, and hospitals largely unaltered since the birth of the NHS, can be a barrier to the personalised and coordinated health services patients need. GPs and hospitals roles tend to be rigidly demarcated in ways which do not reflect patient's needs for care.

Part of the pressure of demand relates to the rising needs of our ageing population with increased chronic disease and the health issues created by deprivation. But it is also the case that patients often go to their GPs with issues which could be dealt with elsewhere and do not require skilled medical intervention. The open access nature of GP services, an important strength, means that GPs are a point of service for a wide range of demands.

We want to hear from primary care practitioners about these issues, particularly from GPs. We have included questions to prompt feedback but are happy to hear from you in any form and we would welcome feedback by the end of October 2015. **The questions can be completed on a template accessible on the engagement website at www.nhsggc.org.uk/gpservicesfuture or views can be emailed to:- gpservicesfuture@nhsggc.org.uk**

This is a joint engagement and listening exercise between the Heath Board and our new Integrated Partnerships. There will be local engagement and discussions as well as this communication.

The engagement website includes further background information about GP services and the pressures they are under including "A day in the life of a GP..." and "Quality First: Managing Workload to deliver safe patient care" information.

2. Developing GP Services: the 2020 Vision

The 2020 vision for Health and Social Care and the NHS Scotland Quality Strategy provide the priorities and framework in which the health service in Scotland will evolve and develop to meet future health and care requirements and to deliver safe, effective and patient centred care.

2020 Vision

- Integrated health and social care
- Focus on prevention, anticipation and self management
- Emphasis on community based care
- Day case care in hospitals will be the norm
- Improving safety
- Reducing health inequalities

Quality Strategy

- Safe, effective and patient centred care
- Putting people at the heart of our NHS – shared vision and responsibilities
- Measurable improvement in the quality of care
- Alignment of staff experience and wellness and
- patient care

In our view delivering this vision will require substantial changes to the way the NHS works, including:-

- More services organised around GP practices, more resources for primary care and new models of primary care delivery;
- More investment in social care services to support people living in the community and in care homes;
- Intermediate care nurse and pharmacy services in local areas: medical skills, including out of hours GPs serving larger populations;
- Concentration of specialist inpatients services accessed for the shortest possible periods of intervention; acting as hubs to outreach to more remote areas with outreach for rapid response and resuscitation linked to major centres so changes to the boundaries for service delivery with more focus on regional and national arrangements.
- Ambulatory care provided to all substantial population centres acting as hubs to outreach to more remote areas
- Widespread use of telehealth and telecare services by patients and staff across Scotland providing remote care more under the control of patients and a reducing number of physical visits less face to face contact
- More people supported to die at home not in hospital;
- Services which enable people to manage their own conditions
- Specialist NHS medical and nursing skills supporting local and community based services, including care homes rather than focussing on hospitals;
- Care homes used more flexibly, providing better care and meeting higher levels of physical and mental frailty and need ;
- Creating a reshaped workforce to deliver this strategic direction with less staff in hospital services, more in community settings and more care delivered by multi disciplinary teams.

3. Developing GP Services: why now?

Our model of GP services brings together the management of illness and disease, increasingly complex, with continuity, empathy and humanity. GP services are the bedrock of the NHS delivering over 90% of our patient contacts, skilfully assessing undifferentiated patient presentations. We have over 240 practices with nearly 800 doctors and spend £154 million on our GP services.

There are a number of different reasons why we need to launch this programme now:-

- We hear from GPs about the pressures they are experiencing in the level of demand, the complexity of the care they need to deliver; the challenges of responding to the needs of deprived patients; the growing number of patients with chronic diseases and an increasing elderly population;
- As well as those general pressures, many of our practices are involved on the Deep End national group which brings together GPs from the most deprived practices in Scotland. This Group has worked to highlight the major issue of unmet needs for patients in deprived areas.

- GP also describe the issue of inappropriate use of their services and skills with demand increasing from a range of routes including in relation to social security benefits, acute hospital services and NHS 24, as well as the increasing demands for care from patients;
- There are major challenges in recruiting and retaining GPs and attracting junior doctors into GP training;
- These pressures on GP services are compounded by pressures elsewhere in the system including on our acute hospitals, on mental health services, on NHS community and social care services and on voluntary and community service organisations.
- We have developed a clinical services strategy for the services which we deliver. The strategy relies on supporting and developing the services which GPs provide.
- There is a Scotland wide process under way to develop a new, Scottish, contract for GP services.....we are the largest Health Board in Scotland and we want to work closely with the Government and with GPs to shape that new contract.
- Our new health and social care partnerships need to establish close relationships with GP practices so that GPs have a central role in the Partnership's responsibilities to plan and commission hospital services for their populations;
- We recognise that the community staff that we employ need to work in different ways with GP practices;
- New information systems enable us to take a fresh look at how GPs and hospital services share information about patients;
- It is increasingly difficult to staff the current out of hours GP services;
- In the current contract it is difficult for GP practices to work together although that may help them address some of these issues and work better with other NHS services.
- We are not able to fully develop the GP premises in the way in which is required for modern within the current contract;

4. Developing GP Services: is this just about resources?

Resources for GP services are definitely a key issue but we don't think this set of fundamental challenges will be addressed by "more of the same".....we have made some changes to try to support GP services more effectively, including:-

- Out of the clinical services review supporting the Paisley programme to develop new ways of working
- establishing an interface group to enable acute services and GP services to work better together;
- Focussing on how to support practices in deprived areas;
- offering practices the option on a different form of contract
- investing in GP premise
- Developing Health Information and Technology across the system
- Funding additional GP services including local enhanced services for chronic disease management and nursing homes;
- Funding additional community services including rehabilitation teams;

These changes have been important but:-

- We don't think they have gone far enough to address the fundamental issues outlined in the earlier sections of this paper.

- They have been a series of separate initiatives rather than a coordinated and integrated set of changes;
- Changes so far have been constrained by the current contract, the opportunity now is to think in more radical ways;
- We need to identify new investment for primary care and ensure that we direct that investment to best effect.
- We have not been able to effectively address the issue of increasing and inappropriate demand for GP services;

5. Developing GP Services: we want to know what you think

This discussion paper provides the basis for wide engagement to contribute to the future shape of GP practices. The paper summarises the issues we have identified but we need to hear from others in order that we can shape an informed direction for these services, including influencing the development of the new national GP contract. The plan is to:-

- Run events in each of our Partnerships to enable local engagement.
- Promote wide discussion of this paper and we will also try to provide input to other meetings and events where this discussion would be appropriate.
- To invite you to use the link at the start of this paper where you will find prompts to give your views.

We want to hear from all of the key interests about the issues which we highlighted in the earlier sections of this paper and we have also set out below some specific questions which you might want to consider and respond to.

We recognise that there are immediate, short term issues which need to be addressed and want to hear ideas on those as well as for the medium term.

We want to hear from GPs and their staff:-

- What are the biggest challenges facing your practice?
- What actions would address these challenges
- What are the most important and best things about GP services?
- And the least important and worst things?
- What works well for you with other community services? What works less well?
- What would your priorities for change be?
- What works well for you with social care services? What works less well?
- What would your priorities for change be?
- What works well for you with secondary care? What works less well?
- What would your priorities for change be?

Other comments or issues?

We want to hear from clinical staff working in hospitals:-

- What works well for you with GP practices?
- What works less well?
- What would your priorities for change be?
- What do you see as the most important things about the way GP services are delivered?
- And the least important?
- How well do GP services work with your service and what would improve that?

Other comments or issues?

We want to hear from other contractors working in primary care and from the community health and social care staff working for the Health Board and Councils:-

- What works well for you with GP practices?
- What works less well?
- What would your priorities for change be?
- What do you see as the most important things about the way GP services are delivered?
- And the least important?
- How well do GP services work with your service and what would improve that?
- Are there things which your service could more appropriately doing to support GPs?

Other comments or issues?

We want to hear from patient representatives:-

- What do you most value about your GP service?
- What works well for you?
- What works less well?
- Have you ideas about changes you would like to see, what are they?

Other comments or issues?

6. Conclusion

This paper has been developed through our Primary Care Steering Group which brings together representatives of all of the GP, Dental, Pharmacy and Optometric Contractors and Clinical, Managerial and Planning Leads from Partnerships and across the NHS Board area.

David Williams, Chief Officer Designate	Glasgow City Partnership
Richard Groden, Clinical Director	Glasgow City Partnership
David Leese, Chief Officer Designate	Renfrewshire Partnership
Stephen McLaughlin, Clinical Director	Renfrewshire Partnership
Julie Murray, Chief Officer Designate	East Renfrewshire Partnership
Alan Mitchell, Clinical Director	East Renfrewshire Partnership
Karen Murray, Chief Officer Designate	East Dunbartonshire Partnership
Graham Morrison, Clinical Director	East Dunbartonshire Partnership
Keith Redpath, Chief Officer Designate	West Dunbartonshire Partnership
Kevin Fellows, Clinical Director	West Dunbartonshire Partnership
Brian Moore, Chief Officer, Designate	Inverclyde Partnership
Hector Macdonald, Clinical Director	Inverclyde Partnership
Catriona Renfrew, Director Planning and Policy	NHS Greater Glasgow and Clyde

NHSGGC: Developing GP Services – Engagement & Listening

West Dunbartonshire Health & Social Care Partnership (HSCP):
Facilitated Submission January 2016

In September 2015, NHS Greater Glasgow and Clyde produced "Developing GP Services: engaging and listening" which considered the development of the direction for GP services for the Health Board area within the context of the Scottish Government's 2020 Vision. The paper and its attendant consultation exercise are detailed at http://www.nhsggc.org.uk/about-us/inform-engage-and-consult/inform-and-engage-phase/developing-gp-services-for-the-future/

As part of the Health's Board consultation exercise, West Dunbartonshire HSCP disseminated the paper within its two localities – Clydebank and Alexandria/Dumbarton - to encourage stakeholders to contribute views directly into the Health Board process. The HSCP also organised a number of engagement events – one set with local General Practitioners and the other set with patients/community representatives – the feedback of which has been captured within this short report for submission into the Health Board process.

Views expressed by General Practitioners

Challenges:

- General Practice is concerned at the training, recruitment and retention of GPs. Medical students no longer see General Practice as an attractive career.
- There are likely to be challenges in recruiting GPs to cover hospital sessions and out of hours when GPs retire.
- There is a significant amount of bad press surrounding General Practice which is predominately related to NHS England and not as evident within General Practice in NHS Scotland. A Scottish campaign to promote General Practice and the opportunities within this medical role to future and current medical students should be undertaken as General Practice is no longer seen as an attractive role for trainee doctors.
- In addition, engagement with the general public in promoting the services provided within General Practice and the community is suggested. Further work is required with patients to educate on the appropriate use of services, for example patients will turn up at general practice with chest pain rather than attend their local hospital services.

Clinical Practice:

- General Practice has seen the advancement in patient care over a number of years. Chronic Disease Management has improved through the implementation of the Quality Outcome Framework (QOF) and the development and implementation of Enhances Services.
- However QOF has also created a number of frustrations, with a feeling that the indicators within it do not always enhance patient care and can feel like a paper exercise with no improvement outcomes.
- There has been a shift in patient care from a secondary to a primary care setting, which has increased the workload within General Practice. This change in practice has not seen resource following patients and General Practice are now undertaking activities in Primary Care without the same level

of cost or adequate reimbursement (e.g. care of type 2 diabetics, drug monitoring, and requests for follow-up of early discharges from hospital).

- An increase in multi-morbid elderly patients requiring more complex care within the community has resulted in an increased and more time consuming workload within General Practice. More patients are being appropriately cared for at home with an ever increasing housebound population. The GP workforce has not increased, there fewer GPs managing an increase in complex patients. The current financial model within General Practice does not take the above into consideration.
- The current model (QOF and Enhanced Services) no longer provide an equitable service within General Practice - activities and payments are based on historical models of care and no longer reflect the care and services provided by General Practice. General Practice has moved from a reliable predictable income to a system which is increasingly reliant on Enhanced Services. This in itself can be unreliable as activities are not repeated from year to year. This makes it difficult for GPs to employ high quality staff required to take on additional work.

Community Health and Social Care Services:

- Within West Dunbartonshire there are good links with community nursing teams including District Nursing and Health Visiting and are fortunate that General Practice and nursing are co-located within the three main centres. The relationships with the nursing teams are very important and valued by GPs.
- It was recognised that other clinical roles could be development within Primary Care to support the demands within General Practice. There was a suggestion to have more “highly” trained District Nurses that can manage more complex patients autonomously.
- There were pros and cons identified with this approach, including resistance from staff and GPs; and additional work for GPs as a result of experience, knowledge and complexity of care.
- The increase in Community Services is very helpful, but not in itself the answer, as there is always a need for decision making and direction and this is where the pressure lies. Often up-skilled community staff are not generalists and do not always have the capacity to take account of multi-morbidity and polypharmacy. The role of one generalist GP is often shared amongst a number of other clinicians ultimately with GP responsibility.
- The recent change in the referral process to the Day Hospital, which allows the Rehabilitation Team to refer directly, is an approach which GP a would welcome more of where appropriate.
- Child protection was cited as a priority for General Practice due to the patient demographic within West Dunbartonshire and the risks associated with this aspect of care. The system for Child Protection works reasonably well. However there was a commonly cited experience of late requests for reports and/or attendance at panels/ meetings. GPs advised the sharing of information worked well in relation to children under-5 aligned to the Health Visiting Teams. However, information on over-5s still remains a challenge. GPs would welcome more information on the outcome from panels / meetings especially for children over-5.
- Communication with social care professionals has improved, and there is the aspiration for those staff to work as effectively with General Practice as Community Nursing Teams.

- Communication could be further enhanced by having joint practice meetings which would include GP, Social Workers and Health Visitors, allowing maximisation of communication and the benefits of having everyone in the same room. This approach is in place within some practices.
- It was acknowledged that work is under way to improve communication between IT systems support within General Practice and Community Children's Services, with a emphasis that this should include Schools.
- The variation between General Practice and Social Care core hours (Primary Care 8-6 and Social Care 8.45 – 4.30pm) can cause challenges depending on the social care issues. There are local out of hours services available that do not need to be accessed via Out of Hours Social Work Service. Waiting times to get through to Social Work Out of hours was highlighted by GPs and the HSCP requested feedback as this is not the standard of service commissioned.
- Overall closer working between General Practice and Community Health and Social Care Services will support further alignment of care in children, adults and older people (this includes urgency of care, although acknowledged that what is defined as "urgent" may not always the same between professional groups).

Secondary Care:

- The introduction of SCI Gateway has enhanced the sharing of information from patients' records and improved the time taken to refer patients. With the introduction and increased use of technology, relationships and communication between GPs and Secondary (Acute) Care professionals has been negatively impacted. GPs previously knew the consultants they were referring to and had the ability to discuss patient care reducing the need for referral. There are occasions when patients are referred to Secondary Care unnecessarily and a better outcome for the patient, Secondary Care and general practice would have been advice from the consultant to the GP. Functionality for this exists within SCI Gateway and could be activated or contact numbers for clinical advice from Secondary Care provided. This process is already in place for Rheumatology.
- GPs are notified of patients who do not attend out patient clinics, with an expectation that General Practice will follow-up the patient and then re-refer. This creates additional work within General Practice and it is suggested that systems are put in place within Secondary Care to follow-up directly with patients and re-allocate appointments as appropriate. The BMA's Local Medical Committee, on behalf on GPs, has written to the Health Board highlighting the waste of time and resource both within Primary and Secondary Care.
- It was noted that discharge information was timely, but that gaps in discharge letters/ template or information recorded in the wrong place creates additional demand within General Practice (e.g. gaps in medication information). This requires telephone calls to confirm the information provided.
- There is an expectation that General Practice will follow-up on tests, results and referrals initiated within Secondary Care, even though there has been previous agreement that follow-up remains the responsibility of the referring professional. As more information is accessible to General Practice there is an expectation that this information will be shared with patients and patients are increasingly approaching GPs for results. The results provided from investigations initiated within secondary care may not be appropriately interpreted within General Practice as they may require specialist knowledge.

- The group expressed their frustration with communication from Secondary Care Clinics and the Golden Jubilee Hospital - letters can still take 6 weeks and during that time patients have contacted their GP for feedback which may require follow-up by the GP, generating unnecessary activity within General Practice. Email could be utilised more for communication rather than written letters and telephone messages. Departments that still require faxing should be reviewed and communication methods updated.
- It was suggested that advanced skills could be further developed within general practice (e.g. the Epley manoeuvre for vertigo). Potentially, if there is an incentive for GPs, this type of procedure could result in more patients being treated locally and a reduction in referral to Secondary Care.
- Challenges remain within NHS 24 and their referrals to the Scottish Ambulance Service.

<u>Views expressed by Patients and Community Representatives</u>

What do you most value about your GP service?

- Staff who are sympathetic and compassionate. Values are good.
- Ongoing support for long term illness, e.g. mental health problems.
- Late night appointments.
- Drop in Service is excellent.
- Use of technology - e.g. use of texts - is good.
- Practices can be good at making follow-up appointments.

What works well for you?

- Being able to see the same GP.
- Good access to appointments, including emergency appointments. Online service for repeat prescriptions is good.
- High level of knowledge and expertise among staff.
- Referrals work well in general.
- Good access to self management/education resources.

What works less well?

- Not being able to see your own GP.
- Criteria for GP Home Visits needs to be clarified.
- Not being able to make appointments in advance.
- Can be difficult to get through on the phone.
- Feeling of being “fobbed off” by the receptionist.
- Not being able to get an emergency appointment.
- Difficulties in registering with a general practice if need addictions support, with attitude to those service users not always good.
- Lack of connection/eye contact between GP and the patient due to use of computers during consultations.
- Should be more patient consultation within and by GP practices.
- NHS 24 would be improved if people got through to a qualified clinician in the first instance to diagnose the condition.
- IT systems need to talk to each other across GP and Secondary Care - lack of communication and access to patient information in a timely fashion is a problem.

Have you ideas for changes and if so what are they?

- Being able to see the same GP.
- Weekend openings.
- Being able to get an appointment with the Practice Nurse quicker.
- Appropriate support at the diagnosis stage of disease should be available and put in place.
- Practice staff should spend more time explaining things and talking to patients more. Communication skills could be better.
- More information on how to access other health professionals e.g. the Practice Nurse, Physiotherapist.
- Regular health checks should be offered, e.g. for over 75s.
- More social prescribing - GPs need to be aware of and use the resources available in the community to refer people to, e.g. Link Up.
- There should be a focus on prevention and self management, with signposting to different supports.
- Reasons for missed appointments should be logged, as may have been unavoidable, and sanctions for people who do not attend appointments should be considered e.g. three strikes policy.
- Better working between GPs and community based resources.
- Multi disciplinary teams would prevent inappropriate use of the GP by referring patients to more appropriate supports.
- The continued development of Homecare in relation to enablement is important as well as intermediate services and step-up/step-down facilities.
- Development of day care and day hospitals to prevent social isolation.
- Early diagnosis of dementia is good, but there needs to more focus on what happens next, what is available and what can be put in place (e.g. aftercare and support groups). All of this would relieve the pressure on GPs, e.g. less repeat appointments to free up time.
- Shorter waiting time for mental health services.
- Peer support programmes for people with addiction issues.
- More use of NHS 24 website and specialist nurses.
- Implementation of the NHSGGC Clinical Services Strategy in West Dunbartonshire should happen in conjunction with the developing Locality Groups and Locality Engagement Networks.

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The Scottish Government
Riaghaltas na h-Alba

To: NHS Chief Executives
Local Authority Chief Executives
Chief Officers, Health and Social Care Partnerships

LEGACY 2014
XX COMMONWEALTH GAMES
SCOTLAND

15 December 2015

Dear Colleague

GMS CONTRACT 2016/17

I am pleased to be able to confirm that we have successfully reached a negotiated settlement with the Scottish General Practitioners Committee (SGPC) of the BMA for the GP contract for next year. We will communicate separately on the full detail of the changes and will be working with Health Board Primary Care Managers and others and Practitioner Services to implement these new arrangements within the broader context of health and social care integration.

You may recall that the background to this was the announcement by the Cabinet Secretary for Health and Wellbeing at the RCGP UK National Conference in Glasgow on Thursday 1 October 2015 of our intention to dismantle the Quality and Outcome Framework (QOF) and introduce transitional arrangements for quality in 2016/17 in preparation for a new Scottish GMS contract in 2017.

The most significant part of the negotiation has been taking the first steps to develop a flexible and non-bureaucratic framework that (a) ensures quality and delivery of outcomes; and (b) encourages a greater degree of multi-disciplinary leadership in the context of health and social care integration.

We recognise that the widespread adoption of cluster working and the development of the multi-disciplinary teams in localities is a longer term ambition and therefore that the agreement for 1 April 2016 is important but only a first milestone in the development of our longer term plans.

The next and more significant milestone in the journey is how quality and local leadership are expressed in the 2017 contract.

The overall level of GMS funding will not change given the QOF funding being transferred into a new core payment is based on existing GP practice achievement levels. Outwith GMS

funding, there are some potential limited increased costs associated with the changes for 2016 onwards. These primarily reflect the increased role of GPs working in clusters and as part of multi-disciplinary teams supporting health and social care integration.

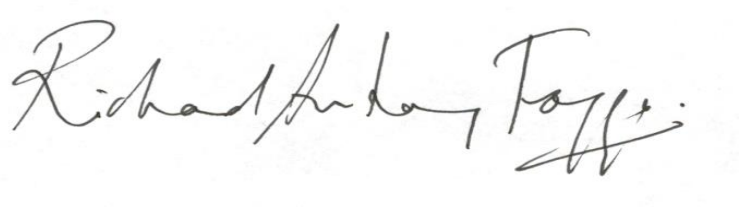
In developing this proposal we have had a clear eye on the need to bind GPs more effectively into the health and social care integration agenda. In areas where this wider GP role is established we would expect local partners to make equivalent arrangements that make best use of their resources. We remain open in the longer run to the most effective way to involve GPs. Our tests of new models of care which are currently underway and are being developed in the months ahead will help us assess the way forward.

We recognise this may require limited local funding outwith the core GMS contract and so as we look to the negotiation of a new Scottish GMS contract from 2017 we will need to engage more fully with you on how you see these arrangements being fully integrated and sustainable. Our expectation for this transition year is that given the critical role these GPs will play locally most if not all of the funding would come from funds delegated to Health and Social Care Partnerships.

I believe a settlement on the basis outlined above will stand us in good stead for the joint work we will be taking forward towards the 2017 Scottish GMS Contract.

Finally I want to put on record our sincere thanks for the support and helpful input from Board colleagues, who have helped us formulate the proposals for discussion and negotiation with SGPC.

Yours sincerely,



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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 17th February 2016

Subject: Pulling Together - The Report of the Independent Review of Primary Care Out of Hours Services

1. Purpose

1.1 To bring attention to *Pulling Together: transforming urgent care for the people of Scotland*, which is the report of the Independent Review of Primary Care Out of Hours Services.

2. Recommendation

2.1 The Partnership Board is recommended to:

- Note the Report of the Independent Review of Primary Care Out of Hours Services.
- Agree that the Chief Officer provides Scottish Government with feedback on the Report's recommendations as set out in this Report and the consideration of the issues by the Partnership Board.

3. Background

3.1 Out of Hours (OOH) primary care services provide care for people who have urgent health or care problems that cannot wait until regular daytime services are available. Out of Hours (OOH) describes the period when general practice services are normally closed. By regulation, general medical (GP) services are provided between 08.00 and 18.30, Monday to Friday, with no obligation to deliver services outwith these times. In practice out of hours provision often starts at 18.00.

3.2 The current model of OOH care in Scotland has evolved from changes in the General Medical Services (GMS) contract in 2004, which allowed GPs to opt out of providing OOH care. Prior to this there was a range of OOH provision, led by GPs, from large urban co-operatives through to remote practices providing their own OOH care with the support of NHS 24. Established in 2001, NHS 24 expanded to become an all-Scotland service by November 2004, providing telephone triage for people or carers seeking urgent primary care. Presently 45 GP practices (out of a Scottish total of 980) in remote and rural areas provide for the OOH care of their registered patients, representing 1.3% of the population.

3.3 Subsequent to this, there has been a significant rise in the demand for OOH primary care and an increasing ambiguity as to what the expectations are for the provision of OOH care. Currently such care is driven by patients or carers accessing care/medical help to deal with a care/medical crisis which cannot

wait for a routine appointment. It is also no longer limited to OOH general practice services but includes access to other services like emergency departments, Scottish Ambulance Service, palliative care services, social care services and the third sector.

3.4 Following the introduction of the 2004 General Medical Services (GMS) Contract, the responsibility for delivery of general practice services during the OOH period transferred from GPs to territorial Health Boards. This has resulted in a number of unforeseen and adverse consequences - including insufficient participation of GPs in OOH services.

3.5 During the one year period 1 May 2014 to 30 April 2015, almost one million contacts were made with primary care OOH services across Scotland. Over the same period, NHS 24 dealt with approximately1.3 million calls. This compares with approximately 900,000 emergency department/A&E attendances in the OOH period, amounting to 56% of their total workload. The over 75 years age group and the under 1 year age group are high volume users of OOH services.

3.6 The annual cost of delivering primary care OOH services reported by Scotland's territorial Boards in 2014/2015 was £81.8 million. NHS 24 incurred costs of £40.4 million, giving a total of £122.2 million invested by the NHS in supporting OOH services across Scotland, excluding Scottish Ambulance Service costs, which are not demarcated by time.

3.7 The increased demand and workforce challenges in daytime general practice have presented increasing day time access issues, resulting in some patients seeking routine care in the OOH period. This may also be about the personal choice of individuals as well - for example where people may no longer accept that they need to take time off work to access health and care services in a culture of 24/7 access to many other services. The demands of daytime working along with flexible working practices have also seen fewer doctors being willing to provide OOH care. Over the past eleven years, NHS Boards have thus had to work creatively to secure OOH provision across Scotland, with an increasing emphasis on multi-disciplinary approaches.

3.8 The Independent Review of Primary Care Out of Hours Services was established by Scottish Government in response to a consistent range of issues for OOH services, e.g.:

- Recruitment and retention of sufficient GPs to work in OOH services reflecting:
  - Shifting attitudes in relation to achieving a work/life balance and the preparedness or willingness of doctors to cover OOH sessions.
  - Busier and more complex day-time general practice reducing the inclination or ability of GPs to work additional OOH sessions.
  - The proximity of some doctors' earnings to key pensionable thresholds.
- Unpredictable staff availability makes it difficult for Health Boards to forecast and plan staffing rotas and achieve necessary balance of skills mix.

- Unpredictable demand leading to difficulty in delivering a consistent service which leads to difficulties in managing public expectation.
- Perceived unreliability of OOH services, increasing demand and inconsistency can cause pressure on other services such as emergency departments and acute hospital services.
- NHS Boards having to to adjust their service delivery at short notice.

3.9 Measures to deliver safe services now regularly include increased session rate payments to attract GPs and secure sessions (with territorial Health Boards often competing with each other to secure GPs and other clinicians) and running the service from fewer local Primary Care Emergency Centre sites.

3.10 As specified in the Public Bodies (Joint Working) Act, General Medical Services - including out of hours - are part of the delegated functions for all integration authorities. With respect to West Dunbartonshire, it is important to recognise that any detailed consideration of such OOH services would have to be undertaken in conjunction with the other five Integration Joint Boards within the Greater Glasgow and Clyde area.

3.11 The aim of the national Review was to evaluate the effectiveness of the delivery of primary care OOH services in Scotland. This evaluation involved reviewing the current situation and recommending action to ensure that primary care OOH services:

- Are person-centred, sustainable, high quality, safe and effective.
- Provide access to relevant urgent care where needed.
- Deliver the right skill mix of professional support for patients during the OOH period.

It should be noted that its remit specifically excluded consideration of dental and optometrist services.

3.12 The Review commenced in February 2015 and reported to the Cabinet Secretary for Health and Wellbeing in November 2015, with its executive summary appended here.

4. Main Issues

<u>The National Review</u>

4.1 The Review Group defined primary care services as encompassing not only GP practices, but community services – including district and community nursing, mental health and dental services, community pharmacies, and optometrists; and for effective health and social care integration, social care services as well as third and independent sector provision.

4.2 In their submission to the Review, the National Health & Social Care Partnership Chief Officers Group proposed the following principles:

- The primary location of the planning for out of hours GP services should be with Integration Joint Boards (IJBs). This should be balanced against the need for consistency within Health Boards that have multiple partnerships and the need for national solutions to problems that can only resolved nationally.
- Out of hours primary care has important connections and opportunities for improvement with out of hours social care and local NHS services. Therefore the review should recommend greater local integration with social care services and other NHS out of hours services e.g. district nursing and mental health.
- There has been an upward spiral and competition of pay rates set locally over the last few years. Payment rates for doctors in out of hours services should be set nationally. Consideration should also be given to the potential for variation locally (within nationally agreed limits) to address capacity in hard to fill areas.

4.3 The Review Group's Report makes a range of headline recommendations, including four specifically related to Health & Social Care Partnerships and their integration authorities, namely:

- Health & Social Care Partnerships and IJBs would be required to provide strong leadership for OOH and urgent care services, going forward. They should place sufficient priority on the delivery, improvement and monitoring of quality and safety for these services working with NHS Boards, Local Authorities, the third and independent sectors.
- The strategic planning process of Health & Social Care Partnerships and IJBs should look for opportunities for integrated OOH service provision from Local Authorities and the NHS, including co-location opportunities, and the provision of optimal urgent care services on a 24/7 basis.
- Future models of care should meet local need and focus on early intervention and prevention. Opportunities should be sought to build on success where best practice has been demonstrated of integrated multi-disciplinary health and social work teams providing 24/7 services. These should include partnership arrangements with the third and independent sectors.
- Joint organisational development plans should focus on supporting staff to integrate cultures and ways of working and increase mutual respect between professions. Learning and development strategies ought to be in place that support strong distributive leadership across professions/sectors.

4.4 Of additional note within the Report is the emphasis on its proposals for Urgent Care Resource Hubs and Urgent Care Cares.

<u>Review Proposal: Urgent Care Resource Hubs</u>

4.5 The Report proposes that OOH services would have a community health and social care co-ordination and dispatch centre where its function is to co-

ordinate, mobilise and orchestrate the most appropriate care response. The term suggested for this is Urgent Care Resource Hub.

4.6 Integration authorities, either working independently or delivering economies of scale by collaborating with partner authorities to provide regional services, would have the responsibility for ensuring that there is this community coordination function within the OOH services they are responsible for providing.

4.7 The size, configuration and location of this co-ordinating function would be determined by local circumstances. It would be supported by patient based information systems such as Key Information Summaries and electronic decision support as well as access to ALISS (A Local Information System for Scotland), the third sector database. All patient information from NHS 24 would go to the Urgent Care Resource Hub, as for governance purposes and because it simplifies the process and ensures a focus for effective local co-ordination of care.

4.8 This proposed model would see an increased number of multi-disciplinary/multiagency patient disposition responses initiated via the co-ordinating centre, which would be responsible for matching patients to the most appropriate response to meet their needs. This would be to a range of community based health and care services including GP OOH services, paramedical practitioners, Advanced Nurse Practitioners, community nursing teams (supporting home visits), community pharmacy, social services, third sector providers, community psychiatric nursing services; requests for patients to attend an OOH centre facility which in some areas might be co-located with this co-ordinating centre.

4.9 The community co-ordination function would also support access to local 'speak to doctor' and professional - to-professional calls - for example, if a telephone call is required between a district nurse, care home nurse or ambulance paramedic who needs to speak to the OOH doctor for further advice. This function would also be required for OOH practitioners to be able to talk to a specialist physician, geriatrician or other specialist in order to aid in management decisions at the time when the OOH practitioner is present with the patient. This function would enable professional-to-professional support for practitioners.

<u>Review Proposal: Urgent Care Centres</u>

4.10 Urgent Care Centres would deliver urgent care within local communities. Their location and fitness for purpose would also need to take into account access issues – especially for patients living in remote and rural areas, and economies of scale. They would be configured as both service delivery and learning environments which are safe and secure for the wellbeing of patients and staff.

4.11 Although primarily configured for OOH service delivery, the infrastructural assets of Urgent Care Centres should be used to best purpose for local care needs on a 24/7 basis. There may be merit in seeing more seriously unwell patients adjacent to A&E/acute services where they are likely to be referred or require investigation where this is an option to do so. This model, co-locating primary care and A&E/acute services is being developed in England and aims to minimise unnecessary transfers of acutely unwell patients. However the Report acknowledges that for some communities such an approach would restrict access and, as a consequence, no prescriptive view has been taken.

Current NHSGGC GP Out Of Hours Arrangements

4.12 The NHSGGC OOH Service is currently configured around a hub located in Cardonald; and 10 Primary Care Centres.

4.13 There is a Team Leader in the Cardonald Hub until midnight during all operational times. The Team Leader has overall management responsibility for the service. There is a Senior Clinician or OOH Service Manager on call at all times. The rota is 1:4 and the Clinical Director and two Medical Advisors are also included in this rota. The Hub provides a telephone advice service (by the GP advisor who has a wide role in co-ordinating the service); and an untriage (pre-prioritised) call service to support NHS24.

4.14 The Primary Care Centres see patients who are directed by NHS24, Emergency Departments or self present. They are located at:

- Victoria ACH – co-located with Minor Injury Service.
- Stobhill ACH – co-located with Minor Injury Service.
- Western Infirmary – co-located with Minor Injury Service.
- Vale of Leven – co-located with Minor Injury Service and part of the hospital cover as well as GP OOH. This centre also serves Helensburgh and the Lochside area as per (to-date) a Service Level Agreement with Highland Health Board.
- South Glasgow University Hospital – co-located with both Adult and Children Emergency Departments– located in Children Hospital Outpatient Clinic.
- Royal Alexandra Hospital – co-located with Emergency Department.
- Inverclyde Royal Hospital – co-located with Emergency Department.
- Greenock Health Centre.
- Easterhouse Health Centre.
- Drumchapel Health Centre.

4.15 Home Visiting Services are provided from both the Primary Care Centres and the Hub at Cardonald. The OOH Service offers a patient transport service to and from its Primary Care Centres for patients who do not have their own transport.

4.16 A review of the existing GP Out of Hours Service across the NHSGGC area has been initiated by its six IJB Chief Officers, which is being led by the Chief

Officer of Renfrewshire Health and Social Care Partnership. This review will look at demand, activity and workforce capacity as well as the current clinical model and the information gathered will be used to inform change and develop new models of care for consideration by Chief Officers and IJBs.

Current Social Work OOH Services

4.17 The Glasgow and Partners Emergency Social Work Service is contracted to provide an out of hours, emergency statutory Social Work Service to seven user councils: Glasgow, Dumfries and Galloway, East Dunbartonshire, East Renfrewshire, Inverclyde, Renfrewshire and West Dunbartonshire. It should be noted that the service to Dumfries and Galloway is a call handling service only.

4.18 The service is managed by Glasgow City Council which acts as the lead authority providing both operational and external management of the service. A Joint User Group oversees the work of the service which has representation from all seven user councils.

4.19 The Glasgow and Partners Emergency Social Work Service deals with Social Work referrals which are too urgent to await the involvement of the local Social Work Area Services the next working day. Referrals can be made by members of the public, external agencies or by day time services on an 'Alert' basis. The Service assesses each referral it receives and prioritises this work, determining the required response for each. Child protection, mental health, and vulnerable frail elderly/adult support and protection which meet the above criteria are given a priority.

4.20 Glasgow and Partners Emergency Social Work Service operates a shift system to provide emergency Social Work Service cover for out of hours, i.e. Monday to Thursday between 5.00 pm and 9.00 am; and from 4.00pm on Friday to 9.00 am on Monday. The Service also covers all public holidays for the seven user councils. A Duty Team Leader is available from 4.00 pm Monday to Thursday; and from 3.30 pm on Fridays. Social Workers commence their rota at 4.00 pm Monday to Thursday; and 3.30 pm on Fridays. This allows Area Services to exchange urgent information to the Glasgow and Partners Emergency Social Work Service and vice versa, by phone, if required.

Summary Reflections on the National Report

4.21 At a headline level the Report is laudable, especially its advocacy for multi-disciplinary arrangements; and its emphasis on all those professionals involved delivering at the top of their registration and grade. Both of these themes are also emphasised within the Health Board's Clinical Services Strategy.

4.22 However, in terms of those recommendations that relate to local service development and provision, there is limited consideration of or suggestions for *how* to actually implement or resource such changes; and to a large extent

are predicated on the agencies involved operating to coterminous geographical areas (even though the Report acknowledges that is rarely the case). Furthermore, whilst the Report acknowledges the need for OOH services to operate effectively within the resources available to them, its call for the inevitably greater investment required to fund its proposals is weakened by its not identifying the specific inefficiencies or excessively expensive elements within the current OOH arrangements that should be addressed in order to release funding for potential reinvestment.

4.23 The Report nonetheless provides much useful food-for-thought for further consideration as part of the NHSGGC area OOH review (as per para 4.16).

5. People Implications

5.1 The Report emphasises that:

- Moving to a sustainable and multi-disciplinary OOH workforce will require new thinking, different ways of working and investment across the workforce using best organisational development practice.
- GPs should no longer be the default health care professionals to see patients for urgent care, but that they should continue to be an essential part of multidisciplinary urgent care teams, providing clinical leadership and expertise, particularly for complex cases.
- An enhanced capacity multidisciplinary OOH workforce should be rapidly built up, including advanced nurse practitioners, community nursing staff, paramedical staff and other allied health practitioners, clinical pharmacists, physician associates and social services staff.
- The contribution of administrative and support staff is crucial and must be clearly valued and recognised.

6. Financial Implications

6.1 The Report recognises that over the next decade it is unlikely that NHS funding will grow at the same rate as the increase on demand for services. All of our services will therefore need to deliver increased efficiency and productivity in order to deliver the safe, high quality care required. Increased investment in primary care generally and OOH services specifically will need to demonstrate best value for money in the context of this overall pressure on budgets.

6.2 The Report emphasises that in its view there will be a need to consider and identify areas of disinvestment to allow for a higher proportion of overall health and care spend to be allocated to primary care services.

7. Professional Implications

7.1 The views of health and social care professionals working in OOH services were taken account of by the Review in a number of ways. Firstly, the structure and process of the Review itself was inclusive and designed to

capture as wide a perspective as possible. Views and opinions were captured during visits to Board areas, NHS Special Boards, at Officer Groups and meetings, in workshops, and at a national consultation event. Secondly, the Review sought contributions from specific professional groups and organisations. Thirdly, as for public views, professional views were sought in writing or electronically.

7.2 A strong theme evident within the Report – and one that it shares with the Health Board's Clinical Services Strategy - is the importance of all professionals providing OOH services operating to the top of their registration and grade.

8. Locality Implications

8.1 The Report stresses that General Medical Practitioners (GPs), as for all health professionals, should be clinically accountable for the provision of safe effective and patient centred care. The Report emphasises that GPs should work within each locality and their OOH service to secure:

- Longitudinal care and continuity of relationships where this is important.
- Access to care at the right time when it is.

9. Risk Analysis

9.1 The Report contends that the present situation for OOH services in Scotland is fragile, not sustainable and will worsen, unless immediate and robust measures are taken. The Report recognises that given the significant financial challenges in the next 10 years it will be particularly important that in doing this, that all services produce increased efficiency and productivity in order to deliver safe, high quality person-centred care. Increased investment in primary care OOH and urgent care services specifically will need to demonstrate best value for money and areas of disinvestment pursued.

9.2 Ensuring safe, accessible services to patients during the Out of Hours period is a key factor in ensuring high quality services to the population of NHS Greater Glasgow & Clyde. Chief Officers of the IJBs across NHSGGC have just begun a review of the existing GP OOH Service. This review will look at demand, activity and workforce capacity as well as the current clinical model and the information gathered will be used to inform change and develop new models of care.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 The Review commissioned the Scottish Health Council to run public

Participation events in all Health Board areas across Scotland. These took place on all Board areas in Scotland with the exception of Orkney. A collated report of findings was subsequently prepared by the Scottish Health Council and submitted to the Review, and that report is now available on the website of the Scottish Health Council (see background papers below).

11.2 Following the publication of the Report, the Scottish Government has written to Health & Social Care Partnership Chief Officers inviting them to provide feedback on the recommendations with. Following the consideration of this item at this Partnership Board meeting, the Chief Officer will reply to that invitation in a manner that reflects key messages/points that emerge from the Partnership Board's discussions.

12. Strategic Assessment

12.1 The Health & Social Care Partnership's Strategic Plan 2015-16 recognises that access to and the development of primary medical services is a key consideration in improving the delivery of services.

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Appendices: Pulling Together: transforming urgent care for the people of Scotland – Executive Summary

Background Papers: Pulling Together: transforming urgent care for the people of Scotland – Main Report
http://www.gov.scot/Resource/0048/00489938.pdf

Gathering views on patient experience of primary care out-of-hours services
http://www.scottishhealthcouncil.org/publications/gathering_public_views/primary_care_out-of-hours.aspx

Wards Affected: All

Pulling together: transforming urgent care for the people of Scotland

The Report of the Independent Review of Primary Care Out of Hours Services

Summary Report

Cabinet Secretary's Foreword

We treasure our National Health Service. I don't believe that starts and stops with core NHS services. We treasure all the incredible services provided day and night by a whole host of social care and other partners, in the public, third and independent sectors.

Following the Christie Commission, our commitment has been to ensure that there is clarity in the increasingly complex landscape so we find ourselves accessing ever more integrated, person-centred services that make sense to us and allow us to feel in control of our own lives. This is at the very heart of our *2020 Vision* for Scotland's Health.

A significant part of what matters to us is our sense that these caring partners – in the NHS and beyond – are there for us when we need them. None of us can take this for granted. Those who provide these services are just like us – they have families, commitments, lives. The challenge of 24/7 365 days a year service delivered to an exceptional standard is considerable.

It is within this integrated framework that out of hours primary care services sit. The GPs, nurses, other professions, administrators and technical staff all help to provide vital access to not only advice but to urgent appointments when we need them at night and at the weekend. Their dedication and commitment is remarkable and makes a real difference to thousands of Scots every night and weekend.

The out of hours primary care system has been under strain for some time now, with pressure of work rising and increasing numbers of people seeking help and advice. So the time was right to review the system and to look for expert advice on how to sustain and build this essential service to the people of Scotland.

It is clear that this would be no simple task. In order to meet the challenges set down by Christie and to deliver our *2020 Vision*, this had to be a wide ranging review, incorporating many different viewpoints and seeking to get a clear view of the contribution that different professions, organisations and sectors could make to building a service for the future that was safe, high quality and sustainable. I was delighted that Professor Sir Lewis Ritchie was able to commit to provide this expert advice and to lead the Review.

I believe that in the report that follows we have the clear, authoritative advice we were looking for. All relevant authorities, organisations and those with a stake in out of hours primary care and urgent care more generally must now reflect on this advice. I expect to set out how the Scottish Government plan to respond early in 2016.

SHONA ROBISON

Cabinet Secretary for Health, Wellbeing and Sport

November 2015

Chairman's Introduction

Purpose: This Summary Report has been prepared to sit alongside the Full Report as a more accessible and concise version: to describe the work, findings and recommendations of the Primary Care Out of Hours Review 'the Review'. Its purpose is to summarise and to guide best use of the extensive and detailed Full Report which should be regarded as a source document.

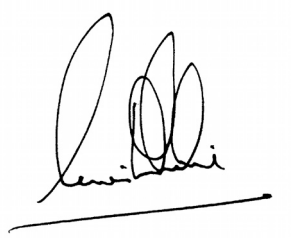
Background: Out of hours primary care services (OOH services) are under considerable pressure, as is daytime general practice, at this time. Services are fragile, are not sustainable and may worsen rapidly if we do not rise to the occasion.

Transformation: We must secure resilient, high quality and safe out of hours (OOH) services, but we must also think anew about what is best for both urgent and emergency care for the people of Scotland on a 24/7 basis. That requires transformational change across many sectors - it will be neither easy nor quick. We must strive for excellent services, which must be valued accordingly and used responsibly. The Review is cast at a pivotal moment for health and social integration and that has galvanised our thinking and actions.

Appreciation: I have been humbled by the dedication and commitment of very many colleagues during the course of the Review who are too numerous to mention, by the steadfast support of the public who helped us and by my support team,.

Expectations: I am very conscious of the limitations of the Review which reaches out to all care sectors and those we serve. I hope that some recommendations will bear fruit in the short term but others will take much longer to come to fruition.

Getting urgent and emergency care right is of paramount importance for the people of Scotland and for those who provide care for them. The case for immediate action is clear. We will need to do this well, to do this with resolve and to do this together.



Lewis D Ritchie

Chairman
National Review of Primary Care Out of Hours Services

Primary care out of hours team at the Urgent Care Centre, Royal Victoria Hospital Edinburgh, including driver, GPs, nurse practitioner, receptionist and centre support staff

Content

Chapters

The Social Care Response Service, Dundee

Our Remit

We were asked evaluate the effectiveness of the delivery of primary care out of hours services in Scotland. This evaluation involved reviewing the current situation and recommending action to ensure that primary care OOH services:

- Are person-centred, sustainable, high quality, safe and effective
- Provide access to relevant urgent care where needed
- Deliver the right skill mix of professional support for patients during the OOH period

Key Definitions

Primary Care: Primary care provides access to care at the right time when it is required and secures ongoing care in the community and continuity of relationships, where this is important. In addition to GP practices, primary care services covers: community services – including: district and community nursing, mental health and dental services, community pharmacies, optometrists - and for effective health and social care integration - social care services, third and independent sector provision

Out of Hours: This describes the period when general practice services are normally closed. By regulation, general medical (GP) services are provided between 08.00 and 18.30, Monday to Friday, with no obligation to deliver services outwith these times. In practice out of hours provision often starts at 18.00

Urgent Care: Urgent care in the community that requires a response before the next routine care service is available

Emergency Care: Care that requires an immediate response to a time-critical health care need

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Scottish Ambulance Service taking care to the patient

1 Key Messages

Purpose: This Section provides key messages about Primary Care Out of Hours Services and answers questions about what future services might look like and how that might happen. It differs from the Key Messages section in the Full Report - in order to improve accessibility

Person-Centred Care

- Putting the person at the centre of care is a fundamental principle of the Scottish Government's future vision for the people of Scotland. In this Review, the 'person' refers both to those who need services - their carers and families - and those who provide services. We need to both deliver excellent care in partnership with patients and we need to value the staff who provide it.

- Urgent care services for problems and care needs that cannot wait for a routine appointment should be more easily accessible and navigable for all but need to be valued and used responsibly.

Service Demand and Sustainability

- During the one year period 1 May 2014 to 30 April 2015, almost 1 million contacts were made with primary care OOH services.

- The demand for urgent care is growing – particularly for rapidly increasing numbers of frail older people with multiple long-term conditions and complex care needs.

- The present situation for OOH services is fragile, not sustainable and will worsen, unless immediate and robust measures are taken to promote the recruitment and retention of sufficient numbers of GPs and other multidisciplinary team members working in both daytime and OOH services.

What will the future look like?

- Future service design and delivery should be based on best meeting the needs of the public and those who deliver services. This should enable tailored advice, support and self care, and where required, direction to the right service, at the right time.

- Patients can no longer expect always to see or receive telephone advice from GPs for urgent care. Future care will be delivered by well trained and well-led multidisciplinary teams. Patients will be seen by the right clinical or caring professional according to need. That could be a GP, an advanced nurse practitioner, a community nurse, a paramedical practitioner, a pharmacist, an allied health professional (AHP) such as a physiotherapist, social services or other team member who might work for the third or independent sector or another agency. GPs must continue to be an essential part of multidisciplinary urgent care teams, providing clinical leadership and expertise.

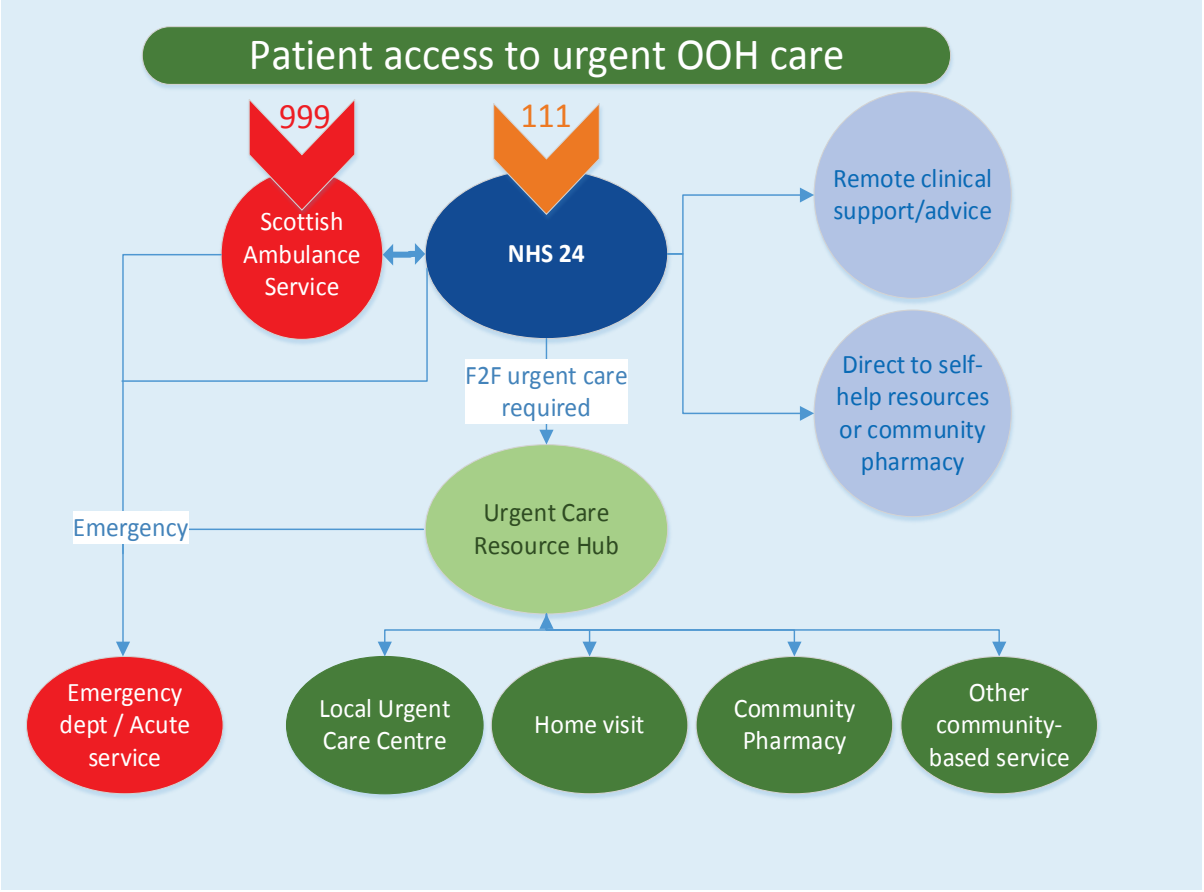

Figure 1 - A new model of out of hours care

How will that be organised?

- At the moment care can be fragmentary and communications can be difficult between professionals to the detriment of best patient care. A new model of urgent care is proposed by developing Urgent Care Resource Hubs – see Figure 1 above. These hubs would provide a coordinating area and locality wide function for multidisciplinary urgent care and should provide remote telephone or video-link support for care professionals from all care sectors. While primarily established for OOH services, they should be considered for 24/7 urgent care coordination. They will need to be piloted and tested to inform future progress.
- An area Urgent Care Resource Hub would normally be networked to several local Urgent Care Centres.
- Local Urgent Care Centres (which are presently known as Primary Care Emergency Centres) should be located to facilitate patient access for care, but also for service resilience. They should be fit for purpose for service delivery and training.

How will out of hours care be accessed?

- In the case of genuine medical emergency care that will continue to be by 999 phone call, to access the Scottish Ambulance Service (SAS), or by direct attendance at A&E services.
- In the case of urgent care for a medical problem – care that cannot wait for a routine appointment, when GP practices are closed, by dialling 111 to access NHS 24, as now. NHS 24 will provide the right advice for self care or direction to the right care service – routed to the area Urgent Care Resource Hub nearest to the patient's location. This Hub will coordinate best care by requesting the patient or carer to visit a local Urgent Care Centre or, if required, by arranging a house call or by direction to another community care service. A house call might be done by an advanced nurse practitioner, by a GP, or parmedical practitioner (paramedic). Some callers will be directed to attend Accident & Emergency services and a small number will have a 999 ambulance dispatched for their immediate assistance.

What will be different?

- NHS 24 and SAS already work closely together, but we have asked them to look again at their care pathways to ensure better coordination of care. This should provide better experience and outcomes for patients and their carers.

- We would expect the public to make greater and better use of local community pharmacies in the future to seek advice and treatment for minor ailments both during daytime and OOH. There is insufficient awareness of the services delivered by community pharmacists and that should change.
- We have looked at a small number of groups of patients with specific needs – children, palliative care patients, frail older people, people with mental health conditions and those who are living in deprived circumstances or who have problems accessing services for a number of reasons. We would expect their care to be improved with better access to services according to need. The work is preliminary only – we suggest that there is much more to do. We identify further work that needs to be considered for prisoner care and for forensic clinical services.
- Increasing use will be made of telehealth and telecare, with remote video-consultations increasing. We have advised that mobile applications 'apps' should be developed and evaluated in order to support self care and best use of services.
- We would expect the third sector, already a large and important provider of care – particularly for vulnerable people – to be playing a greater role in future services in collaboration with all other sectors.
- For the care home sector we would expect better remote professional support and improved recording systems.
- We indicate that greater use could be made of the Scottish Fire and Rescue Service, for prevention and care in the community, if available. They are already working closely with SAS to assist cardiac arrest victims as their vehicles carry defibrillators. We have suggested consideration of further expansion of their first-responder role to help clinical care, in the absence of timely ambulance availability.
- In some remote island communities the RNLI lifeboat service may be deployed to evacuate urgent cases when other transport may not be available or unsuitable, particularly in adverse weather conditions. We have asked for a Memorandum of Understanding to be drawn up between RNLI, SAS and HM Coastguard.
- We would expect the specific needs of remote and rural communities to be taken into account particularly for transport and communication issues. Greater use of remote video consultations may help matters.

How can the public and patients helped to make better access and use of services?

- We have made recommendations about promoting better understanding and use of services. We wish to raise the profile of the meaning of 'urgent' and 'emergency' to promote responsible use of services. We advise that best

practice should be used to achieve that including learning experience, taking into account international best practice.

- We have particularly looked at how to bolster self care and have recommended promoting person-centred care through better self-management and health literacy.
- We call for greater public involvement in health service developments – those who receive services are entitled to shape them.

What about those who provide the services?

- We have indicated that staff providing services need to be valued more, which is why we say person-centred should refer to both those who receive care and those who deliver it.
- We have made a large number of recommendations about workforce issues and have examined the future roles of GPs, advanced nurse practitioners, district nurses, pharmacists, paramedics, AHPs, physician associates and social care practitioners.
- We have called for urgent primary care workforce planning to be developed at national and local levels – this must be done without delay to rapidly enlarge and enhance capacity.
- We have asked for new one year posts to be created for GPs after completion of three year training and for four year training to be better configured for urgent GP care. We want young GPs to be supported and GPs at all career stages to be encouraged and enabled to work in OOH services.
- We commend the Chief Nursing Officer's Reviews of Advanced Nurse Practitioners (ANPs), creating sufficient capacity and uniform standards and also her District Nursing Review – many district nurses will be retiring shortly so this a pressing matter.
- We have already indicated that community pharmacies should play a greater role for urgent care. Clinical pharmacists will contribute more to both daytime and OOH services. Like ANPs we would expect many more pharmacists to be independent prescribers.
- Paramedical practitioners (paramedics) will play greater roles in delivering care to the community – they are already doing it and like NHS 24 have recently supported some GP practices with staffing difficulties, in daytime hours. Ambulances could be regarded in the future as mobile Urgent Care Centres - that may be more important for remote and rural areas.
- AHPs too will have more prominent roles in OOH services, primarily supporting community rehabilitation and fall pathways, which we have recommended should be accelerated and more uniform throughout Scotland.

- Physician Associates (PAs) have been working in the USA for many years and play important roles working with and for doctors. They should be considered for augmenting the Scottish primary care workforce.
- The roles of social services workers continues to grow – the importance of working closely with clinical colleagues should be fostered by the new model we propose. Again awareness of their roles could be improved as they contribute much to the care of society in the OOH period – including the community alarm system and assistance and preventing falls.
- We also indicate how critical OOH support workers are - they should be appreciated and valued.

How will this happen?

- We have made a number of recommendations about improving quality and safety.
- We have asked for a service specification for OOH services to be developed.
- We would like to support services to promote quality improvement and have asked how that can best be achieved.
- We have made a number of recommendations about securing best use of electronic records and consistent data sharing.
- We have yet to truly unleash the potential of information technology for better and safer patient care and we must strive to achieve that.
- We have called for rapid development of comprehensive primary care workforce plans at national and local levels
- We have suggested that undergraduate schools for health and social care professionals should look at the balance and emphasis of their training - as the changing needs of society and workforce capacity/capability, should be closely aligned

Who will support and ensure these recommendations happen?

- We have spoken to and made recommendations about the third sector, the independent sector, Special Health Boards, Health Bodies and other agencies.
- Throughout the Review we heard about the future importance of Health and Social Care Partnerships and Integrated Joint Boards – that is reflected in our recommendations.
- We commissioned academic research to inform our deliberations and uncovered a lack of good evidence and evaluation of OOH Services We offer some priority areas for future research and have recommended that new models of care, such as proposed by the Review are properly piloted and rigorously evaluated.

- We are conscious of how ambitious some of our recommendations are and also their limitations - while some may be delivered in the short term others will take much longer.
- We would expect these recommendations to be considered carefully but also critically – the canvas is wide, but we need to prioritise and in some cases discard for good or unforeseen reasons.
- We have suggested guiding principles for new services should be:

    - Person-centred - for those who receive and those who deliver services
    - Intelligence-led - making the most of what we know about our people and their needs
    - Asset-optimised - making the most of all available assets and resources
    - Outcomes-focused - making the best decisions for safe and high quality patient care and wellbeing

    In addition to these guiding principles, such services should be:

    - Desirable – high quality, safe and effective
    - Sustainable - resilient on a continuous basis
    - Equitable - fair and accessible to all
    - Affordable - making best use of public funds

- We have recommended robust planning to be developed at national and local levels to do determine what are likely to be quick wins and what are not. We thought about prioritising our recommendations, but felt that more detailed deliberations would be required, which would fall outwith our allotted timescale for conducting the Review. The recommendations need wider scrutiny and that is our intention, taking into account stringent resource constraints. However, because of current difficulties and serious challenges ahead, we cannot tarry and need to press on with resolve.
- We need to ensure best use of resources and have offered some proposals regarding financial planning for some of the strategic developments recommended.

Community Pharmacy Team

2 Executive Summary

Purpose: This Section reproduces the Executive Summary from the Full Report, in order to assist accessibility and best use. The Chapters and Annexes referred to are in the Full Report and the OOH Review website is also referred to: http://www.gov.scot/Topics/Health/Services/nrpcooh

Chapter 1 – Key Messages

Headline issues addressed by the Primary Care Out of Hours Review are summarised and high level recommendations made.

Chapter 2 – Recommendations:

Describes and summarises the recommendations made by the Review. These recommendations were synthesised from the views of the public, health and social care professionals, of professional organisations and bodies, published literature and research commissioned by the Review.

Chapter 3 – Review Purpose, Process and Engagement

- A Review Group was established to lead the process with multidisciplinary, multi-sectoral and public membership.
- An Executive Group was established to support the Review and distil all the evidence and recommendations arising from the process and engagement.
- Four thematic Task Groups were established: Models of Care, Workforce and Training, Quality and Safety, Data and Technology. These reported to the Executive Group.
- Workstreams were instigated for groups of people with specific needs and access requirements: Palliative Care, Mental Health, Frail and Older People, Children, and Health Inequalities. Support was provided by the Royal College of Nursing (RCN), Scotland.
- A virtual Reference Group was established with multidisciplinary, multi-sectoral, public and international representation, offering rapid external peer review to the Executive Group.
- A schematic for the Review structure is available as Figure 3.1.
- A Short Life Working Group was established to examine terms and conditions for GPs working in OOH services.

- A rapid systematic literature review and further research was commissioned from the Scottish School of Primary Care (Annex F) and on the Review website.
- Data, statistics and analyses were provided by Information Services Division (ISD) - see - Key facts about services (Annex B).
- Financial data were provided by NHS Directors of Finance (Annex C).

Chapter 4 – Engagement and Consultation

This chapter describes the extensive engagement process for the Review, including visits to al Board Areas in Scotland, visits to, and communications with Special NHS Boards and Public Bodies. Figure 4.1 provides a schematic of the national engagement programme. Local public discussion groups were commissioned via the Scottish Health Council and took place throughout Scotland. The work of the Review was supported by a dedicated website and by intermittent press releases, requesting public and professional views. Wider consultation with many groups and agencies took place, including a national consultation event and a meeting with MSPs took place. The process and interim progress of the Review were shared and discussed with many groups. Account was taken of relevant interfaces with other ongoing Scottish Government workstreams and reviews.

Chapter 5 – Findings

Describes and summarises the views of the public on OOH services, supplemented by the *Health and Experience Survey 2013/14.* The discussion group work, analysis and report provided by the Scottish Health Council were central to this task. This work was supplemented by the national engagement visits to all Board areas and workshops, including one set up by the Health Care Alliance Scotland (Alliance), seeking views about how best to use and access services.

Views of health and social care professionals, the third and independent sectors were captured at meetings during the visitation programme to Board areas. Submissions were received from the Chief Nursing Officer, professional organisations and bodies. These are summarised in Annex D and available in full on the Review website. A requested submission from NHS Health Scotland, regarding health inequalities is summarised in Annex F and available in full on the Review website.

Chapter 6 – Models of Care

A new model of care is described where a multidisciplinary, multi-sectoral urgent care coordination and communication function will be provided at Urgent Care Resource Hubs, which would be configured for both service delivery and training purposes. They would be primarily established to coordinate urgent care for OOH services – but should be considered on a 24/7 basis. They would facilitate multidisciplinary co-location, co-working, co-production and co-learning. They would be able to provide best information about and for the people served in their localities and help deploy the most appropriate services and resources available in order to secure timely and optimal care and support, according to need. This would fit with the principles of a person-centred, intelligence-led, asset-optimised and outcomes-focused service. Modelling, piloting and evaluation will be required. Urgent Care Resource Hubs would be networked to local Urgent Care Centres, presently referred to as Primary Care Emergency Centres which should be fit for purpose and be located to maximise accessibility and service resilience. Figure 2.1 provides a high level schematic of the proposed model. Recommendations are also made about NHS 24 and SAS synergies and the requirements of some groups of people with specific care and access needs (Recommendations 1-7).

Chapter 7 – Workforce and Learning

The importance of valuing our workforce looms large in the Review. At the outset, person-centred was re-defined as applying to both the person receiving care or support and the person delivering it. In order to meet the needs of future OOH and

urgent care services it is essential to develop a high calibre, high morale workforce of sufficient capacity and capability. The Review was established recognising that serious GP shortages were compromising the sustainability of OOH services, which remain fragile and may worsen without resolute and urgent action. Recommendations are made on: workforce planning at national and local levels, interdependent linkages between daytime and OOH services, the importance of the educational and working environment and an organisational development approach. The skills and expertise of all professional working in OOH services must be optimised – with individual practitioners working to maximise use of their skills and the full scope of their practice. Recommendations are made for the future contributions of the GP, nursing, pharmacy, paramedical, other AHP, associate physician and social services workers. The importance of working and learning in professional partnership is stressed across the sectors, as is valuing the vital and unsung contribution of support workers. Strong and resolute professional leadership at all levels will be required to assess and implement the Review's recommendations. (Recommendations 8-19).

Chapter 8 – Quality and Safety

Quality and safety are central to ensuring care and support both for patients and their carers, to secure best results – an outcomes-focused service. Present quality governance arrangements reflect former systems established by individual providers rather than a more holistic, person-centred approach, going forward. The advent of health and social care integration provides an opportunity and obligation to develop robust integrated quality planning, quality improvement, assurance and accountability, across all sectors. Optimal urgent care is a pressing matter for the people of Scotland, a unifying cause and a clarion call to action.

The new model of care proposed by the Review – delivered by a growing multidisciplinary team drawn from all care sectors, requires to be underpinned by a clear and shared service specification which should be rapidly developed. Reflecting a truly person-centred approach, new standards and indicators should incorporate both patient/carer outcomes and staff experience and must also take account of health inequalities. Proportionate and risk based quality of care scrutiny reviews for OOH and urgent care services should be developed collaboratively by Healthcare Improvement Scotland and the Care Inspectorate. Proposals are made to undertake a scoping exercise for improvement support of OOH services at national local levels. A national multi-sectoral Quality Governance Group is recommended to oversee quality and ensure that standards are being set, met and improved upon, including the sharing of best practice (Recommendation 20).

Chapter 9 – Data &Technology

Improved Information Technology (IT) and eHealth systems will help to deliver many of the recommendations made by the Review. This recommendation reflects the guiding principle that future models of OOH and urgent care should be intelligence-led. While IT systems have evolved and significant progress has been made, the huge potential of shared electronic records has yet to be fully realised. Individuals who may be sick and seriously ill may traverse from home through a number of care sectors in a very short space of time. Care providers may access a myriad of separate databases, along the journey of care. Care at interfaces with separate databases and recording systems or methods, adversely impacts on safety and hampers effective communications and collaboration. Person-centred care requires reliable and accurate person-centred information, available at the right time and in the right place. The proposed Urgent Care Resource Hub model offers a potential opportunity to help coordinate and interpret information at area and locality levels – particularly in complex cases and those with enduring conditions. This person-centred intelligence function should help to optimise assets and care outcomes. Consistency in data sharing across sectors should be the rule, preserving security and confidentiality. A collective service review of OOH IT systems currently in use and related governance arrangements is urgently required in order to deliver national consistency in use and optimisation of individual patient care and information.

The deployment of high quality video-links remains patchy and further exploitation is required – connecting Urgent Care Resource Hubs with Urgent Care Centres, in remote and rural areas, in intermediate care settings such as residential homes and community hospitals, in the Scottish Prison Service and for mobile clinical decision support by SAS. Cultural barriers to effective deployment should be addressed as they often outweigh technical issues. Innovation, development, deployment and evaluation of mobile applications ('apps') are also recommended to support self care and best use/access to services (Recommendation 21).

Chapter 10 – Role of Health and Social Care Partnerships and Integrated Joint Boards

Strong strategic leadership will be required for implementing the recommendations made by the Review. Getting OOH services and urgent care right for the people of Scotland should be a compelling priority for all sectors. Excellent care should not be just reactive but be pro-active. Opportunities for prevention and pre-emption should be pursued to add to individual and community resilience (Recommendations 5,15,16). The view of the key leadership role and function of Health and Social care Partnerships and IJBs was commonly and consistently expressed throughout the Review process. Recommendations are made about strategic planning, quality and safety imperatives and promotion of inter-sectoral organisational development - to

help erode cultural differences and to promote the commonweal (Recommendation 22).

Chapter 11 – Role of Special Health Boards and Public Bodies

Special Health Boards and Public Bodies should play key supportive roles going forward for OOH services and urgent care, as they did during the course of the Review. Relevant Review recommendations are mapped on to each organisation, as are the guiding principles adopted by the Review: of person-centred, intelligence-led, assets optimised and outcomes-focused care. The complementary principles of desirable, sustainable, equitable and affordable services are also applicable to the functions of these Boards and Bodies - for example NHS Health provided advice on the impact and mitigation of health inequalities – mapping to the principle of equitable services. The synergistic collaboration of NHS 24 and SAS should be very important as they work together to ensure optimal triage and clinical care processes and dispositions. Equally the regulatory, scrutiny and improvement roles of Healthcare Improvement Scotland and the Care Inspectorate should combine in common cause to ensure the quality and safety of OOH and urgent care throughout Scotland. The imperative of health intelligence cannot be understated and NHS NSS should continue to develop its role and aspirations at national and local levels. The Scottish Health Council should continue to promote best engagement of the people of Scotland in participating and shaping future care services, including self care and best use of urgent and emergency care services. A further proposal was for the Scottish Government to carefully consider optimal governance arrangements for NHS 24, SAS and NHS NSS, in the light of the recommendations of the Review (Recommendation 23).

Chapter 12 – Role of the Third and Independent Sectors and other Agencies

Both the third and independent sectors are significant contributors to OOH care services. The third sector very often attends to particularly vulnerable members of society. The third sector submitted a paper for the Review as did the independent sector via Social Care and both offered recommendations. Many of the proposals by Social Care have been assimilated by generic OOH services recommendations made by the Review. The principles offered by the third sector, several of which were cross-cutting, were considered and with minor changes, were assimilated into the Review recommendations – issues of role awareness, improved intelligence, better inter-sectoral governance, sustainable funding and enhanced inter-sectoral communications were raised.

The assets and future role of the Scottish Fire and Rescue Service should have more prominence in relation to health and social care provision, particularly in their prevention and first responder roles and co-responder roles, in close partnership with SAS. This has immediacy for community cardiac arrest events with cardiac defibrillator equipped vehicles.

Royal National Lifeboat Institution (RNLI) lifeboats may be deployed for evacuation of urgent cases from remote islands when alternative transport arrangements are unavailable or inappropriate, particularly in adverse weather conditions. Where there are working linkages between the RNLI, SAS and HM Coastguard, these should be supported by a formal Memorandum of Understanding.

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The Review heard concerns about capacity and co-dependency of GP personnel across OOH primary care, prisoner care and forensic medical services. The Review was unable to pursue this further, in the available timeframe and therefore recommends that further work should be considered of the issues concerned. This would include better use of telehealth, linked electronic records, quality assurance of OOH services for prisoners, and exploration of the potential for advanced practitioners for clinical forensic services (Recommendation 24).

Chapter 13 – Promoting Person-Centred Care

The first guiding principle of the Review was that optimal OOH care should be person-centred in terms of those who receive care and those who deliver it. Much of the focus of the Review has been on valuing staff. It is appropriate that we return full circle to person-centred care for the people of Scotland. It is a compelling principle which must be heeded:

- Helping people and their carers to be informed and engaged through education, information sharing, addressing health literacy needs, emotional and psychological support
- Helping the professionals to be enabling and collaborative, through leadership, communication skills, training and reflective practice
- An organisational infrastructure that promotes continuity, ease of access, customises time according to need, IT support and service design
- Rich social support, relationships and sustained resources in our communities that keep people well.

There is an opportunity to develop OOH and urgent services that are responsive to the self-management and health literacy needs of people. The rationale and recommendations for these are set out in Scotland's national health literacy action plan Making it Easy and are wholly endorsed by the Review (Recommendations 25 and 5,6,7).

Chapter 14 – Research and Evaluation

The Review commissioned a rapid systematic review of the international literature, and focus group research from the Scottish School of Primary Care and undertook separate survey work (Annex F) and available n full on the Review website.

During the course of this systematic review yielding 274 research papers for scrutiny, a paucity of robust evaluation of models of OOH services was found.

The lack of relevant published literature and planned service evaluations in OOH services have significantly hampered understanding of best practice. Future research and development (R&D) support should inform and evaluate new models of OOH and urgent care services, including economic assessment (Recommendation 26).

Chapter 15 – National Implementation Plan and Local Guidance

The Review has proposed 28 recommendations covering new models of care, workforce - including increased multidisciplinary capacity and capability, quality and safety, data and technology, responsibilities and leadership and enhanced roles for statutory authorities, third and independent sectors and other agencies. These are ambitious - but reflect extant and looming challenges of demographic change, increasing multimorbidity, complexity and rising service demands. The recommendations offered reflect the imperative of transformational rather than incremental change. Careful reflection on the recommendations is therefore essential for all stakeholders at national and local levels. This is amplified by financial constraints and the need to maximise benefits, as discussed in Chapter 16. Set in the context of early and evolving health and social care integration, implementation of the recommendations in the Review will require inter-sectoral collaboration of a very high order. Careful, considered and resolute preparation of quality assured implementation planning is vital at both national and local levels (Recommendation 27).

Chapter 16 – Finance and Best Use of Resources

Recognising significant financial challenges in the next 10 years it will be particularly important that all services produce increased efficiency and productivity in order to deliver safe, high quality person-centred care. Increased investment in primary care OOH and urgent care services specifically will need to demonstrate best value for money and areas of disinvestment pursued. Particular areas for resource allocation

are identified where maximising service benefits will be essential including: Urgent Care Resource Hubs, Urgent Care Centres, eHealth, workforce capacity and capability, SAS in synergistic working with NHS24 and SAS strategic aspirations (Recommendation 28).

Chapter 17 - Conclusions

28 recommendations and a number of sub-recommendations are presented for consideration and reflection. They embrace new models of care, the needs of specific groups, enablement and empowerment, accessibility, health literacy, inequalities and the promotion of person-centred care. Workforce issues occupy a number of our recommendations -capability, capacity, challenges and the need for unprecedented primary care workforce planning at national and local levels with a key focus on valuing, supporting staff throughout their careers. Better quality and safety are essential for optimising patient care and this will be underpinned by better use of and access to electronic records, telehealth, telecare and mobile applications caring for our patients and the people of Scotland, supporting self-care where appropriate and ensuring best access to services when needed. A number of recommendations are made about the future roles of the third and independent sectors and other agencies, the leadership roles of Health and Social Care Partnerships and Integrated Joint Board, and the support roles of Special Health Board and Boards. Recommendations for research and evaluation are mooted and there is a strong emphasis on shared inter-sectoral planning at both national and local levels with the key imperative of ownership. The final recommendation addresses finance and best use of resources.

Community Pharmacy Team at work

3 Recommendations

Purpose: This section reproduces the list of recommendations in the Full Report. The list is lengthy and ambitious, but reflects the need for trans-sectoral transformational, rather than incremental change.

Recommendations 1-4: reflect the need for better, innovative models of care which will improve coordination, communication and more effective multidisciplinary care across the care sectors.

Recommendations 5-7 address the need for patients to know how to make best and responsible use of services, according to need and to support best self-care, where appropriate. The needs of some specific groups are addressed, including accessibility and heath inequalities issues.

Recommendations 8-19 reflect the need for compelling and pressing action to shore up and rapidly enhance the capability of an increasingly diverse and multidisciplinary workforce. We must work and learn together more closely and effectively around the needs of patients and carers, in common endeavour. Joint organisational development programmes will be a key component.

Recommendation 20 makes recommendations of how we must improve quality and safety of OOH services, underpinned by a clear service specification.

Recommendation 21 calls for better access to electronic patient records across all sectors to the right information, for the right patient is available at the right time. Confidentiality and security must be assured at all times but we are equally obliged to make best use of information for best patient care.

Recommendations 22-24 addresses potential future roles of Health and Social Care Partnerships and Integrated Joint Boards, Special Health Boards and Public Bodies, the third and independent sectors and other agencies.

Recommendation 25 seeks to how best to promote person-centred care, health literacy and self management.

Recommendation 26 recognises the lack of good research and evaluation into OOH services and urgent community care and emphasises the need for robust evaluation of new developments.

Recommendation 27 robust national planning, replicated locally will be essential to prioritise plans for the development of future OOH and urgent care services.

Recommendation 28 considers finance, best use of resources, value for money and benefits realisation.

Recommendation 1 - A New Model of Care for Out of Hours and Urgent Care Services

1. It is essential that a whole system, holistic approach is taken for the provision of 24/7 urgent and emergency care for the people of Scotland. Whilst this review has as its core remit a review of out of hours (OOH) primary care services, the model described here takes account of potential future requirements of 24/7 urgent care in the community. This includes the roles of NHS 24 and the Scottish Ambulance Service (SAS), and the key interface with emergency departments/A&E services and acute hospitals, set in the context of health and social care integration.

2. In keeping with the *2020 Vision* for the people of Scotland, for adults and children with urgent care needs, a safe, effective and responsive service must deliver care as close to home as possible for patients, carers and families.

3. In order to achieve that services should:

    - provide better support for people to self-care, when appropriate
    - recognise more the crucial role of carers and to support them to care for their dependants
    - help those who need urgent care to obtain the right advice and support, in the right place, at the right time
    - provide consistent and responsive urgent care services on a 24/7 basis

4. A framework for a new model of OOH and urgent care services across Scotland that is:

    - multi-disciplinary and multi-sectoral
    - person-centred, intelligence-led, asset-optimised and outcomes-focused
    - underpinned by a robust infrastructure that is fit for purpose and clinically safe
    - designed to deliver consistent high quality care supported by a clear service specification

Recommendation 2 – Future Synergy of NHS 24 and the Scottish Ambulance Service

1. NHS 24 and the Scottish Ambulance Service (SAS) presently operate separate triage processes for callers seeking help and assistance. Greater synergistic working should occur between NHS 24 and SAS to improve patient pathways of care. A joint review of all clinical triage processes, pathways and dispositions, is recommended, involving independent experts.

2. NHS 24 should rapidly develop a five year strategy and implementation plan, which maximises and quality assures the functionality of its services and infrastructure. This should include digital innovation by the Scottish Centre for Telehealth and Telecare, taking into account the particular needs of urban, remote and rural communities. The optimal deployment and location of staff, including exploration of working from home options should also be considered.

3. SAS should continue to implement its community care outreach aspirations in its strategy *Towards 2020: Taking Care to the Patient*, ensuring and maximising service benefit and best use of resources. Paramedical practitioners (paramedics) are currently supporting OOH services in a number of models across Scotland and an early review, aimed at organisational learning and governance arrangements, is proposed (Recommendation 14). The development of additional urgent care capacity in SAS should be pursued, while ensuring that further improvements in emergency care are also delivered - including the role of SAS in Scotland's *Out of Hospital Cardiac Arrest Strategy*.

Recommendation 3 - Urgent Care Resource Hubs

1. Coordinating urgent care: The future model proposed by this Review is based on the development and evaluation of Urgent Care Resource Hubs, co-ordinating well-led and well-supported multidisciplinary health and social care teams to deliver urgent care – including third and independent sector providers.

2. 24/7 urgent care: Although primarily established for OOH service requirements, these Urgent Care Resource Hubs should be considered for coordination and support of urgent care on a 24/7 continuous basis.

3. Electronic records and anticipatory care plans: Urgent Care Resource Hubs should have secure and confidential access to appropriate electronic records to support optimal decision making about the needs of patients -

particularly those with complex or enduring physical or mental health conditions, and their carers. This includes access to third sector electronic databases, including ALISS (A Local Information System for Scotland). This should also be enhanced by more systematic locality and general practice anticipatory care planning (Recommendations 6 and 21).

4. Location and capacity: The location and capacity of these Resource Hubs should focus on Health Board area and locality requirements but should also take account of inter-Board patient flows. Economies of scale and critical mass should also be considered and therefore regional coverage may be appropriate for example, for the Highlands and Islands.

5. Effective communications: Urgent Care Resource Hubs would operate on the basis of a single point of contact, to streamline best professional-to-professional communications.

6. Asset optimisation - managing demand and supply: These centres should keep continuously updated about service demand and all available staff and care resources, including: care at home, acute hospital and community/ intermediate care beds/resources (community hospitals, residential nursing and care homes), status and location of third and independent sector services, hospital-at-home and rapid response teams provision, and the operational status of all general practices and community pharmacies. This should add to resilience and result in more effective and rapid deployment of resources.

7. The Scottish Ambulance Service is presently and continuously aware of the operational status and whereabouts of all their vehicles. This capability needs to be extended both nationally and locally to underpin resilient services and best use of available human and physical resources. Other asset mapping capacity is already happening in SAS in relation to BASICs doctors, community first responders and the location of publically accessible heart defibrillators. This asset based collaboration with the Scottish Fire and Rescue Service underpins present cardiac arrest co-response pilot studies (Recommendation 24).

8. Training and learning function: Urgent Care Resource Hubs are a potential platform for shared learning across sectors. The design and implementation of these hubs should be considered in developing this approach.

9. Care pathways: Local care pathways need to be developed, clearly understood and effectively implemented, particularly at the interface between

urgent community care services, emergency departments, other acute hospital services and the Scottish Ambulance Service. Clinical decisions should be supported by directly accessible professional-to-professional advice arrangements when required.

10. Remote and rural challenges: Developing robust pathways of care is particularly crucial for remote, rural and island communities with unique challenges of geography, population sparsity, workforce recruitment constraints and poor mobile and broadband connectivity (Recommendations 6, 21 and 24).

11. Potential public health role: In addition to their core role in coordinating day-to-day urgent primary care activity, Urgent Care Resource Hubs might be considered, suitably augmented, for a coordinating role in relation to responding to significant public health emergencies such as communicable disease outbreaks (including the interface with Health Protection Scotland and the support of civil contingency emergencies).

12. Evaluation: This proposed new model, which significantly builds upon existing administrative functions for OOH services, requires robust piloting and evaluation in order to inform future progress and development.

Recommendation 4 - Urgent Care Centres

1. Urgent Care Centres (presently described as Primary Care Emergency Centres), should be developed to deliver local OOH urgent care services. They should be fit for purpose, technologically enabled and robustly networked to an Urgent Care Resource Hub.

2. Urgent Care Centres should be safe and secure environments which are appropriate for the optimal care and wellbeing of patients, multidisciplinary care teams and volunteer workers.

3. Urgent Care Centres should normally be configured as both clinical and educational environments, to facilitate training and learning.

4. Urgent Care Centres should be located in the right place, taking due account of transport and travel factors for patients and staff, in order to optimise both access for the public and resilience for the service. They may be co-located with Urgent Care Resource Hubs, emergency departments or minor injury units, providing opportunities for collaboration, co-working and co-production,

encouraging patients and carers to use the service best suited to meet their needs.

Recommendation 5 - Public Awareness, Support and Best Use of Services

1. OOH services remain poorly understood across Scotland both by the public and by professionals, often resulting in people finding it difficult to know where to seek advice or to go with their urgent care requirements. This has at times, resulted in poor alignment of services with clinical needs. In order to enable optimal person-centred care, it is recommended that a specific and sustained high profile campaign and programme be developed to promote public awareness and engagement, using models of best practice. This includes learning through experience of using urgent care services (experiential learning).

2. In addition to enabling better care, and assistance for carers, this programme should promote best access to, and effective use of urgent and emergency services, including clarity of the terms ‘urgent’ and ‘emergency’ care. This should also include meaningful participation of the public in the shaping and delivery of locality based services, innovative use of digital technology, websites and development of relevant mobile applications (Recommendation 21). International experience should also be assimilated, including the Nuka programme in Alaska.

Recommendation 6 - People with Specific Needs

1. It is essential that people with specific needs receive appropriate care and support. Recommendations are therefore made about a small number of groups with specific needs: Children; Palliative Care; Mental Health; Frail and Older People and those with Special Access Requirements. This is preliminary work only and should be developed further. Condition-specific local care pathways and care provision, for example for patients with cancer or chronic obstructive pulmonary disease, should also be considered.

2. People should be supported to access resources to prevent escalation or deterioration of their health problems, including comprehensive implementation of anticipatory care plans.

Palliative Care

1. People at the end of life and their carers should be able to directly access care and assistance, by local helpline on a 24/7 basis, without recourse to national NHS 24 triage - in order to secure swift, effective and compassionate care.

2. Palliative care patients and their carers should have extended access to responsive and timely community nursing support, including Macmillan and Marie Curie nurse practitioners, alongside allied health professionals (AHPs), as required.

3. Local care pathways for palliative care should be developed systematically, be clearly understood by service users and providers, implemented effectively, and quality assured. There should be an emphasis on home, and hospice care at home support, wherever possible.

4. All of the former recommendations to be underpinned by safe and secure shared electronic records and comprehensive anticipatory care plans (Recommendation 21).

Mental Health

1. Psychiatric urgent care and emergencies must be prioritised no less than physical conditions.

2. The work of the Mental Health Scottish Patient Safety Programme around transitions of care should continue to ensure that all transfer arrangements are appropriate, and where delivered by SAS, this is done in a timely fashion, irrespective of location. The challenging area of air ambulance and other reliable transport support for remote locations should be part of this work

3. Distress Brief Interventions should be piloted and evaluated to determine their benefits.

4. Health and Social Care Partnerships and Integrated Joint Boards (IJBs) should work with partners to make available more community-based places of safety for people experiencing mental health crisis or who are under the influence of drink or drugs to avoid the default use of custody suites or emergency departments where these are not appropriate locations for their care and support. This will require close collaboration between statutory, third and independent sector assistance, particularly with the support of Police Scotland.

Frail and Older People

1. Daytime and OOH services should be configured and responsive to the growing numbers of frail and older people in Scotland, many with complex conditions.

2. The access needs of frail and older people should be carefully addressed in future provision of urgent care and OOH services (see Special Access Requirements below).

3. Anticipatory care planning should be implemented systematically, taking best account of the needs and wishes of frail and older people, their carers and families (Recommendations 2 and 21).

4. Care homes should be able to access a wider set of community supports to reduce avoidable admissions of older, frail people from this sector in the OOH period.

5. The care of frail and older people - who have the misfortune to fall and are unable to resume their previous position unaided -.is variable. A minority (7 of the 31) Integrated Joint Boards in Scotland at the time of writing of this report have agreed and implemented systematic plans to respond to the needs of uninjured people who fall. This should be remedied as a matter of urgency, in the context of the *Prevention and Management of Falls in the Community Framework for Action 2014-16*.

Children

1. GPs, advanced nurse and paramedical practitioners, should have rapid access to telephone advice from paediatric specialist staff during daytime and OOH periods.

2. GP, advanced nurse and paramedical practitioner training, should include a strong focus on paediatric clinical skills.

3. The NHS Inform (NHS 24) website should have a clearly signposted section on young children who become unwell with common causes and suggestions for parents as well as primary and secondary school staff and others caring for children. This should be extended to the development of appropriate mobile applications (Recommendation 21).

4. NHS 24, territorial Health Boards and Integrated Joint Boards (where children's services are delegated) should continue to work together to

develop local urgent care pathways for children, and to ensure they are effectively implemented in accordance with the principles of *Get it Right for Every Child* (GIRFEC).

5. Regular local interactive multidisciplinary educational sessions - supported by consultants with paediatric responsibilities, should be encouraged and resourced to facilitate clinical quality improvement and service development

Special Access Requirements

1. The needs of individuals with special access requirements should be carefully addressed in future service provision, in particular for people with sensory or other physical impairments, people whose first language is not English and people who are frail, older or who have dementia.

2. Access to services may also be compromised by poor literacy, poverty constraints, telephone or IT/computer access issues, additional support needs and travel difficulties, particularly in remote and rural areas where transport - including local community arrangements - should be configured to support equity of access in the OOH period (Recommendation 7).

Recommendation 7 - Health Inequalities

1. The design and implementation of all OOH services should demonstrate how they are ensuring equity of access and outcome, in proportion to the levels of need for everyone who presents with an urgent healthcare requirement.

2. Service specifications for delivering OOH services should take account of social as well as clinical needs of the population they serve. Quality and safety implementation and monitoring of OOH services should be assessed for their impact on health inequalities.

3. Current primary care resources for general practices are maldistributed by health care needs, according to socioeconomic status (McLean et al). Levels of multimorbidity increase with increasing deprivation. This should be taken into account, when configuring future daytime and OOH service provision, including the experience of ‘Deep End’ practices.

Recommendation 8 - Effective Workforce Planning

1. A national primary care workforce plan should be developed and implemented without delay – including enhanced and sufficient training places for future

GP, nursing, pharmacy and AHP workforce requirements, for both daytime and OOH primary care services. This should also include re-appraisal of the specific contributions of, and recruitment by: Medical Schools, Schools of Nursing, Schools of Pharmacy, the Scottish Ambulance Academy, educational providers for other Allied Health Practitioners, social services workers, and the key role of NHS Education Scotland (NES).

2. Robust workforce planning also needs to be urgently replicated at NHS Board, local authority and Health and Social Care Partnership and IJB levels, in order to secure a sustainable and empowered multidisciplinary workforce for the future in the short, medium and longer term. These workforce plans need to be continuously kept under review. Robust workforce planning needs to be in place and include organisational development strategies that support the delivery of future models of care.

3. An organisational development (OD) approach should be adopted that supports a better understanding of role/task across professions/sectors to determine where there is a need to do things differently. This would support the development of multidisciplinary/multi-sectoral teams with the potential to up-skill the workforce to undertake more enhanced roles, where appropriate, and with the training and support to do so. This should enhance the capacity to create teams that get the right support to people at the right time. This extends to the role of carers, third and independent sectors, given the important contribution they make to supporting people in communities.

Recommendation 9 - Interdependent Linkage between Daytime and OOH Services

1. Daytime primary care and OOH services are inextricably linked. A robust inter-relationship between daytime provision and OOH care needs to be in place to enable reciprocal support systems and processes to operate effectively. In particular, it is important that any changes made to OOH services do not destabilise daytime provision or the converse, and that the resilience of both are strengthened. The same principle applies to the interface between community, primary care and acute hospital services.

Recommendation 10 - The Importance of the Working and Educational Environment

1. Capability: Sustainability of the OOH service requires continual training and experiential learning opportunities for new and future clinical and care staff.

In particular, this includes doctors in training and those training for advanced practitioner roles in nursing and the allied health professions. A positive organisational development culture values and sustains quality training in environments that are safe for patients and supportive both for learners and educators.

2. Capacity: Achieving the above conditions requires adequate numbers of clinical staff to engage in these important roles and workforce levels should be commensurate with this requirement.

3. Career development: While necessary, it is no longer sufficient to provide exemplary undergraduate and postgraduate training for practitioners. Provider organisations must focus greater attention on optimal use of the workforce, irrespective of stage of career. This should take the form of career development support, better succession planning and could help to improve job-fulfilment and staff retention. This is a generic recommendation which applies both to daytime and OOH services and to all care sectors, including acute hospital care.

Recommendation 11 - Future Contribution of the GP Workforce

1. General Medical Practitioners (GPs), as for all health professionals, should be clinically accountable for the provision of safe effective and patient centred care. They should work within each locality and their OOH service to secure:

    - Longitudinal care and continuity of relationships where this is important
    - Access to care at the right time when it is required

2. Contracts: Appropriate engagement, contractual arrangements and best practice should be in place to enable and incentivise these new commitments in order to improve access to services and encourage more flexible working, as capacity allows. Key to this is flexibility about timing and duration of shift patterns, superannuated/non-superannuated contracts, indemnity provision and development support, as required. This includes adequate recognition and support for GPs who continue to provide 24/7 care for their patients, as occurs in some remote and rural areas. This same principle applies equally to all members of multidisciplinary teams undertaking new or extended roles.

3. National GP Performers' List: Arrangements should be put in place to streamline this process and effectively create a National GP Performers' List to enable GPs to work flexibly across Health Board boundaries.

GP Specialty Training: *Shape of Training: Securing the future of Excellent Patient Care* (The Greenaway Report) proposed that GP specialty training should be enhanced. The RCGP have recommended that this be achieved by a fourth year of training. However there has been a lack of progress to move to an enhanced four year training programme on a UK wide basis. GPs at completion of their certificate of training (CCT), after three year specialty training are competent, but may feel insufficiently experienced. This may be contributing to a reluctance to undertake OOH work. Existing four year training posts in Scotland should be reviewed to ensure the experience maximises educational opportunities for the future GP workforce. In the meantime newly qualified GPs should be offered a salaried one year post, which will include OOH work with enhanced support and continuing professional development (CPD) in OOH medical care.

4. OOH Commitment from GPs: RCGP Scotland and the Scottish General Practitioner Committee of the BMA submitted a joint principle to the Review that it is a core professional value that GP care in the community is available at anytime and it is essential that GPs remain a central part of OOH services to ensure holistic, coordinated patient care. GPs should be encouraged and enabled to contribute a proportion of work in OOH services. GPs within five years of completing their CCT and those returning to work in OOH services after a service break, should receive help and support from a GP mentor.

Recommendation 12 - Future Contribution of the Nursing Workforce

1. Advanced Nurse Practitioners: Advanced Nurse Practitioners (ANPs) have a significant contribution to make in delivering sustainable and consistently high quality OOH care. It will be important o ensure that there are sufficient ANPs, who can work to their maximum potential. The results of the Chief Nursing Officer's (CNO's) review of ANPs should inform delivery and improvement of these services and is due in April 2016.

2. A national definition of advanced nursing practice should be developed which will support better and consistent understanding of the scope and responsibilities of their role, including independent prescribing.

3. Consistent standards for the training and education of all ANPs and clear nursing career development pathways should be designed.

4. A model role descriptor and an agreed set of national ANP competencies for different fields of practice will ensure that the level of practice of ANPs is recognised consistently across Scotland within the terms of *Agenda for*

Change, for both the current and future workforce. There should be national consistency in definitions, roles, education (including fast tracking) and remuneration. This is required for good governance and service monitoring.

5. District Nursing: The CNO's current review of district nursing contributions includes a specific focus on their role in OOH services. The role of district nurses is essential to support 24/7 community healthcare. The review is seeking to underpin a nationally consistent district nursing role, were nurses have the capacity, capability infrastructural support and access to resources, enabling to meet patient need. The CNO's review is expected to report in April 2016.

6. Health Boards should consider the full range of options at their disposal to deal with recruitment and retention issues within their nursing workforce to ensure sustainable OOH services. This could include the use of temporary measures such as recruitment and retention premia to fill hard-to-recruit-to posts. Nurses should have access to relevant resources and support to effectively deliver their roles.

Recommendation 13 - Future Contribution of the Pharmacy Workforce

1. Community pharmacies throughout Scotland make an essential contribution to care both in daytime and during the OOH period. Community pharmacies should have a greater profile and urgent care role going forward.

2. Electronic Record Access: In order to undertake their role effectively, they will require protocol-driven secure access to electronic patient information to underpin best care and to facilitate optimal communications with other health services.

3. Minor Ailments Service: Greater public awareness and use of the Minor Ailment Service (MAS) should be encouraged in community pharmacies to advise and treat these and other common clinical conditions.

4. Patient Group Directions: Extension of the community pharmacy patient group directions (PGDs) to enable assessment and management of a broader range of common clinical conditions should be carried forward.

5. Enhanced Clinical Skills: The developing role of pharmacists with additional clinical skills and prescribing capability should be further encouraged and utilised, including their role in OOH services and within NHS 24. This will require appropriate educational and training support.

6. These recommendations, including the extended set of recommendations provided jointly by Community Pharmacy Scotland, Health Board Directors of Pharmacy and the Royal Pharmaceutical Society Scotland, should be taken forward in the context of the *Prescription for Excellence* strategy for pharmaceutical care in Scotland.

Recommendation 14 - Future Contribution of the Paramedical Workforce

1. Paramedical practitioners (known as paramedics) and specialist paramedical practitioners currently make a significant contribution to urgent care 24/7 in all communities in Scotland. In the future they should have a more substantive role in working with other colleagues including GPs, ANPs, community nurses, AHPs, clinical pharmacists, physician associates and social services staff to ensure the delivery of consistently high quality OOH urgent and emergency care. These roles are described in the forward strategy of SAS: *Towards 2020: Taking Care to the Patient.*

2. A clear description of the training and competency framework of specialist paramedical practitioners should be developed which should support better and consistent understanding of the scope and responsibilities of the role.

3. Consistent standards for the training and education of all paramedical grades should be prepared

4. Clear paramedical career development pathways should be designed.

Recommendation 15 - Future Contribution of Allied Health Professionals and Physician Associates

1. In addition to paramedical practitioners, other Allied Health Professions (AHPs) have key and developing roles in the effective management of patients to ensure that they receive the most appropriate urgent care in a community setting. This includes AHPs supporting the work of NHS 24 - for example physiotherapist input to musculoskeletal disorders.

2. AHPs have a particularly important role to play in integrated community rehabilitation teams, maximising the potential of prevention and planned care to pre-empt avoidable urgent care and hospital admission. That role will require flexible access to services, including weekend working.

3. AHPs should play a leading role in the implementation, spread and sustainability of the *Falls Up and About* pathway, to aid early identification of triggers for repeat falls/attendees (Recommendation 6 – Frail and Elderly).

4. As urgent care develops, it is likely that point-of-care testing (POCT) will increasingly be deployed. AHPs will have an important role in cost-effective implementation and. governance.

5. The role of physician associates (PAs - also known as physician assistants) who work for, and with doctors, should also be considered for inclusion in the required skill mix of the future clinical workforce.

Recommendation 16 – Future Contribution of Social Services Workforce

1. The Social Service workforce will have key and developing roles in supporting individuals to ensure they receive the most appropriate support in a community setting.

2. Along with other members of inter-sectoral teams, they will continue to play key and developing role in the prevention of, and response to falls in the community and other urgent care needs – for example via the community alarm system. In the future this should include other forms of innovative remote monitoring via telecare, video-linking and mobile applications (Recommendations 15, 21).

3. Learning and development programmes should be inter-professional for all practitioners and be embedded within formal performance and development plans.

Recommendation 17 - Working and Learning in Professional Partnership

1. As health and social care partnerships continue to develop their role, OOH social services will work more closely with clinical services and these professional links should be strengthened. This becomes an integral part of client/patient support wherever and whenever needed.

2. Inter-professional learning should become normal practice and there should be a clear and consistent education and training programmes for all practitioners working at advanced practice level, irrespective of discipline, which includes academic and experiential learning, and practitioners should have annual appraisals, including a review of skills.

Recommendation 18 – Valuing Support Staff

1. The importance and value of support staff who currently lead the planning, logistics and resourcing of OOH services should be better recognised and valued by NHS Scotland. This includes: administrative, managerial, control room and technical staff, receptionists, call handlers and drivers.

2. As for the nursing workforce, Health Boards, Local Authorities, Health and Social Care Partnerships and IJBs should consider the full range of options at their disposal to deal with recruitment and retention issues to ensure a sustainable OOH service (Recommendation 16).

Recommendation 19 - Leadership

1. In order to implement the recommendations made by the Review, strong leadership will be crucial at all levels, supported by professional managerial and support staff. Sufficient leadership calibre, capacity and training are essential in order to shape and lead the future development of urgent care services both locally and nationally

Recommendation 20 – Quality and Safety

1. This recommendation reflects the guiding principle that future models of OOH and urgent care should be outcomes-focused.

2. Quality and safety are central for the future development of OOH and urgent care services. All care sectors should place sufficient priority on the delivery, improvement support and monitoring of quality and safety for these services.

3. The new model of service delivery proposed by the Review should be underpinned by a clear service specification. This should be rapidly developed by Healthcare Improvement Scotland in collaboration with key stakeholders.

4. Existing standards and indicators should be revised to support future OOH and urgent care service specifications, incorporating both patient/carer outcomes and staff experience. This should take full account of individual care needs, including health inequality issues.

5. OOH and urgent care services should be incorporated as a key focus of proportionate and risk based quality of care scrutiny reviews by Healthcare Improvement Scotland and the Care Inspectorate.

6. Health Improvement Scotland should be commissioned to undertake a scoping exercise of improvement support requirements for OOH and urgent care services at national and local levels, in liaison with the Care Inspectorate.

7. Quality governance systems embrace quality planning, quality improvement, assurance and accountability. OOH and urgent care services should reflect best practice across all care sectors.

8. A national multi-sectoral Quality Governance Group should be established to oversee quality and ensure that standards are being set, met and support continuous improvement in OOH and urgent care services. This Group should also actively promote the sharing of best practice throughout Scotland.

Recommendation 21 – More Effective Use of Data and Technology

1. This recommendation reflects the guiding principle that future models of OOH and urgent care should be intelligence-led.

2. Improved Information Technology (IT) and eHealth systems will help to deliver many of the recommendations made by the Review and take into account the aspirations of the *Scottish eHealth Strategy 2014-17.*

3. A consistent view is required of all relevant health and social care information necessary to provide optimal OOH and urgent care. Subject to agreed consent, this information should be available securely to the right people at the right time, irrespective of care setting and location.

4. Consistency of data sharing should be improved and should underpin better person-centred care. All health and social care stakeholders should agree a common summary of defined data items and updating protocols.

5. Current referral records and mechanisms are fragmentary and are often still paper based. Referrals from OOH services to all care sectors should be electronic and fully auditable, in order to ensure effective and timely continuity of care.

6. The NHS NSS National Unscheduled Care Framework presently advises on the procurement of NHS IT systems. In partnership, this framework should now be reviewed in the light of future health and social care integration requirements.

7. A collective service-led review of OOH IT systems currently in use and related governance arrangements is urgently required in order to deliver

national consistency in use and optimisation of individual patient care and information.

8. High quality and reliable video links should be in place between Urgent Care Resource Hubs and local Urgent Care Centres (Recommendations 3 and 4). This technology should also be deployed to support practitioners in remote and rural locations, in intermediate care settings - residential care homes and community hospitals, in the Scottish Prison Service and for mobile healthcare delivered by SAS. The technology may also be appropriate for location in the homes of some patients with complex care needs.

9. The Scottish Centre for Telehealth and Telecare, in collaboration with the Digital Health & Care Institute, should look to support the development and roll-out of proven technologies at scale, including innovation and accredited mobile applications for self-care and access to the most appropriate care services. Such innovation should be subject to appropriate evaluation.

Recommendation 22 – Future Role of Health and Social Care Partnerships and Integrated Joint Boards

1. Strong leadership for urgent care and OOH services will be required from Integrated Joint Boards (IJBs) and Health and Social Care Partnerships going forward. They should place sufficient priority on the delivery, improvement support and monitoring of quality and safety for OOH and urgent care services (Recommendation 20).

2. The strategic planning process of Partnerships and IJBs should look for opportunities for integrated OOH service provision from Local Authorities and the NHS, including co-location opportunities, and the provision of urgent services on a 24/7 basis.

3. Future models of care should meet local need and focus on early intervention and prevention. Opportunities should be sought to build on success where best practice has been demonstrated of integrated multi-disciplinary health and social work teams providing 24/7 services. These should include partnership arrangements with the third and independent sectors.

4. Joint organisational development plans should focus on supporting staff to integrate cultures and ways of working and increase mutual respect between professions. There is a need for learning and development strategies to be in place that support strong distributive leadership across professions/sectors.

These are crucial factors if effective co-working is to become embedded across Health and Social Care Partnerships and IJBs.

Recommendation 23 – Future Role of Special Health Boards and Public Bodies

1. NHS National Services Scotland should play a lead role in interpreting and delivering the Review recommendations from a public health intelligence perspective at national and local levels, in active collaboration with territorial Health Boards. This includes live operational use of intelligence, as well as for strategic planning, service monitoring and development purposes. Work is already in progress on this, including the development of a health and social care dataset at individual patient/service user level to inform local strategic commissioning. This needs to be coordinated across all urgent care sectors, not just the NHS, and conforms to the principle of intelligence-led services (Recommendations 1,3,21).

2. NHS 24 and the Scottish Ambulance Service should be encouraged to work together more closely across all their processes, with a view to improving effectiveness and efficiencies of the patient journey of care in order to deliver best outcomes (Recommendation 2 - see also for NHS 24 Recommendation 21).

3. NHS Education Scotland should continue to deliver the lead role in developing training and leadership support for a reconfigured clinical workforce, in order to secure optimal urgent care for the people of Scotland (Recommendations 8-19).

4. NHS Health Scotland should lead the delivery of a health inequalities impact assessment process, following assimilation of the recommendations from this Review. This contribution should also inform supported self care and best use of health and care services, with a view to best patient outcomes and narrowing health inequalities (Recommendation 7).

5. Healthcare Improvement Scotland should strengthen its support for quality improvement approaches and resources applicable to urgent care in the community, in active and synergistic collaboration with the Care Inspectorate. (Recommendation 20).

6. The Scottish Health Council should continue to promote best engagement of the people of Scotland, in participating and shaping future care services at

national and local levels, including self care and best use of urgent and emergency care services (Recommendation 5).

7. In light of the recommendations made in this Report, the Scottish Government should carefully consider optimal governance arrangements of the national services provided by NHS 24, SAS and NHS National Services Scotland.

Recommendation 24 – Future Role of the Third and Independent Sectors and other Agencies

1. The future role and contribution of the third and independent sectors and other agencies should be clarified and expanded, as appropriate, according to defined needs. These should take into account the following principles:

- Improve understanding and support for their contribution to OOH and urgent care services, prevention and self management
- Improve intelligence about their contribution to Scotland's health and wellbeing in both daytime and OOH services
- Explore models of governance in statutory and non-statutory organisations to ensure a person-centred safe and effective service
- Health and Social Care Partnerships and IJBs should explore models of funding to the third sector to ensure their agreed contribution to both daytime and OOH services is sustainable
- Improve systems for communication and for connecting both statutory and non-statutory providers of care*

Which could potentially be addressed via the Urgent Care Resource Hub model*

2. The future role and assets of the Scottish Fire and Rescue Service should have more prominence in relation to health and social care provision, particularly in their prevention and first responder roles. This has immediacy for community cardiac arrest events, in close partnership working with the Scottish Ambulance Service. The Scottish Fire and Rescue Service is well placed and willing to contribute further to the urgent care and wellbeing of the Scottish people, beyond their traditional roles, including as first responders. Their potential future contributions to prevention and urgent care provision should be carefully considered, defined and valued - including potential involvement in uninjured falls pathways.

3. Where there are working linkages between the SAS, the Royal National Lifeboat Institution (RNLI) and HM Coastguard, these should be supported by a formal Memorandum of Understanding. This is particularly relevant for patient transport/evacuation requirements from island communities - where

alternative transport arrangements are unavailable or inappropriate and in adverse weather conditions. The Review heard concerns about capacity and co-dependency of GP personnel across OOH services, prisoner care and Police Scotland healthcare and forensic medical services. The Review was unable to pursue this further in the available timeframe and therefore recommends that further work should be considered of the issues concerned. In particular, further exploration should be considered of the potential of remote telehealth consultation, electronic national record linkage (Recommendation 21) and quality assurance of OOH services delivered across Scottish prisons (Recommendation 20). In relation to forensic medical services, a multidisciplinary approach should be considered, in keeping with the recommendations for OOH services future development by the Review, in the context of the National Guidance on the Delivery of Police Care Healthcare and Forensic Medical Services (2013).

Recommendation 25 – Promoting Person-Centred Care

1. Individual quality improvements by themselves do little to support self management and there is a growing understanding that a whole system approach that promotes the process of partnership working to plan and coordinate care (care and support planning) is required. Key ingredients include:

- Helping people and their carers to be informed and engaged through education, information sharing, addressing health literacy needs, emotional and psychological support
- Helping the professionals to be enabling and collaborative, through leadership, communication skills, training and reflective practice
- An organisational infrastructure that promotes continuity, ease of access, customises time according to need, IT support and service design
- Rich social support, relationships and sustained resources in our communities that keep people well

2. There is an opportunity to develop OOH and urgent services that are responsive to the self-management and health literacy needs of people. The rationale and recommendations for these are set out in Scotland's national health literacy action plan Making it Easy

Recommendation 27 - Research and Evaluation

1. The lack of relevant published literature and planned service evaluations in OOH services have significantly hampered understanding of best practice. Future research and development (R&D) support should inform and evaluate new models of care, including economic assessment (Annex F). A number of agencies and institutions should be involved. The Scottish School of Primary Care, a funded part of the Primary Care Transformation Programme, should provide an important contribution.

Recommendation 26 - National Implementation Plan and Local Guidance

1. A national implementation plan is recommended, including performance impact, key indicators and timescales. This should include support for local implementation guidance, including a service specification, as local ownership is key for success.

2. The plan should also take account of related work streams already in place and underway, including: the National Clinical Strategy, the Task Force on Sustainability and Seven Day Services, the National Unscheduled Care Programme, the Chief Nursing Officer's Review of Advanced Care Practitioners and District Nurses, the Public Health Review and the eHealth Strategy.

Recommendation 28 – Finance and Best Use of Resources

1. All recommendations offered should be scrutinised for affordability and resource implications. This includes clinical and cost-effectiveness considerations, opportunity costs and potential cost savings.

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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 17 February 2106

Subject: Financial Report 2015/16 as at Period 9 (31 December 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 West Dunbartonshire Health & Social Care Partnership covering the period to 31December 2015 (Period 9).
- An update on the financial planning process for both health care and social care for 2016/17.

2. Recommendations

2.1 The Partnership Board is recommended to note:

- The added complexity of reporting the financial performance of the Community Health & Care Partnership (CHCP) and Health & Social Care Partnership (HSCP) due to the in year establishment of the formal arrangements.
- The contents of the report showing a forecast full year adverse revenue variance of £0.326m and £0.146m for the period from 1 July 2015, highlighting a favourable movement of £341,000 when compared to the previous reporting period forecast overspend of £0.487m.
- The key requirement for the HSCP Senior Management Team to continue to implement the recovery plan to address the projected overspends.
- That elements of corrective actions already in place as described within the report.
- The ongoing requirement to report the financial performance of Health Board Acute Services Set Aside notional budget; and Hosted services covering both Health Board Acute Services and Council Housing services. An update will be provided at the next reporting session for year end purposes.
- The current position regarding capital work progress on projects.
- The agreed position on the allocation of the new social care monies as set out at Para 4.23.

2.2 The Partnership Board is recommended to approve:

- Health Care budget virements of £0.017m as described under section 3.2 of this report.

3. Background

Health Board Budget 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 HSCP budget of £74.970m.

3.2 Since the previous reported budget the following budget adjustments have taken place from period 6 to period 9 revising the budget to £76.918m

Budget at Period 6	**£76.713m**
Additional Allocations of:	
Children's Services Growth Post's (Health Visitor Caseload Review)	£0.034m
Scottish Government – Improve Quality of Care	£0.048m
Ophthalmology quality Initiatives from Acute to Retinal Screening Hosted Services	£0.021m
Specialist Children's Service Paediatrics Family Health Services – GP Prescribing allocation	£0.118m
Deduction of Allocations:	
Transfer Care Home Liaison Nurse post budget to East Dunbartonshire HSCP	(£0.017m)
Revised Budget	**£76.918m**

Council Budget 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 HSCP budget of £61.321m.

3.4 Since the previous reported budget the following budget adjustments have taken place from period 6 to period 9 revising the budget to £60.569mm.

Budget Agreed by Council 6th February 2014	£60.439m
Corporate Council contingency fund transfer Additional costs Kinship link carers	£0.130m
Revised Budget	£60.569m

4. Main Issues

Summary Position

4.1 The West Dunbartonshire HSCP revenue position is reporting for the period 1 April to 31 December 2015 an overspend of £248,300 (0.25%). Contained within the overall revenue position an overspend of £67,400 is reported from 1 July to 31 December 2015 to highlights the HSCP revenue position from the 1 July 2015.

4.2 The HSCP's Health Care budget is reporting a net underspend of £11,200 - 0.02% (£7,300 HSCP) and the Social Care budget is reporting a net overspend of £259,500 – 0.61% (£74,800 HSCP) for the period 1st April to 31 December 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 4.6 and 4.7 of this report. (overleaf)

	Annual Budget	YTD Budget	YTD Actuals	Variance (Period 9)	Variance	HSCP YTD Actuals (July - Dec)
	£000's	£000's	£000's	£000's	%	£000's
Health Care	76,917.5	57,455.4	57,444.2	11.2	0.02%	7.3
Social Care	60,569.0	42,398.5	42,658.0	(259.5)	-0.61%	(74.8)
Total Net Expenditure	**£137,486.5**	**£99,853.9**	**£100,102.2**	**£(248.3)**	**-0.25%**	**£(67.4)**

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 The summary Community Health & Care Partnership (CHCP) revenue position for the period 1st April to 30th June 2105 reported an overspend of £180,900 (0.56%). The revenue position for this period was reported to the Health & Social Care Partnership Board at the November meeting and is currently under review for year end purposes. The final position will be subject to audit approval.

4.5 The full year forecast reports an overspend of £326,400 of which £145,500 is reported from the 1 July 2015 highlighting a favourable movement of £341,000 when compared to the previous forecast overspend position of £486,500. This represents a significant recovery on the previous reported position.

	Variance (Period 3) YTD	Forecast Variance (Period 9) Full Year		HSCP Forecast (Period 6) YTD	HSCP Forecast (Period 9) YTD	Current Forecast Period Movement
	£000's	£000's		£000's	£000's	£000's
Health Care	3.9	15.6		11.7	11.7	0.0
Social Care	(184.8)	(342.0)		(498.3)	(157.3)	341.0
Total Net Expenditure	**£(180.9)**	**£(326.4)**		**£(486.5)**	**£(145.5)**	**£341.0**

Additional detailed breakdown of individual costs at care group level are reported in Appendix 1 and 2 of this report.

Significant Variances – Health Care

4.6 The net underspend position is £11,700. The key areas are:

- **Addictions – Community Services** is reporting an underspend of £34,800 mainly due to vacancy slippage and workforce planning as part of a service redesign review.

- **Health & Community Care** is reporting an underspend of £22,400. However contained within the overall position pressure within Equipu (£118,000) have been offset by underspends within Nursing Pays.

- **Child Services – Specialist** is reporting underspend of £30,600 mainly due to pays underspends reported within CAMHs.

- **Child services – Community** is reporting underspend of £34,600 mainly due to nursing pays slippage.

- **Mental Health – Adult Community Services** is reporting an underspend of £77,000. This is mainly due vacancy slippage and workforce planning as part of a service redesign review.

- **Other Services** is reporting an overspend of £344,800 mainly due to a review of anticipated service pressures within the financial year.

- **Planning Health & Improvement** is reporting underspend of £117,300 due to service plan slippage.

- **GP Prescribing for Partnerships in 2015/16**

  The reported GP Prescribing result is based on the actual result for the month to 31 October 2015 extrapolated to 31 December 2015. To October 2015,

Greater Glasgow & Clyde GP Prescribing is £2m (1.5%) over-spent on a year to date budget of £132.6m.

The £2m over-spend extrapolated to 31 December 2015 results in a forecast year to date over-spend of £2.6m.

West Dunbartonshire HSCP is reporting a £0.463m (3.4%) over spend as at 31 December 2015 based on October dispensing costs, however, under the risk sharing arrangement the over spend has been adjusted to report a cost neutral position in period 9.

The Board is continuing to forecast a break-even position by the end of the financial year, therefore, a cost neutral position has been reported in each HSCP in accounting period 9.

However, there are increasing concerns that a break-even position is achievable and the Board has identified some prescribing related non-recurring funding that will help to offset any over-spends but we are unsure if this will be sufficient given the extreme volatility of GP Prescribing.

The intention is still to maintain the risk sharing arrangement and not to pass any over-spends to the HSCPs in 2015/16 but this will be kept under review in light of the Board's financial 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 HSCP are currently being investigated by Prescribing Advisors.

<u>Significant Variances - Social Care Services</u>

4.7 The net overspend position is £259,500. The key areas are:

- **Strategy, Planning & Health Improvement** is reporting underspend of £57,000 mainly due to service plan slippage.

  At this stage the forecast underspend is £80,000 and is subject to ongoing monitoring and review.

- **Childcare - Community Placements** is reporting a year to date overspend of £62,000. This is due to continuing 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 £82,000 and is subject to ongoing review.

- **Residential Accommodation for Young People with Disabilities** is reporting a year to date underspend of £38,000 due to a client cost increase and increased employee costs due to the use of sessional staff and overtime to cover sickness absence.

  At this stage the forecast overspend is £50,000 and is subject to ongoing monitoring and review of client packages.

- **Children's Residential Schools** is reporting a year to date overspend of £117,000 more than anticipate within the budget due to residential placements of two clients placed in July and October with a further two additional clients placed in December and January of this year. 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 £156,000 and is subject to ongoing monitoring and review.

- **Other Services – Young People** is reporting underspend of £55,000 mainly due to vacancy slippage and payment to other bodies for support services.

  At this stage the forecast underspend is £73,000 for the remainder of the financial year.

- **Residential Accommodation for Elderly** is reporting a year to date overspend of £260,000 due to staff absence cost pressures.

  Ongoing work in respect of absence management to reduce need for cover along with closing units to get numbers down to the levels needed for new care homes has resulted in a £400k drop in staff costs and it is hoped that staffing will come in on budget this year. Despite closing units resulting in lower income there is still a £92k improvement overall since 14/15.

  Robust absence management controls are ongoing in the monitoring of sickness levels and resulted in reduced staff costs. 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 £346,000 and is subject to ongoing monitoring and review.

- **Residential Learning Disability** is reporting underspend of £79,000 due to reduced package costs as a result of a number of clients moving from residential to new housing support accommodation. In addition there has also has been a reduction in number of packages.

  At this stage the forecast underspend is £105,000 for the remainder of the financial year.

- **Physical Disability** is reporting a year to date overspend of £105,000 due to an increase in the number of clients within residential accommodation and increases 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 £140,000 and is subject to ongoing monitoring and review.

- **Homecare** is reporting a year to date overspend of £470,000 due to increased number of homecare hours being delivered based on current client assessed needed. Also higher than estimated overtime and agency usage to cover for sickness and vacancies. Income is also showing an adverse position mainly due to the increase in clients being provided with short term focussed reablement homecare rather than longer term chargeable hours.

  At this stage managers are reviewing best options to achieve maximum staff utilisation and the use of a bank of supply staff has been set up. This will increase the capacity and flexibility of in house hours and reduce the need for overtime / agency staff. This and more efficient work scheduling have already resulted in the reduction of overtime costs within the service. The homecare care organisers are targeting clients who are not currently on a charge in order to increase income levels and reduce the current projected under recovery.

  If absence rates improve and supply staff are utilised it is anticipated that the overspend may reduce further.

  At this stage the forecast overspend is £626,000 and is subject to ongoing close monitoring and review.

- **Addictions Services** is reporting a year to date underspend of £51,000 due to reduced client package costs.

The underspend is forecast at £68,000 by year end which will offset service pressures within the overall HSCP.

- **Other Services** (including HSCP HQ) is reporting a year to date underspend of £221,000 mainly due to anticipated burden incorporated into budgets for some specific clients with no in year requirement due to change in clients' circumstances.

  The underspend is forecast at £383,000 by year end which will offset service pressures within the overall Health & Social Care Partnership.

  Savings Performance to Date – Health Care

4.8 From within NHSGGC Partnerships overall savings plan, West Dunbartonshire HSCP was allocated a local savings target of £0.630m against its directly managed services.

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 HSCP was £1.47m against its Social Care budget.

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 budget remains under pressure, mainly due to the increased level of demands for services. It is anticipated that the actions outlined within section 4.7 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 HSCP's financial performance will be provided routinely.

- The HSCP is reporting a forecast overspend £145,500 from the 1 July to the 31 December 2015. The HSCP 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 a recovery plan in place to address areas of significant overspend reported under section 4.6 of this report.

2016/17 Savings Plan – Health & Social Care

4.14 At this stage the Health Board's Chief Executive has outlined a draft cash-releasing savings target of £69m for 2016/17 based on the latest funding gap.

4.15 For 2016/17 an indicative savings target across all NHSGG&C Partnerships remains under discussion between the HSCP Chief Officers and the Health Board's Corporate Management Team following the Boards confirmed national uplift. It remains an expectation that the level of savings for the NHSGG&C Partnerships will be between £18m-£23m.

4.16 It should be noted that given there are relatively few collective service redesign programmes in place it is likely local savings targets will be higher than in previous years.

4.17 The outcome of this work will be included within the final 2016/17 revenue budget subject to approval of final plans.

4.18 The Council's 2016/17 budget will be formally agreed by Councillors at a meeting on 24 February 2016.

4.19 With respect to both Health Care and Social Care financial planning processes, significant effort has been applied to ensure budget reductions will be obtained wherever possible through service redesign and efficiency programmes.

2016/17 Integration Funding

4.20 The Scottish Government Health & Social Care Directorates has provided £250.0m, to be directed to Health & Social Care Partnerships, to ensure improved outcomes in Social Care.

4.21 The Integration Funding is split into 2 parts:

- £125m to support the aims of integration boards including costs arising from increased demand; also to fund any changes made to social work charging regime; and

- £125m to help local authorities meet a range of existing costs in the delivery of effective and high quality health and social care services. Councils can access up to their share of this £125m though it is expected that this will include the funding of the increase in the living wage to £8.25 per hour.

4.22 In relation to the first £125m funding stream discussions between the S95 officer's of the Council and the HSCP Board concentrated on the demographics around older people and additional costs of £300k already built into the Council's draft budgeted contribution to the HSCP Board for 16/17. It was agreed to allocate funding of £300k to cover the additional costs.

4.23 In relation to the second £125m funding stream the SG has estimated living wage to cost £76m in a full year. This is made up of £20m for Care Homes and previously agreed and implemented, leaving a balance of £56m (full year) for all other care sectors to cover the cost of the new National Living Wage increasing to £8.25 per hour from 1st October 2016. The WDC share of the remaining £49m is estimated at £960k.

4.24 The total allocation share to West Dunbartonshire Council is £4.925m. The £300k and the £960k will be retained by WDC leaving £3.660m allocated to the HSCP, of which £1.5m (share of £76m) would be for living wage and potentially up to £1m would be required re charging changes (worst case if charges were abolished), leaving £1.160m ongoing to fund the strategic priorities to be set out within the HSCP Strategic Plan.

2015/16 Capital Expenditure

4.25 The progress to date of the individual "live" schemes funded within the HSCP is as follows.

4.26 On 23rd June 2015 the Scottish Government announced that a new £19 million **Clydebank Health & Care Centre** would be funded through using the HUB model of Design Build, Finance and Maintain (DBFM). The Health Board - with input from the HSCP's Senior Management Team - has now appointed architects for the project and developed a draft programme for key stages, with an initial agreement currently being completed as per the Scottish Government approval process.

Following a resolution of the ESA (European System of Accounts) 10 asset classification issues, the initial agreements for Clydebank and Greenock will be presented to the Health Board for approval at the same time, and

thereafter formally submitted to the Scottish Government Capital Investment Group as a single "bundle" for consideration. The Initial Agreement for the Clydebank Health and Care Centre was formally presented to and endorsed by the Partnership Board's Audit Committee at its January 2016 meeting.

4.27 The design and construction of replacement elderly care homes and day care centres in Dumbarton and Clydebank areas continue to progress.

Dumbarton – Enabling works were completed on the 16th September to allow the main construction work to begin on the 17th following the completion of Financial Close (FC). The build programme is scheduled to last for 72 weeks and will see the handover of the building to the Council in February 2017. The final price for the Project at FC was £13.170m and as has been previously reported the increase in costs has been due to a number of unanticipated issues associated with the site, requirements associated with planning conditions and significant building cost inflation in the period since the Project was first proposed in 2012. The delays in finalising this Project and achieving FC were primarily associated with the affordability of the Project which has twice been the subject of increased funding bids to the capital programme and has also seen reductions in the number of bedrooms from 90 to 84 as well as the overall floor area of the building (GIFA) and has achieved reductions of costs of over £1.3m in a Value Engineering (VE) Review.

The Project also had to adsorb the (time) impact of the original contractor pulling out and the replacement contractor having to come in and recover some of the work that had already been done, primarily the market testing.

Construction work is currently tracking 2 weeks behind programme due to adverse weather conditions however remains on budget overall. Whilst the completed care home will be handed over to WDC on 7th February 2017 it is not anticipated to be fully operational until 13th March 2017 to allow a 4 week migration period for clients from existing homes.

The development will proceed in accordance with agreed timescale and budget.

Clydebank - Following interviews and a scored assessment with two other Frameworks and the WDC Consultancy Services Team (CS), the Project Board agreed to appoint CS to lead in the development and procurement of the Clydebank Care Home on an open tender D&B basis. The design team has now been appointed and a preliminary order of cost and programme have been shared with the project board. Planning consent will be contingent upon planning approval for the overall Queens Quay Masterplan and the installation of infrastructure works. Planning permission in principle application for the Masterplan was submitted on 30th October 2015 and the long stop date for this being determined is March 2016. Indicative dates for the completion and handover of the care home is currently April 2018. The remaining budget

available for Clydebank of £9.5m is unlikely to be sufficient for an 84 bedded care home and although different planning requirements and construction methodologies will be brought to bear the completion date of 2018 means that the Project will also be subject to the same inflationary pressures as Dumbarton. Consequently it is estimated that an additional budget of approximately £2.4m will be required to complete the Clydebank care home. This increased requirement will be included for consideration within the capital plan refresh to be reported to Council in early 2016. The completed care home is anticipated to be handed over to WDC in April 2018 and become fully operational by May 2018 to allow a 4 week migration period.

The development will proceed in synergy with development of new health centre and in the context of the Queens Quay masterplan and infrastructure projects, albeit any increased budget will require to be approved by Council.

4.28 **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. Final account is now concluded.

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.

4.29 The summary capital expenditure position is reported below within the following table and the significant variances affecting the overall position reported above are monitored routinely as part of the Councils capital planning process.

WEST DUNBARTONSHIRE COUNCIL
GENERAL SERVICES CAPITAL PROGRAMME
ANALYSIS OF PROJECTS AT RED ALERT STATUS

MONTH END DATE	**31 December 2015**
PERIOD	**9**

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	3,378	14%	25,819	2,455	11%
Current Year Financials						
HSCP	7,385	1,956	26%	3,322	(4,063)	-55%

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.

Author: Jeanne Middleton – Chief Financial Officer
West Dunbartonshire Health & Social Care Partnership

Date: 17 February 2016

Person to Contact: Jeanne Middleton – Chief Financial Officer, Garshake Road, Dumbarton, G82 3PU.
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Appendices: Appendix 1 - Health Financial Statement (P9 Budget report)
Appendix 2 - Social Care Financial Statement (P9 BCR)

Background Papers: None

Wards Affected: All

Appendix 1

Health Budget Report – Period 9 (as at 31 December 2015)

Care Group	Annual Budget £'000	Cumulative Budget £'000	Cumulative Actuals £'000	Cumulative Variance £'000
Addictions - Community	1,966.4	1,483.4	1,448.6	34.8
Adult Community Services	11,276.9	8,020.7	7,998.2	22.4
Integrated Care Fund	1,584.3	980.3	980.3	0.0
Child Services - Specialist	1,914.8	1,446.5	1,415.9	30.6
Child Services - Community	2,623.0	1,963.3	1,928.7	34.6
Fhs - Prescribing	17,894.4	13,868.2	13,868.2	0.0
Fhs - Gms	12,138.8	8,996.8	8,996.8	0.0
Fhs - Other	11,185.6	8,418.6	8,418.6	0.0
Hosted Services	878.6	593.4	572.1	21.3
Learn Dis - Community	425.2	354.8	337.3	17.5
Men Health - Adult Inpatient	0.0	0.0	(0.2)	0.2
Men Health - Adult Community	4,631.8	3,464.1	3,387.0	77.0
Men Health - Elderly Services	3,273.8	2,494.6	2,494.5	0.1
Other Services	3,433.8	2,235.0	2,579.8	(344.8)
Planning & Health Improvement	1,152.5	779.3	662.0	117.3
Resource Transfer - Local Auth	7,774.8	5,831.1	5,831.1	0.0
Expenditure	82,154.7	60,930.1	60,918.9	11.0
Addictions - Community	(95.3)	0.0	0.0	0.0
Adult Community Services	(488.1)	(373.6)	(373.6)	0.0
Child Services - Specialist	(784.5)	(482.3)	(482.3)	0.0
Child Services - Community	(373.8)	(133.3)	(133.3)	0.0
Fhs - Other	(974.4)	(787.4)	(787.4)	0.0
Learn Dis - Community	(160.0)	(160.0)	(160.0)	0.0
Men Health - Adult Community	(1,072.3)	(650.8)	(650.8)	0.0
Men Health - Elderly Services	(195.8)	(195.8)	(195.8)	0.0
Other Services	(893.8)	(536.6)	(536.6)	0.0
Planning & Health Improvement	(20.0)	(20.5)	(20.5)	0.0
Resource Transfer - Local Auth	(179.2)	(134.4)	(134.4)	0.0
Income	(5,237.2)	(3,474.7)	(3,474.7)	0.0
West Dunbartonshire Hscp	**76,917.5**	**57,455.4**	**57,444.2**	**11.0**

WfST DUNBARTONSHIRE COUNCIL
REVENUE BUDGETARY CONTROL 2015/2016
HSCP SUMMARY

APPENDIX 2

MONTH END DATE 31 December 2015

PERIOD 9

Actual Outturn 2014/15	Departmental / Subjective Summary	Full Year Budget 2015/16	Year to Date Budget 2015/16	Spend to Date 2015/16	Variance	Forecast Spend 2015/16	Forecast Variance 2015/16		RAG Status
£000		£000	£000	£000	£000	£000	£000	%	
1,002	Strategy, Planning & Health Improvement	1,190	828	771	57	1,110	80	10%	↑
3,580	Residential Accommodation for Young People	3,074	2,429	2,466	(38)	3,124	(50)	-2%	↓
2,876	Community Placements	2,987	2,253	2,314	(62)	3,069	(82)	-4%	↓
1,880	Residential Schools	846	710	827	(117)	1,002	(156)	-22%	↓
3,945	Childcare Operations	3,775	2,875	2,878	(3)	3,779	(4)	0%	↓
3,951	Other Services - Young People	3,952	2,761	2,706	55	3,879	73	3%	↑
6,076	WDC Residential Accom for Older People	5,742	4,338	4,597	(260)	6,088	(346)	-8%	↓
6,531	External Residental for Older People	6,922	5,795	5,777	18	6,898	24	0%	↑
1,390	Sheltered Housing	1,448	1,232	1,222	10	1,435	13	1%	↑
1,107	Day Centres Older People	1,039	781	797	(17)	1,061	(22)	-3%	↓
90	Meals on Wheels	81	55	56	(2)	83	(2)	-4%	↓
278	Community Alarms	146	183	179	4	141	5	3%	↑
3,046	Community Health Operations	2,722	1,956	1,966	(11)	2,736	(14)	-1%	↓
9,476	Residential Learning Disability	9,634	5,099	5,020	79	9,529	105	2%	↑
2,065	Physical Disability	1,968	1,403	1,508	(105)	2,108	(140)	-10%	↓
1,478	Day Centres Learning Disability	1,573	1,150	1,109	41	1,518	55	5%	↑
245	CHCP HQ	320	306	(221)	527	(383)	703	230%	↑
1,603	Mental Health	2,066	993	1,012	(20)	2,092	(26)	-3%	↓
9,878	Homecare	9,853	7,009	7,478	(470)	10,479	(626)	-9%	↓
1,049	Addiction Services	1,230	794	743	51	1,162	68	9%	↑
(100)	Integrated change Fund	0	(547)	(547)	0	0	0	0%	→
61,446	**Total Net Expenditure**	**60,568**	**42,399**	**42,658**	**(260)**	**60,910**	**(342)**	**-1%**	↓

£000	Subjective Summary	£000	£000	£000	£000	£000	£000	%	
36,934	Employee	36,736	26,926	27,095	**(170)**	36,962	(226)	-1%	↓
977	Property	965	636	687	**(51)**	1,029	(64)	-7%	↓
1,431	Transport and Plant	1,186	834	844	**(10)**	1,199	(13)	-1%	↓
1,228	Supplies, Services and Admin	1,125	832	820	**12**	1,109	16	1%	↑
36,674	Payments to Other Bodies	37,453	24,243	24,511	**(269)**	37,811	(358)	-1%	↓
1,345	Other	1,450	1,272	1,378	**(106)**	1,591	(141)	-10%	↓
78,589	**Gross Expenditure**	**78,915**	**54,743**	**55,335**	**(593)**	**79,701**	**(786)**	**-1%**	↓
(17,143)	**Income**	**(18,347)**	**(12,344)**	**(12,677)**	**333**	**(18,791)**	**444**	**-2%**	↑
61,446	**Net Expenditure**	**60,568**	**42,399**	**42,658**	**(260)**	**60,910**	**(342)**	**-1%**	↓

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD AUDIT COMMITTEE

At a Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit Committee held in Committee Room 3, Council Offices, Garshake Road, Dumbarton, on Wednesday, 13 January 2016 at 2.00 p.m.

Present: Ros Micklem (Chair), Gail Casey, Martin Rooney, Heather Cameron and Allan Macleod.

Attending: Jeanne Middleton, Chief Financial Officer; Chris McNeill, Head of Community Health and Care; Soumen Sengupta, Head of Strategy, Planning and Health Improvement; Jackie Irvine, Head of Children's Health, Care and Community Justice; Colin McDougall, Chief Internal Auditor; Peter Lindsay, Senior Audit Manager (Audit Scotland); Laurence Slavin, Senior Auditor (Audit Scotland) and Nuala Borthwick, Committee Officer (West Dunbartonshire Council).

Also Attending: Non-Voting Members of the Partnership Board - Barbara Barnes and Anne McDougall.

Apology: An apology for absence was intimated on behalf of Jonathan McColl.

Ros Micklem in the Chair

WELCOME AND INTRODUCTIONS

The Chair welcomed everyone present to the meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit Committee and thereafter introductions were made around the table.

DECLARATIONS OF INTEREST

It was noted that there were no declarations of interest in any of the items of business on the agenda at this point in the meeting.

MINUTES OF PREVIOUS MEETING

The Minutes of Meeting of the West Dunbartonshire Health and Social Care Partnership Audit Committee held on 30 September 2015 were submitted and approved as a correct record.

Having heard the Chair, Ms Micklem, the Committee agreed:-

(1) that a rolling action list would be maintained to ensure that Members did not lose track of actions arising at meetings of the Audit Committee; and

(2) to acknowledge the work of officers such that West Dunbartonshire Health and Social Care Partnership Board was the first Integrated Joint Board in Scotland to have Audit Committee arrangements in place.

FINANCIAL GOVERNANCE UPDATE

A report was submitted by the Chief Financial Officer seeking approval:-

(a) of the Scheme of Delegation arising from the Partnership Board's Financial Regulations;

(b) for the Partnership Board to join the Clinical Negligence & Other Risks Indemnity Scheme (CNORIS); and

(c) to endorse the integrated approach towards business continuity.

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

(1) to approve the delegation of expenses incurred by Members and authorised by the Chief Officer and Chief Financial Officer and that national guidance would be sought from the Scottish Government on expenses arrangements for members of the Partnership Board;

(2) to approve the Partnership Board's joining of CNORIS;

(3) to endorse the integrated approach towards business continuity; and

(4) that a presentation on the structure of business continuity planning would be provided at the next meeting of the Audit Committee scheduled to be held on Wednesday, 23 March 2016 to ensure Members are satisfied that there was rigorous continuity planning processes in place.

RESERVES POLICY

A report was submitted by the Chief Financial Officer providing information on the proposed Reserves Policy and the purposes for which reserves may be held.

After discussion and having heard the Chief Financial Officer and the Head of Strategy, Planning and Health Improvement in further explanation of the report and in answer to Members' questions, the Committee agreed to approve the Reserves Policy.

NHS GREATER GLASGOW & CLYDE HEALTH BOARD – HEALTH & SOCIAL CARE INTEGRATION: SEPTEMBER 2015 OPENING BUDGET REPORTS

A report was submitted by the Chief Financial Officer providing information on the report from NHS Greater Glasgow & Clyde Health Board's 2015/16 Opening Budget report. It was noted that the Health Board's report included the West Dunbartonshire Health & Social Care Partnership Health Care budget.

After discussion and having heard the Chief Financial Officer and the Head of Strategy, Planning and Health Improvement in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to note the budget setting approach followed by NHS Greater Glasgow & Clyde;

(2) to note the due diligence work undertaken as the basis for the 2015/16 Health Care budget;

(3) to note that the opening budgets for each Integration Joint Board detailed within the report was consistent with the budgeting approach undertaken in prior years;

(4) to note that the NHS Greater Glasgow & Clyde financial plan and budgeting approach had been considered and approved at Health Board level;

(5) to note that further work was required to enable agreement of remaining elements of proposed delegated budgets and to identify all required savings/plans to address cost pressures; and

(6) to note that all budgets, as tested, would be subject to further alteration, with input from the Chief Financial Officer (or current equivalent) for each partnership area before being submitted to the Health & Social Care Partnership Board for final approval within the context of its Strategic Plan.

CARE INSPECTORATE REPORT FOR OLDER PEOPLE'S RESIDENTIAL CARE SERVICES OPERATED BY WEST DUNBARTONSHIRE COUNCIL

A report was submitted by the Head of Community Health and Care providing information on the most recent inspection reports for two of the Council's Older People's Residential Care Home Services.

The Action Plan agreed with the Care Inspectorate Action Plan in response to the inspection report on Willox Park was circulated (tabled) at the meeting.

After discussion and having heard the Head of Community Health and Care in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) that future reports would provide information to assist those members unfamiliar with care establishments included in reports, e.g. the capacity of care homes and any issues associated with the premises or the service;

(2) to congratulate the staff at Langcraigs Care Home in achieving grades of a consistently high level; and

(3) to note the content of the report and the work undertaken to ensure grades awarded reflected the quality levels expected.

CARE INSPECTORATE REPORTS FOR SUPPORT SERVICES OPERATED BY THE INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE

A report was submitted by the Head of Strategy, Planning and Health Improvement providing a routine update on the most recent Care Inspectorate assessments for four independent sector support services operating within the West Dunbartonshire area.

After discussion and having heard the Head of Community Health and Care, the Head of Strategy, Planning and Health Improvement and the Head of Children's Health, Care and Criminal Justice in further explanation of the report and in answer to Members' questions, the Committee agreed to note the content of the report.

DECLARATION OF INTEREST

At this point in the meeting, Councillor Rooney declared a financial interest of his spouse in the undernoted report, given that his spouse was a member of staff at a care home in West Dunbartonshire, and intimated that he proposed to take part in the decision on this item.

CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S CARE HOMES OPERATED BY INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE

A report was submitted by the Head of Strategy, Planning and Health Improvement providing a routine update on the most recent Care Inspectorate assessments for three independent sector residential older peoples' Care Homes within West Dunbartonshire.

After discussion and having heard the Head of Community Health and Care, the Head of Strategy, Planning and Health Improvement and the Head of Children's Health, Care and Criminal Justice in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) that future reports would provide information to assist those members unfamiliar with care establishments e.g. the capacity of care homes; the trend of grades awarded to independent sector care providers and the specific associated budget implications; and

(2) otherwise to note the content of the report.

CARE INSPECTORATE REPORT FOR CHILDREN & YOUNG PEOPLE'S SERVICES OPERATED BY WEST DUNBARTONSHIRE COUNCIL

A report was submitted by the Head of Children's Health, Care and Criminal Justice providing information on the most recent inspection report for one of the Council's own residential services for children and young people.

The Action Plan agreed with the Care Inspectorate in response to the inspection report on Craigellachie Children's Home was circulated (tabled) at the meeting.

After discussion and having heard the Head of Children's Health, Care and Criminal Justice in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to note the work undertaken to ensure grades awarded are sustained and reflect the high quality of care expected; and

(2) otherwise to note the content of the report.

TRANSFORMING CARE IN CLYDEBANK – INITIAL AGREEMENT

A report was submitted by the Head of Strategy, Planning and Health Improvement presenting the Initial Agreement prepared for a new Clydebank Health and Care Centre.

After discussion and having heard the Head of Strategy, Planning and Health Improvement and the Head of Community Health and Care in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to endorse the Initial Agreement for a new Clydebank Health and Care Centre; and

(2) to note the Committee's support for such a high quality and integrated facility being delivered as soon as was practically possible.

Note: Councillor Rooney left the meeting during consideration of the above item of business.

INTEGRATED CARE FUND MID YEAR REPORT

A report was submitted by the Head of Community Health and Care providing an update on the use of the Integrated Care Fund for the first half of the 2015-16 financial year.

Annex A Integrated Care Fund 2015/16 – Progress towards Outcomes and Annex B Integrated Care Fund – Indicators of Progress were circulated (tabled) at the meeting.

After discussion and having heard the Head of Community Health and Care, the Committee agreed that an updated version of the report would be provided to the next meeting of the Health & Social Care Partnership Board on Wednesday, 17 February 2016.

INTERNAL AUDIT - UPDATE

The Chief Internal Auditor updated the Committee on the current internal audit service provided to the Partnership Board.

It was noted:-

(1) that preparation was underway for the Audit Plan 2016/17, with the intention being to submit the draft plan to the next meeting of the Audit Committee on 23 March 2016; and

(2) that the Chief Financial Officer would work with the internal auditors of the Health Board, the Council and the Partnership Board to ensure that there was clarity and consistency with respect to the appropriate auditing of the work of the Partnership Board and the Health & Social Care Partnership.

AUDIT SCOTLAND REPORT ON NHS IN SCOTLAND 2015

A report was submitted by the Chief Financial Officer providing information on the recently published Audit Scotland report on NHS in Scotland 2015.

After discussion and having heard the Senior Audit Manager (Audit Scotland) and the Head of Strategy, Planning and Health Improvement in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) that the emphasis within the report on workforce planning was timely given that the Partnership's Workforce and Organisational Development Strategy had been endorsed at the previous meeting of the Partnership Board; and

(2) otherwise to note the findings of the Audit Scotland report.

FORTHCOMING AUDIT SCOTLAND REPORT – SOCIAL WORK IN SCOTLAND

A report was submitted by the Head of Strategy, Planning and Health Improvement advising of a national audit of Social Work in Scotland that has been initiated by Audit Scotland and was of direct relevance to the work of the Health and Social Care Partnership.

After discussion and having heard the Head of Strategy, Planning and Health Improvement and the Senior Audit Manager (Audit Scotland) in further explanation of the report, the Committee agreed:-

(1) to note the work being undertaken by Audit Scotland; and

(2) to direct the Chief Officer to bring a report to the Audit Committee on this national audit once the final report was published.

AUDIT SCOTLAND REPORT ON HEALTH & SOCIAL CARE INTEGRATION

A report was submitted by the Head of Strategy, Planning and Health Improvement providing information on the recently published Audit Scotland report on Health and Social Care integration.

After discussion and having heard the Head of Strategy, Planning and Health Improvement and the Senior Audit Manager (Audit Scotland) in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to acknowledge the work undertaken by officers in delivering the considerable progress that had been already been made within West Dunbartonshire with respect to issues raised within the report and as recognised by the Senior Audit Manager (Audit Scotland);

(2) that officers give consideration to how best to provide Members with a more detailed overview of the actions being taken to progress key issues noted within the report;

(3) that the Chief Internal Auditor use the relevant recommendations made by Audit Scotland within this national report to inform and shape their internal audit of the local implementation of the Public Bodies (Joint Working) Act during 2016/17 following the first year of the HSCP Board's establishment.; and

(4) otherwise to note the findings of the Audit Scotland report.

The meeting closed at 4.07 p.m.

ARGYLL, BUTE AND DUNBARTONSHIRES' CRIMINAL JUSTICE SOCIAL WORK PARTNERSHIP JOINT COMMITTEE

At a Meeting of the Argyll, Bute and Dunbartonshires' Criminal Justice Social Work Partnership Joint Committee held in Committee Room 2, Council Offices, Garshake Road, Dumbarton on Thursday, 10 December 2015 at 2.00 p.m.

Present: Councillors Elaine Robertson and Anne Horne (Argyll and Bute Council); Councillor Gemma Welsh (East Dunbartonshire Council) and Councillors Gail Casey and *Jonathan McColl (West Dunbartonshire Council).

* Arrived later in the meeting.

Attending: **Argyll and Bute Council:** Kirsteen Green, Business Support Manager, Criminal Justice Services.

West Dunbartonshire Council: Norman Firth, Criminal Justice Partnership Manager, Terry Wall, Business Partner Corporate Functions and Nuala Borthwick, Committee Officer.

East Dunbartonshire Council: Keith Gardner, Acting Chief Social Work Officer.

Apologies: Apologies for absence were intimated on behalf of Councillor Michael O'Donnell, East Dunbartonshire Council; Jackie Irvine, Head of Children's Health, Care and Criminal Justice Services; Carol Muir, Argyll and Bute Alcohol and Drug Partnership; Rona Gold, Community Planning Manager, Argyll and Bute Council; Gerard McCormick, Community Planning Manager, East Dunbartonshire Council and Amanda Coulthard, Community Planning Manager, West Dunbartonshire Council.

APPOINTMENT OF CHAIR

In terms of the Appointment of Chair of the Joint Committee, it was agreed that Councillor Elaine Robertson be appointed Chair and Councillor Gail Casey be appointed as Vice Chair of the Partnership.

MINUTES OF PREVIOUS MEETINGS

The Minutes of Meeting of the Joint Committee held on (a) 11 June 2015 and (b) the informal note of the inquorate meeting held on 3 September 2015 were submitted and approved as correct records.

MINUTE OF AGREEMENT

With reference to the Minutes of Previous Meetings of the Partnership held on 12 March 2015 and 11 June 2015, Members reviewed the Partnership's Minute of Agreement at Paragraph 6 – Quorum and agreed the undernoted amended wording of the paragraph to enable Members to attend future meetings by way of teleconferencing, when necessary, due to unforeseen circumstances, eg inclement weather, road closures, etc:-

> "A quorum of the Joint Committee shall be three persons constituted by the attendance in person or by way of teleconference facilities, of one member of each Member authority or his/her substitute. If a quorum is not present in person or by way of teleconference, within one half hour from the time fixed for any meeting that meeting shall be adjourned to such time and place, within the next ten days as the three Councils' representatives shall agree or failing which as shall be determined by the Chair for the meeting."

Note: Councillor McColl entered the meeting at this point.

REVENUE BUDGETARY CONTROL REPORT 2015/2016 AS AT PERIOD 6 (30 SEPTEMBER 2015)

A report was submitted by the Treasurer to the Partnership Joint Committee providing an update on the financial performance of the Criminal Justice Partnership to 31 July 2015.

After discussion and having heard the Partnership Manager and the SDS Accountant in further explanation of the report and in answer to Members' questions, the Joint Committee agreed:-

(1) to note the contents of the report which indicated an adverse variance of £0.082m as at 30 September 2015 with a full year projected adverse variance to 31 March 2016 of £0.166m; and

(2) to note the concern expressed in relation to the £48,000 overspend in administrative costs and that further explanation would be sought from East Dunbartonshire Council in relation to this overspend.

CRIMINAL JUSTICE SOCIAL WORK ANNUAL REPORT 2014/15

A report was submitted by the Chief Officer providing information on the annual report submitted to North Strathclyde Community Justice Authority with regard to work undertaken by Criminal Justice Social Work in 2014/15.

After discussion and having heard the Partnership Manager in further explanation of the report and in answer to Members' questions, the Joint Committee agreed:-

(1) that the Partnership's 'Good Practice Guide on Responding to Violence Against Women – Supporting Survivors and Managing Risks' would be sent to all Members for information;

(2) to note the concerns of the Partnership in relation to raising awareness and addressing the training requirements for keeping children and young people safe whilst on line with people unknown to them; and

(3) to note the good work being carried out by the Empowered Group in East Dunbartonshire Council which brings together different groups of people and covers Violence against Women.

Note: Councillor McColl left the meeting at this point in the meeting.

AGGREGATE RETURN 2013/14

A report was submitted by the Chief Officer providing information on the Partnership's Aggregate Return figures for 2013/14.

After discussion and having heard the Partnership Manager in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) that the partnership would continue to monitor and analyse aggregate return data;

(2) to note the terms of the discussion in relation to the reduction in young male offenders and the possible reasons for this reduction e.g. ageing and declining population, change in models of policing and results of early years education work; and

(3) to otherwise note the contents of this report.

MULTI-AGENCY PUBLIC PROTECTION ARRANGEMENTS: ANNUAL REPORT: 2014-2015

A report was submitted by the Chief Officer providing information on the publication of the North Strathclyde Community Justice Authority, Multi-Agency Public Protection Arrangement (MAPPA): Annual Report 2014-15.

After discussion and having heard the Partnership Manager and the Acting Chief Social Work Officer in further explanation of the report and in answer to Members' questions, the Committee agreed to note the contents of the report.

COMMUNITY JUSTICE REDESIGN: TRANSITION PLAN

A report was submitted by the Chief Officer providing an update on the formulation of a transition plan regarding transfer responsibility for the strategic planning and delivery of community justice from Community Justice Authorities to Community Planning Partnerships.

After discussion and having heard the Partnership Manager in further explanation of the report and in answer to Members' questions, the Partnership agreed:-

(1) to note the Transition Plan 2016-17 with regard to community justice redesign;

(2) to note that a local consultation event was held on 30 October 2015 bringing together statutory partners and third sector representatives and that the transition plan reflects issues raised at that event;

(3) to note that the Partnership authorities had pooled the transition funding for each authority in order to derive maximise benefit in terms of resourcing a Transition Officer post to driver matters forward and also to support local partnership working and consultation initiatives; and

(4) that the Partnership Manager would continue to provide regular updates on progress of transition to the new model.

CONSULTATION ON PROPOSALS TO STRENGTHEN THE PRESUMPTION AGAINST SHORT PERIODS OF IMPRISONMENT

A report was submitted by the Chief Officer advising of the Scottish Government consultation regarding Extension of Presumption against Short Sentences and seeking approval to respond on behalf of the Criminal Justice Social Work Partnership.

After discussion and having heard the Partnership Manager and the Acting Chief Social Work Officer in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to approved the response to the above consultation for submission to the Scottish Government; and

(2) that the Partnership Manager would advise the Joint Committee of any future developments.

The meeting closed at 4.20 p.m.

West Dunbartonshire Health & Social Care Partnership

Meeting: **Clinical & Care Governance Group**

Date: **29 January 2016**

Time: **9.30am**

Venue: **Meeting Room 6, 3rd Floor, Garshake Road**

MINUTE

Present: Keith Redpath, Chief Officer (Chair)
Jackie Irvine, Chief Social Work Officer, Head of Children's Health, Care and Criminal Justice
Kevin Fellows, Clinical Director
Soumen Sengupta, Head of Strategy, Planning & Health Improvement
Chris McNeill, Head of Community Health & Care
John Russell, Head of Mental Health, Addictions & Learning Disability
Stephen McLeod, Head of GGC Specialist Children's Services (hosted)
Wilma Hepburn, Professional Nurse Adviser
Janice Miller, MSK Physiotherapy Services Manager and Allied Health Professions Professional Advisor
Jeanne Middleton, Chief Financial Officer
Serena Barnatt, Head of People & Change

In Attendance: Irene McKenzie (minute)

Item	**Description**	**Action**

1. Welcome & Apologies
K Redpath welcomed everyone to the meeting. There were no apologies.

2. Minute of Meeting held on 27 November 2015
The Minute was accepted as an accurate record of the meeting.

3. Matters Arising
There were no matters arising not covered elsewhere on the agenda.

4. Quality Assessment
a) Local Government Benchmarking Framework (LGBF) National Overview Report

S Sengupta introduced the report which summarised national trends and included the position within West Dunbartonshire. Following discussion, the report was noted.

b) Children and Young People Act

J Irvine presented a briefing note providing a short summary of the Children and Young People (Scotland) Act 2014, specifically drawing attention to the need for the Health Board and Council to develop a dedicated complaints process in regards to Named Person and Children's Care Plan.

Following discussion it was confirmed that J Irvine will make enquiries regarding additional funding for new kinship carer regulations. **JI**

c) NHSGGC Formulary Compliance

C McNeill spoke to the report on Formulary Compliance which was compiled by Pamela Macintyre, WDHSCP Prescribing Lead. Formulary compliance remains high in West Dunbartonshire.

There was discussion around setting the prescribing budget for 2016/17. It was agreed that J Middleton would circulate the paper which was considered at GGC HSCP Chief Financial Officers' most recent meeting. **JM**

d) Standards for Diabetic Retinopathy Screening – Consultation

C McNeill brought to the group's attention the Health Improvement Scotland (HIS) Draft Standards for Diabetic Retinopathy Screening Consultation. This consultation is of particular relevance to WDHSCP given that it hosts the Diabetic Retinal Screening Service on behalf of the Health Board.

C McNeill advised that a response had been submitted on behalf of the HSCP and that confirmed the consultation response would be circulated to the group. **CMcN**

e) Care Inspectorate Grades for Independent Providers

S Sengupta presented an overview report on Care Inspectorate Grades in relation to independent providers. There were no major issues.

There then followed a discussion of national developments regarding payments to providers in respect of the national living wage and sleepover arrangements. It was agreed that Heads of Service would collate a list of all providers who provide a sleepover service; that S Sengupta will draft a letter to all those providers to make them aware of our local review of these matters; and that J Middleton will undertake a financial impact scoping exercise in relation to these matters. **HoS** **SS** **JM**

f) Notification of Data Security Breaches to ICO

S Sengupta introduced a paper that provided guidance on how to

determine when a data security concern represents a data security breach for reporting to the ICO. Following discussion, it was agreed that S Sengupta would provide a short briefing note to staff to summarise how such a determination would be made within the HSCP. **SS**

g) Development of Clinical and Care Governance Action Plan

S Sengupta will circulate a draft Action Plan which will then be signed off at the next Clinical and Care Governance Group meeting. **SS**

5. Risk Management

a) Clinical Incident Reporting

K Fellows presented a paper covering incidents reported on Datix in October, November and December 2015. The contents of the paper were discussed and it was confirmed that there were no issues evident requiring action from this group.

b) Partnerships Clinical Risk Report

K Fellows presented the overarching Health Board paper which provides an overview of the clinical risk activity within Partnerships in relation to Significant Clinical Incidents; any new issues identified by clinical risk team for consideration; and Avoiding Serious Events monitoring. The contents of the paper were discussed and it was confirmed that there were no issues evident requiring action from this group.

It was confirmed that K Redpath and S McLeod would separately review arrangements in respect of the hosted Specialist Children's Services. **KR/SMcL**

6. Service User Feedback

a) Freedom of Information (FOI) Update

S Sengupta presented a summary paper which listed the Freedom of Information requests received by West Dunbartonshire Council in October-December 2015 and responded to by the HSCP. The contents of the paper were discussed and it was confirmed that there were no issues evident requiring action from this group.

S Sengupta agreed to work with Health Board corporate colleagues to develop a similar report in relation to relevant NHSGGC FOIs. **SS**

b) Complaints Report

S Sengupta presented a summary paper which described the numbers and types of complaints received within the HSCP and summarised the main learning and actions taken. The contents of

the paper were discussed and it was confirmed that there were no issues evident requiring action from this group.

c) Citizen's Panel Survey – Findings

S Sengupta presented the above Summary of Key Findings in relation to health and social care services. Overall the findings were very positive. The results of the survey will be incorporated into the next HSCP Performance Report and the strategic planning process.

d) Implementation of Ombudsman Findings

For information, S Sengupta brought to the group's attention that the SPSO have implemented a new system to ensure that Health Boards provide written evidence of compliance.

7. Continuous Improvement

a) Self-Evaluation (PDSA/PSIF) Activities

S Sengupta presented a paper which described the requirement for a continued commitment to self-evaluation to support expected joint inspections by the Care Inspectorate and Healthcare Improvement Scotland in 2016/17. The contents of the report were discussed and noted.

b) Impact Assessment Tool – Osteoporosis and Epilepsy

K Fellows presented two SIGN Guidelines Impact Assessment Tools for discussion. It was confirmed that it is the responsibility of the Clinical Director to judge the most appropriate forum for consideration of health care guidelines dependent on topic, patient/client group and potential implications, e.g. particular service team meetings or locality groups. The group was reassured that there is an adequate system in place to circulate guidelines and NHS Safety Action Notices across services.

c) Clinical and Care Governance Forum

S Sengupta presented the programme for the Clinical and Care Governance Forum to be held on 12 February 2016, the first of four sessions scheduled for this year. It was agreed that the invitation to the Forum should be extended to Seniors/Team Leads. **HoS**

8. Staff Governance

a) HR Update – Absence & PDP

S Barnatt presented a paper describing the latest workforce information and updated figures until the end of November 2015. Figures relating to sickness absence for staff within the HSCP, NHSGGC and WDC, were provided in the report along with a trends analysis. All Heads of Service were asked to ensure

KSF/PDPs were completed. The contents of the report were discussed and noted. **HoS**

b) NMC Registration Update

A paper prepared by Val McIver, Senior Nurse/District Nursing, and Jackie Hamill, Senior Nurse/Children's Services, was presented, outlining local arrangements for monitoring NMC revalidations and confirming that compliance is currently 100%.

c) WDC and NHS Staff Survey Results 2015

S Barnatt presented the Staff Survey Results for HSCP staff from both NHSGGC and WDC. These had been discussed at the most recent HSCP Joint Staff. The findings were broadly positive with areas for further improvement identified for development within the forthcoming update of the local staff and practice governance framework.

d) Healthy Working Lives (HWL) Staff Survey 2015

S Sengupta advised that a specific health and wellbeing survey of staff within the HSCP will be carried out on 8 February 2016 for a period of 4 weeks. This survey will complement the previously discussed staff surveys and also support the HSCP's next HWL Gold Award assessment later this year. The findings of this survey will inform the forthcoming update of the local staff and practice governance framework.

7. Date of Next Meeting

23 March 2016, 9.30am

West Dunbartonshire Health & Social Care Partnership

Meeting: **Clydebank Locality Meeting**

Date: **22 October 2015**

Time: **1000 - 1200**

Venue: **Conference Room, Clydebank Health Centre**

MINUTE

Present:	Dr Alison Wilding	-	GP, Red Wing
	Chris McNeil	-	Head of Adult Health & Care Services
	Jane McNiven	-	Practice Manager, Green Wing
	Dr Anthony Kearney		GP, Erskine View
	Dr Arun Rai	-	GP, Purple Wing
	Pamela Ralphs	-	Acute Rep, GG&C
	Dr Eddie Crawford	-	GP, Orange Wing
	Dr Neil Chalmers	-	GP, Yellow Wing
	Anna Crawford	-	Primary Care Development Lead
	Lyndsay Steel	-	Prescribing Support Pharmacist
	Val McIver	-	Senior Nurse
	Dr James Miller	-	GP, Blue Wing
	Marie Rooney	-	Operation Manager, Mental Health
	Lilian Wanless	-	Consultant Psychologist
	William Wilkie	-	Lead Optometrist
	Brian Polding-Clyde	-	Development Officer, Scottish Consortium
	Linda Young	-	COPT Team Leader
	Dr Neil Murray	-	GP, Green Wing
	Lynne McKnight	-	Integrated Operations Manager
	Selina Ross,	-	West Dunbartonshire Community Voluntary Service
	Yvonne Milne	-	Team Leader Mental Health
	Kirsten MacLennan	-	Senior Social Worker CDT
Apologies:	Dr Kevin Fellows,	-	Clinical Director
	Magee Ferrie	-	Practice Nurse, Blue Wing
	Pamela Macintyre	-	Lead for Prescribing and Clinical Pharmacy
	John Russell	-	Head of Mental Health & Addictions
	Mary Angela McKenna		Integrated Operation Manager, COPT
	Mark Dickinson	-	Lead Community Pharmacist
	Jamie Dockery	-	Policy Officer (Housing Development)

Item	Description	Action
1.	**Welcome & Introductions**	
2.	Minutes of meeting held on 13th August 2015 were accepted as a accurate account of the meeting.	
3.	**Matters Arising** **Community Pharmacist Representative** Mark Dickinson, Lead Community Pharmacist has been invited on to the membership of the Clydebank Locality Meeting. M Dickinson was unable to attend to-day's meeting due to lack of locum cover and provided his apologies.	
4.	**Mental Health Service Review – Workshop** A Wilding provided the back ground to the workshop and its agreed focus. The group emphasied the need for Public Engagement around the developments / improvements within Mental Health Services and were advised of the West Dunbartonshire Mental Health Forum and its participation in the Mental Health Strategy Group and the planned links to the Local Engagement Network. The Group requested consideration of Locality based engagement with patients and public representation, this will be progressed through the Locality Sub Group. M Rooney provided the background to developments within Mental Health Services and areas highlighted from previous engagement with General Practice in Clydebank. The Locality meeting split into 3 groups to look at: **Group 1**: Adult/Older adult co-location at GRC. Pilot of single point of access, as transition towards stepped-care model. **Group 2**: Proposed patient pathway for Borderline Personality disorder. **Group 3**: Co-morbid presentations and interfaces between services. The Groups fed back on the issues discussed and agreed actions to be progressed by the Mental Health Locality sub group. The Locality agreed to form a subgroup which will develop a Workplan to progress and monitor actions agreed within the Workshop. Key stakeholders were identified to participate in the Locality Sub Group to take forward actions identified within the locality	**AC**

workshop. A Crawford to arrange meeting to progress.

5. Local Engagement Network – Mental Health Engagement

The Group agreed the links and engagement would be progressed by the Locality Sub Group.

6. Any Other Business

Next Session – Winter Planning

AC to contact practices to request feedback on Practice Winter Plan and Business Continuity Management arrangements. **AC**

P Ralph agreed to look at performance data in the Immediate Assessment unit within Queen Elizabeth University Hospital and provide update as part of wider Winter Planning discussions. **PR**

It was agreed GPs need to be informed of issues within local acute services to ensure understanding of wider system challenges.

AC to arrange pre-meeting with A Wilding / P Ralph as soon as possible to support planning of December meeting. **AC**

7. Date of Next meeting

17th December 2015, 10.00am

West Dunbartonshire Health & Social Care Partnership
Mental Health Workplan

Locality: Clydebank Locality

Clinical Lead: Marie Rooney

Subgroup Members: Alison Wilding, Neil Murray, Eddie Crawford, Marie Rooney, Anna Crawford, Selina Ross, Anthony Kearney

Action	Responsible officer	Date for completion	Progress	RAG
Pathways				
Liaise with Lois Fleming re the development of SCI Gateway – Single Gateway Referral for Older Age and CMHT	Marie Rooney	January 2016	Meeting to be arranged with Wendy Cox and Lois Fleming to facilitate agreed change.	G
Develop Single Assessment Document	Marie Rooney	March 2016	Document developed and currently being piloted within CMHT, PCMHT and the Crisis Team for 3 months. Copy of Initial Assessment Document shared with GPs and Practice Managers for comment by 29th January 2016.	G
Discuss with Addictions team the possibility of adopting the Single Assessment document being piloted above	Marie Rooney / Julie Lusk	December 2015	Addictions to review and consider Initial Assessment document for use within service.	G
CMHT to consider a 1 page summary report for patients 6 month review which is shared with General Practice	Marie Rooney	March 2016	Marie will take suggestion to Business Meeting in December and feedback To be considered further following completion of Initial Assessment Document and pilot.	G
Mental Health to work with Community	Marie	March 2016		G

Action	Responsible officer	Date for completion	Progress	RAG
Older People Team to ensure joint working continues in new arrangements	Rooney / Mary Angela McKenna			
Training needs in Mental Health Team and community service to be identified	Marie Rooney	January 2016	Training needs identified within Mental Health Team. Training to be provided by psychologist enabling a focus on outcomes. CMHT staff to be trained to NES level 1 & 2, Trauma Training.	G
Interface with GPs to be further developed	GPs/ Mental Health Service	March 2016	GP interface being progressed through engagement and Locality Sub Group and will be further enhanced through review/ consultation of re-drafted pathways.	G
Multi-professional involvement in the development of models for specific pathways' • Eating Disorder • Personality Disorder recognising risks and level of support available within community. Consider interface for shared care through pathway development	Marie Rooney	March 2016	Marie Rooney to discuss with Lilian Wanless opportunities for engagement with Wider GP group on draft pathways. Eating Disorder Pathway under development GG&C wide. Marie to request update. Work still in progress.	G
A&E and use of Liaise Psychiatry, triage methodology. Group discussions to be fed in to Acute discussions.	Pamela Ralphs		Work is ongoing to review the issue highlighted. This has been raised formally through the Acute Mental Health Liaison Interface Group. Meeting undertaken to review the links between the OOH CPN service and emergency departments.	G
Involve GPs in the review group for the Mental Health / CAT Protocol - agree common commitment on way forward	Julie Lusk / Marie Rooney	March 2016	Marie to discuss with Julie Lusk.	G
Consider session on addictions within future Locality Meeting	Locality Meeting		Marie will discuss with Julie Lusk and John Russell	G

Action	Responsible officer	Date for completion	Progress	RAG
Work in parallel with public to agree approach and engagement links.	Selina Ross	March 2016	The HSCP LEN will have their first meeting in January 2016. Mental Health Service agreed to link to Mental Health Forum to engage re developments. CVS to link to 3rd Sector.	G
Marie Rooney to discuss with Julie Lusk Addictions involvement within the Mental Health Sub Group	Marie Rooney	December 2015	Meeting week beg 7/12/15	G
Invite Gerry Montgomery along to Sub Group Meetings	Anna Crawford	December 2015	Gerry Montgomery happy to be part of the group.	C
Find out number of PCMH patients >65 and promote the PCMHT to the Care of the Elderly Team	Marie Rooney	December 2015	Marie will obtain from PCMHT reports and feedback.	G
Involve representation from the COPT team on the Mental Health Sub-Group	Anna Crawford	January 2016		G
Improve links to Mental Health Teams out with West Dunbartonshire to ensure	Marie Rooney	March 2016		G

West Dunbartonshire Health & Social Care Partnership

Meeting: **Alexandria & Dumbarton Locality Meeting**

Date: **6 November 2015**

Time: **10.00 am**

Venue: **Seminar Room, Vale Centre for Health and Care**

MINUTE

Present:

Elaine Mackay	**-**	**Team Lead, Pulmonary Rehab**
Brian Polding-Clyde	**-**	**Development Worker, Scottish Care**
Daren Borzynski	**-**	**WDCVS**
Lynne McKnight	**-**	**Integrated Operations Manager**
Jane Young	**-**	**GP**
Elizabeth Davidson	**-**	**Lead OT – Riverview RC**
Anna Crawford	**-**	**Primary Care Development Lead**
Kevin Fellows	**-**	**Clinical Director/GP**
Chris McNeill	**-**	**Head of Community Health & Care Svs**
Stephen Dunn	**-**	**GP**
David Clark	**-**	**GP**
Jamie Gillies	**-**	**VCHC**
Val McIver	**-**	**Lead Nurse**
Kathryn McLachlan	**-**	**VCHC**
David Allen	**-**	**Practice Manager**
Fiona Wilson	**-**	**GP**
Pamela Macintyre	**-**	**Pharmacy**
Mary-Angela McKenna	**-**	**Integrated Ops Manager – Older People**
Saied Pourghazi	**-**	**GP**
Selena Ross	**-**	**WDCVS**
Marjorie Johns	**-**	**GG&C Acute**

Apologies: **Joanne Martin, Neil McKay, William Wilkie, Yvonne Milne, Mark Dickinson, Jackie Irvine**

Item	**Description**	**Action**

1. Welcome & Introductions

Dr. Dunn welcomed everyone to the meeting and introduced Jamie Gillies, the new COPD Nurse covering Clydebank and Alexandria areas.

2. Minute of Meeting Held on 4 September 2015

The minutes of the meeting held on 4th September 2015 were accepted as an accurate record.

3. Matters Arising

- The Protected Learning Event will take place on 26

November 2015 in the Clydebank Town Hall.

- Dr. Dunn congratulated P Macintyre as this year's winner of the Scottish Health Award for Leading and Managing for Quality. The Palliative Team also won the Herald Society Health and Social Care Integration Award.

4. COPD Workshops – How can we improve care of COPD.

K Fellows provided the background to the workshop on COPD and areas highlighted from previous engagement with General Practice in Alexandria / Dumbarton.

Group 1 – How can we improve care of COPD, + Prescribing
Group 2 – How can we improve care of COPD, + Community Support and Third Sector
Group 3 – How can we improve care of COPD, + Secondary Care and Pulmonary Rehab

The Groups provided feedback on the issues discussed and agreed actions to be progressed by the COPD Locality sub group. A meeting has been scheduled for 4th December to Progress. The Group was keen to continue to involve Dr Jane Gravel, Consultant Physician at the Royal Alexandra Hospital in local discussions. A Crawford agreed to invite Dr Gravel to the subgroup meeting. The subgroup will develop a Workplan to progress and monitor actions agreed within the Workshop and feedback to the Locality meeting in January 2016. **AC**

Key stakeholders were identified to participate in the Locality Sub Group to take forward actions identified within the locality workshop. A Crawford to arrange meeting to progress. **AC**

K Fellows suggested a small formalised group be pulled together to collate and disseminate the outcome of these discussions. Suggested participants were D Borzynski, J Young, J Gillies, P Macintyre, S Ross, N MacKay and S Dunn.

It was agreed that 'Frailty' be the topic for the next locality meeting, and that Dr Deborah Mack, Consultant Physician should be invited to attend.

5. Local Engagement Network

Group agreed this should be included within the wider discussion on the Subgroup.

6. Any Other Business

- Dr. Young suggested that 'Recruitment of GPs' should also be a topic for a future meeting, K Fellow advised this topic should be discussed at the Developing GP Services meetings scheduled for 19th November at Vale Centre for Health Care and 25th November in Clydebank Health Centre.

- Winter Planning - Chris advised that the Board was keen to discuss the Winter Planning Programme and stated it was important that we have a local discussion and suggested an hour session in Alexandria and Dumbarton health centres to discuss. A Crawford agreed to organise. **AC**
- M Johns advised that the remaining out patient and day care services would be transferred from Yorkhill Hospital to the new Queen Elizabeth University Hospital on the 7th December and minor injuries from the Western will transfer on the 4th December. C McNeil requested a copy of the patient leaflet be disseminated to practices. **MJ / CMCN**
- All future Alexandria and Dumbarton Locality Meetings will be held in the Seminar Room, Vale Centre for Health and Care.

7. Date of Next Meeting

15th January 2016 in the Seminar Room, Vale Centre for Health and Care.

West Dunbartonshire Health & Social Care Partnership
COPD Workplan

Locality: Alexandria / Dumbarton Locality

Clinical Lead: Kevin Fellows

Subgroup Members: Val McIver, Dr Jane Gravil, Pamela Macintyre, Dr Jane Young, Dr Stephen Dunn, Dr Neil MacKay, Dr David Clark, Jamie Gillies, Daren Borzynski, Frank Gow, Elaine MacKay

Action	Responsible officer	Date for completion	Progress	RAG
Plan and deliver Education Session for GPs and practice nurse staff on COPD: • Early Diagnosis • Smoking Cessation • Medication • Inhaler technique	A Crawford	June 2016	Jane Gravel has agreed to support. Session will be discussed further at the next Sub group meeting in February 2016.	G
Consider education sessions for carers and patients	J Gilles / A Crawford	June 2016		G
Map existing COPD services and identify gaps in West Dunbartonshire	A Crawford	February 2016	Collation of service information is underway.	G
Explore criteria and model for use of Nebulisers in the community	P Macintyre	March 2016	All nebulisers accessed via ward. Further discussion required.	G
Incorporate the use of the checklist for Dexa referrals guidelines and the risk of ostephorisis	J Gillies	January 2016		G
Consider undertaking an audit of steroid use and referral for dexa scans	P Macintyre	TBC		G

Action	Responsible officer	Date for completion	Progress	RAG
Develop standardised patient information packs	A Crawford	June 2016		G
Link to British Lung Foundation to discuss activity and opportunity in West Dunbartonshire	F Gow	March 2016	Meeting arranged with F Gow, D Borzynski and A Crawford for 25/02/2016.	G
Link to Chest Heart & Stroke to discuss activity and opportunity in West Dunbartonshire	F Gow	March 2016		G
Add trigger to link up system for COPD specific services and link to be-friending service	S Ross/ F Gow	March 2016	WD CVS submitted a funding application in December 2015 to the Transforming Self Management in Scotland Fund. The application included developing links for COPD to Link-up Service. Outcome of application anticipated Feb/Mar 2016.	G
Explore the opportunity for transport for patients to Pulmonary Rehab through volunteering	S Ross/ F Gow	March 2016	WD CVS submitted a funding application in December 2015 to the Transforming Self Management in Scotland Fund. Transport through volunteering was included. Outcome of application anticipated Feb/Mar 2016.	G
Explore opportunities to link COPD patients to Walking Groups	S Ross/ F Gow	March 2016	WD CVS submitted a funding application in December 2015 to the Transforming Self Management in Scotland Fund. Linking COPD to walking groups was included. Outcome of application anticipated Feb/Mar 2016.	G
Improve eKIS for COPD patients (including update and content)	Practices	March 2016		G
Prompt access/ use of eKIS within secondary care	K Fellows	January 2016	K Fellow has contacted L McTaggart await feedback.	G
Disseminate Pulmonary Rehab referral criteria to GP / PN / COPD Nurse	E MacKay	December 2015	Referral criteria available within EMIS system. Copy of patient leaflet to be made available to	G

Action	Responsible officer	Date for completion	Progress	RAG
			practices	
Ensure each patient appropriate for Pulmonary Rehab is provided with the opportunity to attend	Practices	Ongoing		G
Pulmonary rehab to explore recall system for patients who have accessed the service	E MacKay	March 2016		G
Review Pulmonary Rehab referrals per practice and compare to population and prevalence	A Crawford / E MacKay	January 2016		G
Pulmonary Rehab service to consider expanding patient transport opportunities	E MacKay	March 2016		G
Review patient letter in relation to transport	E MacKay	March 2016		G

DRAFT Minute

West Dunbartonshire Health & Social Care Partnership

Meeting: **Joint Staff Forum**

Date: **27th January 2016**

Time: **10.00am (Staffside pre meeting at 9.00am)**

Venue: **Committee Room 2, Garshake Road**

Present:
Diana McCrone, Unison, NHS (Co-Chair)
Keith Redpath, Chief Officer, HSCP (Co-Chair)
Nazerin Wardrop, Unite, WDC
Val Jennings, Unison, WDC
Kenny McColgan, Unison, NHS
Elaine Smith, Unison, WDC
Paul Britten, Unite, NHS
Andrew McCready, Unite, NHS
Gillian Gall, People and Change Manager, HSCP
Nicola Bailey, Lead HR Adviser, WDC
Jackie Irvine, Head of Children's Health, Care and Criminal Justice Services, HSCP
Serena Barnatt, Head of People and Change, HSCP
Jeanne Middleton, Chief Finance Officer, HSCP
Soumen Sengupta, Head of Strategy, Planning and Health Improvement, HSCP
John Russell, Head of Mental Health, Learning Disability and Addictions, HSCP

Apologies:
Angela MacEachran, MSK Physiotherapy CSP
Chris McNeil, Head of Community Health and Care, HSCP
Ester O'Hara, Unite, NHS
Julie Ballantyne, Unison, NHS
Peter O'Neill, Unison, WDC (Co-Chair)
Tom Morrison, Unison, WDC

In Attendance: Heather Napier (Minute)

Item	Description	Action
1.	**Welcome & Introductions** D McCrone thanked the group for attending and introductions were made.	
2.	**Minute of Meeting Held on 28th October 2015 –** paper/01 Minutes from the Joint Staff Forum meeting held 28th October 2015 were accepted as a true record with the following amendments: • Page 1- add Andrew McCready, Unite, NHS to list of attendees. • Page 3- amend "*NHSGGC APF Constitution"* to "*NHSGGC Partnerships Agreement".*	
3.	**Minutes from Other Meetings for noting:** • **APF Agenda 25th November 2015** – paper/02 The Agenda was reviewed and the contents noted. Letter from the APF with regards to Trade Union Bill to be circulated. • **JCF Minute 10th December 2015**– paper/03 The Minute was reviewed and noted. • **Employee Liaison Group Minute 14th December 2015** – paper/04 The Minute was reviewed and noted.	**HN**
4.	**Matters Arising from JSF Meeting 28th October 2015** • **Care Home Update** K Redpath updated the group. The business case and financial profiling were agreed at the end of December. The Care Home newsletter was noted along with the Community Care Convenors minute. K Redpath highlighted the Dumbarton Care Home is due to open in March 2017 and the Clydebank Care Home is due to open in early 2018. K Redpath recognised there is a balance between the existing Care Homes continuing to run effectively and the migration of staff to the new Care Home in March 2017. Discussions about staffing structure will be progressing in forth coming weeks. TU's requested paper for next meeting. N Wardrop highlighted the growing anxiety amongst staff even though, provisions have been put in place to reduce this i.e. Managing change workshops and the staff newsletter. S Barnatt advised that a detailed piece of work had been completed by UNISON. C McNeill had reviewed and discussed with Joint Trade Unions.	**CMcN**

	• **Health Improvement, Strategy & Planning Redesign** S Sengupta and S Barnatt meeting today to discuss re-design with the Trade Unions, S Sengupta to provide an update at next meeting. • **Joint Staff Forum Constitution**- paper/07 P O'Neill, D McCrone and S Barnatt met on 18th January to discuss the JSF Constitution. Amend point 15 and remove logo from Appendix 1 and agreed to sign off revised Constitution.	**SS** **HN**
5.	**Finance** J Middleton provided a presentation on the current Financial Position for the HSCP. This included savings for overall HSCP budget. Discussion took place around the savings options and it was acknowledged the settlement for Council budgets was still to be agreed.	
6.	**Service Updates** **Children Services and Criminal Justice** • LIG Minute- paper/08 The minute was noted. No issues that need highlighted. P Britten joining the Children's LIG. J Irvine to send invite to the group. • Termination of Service Level Agreements J. Irvine provided an update on the termination of the specialist children's services SLA provided to Highland Health Board. On track to terminate by the end of March 2016. Staff were given 6 months notice of intention to terminate. Staff affected by TUPE have been met with on one-to-one basis and the transfer will happen 1st April 2016. • Criminal Justice Redesign J. Irvine provided an update on the commencement of the Criminal Justice Services redesign. J Irvine had met with convenors and formal consultations with affected employees will commence on 15th February 2016. Staff involved will receive letters and Trade Unions are currently involved. The Joint Staff Forum will be provided an update at the next meeting. **Health and Community Care** • Integrated Care Fund K Redpath updated the group and previous minute was noted. D Markham and D McCrone currently sitting on the Integrated Care Fund group as Trade Union Representatives.	**JI** **JI**

	Mental Health Services • Hardgate Relocation- paper/09 J Russell provided an update on the relocation from Hardgate to Goldenhill. There is a working group in place looking at the relocation. Relocation begins end of February 2016. • Proposed Transfer of Beds- paper/10 J Russell provided an update on the transfer of Dementia beds from Gartnavel Royal Hospital to Glenarn Ward at Dumbarton Joint Hospital. Discussed at the Integrated Joint Board.	
7.	**Standing Items:** • Health & Social Care Partnership Board K Redpath provided an update. The group met in November 2015 discussed mid year performance on Integrated Care Fund. Highlighted Primary Care out of hours service work is being undertaken locally. The Agenda is still to be agreed. K Redpath confirmed there will be an update on Finance, Integrated Care Fund and Primary Care Developments. • Discipline & Grievance Report- paper/11 N Bailey and G Gall provided an update on the quarterly Discipline and Grievance report. N Bailey and G Gall answered questions from the Joint Trade Unions. • Attendance Management Report- paper/12 N Bailey and G Gall provided an update report on Absence for the HSCP. N Bailey and G Gall answered questions from the Joint Trade Unions. • Health & Safety Forum Minutes- paper/13 The Minute was noted and reviewed. S Barnatt highlighted that the WDC Health and Safety team have introduced Figtree. The group have reviewed the Management Manual Holders and Fire Wardens, these have been updated accordingly as part of the Annual update. • CAS Project Board Minute- paper/14 The Minute was noted and reviewed. KR still in discussions with Council Chief Executive regarding the Council Administration Review. Future updates will be provided to the group.	**KR**
8.	**Staff Survey Results 2015** N Bailey and G Gall provided a presentation on the latest Staff Survey results from WDC and NHS for staff working in the HSCP. The presentation covered areas where scores were positive and suggested areas for improvement. Nominations were sought from Trade Unions for representatives to participate on the Short Life Working Group to look at results in	

	more detail. G Gall will reconvene the working group to update the Staff Governance and Practice Framework; any nominations go directly to G Gall. An update on the Staff Governance and Practice Framework to be brought to the next meeting.	**GG/NB**
9.	**NHS Pension Re-enrolment-** paper/15 The paper was noted for the groups information.	
10.	**Trade Unions Bill** Trade Unions Bill is an item on APF agenda. Staff side and Management opposed to the proposals. H Napier to circulate email from D McCrone to JSF members.	**HN**
11.	**Foot care in Residential Care Homes** N Wardrop requested Foot care in Residential Care Homes as an agenda item. Podiatry service has stopped cutting patient toenails. Care staff are currently undertaking this role however, an incident recently occurred. K Redpath suggested discussing this in C McNeill's Community Care Convenors meeting. N Wardrop agreed to pick this up with C McNeill outwith the JSF.	**NW**
12.	**Nursing Revalidation** There has been great support within the HSCP surrounding nursing Revalidation. Heads of Service confirmed arrangements were in place to support staff with nursing revalidation. .	
13.	**Dates for Meetings** HN to circulate proposed meeting schedule to all JSF members.	**HN**
14.	**Any Other Business** There was no further business and the meeting closed at 12.00pm.	
15.	**Date of Next Meeting** To be confirmed.	