

Agenda

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board

Date: Wednesday, 22 November 2017

Time: 14:00

Venue: Council Chamber, Clydebank Town Hall, Dumbarton Road, Clydebank

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

Dear Member

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

The business is shown on the attached agenda.

Yours faithfully

BETH CULSHAW

Chief Officer of the
Health & Social Care Partnership

Distribution:-

Voting Members

Marie McNair (Chair)
Denis Agnew
Allan Macleod
John Mooney
Rona Sweeney
Audrey Thompson

Non-Voting Members

Barbara Barnes
Kenneth Ferguson
Wilma Hepburn
Jackie Irvine
John Kerr
Neil Mackay
Diana McCrone
Anne MacDougall
Kim McNabb
Janice Miller
Peter O'Neill
Keith Redpath
Selina Ross
Julie Slavin
Alison Wilding
Vacancy

Senior Management Team – Health & Social Care Partnership

Date of issue: 9 November 2017

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

WEDNESDAY, 22 NOVEMBER 2017

AGENDA

1 APOLOGIES

2 DECLARATIONS OF INTEREST

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

3 MINUTES OF PREVIOUS MEETING 9 - 15

Submit, for approval as correct record, Minutes of Meeting of the West Dunbartonshire Health & Social Care Partnership held on 23 August 2017.

4 MEMBERSHIP OF THE PARTNERSHIP BOARD 17 - 18

Submit report by the Head of Strategy, Planning & Health Improvement requesting confirmation of a new non-voting member of the Partnership Board.

5 (a) PRESENTATION ON PERFORMANCE OF THE HEALTH AND SOCIAL CARE PARTNERSHIP

The Head of Strategy, Planning and Health Improvement and the Chief Finance Officer will provide a presentation on the current performance of the Health and Social Care Partnership.

(b) PUBLIC PERFORMANCE REPORT APRIL TO JUNE 2017 19 - 44

Submit report by the Head of Strategy, Planning & Health Improvement presenting the Health & Social Care Partnership's Public Performance Report for the first quarter of 2017/18 (April to June 2017).

6/

6 MOVING FORWARD TOGETHER: NHS GREATER GLASGOW & CLYDE'S HEALTH AND SOCIAL CARE TRANSFORMATIONAL STRATEGY PROGRAMME 45 - 99

Submit report by the Head of Strategy, Planning & Health Improvement advising of work being carried out by NHS Greater Glasgow and Clyde to develop a Transformation Strategy for services within the Health Board area.

7 REGIONAL PLANNING WITH REGARD TO THE SCOTTISH GOVERNMENT'S HEALTH AND SOCIAL CARE DELIVERY PLAN 101 - 187

Submit report by the Head of Strategy, Planning & Health Improvement advising of work being led by the Chief Executive of NHS Ayrshire and Arran in his capacity as Regional Implementation Lead (West of Scotland) to develop a regional plan for the West of Scotland in accordance with the national Health and Social Care Delivery Plan.

8 CHIEF SOCIAL WORK OFFICER'S ANNUAL REPORT 2016 - 2017 189 - 235

Submit report by the Chief Social Work Officer presenting the West Dunbartonshire Chief Social Work Officer's Annual Report for the period 1st April 2016 to end of March 2017.

9 FREEDOM OF INFORMATION POLICY 237 - 250

Submit report by the Head of Strategy, Planning & Health Improvement seeking approval of a new Freedom of Information Policy, as detailed within the appendix to the report.

10 STRATEGIC RISK REGISTER - UPDATE 251 - 260

Submit report by the Head of Strategy, Planning & Health Improvement seeking approval of the updated Strategic Risk Register, as detailed within the Appendix to the report.

11 CLIMATE CHANGE REPORT 261 - 277

Submit report by the Head of Strategy, Planning & Health Improvement seeking approval of the Climate Change Report for formal submission to the Scottish Government in advance of the 30 November 2017 deadline.

12/

12 AUDITED ANNUAL ACCOUNTS 2016/17 279 - 345

Submit report by the Chief Financial Officer presenting the Annual Audit Report, prepared by the HSCP Board's external auditors, Audit Scotland and the Annual Accounts for the year ended 31 March 2017.

13 2017/18 BUDGET UPDATE AND FINANCIAL PERFORMANCE REPORT AS AT PERIOD 6 (30 SEPTEMBER 2017) 347 - 364

Submit report by the Chief Financial Officer providing:-

- (a) an update on the 2017/18 revenue budget position;
- (b) an update on the financial performance as at period 6 to 30 September 2017;
- (c) an update on the Scottish Living Wage extending to sleepovers; and
- (d) an update on the 2018/19 budget setting process.

14 UNSCHEDULED CARE (WINTER) PLAN 2017/18 365 - 380

Submit report by the Head of Strategy, Planning & Health Improvement seeking approval of the Unscheduled Care (Winter) Plan, as detailed within the appendix to the report.

15 WEST DUNBARTONSHIRE LOCAL OUTCOME IMPROVEMENT PLAN 381 - 401

Submit report by the Head of Strategy, Planning & Health Improvement seeking endorsement of the West Dunbartonshire Local Outcome Improvement Plan 2017-2027.

16 WORKFORCE AND ORGANISATIONAL DEVELOPMENT SUPPORT PLAN UPDATE 403 - 419

Submit report by the Head of People and Change seeking endorsement of the Workforce and Organisational Development Strategy update for 2017 and revised support plan for 2018, as detailed within appendix 1 to the report.

17/

Submit for information, the undernoted Minutes of Meetings:-

- (a) Minutes of Meeting of the West Dunbartonshire HSCP Audit Committee held on 20 September 2017.
- (b) Minutes of Meeting of the Clinical & Care Governance Group held on 27 September 2017.
- (c) Minutes of Meeting of the Joint Staff Forum held on 17 October 2017.
- (d) Minutes of Meeting of the Health & Social Care Partnership Joint Locality Group for Clydebank held on 22 August 2017.
- (e) Minutes of Meeting of the Health & Social Care Partnership Joint Locality Group for Dumbarton and Alexandria held on 1 September 2017.
- (f) Note of the West Dunbartonshire Local Engagement Network Physical Disability/Adults with Complex Needs Service Providers and Service Users Workshops: September 2017.

18 PROGRAMME OF DATES FOR FUTURE MEETINGS OF THE PARTNERSHIP BOARD AND AUDIT COMMITTEE

The next meeting of the Health & Social Care Partnership Board will be held on **Wednesday, 31 January 2018 at 2.00 p.m.** in Committee Room 3, Council Offices, Garshake Road, Dumbarton.

Members are requested to agree the undernoted programme of dates for future meetings of both the Partnership Board and Audit Committee (venues for meetings will be confirmed following the move to the new Council offices):-

Health & Social Care Partnership Board

Wednesday, 2 May 2018 at 2.00 p.m.
Wednesday, 8 August 2018 at 2.00 p.m.
Wednesday, 14 November 2018 at 2.00 p.m.

Wednesday, 20 February 2019 at 2.00 p.m.
Wednesday, 8 May 2019 at 2.00 p.m.
Wednesday, 7 August 2019 at 2.00 p.m.
Wednesday, 13 November 2019 at 2.00 p.m.

Wednesday, 19 February 2020 at 2.00 p.m.
Wednesday, 20 May 2020 at 2.00 p.m.

Wednesday, 5 August 2020 at 2.00 p.m.
Wednesday, 4 November 2020 at 2.00 p.m.

Wednesday, 27 January 2021 at 2.00 p.m.
Wednesday, 19 May 2021 at 2.00 p.m.
Wednesday, 4 August 2021 at 2.00 p.m.
Wednesday, 3 November 2021 at 2.00 p.m.

Wednesday, 2 February 2022 at 2.00 p.m.

Health & Social Care Partnership Audit Committee:-

Wednesday, 14 March 2018 at 2.00 p.m.
Wednesday, 20 June 2018 at 2.00 p.m.
Wednesday, 26 September 2018 at 2.00 p.m.
Wednesday, 12 December 2018 at 2.00 p.m.

Wednesday, 13 March 2019 at 2.00 p.m.
Wednesday, 12 June 2019 at 2.00 p.m.
Wednesday, 25 September 2019 at 2.00 p.m.
Wednesday, 11 December 2019 at 2.00 p.m.

Wednesday, 1 April 2020 at 2.00 p.m.
Wednesday, 17 June 2020 at 2.00 p.m.
Wednesday, 23 September 2020 at 2.00 p.m.
Wednesday, 9 December 2020 at 2.00 p.m.

Wednesday, 31 March 2021 at 2.00 p.m.
Wednesday, 16 June 2021 at 2.00 p.m.
Wednesday, 15 September 2021 at 2.00 p.m.
Wednesday, 8 December 2021 at 2.00 p.m.

Wednesday, 23 March 2022 at 2.00 p.m.



WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

At a Meeting of the West Dunbartonshire Health & Social Care Partnership Board held in Committee Room 3, Council Offices, Garshake Road, Dumbarton, on Wednesday, 23 August 2017 at 2.00 p.m.

Present: Councillor Marie McNair (Chair), Bailie Denis Agnew and Councillor John Mooney, West Dunbartonshire Council; Allan Macleod and Audrey Thompson, NHS Greater Glasgow and Clyde Health Board.

Non-Voting Members: Beth Culshaw, Chief Officer; Julie Slavin, Chief Financial Officer; Kenneth Ferguson, Clinical Director for the Health & Social Care Partnership; Barbara Barnes, Chair of the Local Engagement Network – Alexandria & Dumbarton; Wilma Hepburn, Professional Nurse Advisor; Jackie Irvine, Chief Social Work Officer; Jamie Dockery – Housing Strategy Officer (substitute for John Kerr); Diane McCrone, NHS Staff Side Co-Chair of Joint Staff Forum; Anne MacDougall, Chair of Local Engagement Network – Clydebank; Neil Mackay, Chair of Locality Group – Alexandria & Dumbarton; Janice Miller, Lead Allied Health Professional; Peter O'Neill, WDC Staff Side Co-Chair of Joint Staff Forum.

Attending: Serena Barnett, Head of People and Change; Julie Lusk, Head of Mental Health, Learning Disability & Addictions; Chris McNeill, Head of Community Health & Care; Soumen Sengupta, Head of Strategy, Planning and Health Improvement; Nigel Ettles, Principal Solicitor and Nuala Borthwick, Committee Officer.

Apologies: Apologies for absence were intimated on behalf of Rona Sweeney, NHS Greater Glasgow and Clyde and Dr Martin Perry, Acute Consultant.

Councillor Marie McNair in the Chair

DECLARATIONS OF INTEREST

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

MINUTES OF PREVIOUS MEETING

The Minutes of Meeting of the West Dunbartonshire Health & Social Care Partnership Board held on 31 May 2017 were submitted and approved as a correct record.

MEMBERSHIP OF THE PARTNERSHIP BOARD

A report was submitted by the Head of Strategy, Planning & Health Improvement requesting that the Partnership Board note the confirmation by the Health Board of a new voting member of the Partnership Board.

Having heard the Chair, Councillor McNair, and following a welcome and introductions, the Partnership Board agreed to note the confirmation by the Health Board of Audrey Thompson as a new voting member of the Partnership Board.

APPOINTMENT OF CHIEF OFFICER

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

After discussion and having heard from the Chief Officer, the Board agreed to formally appoint Beth Culshaw as Chief Officer of the Partnership Board.

WEST GLASGOW MINOR INJURY SERVICES

A report was submitted by the Clinical Director providing an update on a review of West Glasgow Minor Injury Services, currently being undertaken by NHS Greater Glasgow & Clyde and Glasgow City Health & Social Care Partnership.

After discussion and having heard the Chief Officer and the Clinical Director, WDHSCP in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

- (1) to provide the undernoted comments on the review of West Glasgow Minor Injury Services:-
 - (a) that concerns were expressed around the lack of consultation with residents of West Dunbartonshire and that it be recommended to NHS Greater Glasgow & Clyde and Glasgow City Health & Social Care Partnership that the consultation be extended to include residents of West Dunbartonshire; and
 - (b) that improved transport links for access to Minor Injury Services were required for residents of West Dunbartonshire; and

- (2) that any future communication with Glasgow City Health & Social Care Partnership would be delegated to the Chair of the West Dunbartonshire Health & Social Care Partnership Board.

NHS GGC MUSCULOSKELETAL PHYSIOTHERAPY SERVICE REPORT

A report was submitted by the MSK Physiotherapy Service Manager providing an annual update from the NHS Greater Glasgow & Clyde Musculoskeletal Physiotherapy Service which is hosted by West Dunbartonshire Health & Social Care Partnership.

After discussion and having heard the Chief Officer and the MSK Physiotherapy Service Manager in further explanation of the report and in answer to Members' questions, the Board agreed to note the contents of the report.

Note: Jamie Dockery entered the meeting at this point.

ANNUAL PUBLIC PERFORMANCE REPORT 2016/17

A report was submitted by the Head of Strategy, Planning & Health Improvement presenting the Partnership Board with the second Annual Public Performance Report for the HSCP including a complaints management overview for that full year.

After discussion and having heard the Head of Strategy, Planning & Health Improvement and the Head of Children's Health, Care and Criminal Justice/Chief Social Work Officer in further explanation of the report and in answer to Members' questions, the Board agreed to approve the Annual Public Performance Report for publication.

STRATEGIC PARTNERSHIP AGREEMENT – Y SORT IT

A report was submitted by the Head of Strategy, Planning & Health Improvement seeking approval of the Strategic Partnership Agreement with Y-Sort-It.

After discussion and having heard the Head of Strategy, Planning & Health Improvement in further explanation of the report and in answer to Members' questions, the Board agreed to approve the strategic partnership agreement with Y-Sort-It.

THE NATIONAL HEALTH AND SOCIAL CARE STANDARDS – MY SUPPORT, MY LIFE

A report was submitted by the Head of Strategy, Planning & Health Improvement providing information on the recently launched National Health and Social Care Standards.

Having heard the Head of Strategy, Planning & Health Improvement in further explanation of the report, the Board agreed:-

- (1) that paragraph 3.4 of the report be amended to read 'June 2017'; and
- (2) to otherwise note the terms of the new National Health & Social Care Standards – My Support, My Life.

WEST DUNBARTONSHIRE COMMUNITY PLANNING PARTNERSHIP CHILDREN'S SERVICES PLAN 2017 - 2020

A report was submitted by the Head of Children's Health, Care and Criminal Justice presenting the West Dunbartonshire Community Planning Partnership Integrated Children's Services Plan, in line with the requirements of the Children and Young People's Act (2014).

After discussion and having heard the Head of Children's Health, Care and Criminal Justice/Chief Social Work Officer in further explanation of the report and in answer to Members' questions, the Board agreed:-

- (1) to note that the plan, subject to minor amendments, would be submitted to the Community Planning West Dunbartonshire Management Board on 14 September 2017 for approval;
- (2) to re-affirm its commitment to the priorities within the Children Services Plan across West Dunbartonshire Community Planning Partners; and
- (3) to otherwise note the content of the report and the attached Integrated Children's Services Plan 2017-2020.

UNISON'S ETHICAL CARE CHARTER

A report was submitted by the Head of People and Change providing information on the principles of UNISON's Ethical Care Charter.

After discussion and having heard the Chief Officer and the Head of People and Change in further explanation of the report and in answer to Members' questions, the Board agreed:-

- (1) to accept and adopt the principles outlined in the UNISON Ethical Care Charter; and
- (2) that a standing item of business entitled 'UNISON Ethical Care Charter' would be included on future agendas of the Joint Staff Forum to provide a route for the Trade Union representatives to raise and resolve any issues relating to adoption of the Charter.

2017/18 BUDGET UPDATE AND FINANCIAL PERFORMANCE REPORT AS AT PERIOD 3 (30 JUNE 2017)

A report was submitted by the Chief Financial Officer:

- (a) providing an update on the 2017/18 revenue budget position;
- (b) providing an update on the financial performance of the WD Health & Social Care Partnership as at period 3 up to 30 June 2017; and
- (c) providing an update on the 2018/19 budget setting process.

A copy of a letter from James Hobson, Assistant Director of Finance, NHS Greater Glasgow and Clyde (NHSGGC), providing an updated budget proposal for 2017/18 was distributed.

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

- (1) to note the updated position in relation to the 2017/18 budget allocation offer from NHSGGC as detailed in the above mentioned letter and approve the budget offer as it now satisfies the requirement to maintain budget at 2016/17 cash levels;
- (2) to approve the application of £3.6m reduction in 2017/18 across all HSCPs by way of a recharge from NHSGGC for one year only;
- (3) to note the revenue position for the period 1 April 2017 to 30 June 2017 was reporting an overspend of £0.212m (-0.60%);
- (4) to note the commencement of the 2018/19 budget setting process and the potential level of savings required to be met will be in the region of 5%; and
- (5) that a Members Briefing Session would be scheduled to provide an opportunity to discuss future budget challenges.

ANNUAL REPORT AND ACCOUNTS 2016/17 PROCESS

A report was submitted by the Chief Financial Officer providing an outline of the legislative requirements and key stages of the Annual Report and Accounts process for the HSCP covering the period 1 April 2016 to 31 March 2017.

After discussion, the Partnership Board agreed:-

- (1) to note that the Annual Report and Accounts would be subject to audit review; and

- (2) to delegate authority to the HSCP Audit Committee to formally approve the audited accounts at its meeting scheduled to be held on 20 September 2017, prior to submission to the Accounts Commission by 30 September 2017 in line with the approved Partnership Board's Terms of Reference.

MINUTES OF MEETINGS FOR NOTING

The undernoted Minutes of Meetings were submitted and noted:-

- (1) Minutes of Meeting of the Health & Social Care Partnership Board Audit Committee held on 22 June 2017.
- (2) Minutes of Meeting of the Clinical & Care Governance Group held on 31 May 2017.
- (3) Minutes of Meeting of the Joint Staff Forum held on 18 July 2017.
- (4) Minutes of Meeting of the Health & Social Care Partnership Locality Group for Alexandria & Dumbarton held on 19 May 2017.
- (5) Minutes of Meeting of the Health & Social Care Partnership Locality Group for Clydebank held on 25 April 2017.
- (6) Minutes of Joint Localities Local Engagement Network Open Forum Workshop: COPD held on 9 June 2017.

DATES OF FUTURE MEETINGS

Members noted that the next meeting of the Partnership Board will be held on Wednesday, 22 November 2017 at 2.00 p.m. It was agreed that venue for the meeting be changed to Clydebank Town Hall, 49 Dumbarton Road, Clydebank G81 1UA.

It was agreed that a further meeting of the Partnership Board would be held on Wednesday, 31 January 2018 in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU (venue to be confirmed given pending move to new Council Building).

EXCLUSION OF PRESS AND PUBLIC

The Committee approved the undernoted 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 item of business involves the likely disclosure of exempt information as defined in Paragraph 6 of Part 1 of Schedule 7A to the Act.”

Note:- All officers with the exception of Beth Culshaw, Chris McNeill, Ken Ferguson, Nigel Ettles and Nuala Borthwick left the meeting at this point in the proceedings.

DUMBARTON HEALTH CENTRE GP PRACTICE

A report was submitted by the Clinical Director providing a detailed description on changes to the former Dr Neilson and Dr McGonagle Practice in Dumbarton Health Centre.

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

- (1) to note the outcome of the comprehensive process followed by NHS Greater Glasgow & Clyde and the WD Health & Social Care Partnership to ensure safe and sustainable provision of GP services to patients of the practice; and
- (2) to thank the Clinical Director and his team for bringing a positive resolution to the situation.

The meeting closed at 3.22 p.m.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP**Health & Social Care Partnership Board: 22nd November 2017**

Subject: Membership of the Partnership Board**1. Purpose**

1.1 To nominate a new non-voting member to the Partnership Board.

2. Recommendation

2.2 The voting members of the Partnership Board are recommended to appoint the nominated non-voting member 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 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 states that an integration joint board's non-voting membership must include a registered medical practitioner employed by the Health Board and not providing primary medical services (as one of its professional advisors).

3.3 The Health Board's Medical Director has notified the Chief Officer that Martin Perry (Consultant/Clinical Lead at the Vale of Leven Hospital) will be stepping down from the Partnership Board; and has identified Christopher Jones (Chief of Medicine) as his successor.

4. Main Issues

4.1 The Partnership Board is asked to appoint Christopher Jones as a non-voting member and professional advisor on the Partnership Board.

5. People Implications

5.1 None.

6. Financial Implications

6.1 None.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 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.

10. Impact Assessments

10.1 Not applicable.

11. Consultation

11.1 Not applicable.

12. Strategic Assessment

12.1 Not applicable.

Author: Mr Soumen Sengupta – Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Social Care Partnership.

Date: 8 November 2017

Person to Contact: Soumen Sengupta
Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Social Care Partnership,
West Dunbartonshire HSCP HQ, West Dunbartonshire
Council, Garshake Road, Dumbarton, G82 3PU.
E-mail: soumen.sengupta@ggc.scot.nhs.uk

Appendices: None

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

HSCP Board Report (May 2016): Membership of the
Partnership Board

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

HSCP Board Report (July 2015): Integration Scheme

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 22nd November 2017

Subject: Public Performance Report April to June 2017

1. Purpose

1.1 To present the Partnership Board with the Health & Social Care Partnership's Public Performance Report for the first quarter of 2017/18 (April to June 2017).

2. Recommendations

2.1 The Partnership Board is recommended to approve the Partnership Public Performance Report for April to June 2017 for publication.

3. Background

3.1 The Health & Social Care Partnership's Strategic Plan 2016-2019 was approved by the Partnership Board at its August 2016 meeting.

3.2 As the Partnership Board will recall, the strategic performance framework for the Strategic Plan reflects two key principles articulated within the National Framework for Clinical and Care Governance, namely that:

- Values of openness and accountability are promoted and demonstrated through actions.
- All actions are focused on the provision of high quality, safe, effective and person-centred services.

3.3 Building on the Annual Performance Report 2016/17 (received by the Partnership Board at its August 2017 meeting), the first quarterly Public Performance Report for 2017/18 is appended here for consideration.

4. Main issues

4.1 The Public Performance Report for April – June 2017 focuses on those key strategic performance indicators for the Partnership where performance data is available for that specific time period. It has been augmented with data on key aspects of workforce and financial performance (the latter of which have been previously reported to the Partnership Board by the Chief Financial Officer for that period).

4.2 The Public Performance Report has already been formally scrutinised internally by the Partnership's Senior Management Team as part of the internal performance management regime. Once considered by the Partnership Board, this first quarterly Public Performance Report will be published on the Health & Social Care Partnership's website and cascaded to stakeholders.

5. People Implications

- 5.1** The Public Performance Report has been augmented with data on key aspects of workforce performance linked to the Partnership's Workforce & Organisational Development Strategy 2015-2018 (approved by the Partnership Board at its November 2015 meeting).

6. Financial Implications

- 6.1** The Public Performance Report has been augmented with data on key aspects of financial performance (the latter of which have been previously reported to the Partnership Board by the Chief Financial Officer for that period).

7. Professional Implications

- 7.1** No specific implications associated with this report.

8. Locality Implications

- 8.1** No specific implications associated with this report.

9. Risk Analysis

- 9.1** Audit Scotland has stated that public reporting is an important element of best value. This Public Performance Report has been informed by the practice promoted by Audit Scotland, and work will continue to develop local arrangements accordingly.

10. Impact Assessments

- 10.1** None required.

11. Consultation

- 11.1** None required.

12. Strategic Assessment

- 12.1** The Public Performance Report has been produced to enhance in-year scrutiny of the delivery of the Strategic Plan in an open and accountable manner.

Author: Soumen Sengupta - Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Care Partnership

Date: 06 November 2017

Person to Contact: Soumen Sengupta - Head of Strategy, Planning & Health Improvement, Garshake Road, Dumbarton.

E-mail: soumen.sengupta@ggc.scot.nhs.uk
Telephone: 01389 737321

Attached: West Dunbartonshire Health & Social Care Partnership
Public Performance Report April – June 2017

Background Papers: HSCP Board Report (August 2016): Strategic Plan
2016-2019

HSCP Board Report (August 2017): Annual Performance
Report 2016/17

HSCP Board Report (November 2015): Workforce &
Organisational Development Strategy & Support Plan

Scottish Government (2015) National Framework for
Clinical and Care Governance:
<http://www.gov.scot/Resource/0049/00491266.pdf>

Audit Scotland (2010) Best Value Toolkit: Public
Performance Reporting: [http://www.audit-
scotland.gov.uk/docs/best_value/2010/bv_100809_public
performance_reporting_toolkit.pdf](http://www.audit-scotland.gov.uk/docs/best_value/2010/bv_100809_public_performance_reporting_toolkit.pdf)

Wards Affected: All

Public Performance Report

April – June 2017

West Dunbartonshire

Health and Social Care Partnership



Introduction

Welcome to West Dunbartonshire Health and Social Care Partnership's first Public Performance Report for 2017/18.

Building on our [Strategic Plan for 2016-2019](#) we are committed to providing clear and transparent updates on our progress in key priority areas; on an ongoing basis.

More information about Health and Social Care Partnership services is available on our website at www.wdhscp.org.uk.

We are always keen to receive feedback, so whether you want to provide constructive comments on the contents of this report or any of our services more generally, please contact us at www.wdhscp.org.uk/contact-us/headquarters/.

Mr Soumen Sengupta

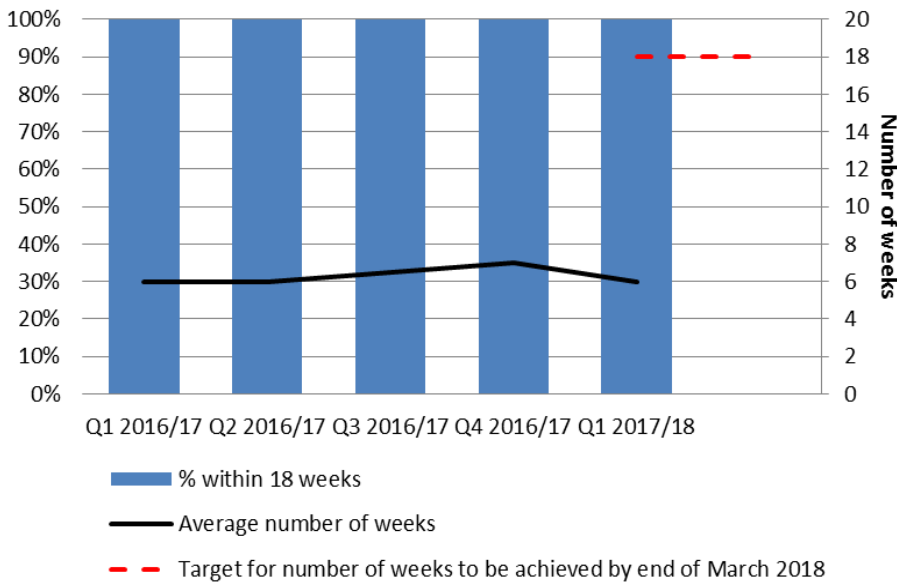
Head of Strategy, Planning & Health Improvement

The West Dunbartonshire Health and Social Care Partnership Board's:

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

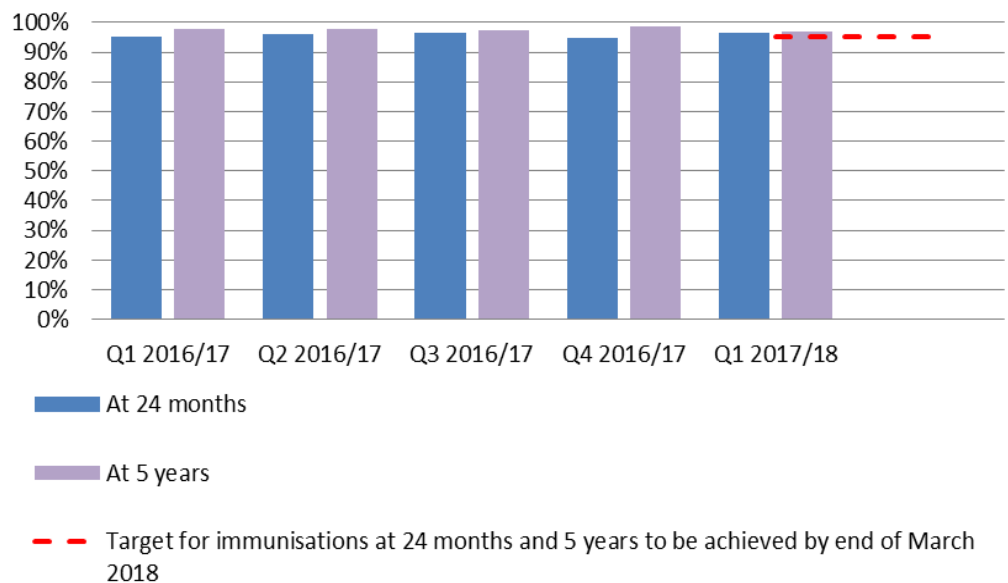
Supporting Children and Families

Child and Adolescent Mental Health Service (CAMHS) Referral to Treatment



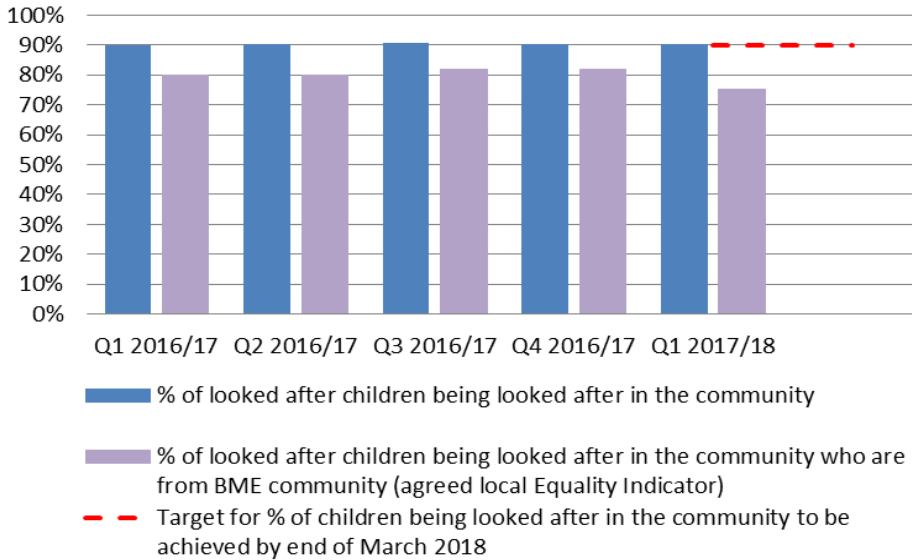
102 children and young people were referred to CAMHS in Qtr1 2017/18, an increase of 8 on the previous quarter. The average time for referral to treatment continues to be well below the 18 week target at 6 weeks.

% Measles, Mumps & Rubella (MMR) immunisations at 24 months and 5 years



198 children had an MMR immunisation at 24 months (96.6%) and 244 children had an MMR immunisation at 5 years (96.8%) in Qtr1 2017/18.

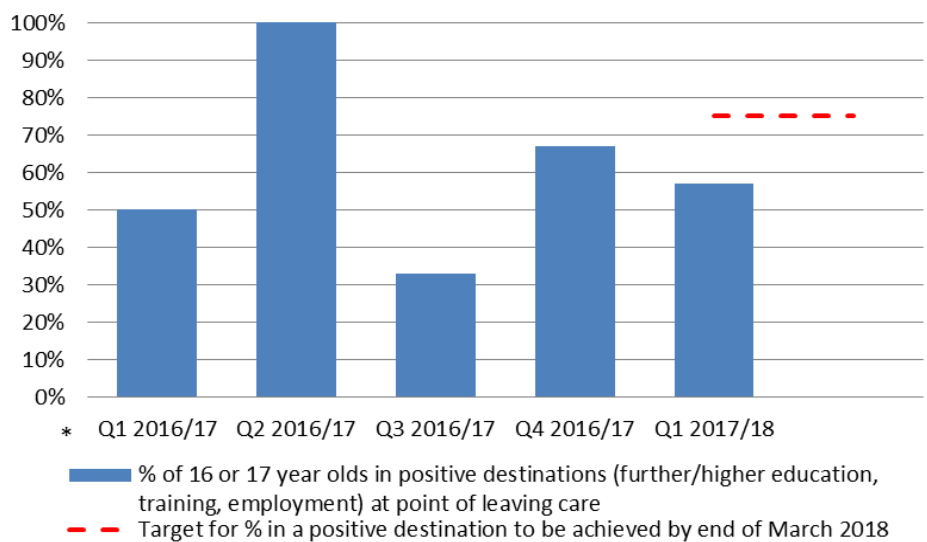
Children Looked After in the Community



389 of the 430 looked after children were looked after in the community (90.5%) in Qtr1 2017/18.

Of the 8 looked after children who happened to be BME (Black & Minority Ethnic), 6 were looked after in the community (75%) in Qtr1 2017/18.

Looked after children entering positive destinations



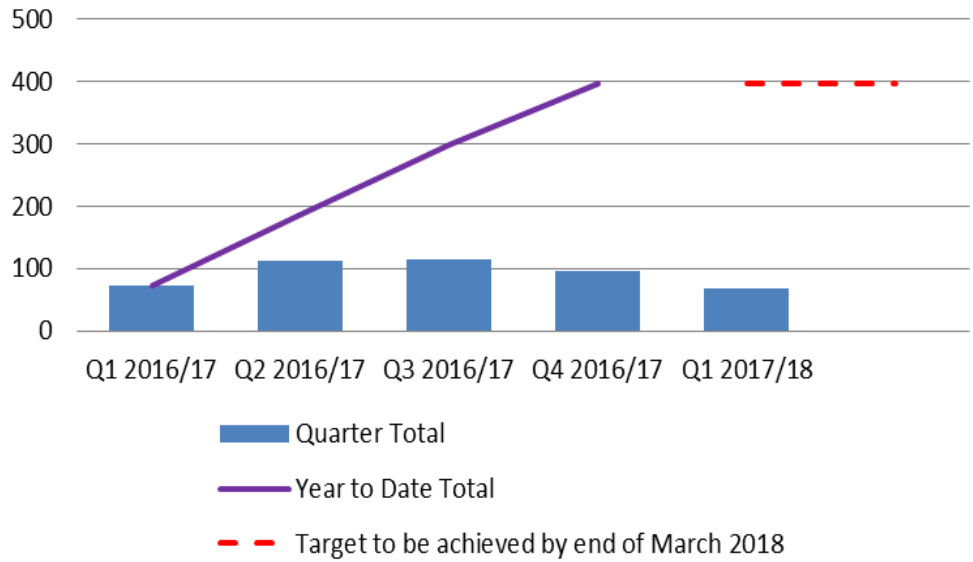
4 of the 7 children (57%) who left care in Qtr1 2017/18 entered a positive destination.

This indicator relates to a very small number of children and therefore the percentage can fluctuate significantly.

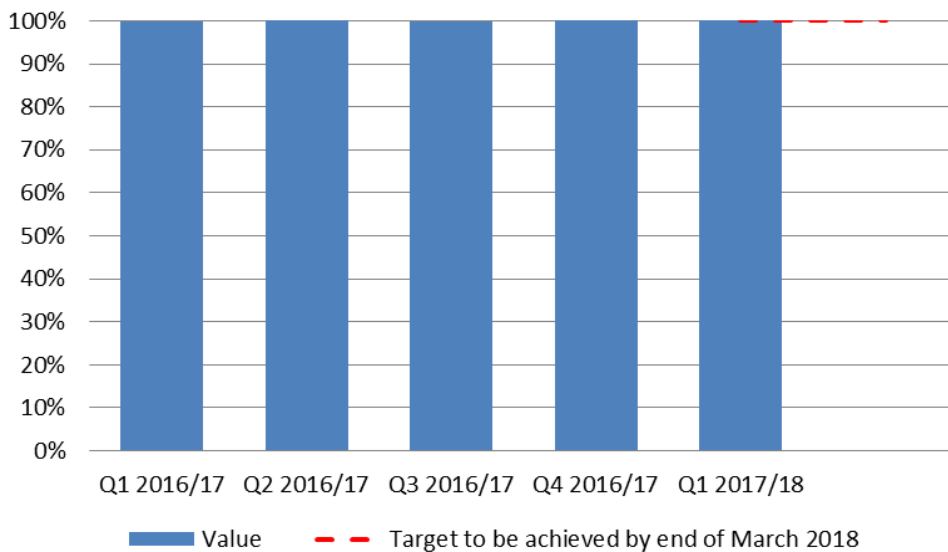
* 2016/17 quarterly figures revised at year end

Number of referrals to the Scottish Children's Reporter on care and welfare grounds

67 children were referred to the Scottish Children's Reporter (68 referrals) on care and welfare grounds during Qtr1 2017/18.



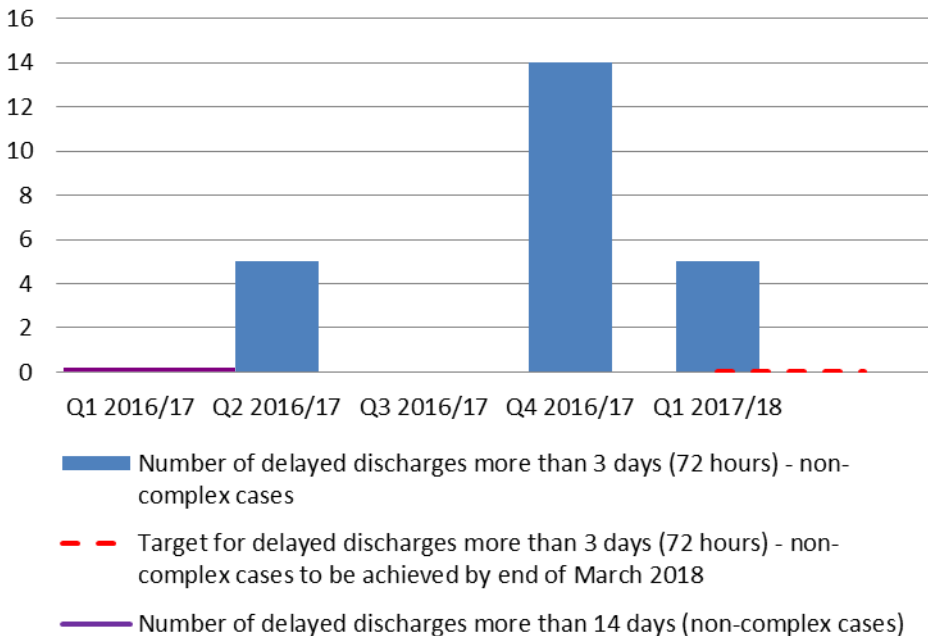
% of all children aged 0-18 years with an identified "named person" as defined within the Children's and Young People's Act 2014



18,807 children (100%) had an identified named person in Qtr1 2017/18.

Supporting Older People

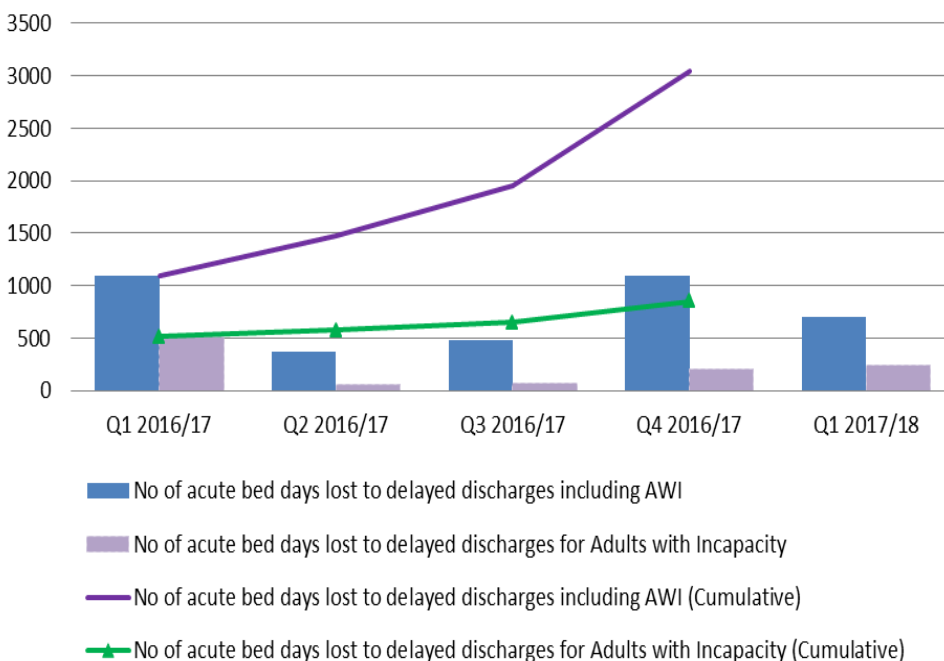
Delayed Discharges



The Scottish Government changed the way delayed discharges are counted from 1st July 2016. The previous figure for delays of more than 14 days has been included in the chart for context/ comparison.

There were 5 delays of more than 3 days for non-complex cases at the census point in Qtr1 2017/18.

Acute bed days lost to delayed discharge (aged 65 and over)

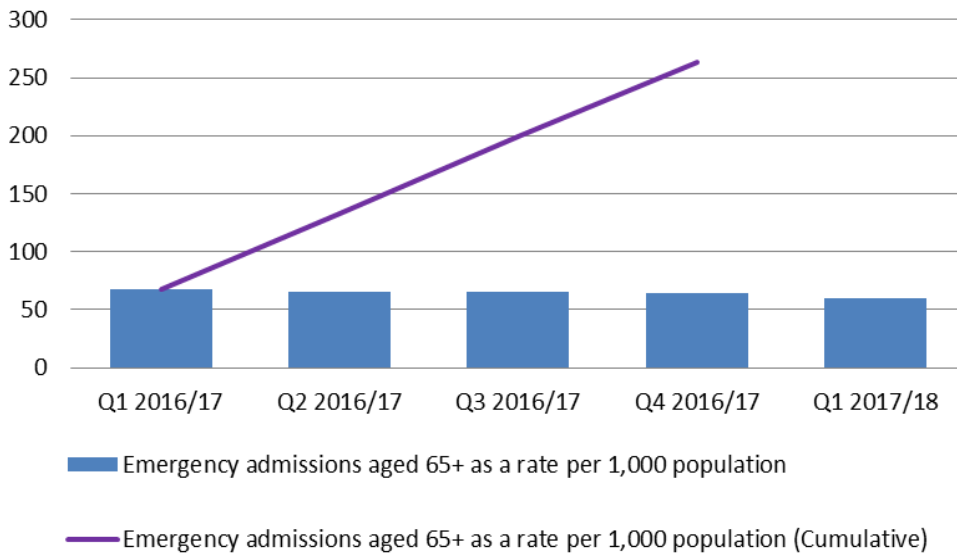


697 bed days were lost to delayed discharge for people aged 65 and over in Qtr1 2017/18. 239 of these bed days were lost to delayed discharge for Adults with Incapacity (AWI).

During the same period in 2016/17, there were 1,095 bed days lost, 516 of which were for AWI.

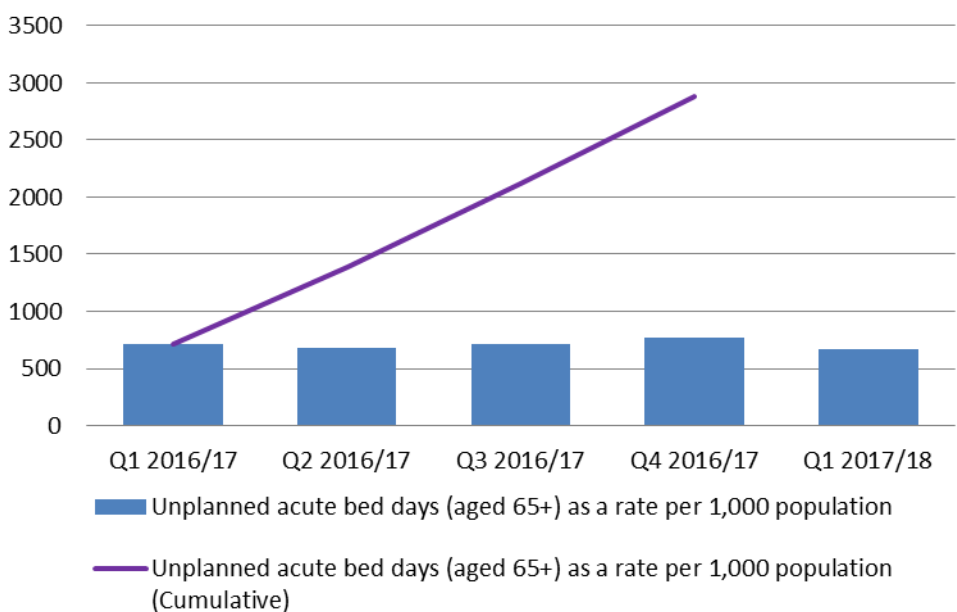
As part of the Scottish Government's Unscheduled Care Planning, targets for reductions in unscheduled or unplanned care are being developed by NHS Greater Glasgow and Clyde. Local targets will be set in line with these.

Emergency Admissions aged 65 and over



There were 953 emergency admissions of people aged 65 and over in Qtr1 2017/18: a rate of 60 per 1,000 population. During the same period in 2016/17, there were 1,076 emergency admissions: a rate of 68 per 1,000 population. Local targets will be set in line with NHS Greater Glasgow and Clyde's Unscheduled Care targets.

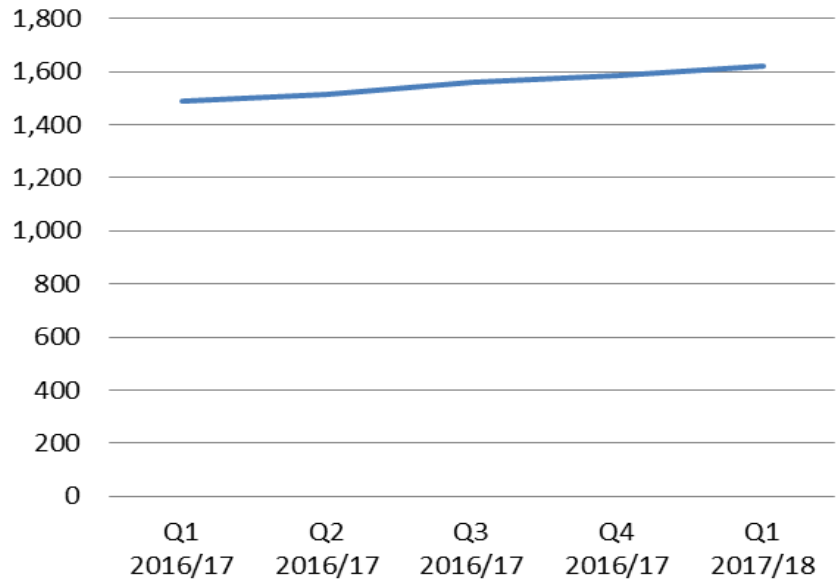
Unplanned acute bed days aged 65 and over



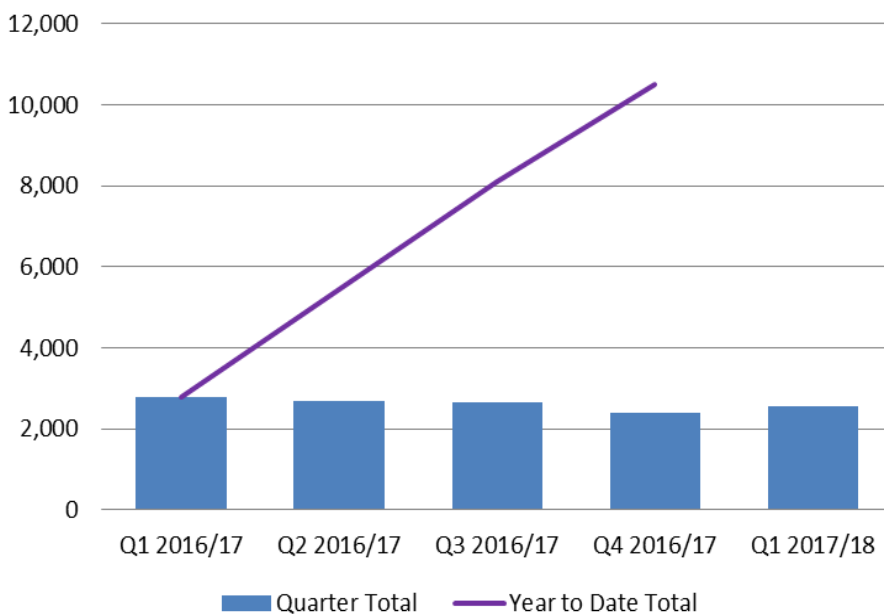
There were 10,643 unplanned acute bed days used by people aged 65 and over in Qtr1 2017/18: a rate of 670 per 1,000 population. During the same period in 2016/17, there were 11,415 unplanned acute bed days used: a rate of 718 per 1,000 population. Local targets will be set in line with NHS Greater Glasgow and Clyde's Unscheduled Care targets.

Rates of attendance per month at Accident and Emergency (A&E) per 100,000 population - Rolling Year

4,594 people attended A&E in Qtr1 2017/18. During the same period in 2016/17, 4,206 people attended A&E. Local targets will be set in line with NHS Greater Glasgow and Clyde's Unscheduled Care targets.

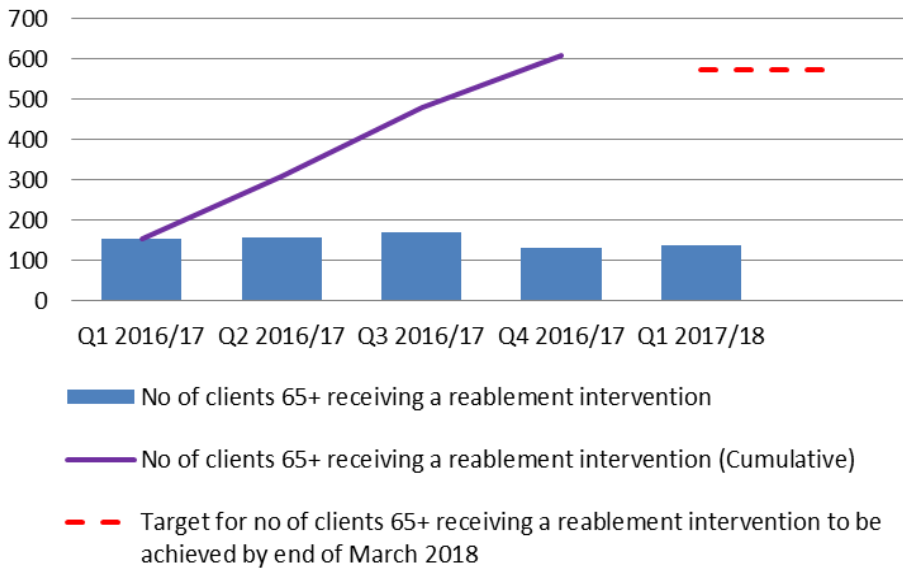


Non-elective inpatient admissions

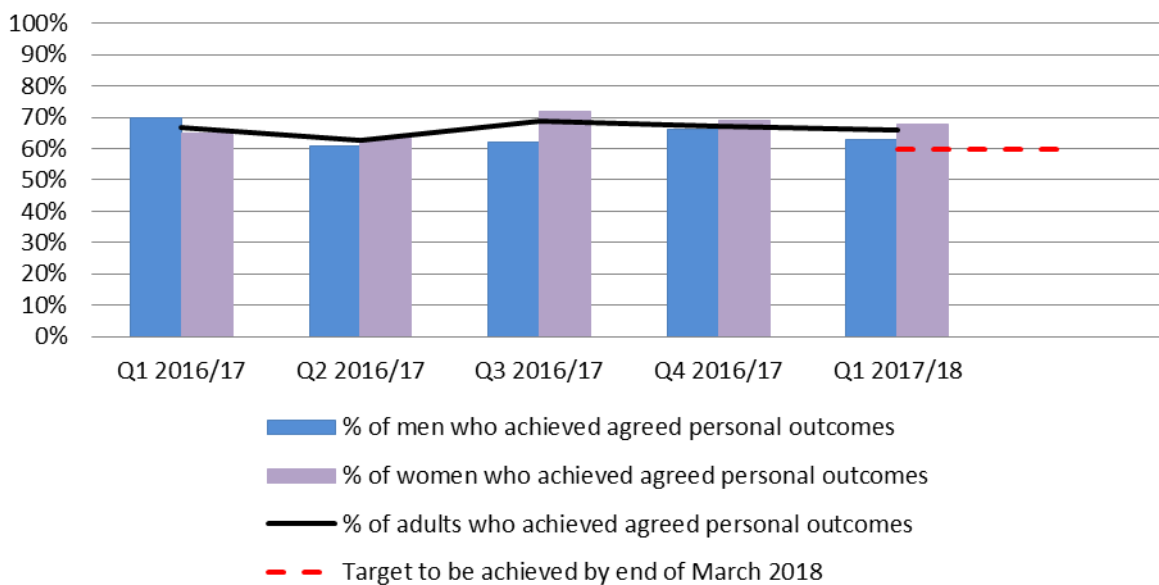


There were 2,556 non-elective inpatient admissions in Qtr1 2017/18. During the same period in 2016/17, there were 2,776 admissions. Local targets will be set in line with NHS Greater Glasgow and Clyde's Unscheduled Care targets.

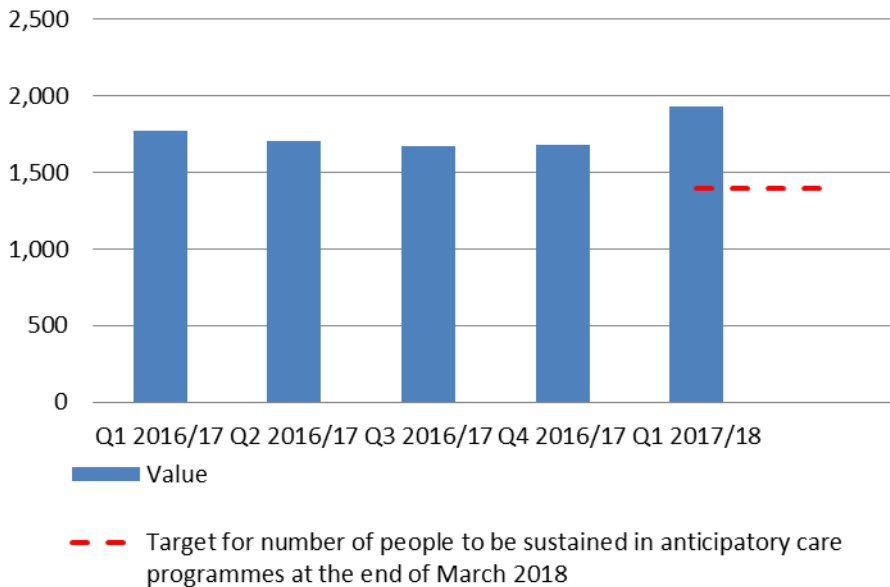
Number of people receiving a reablement intervention



Percentage of adults with assessed care at home needs and a reablement package who have reached their agreed personal outcomes

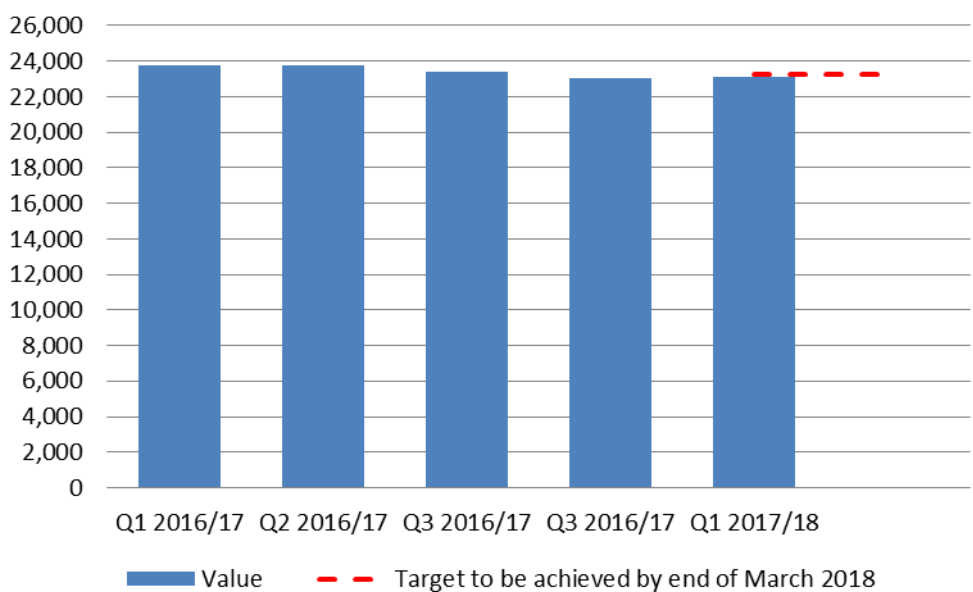


Number of people in anticipatory care programmes



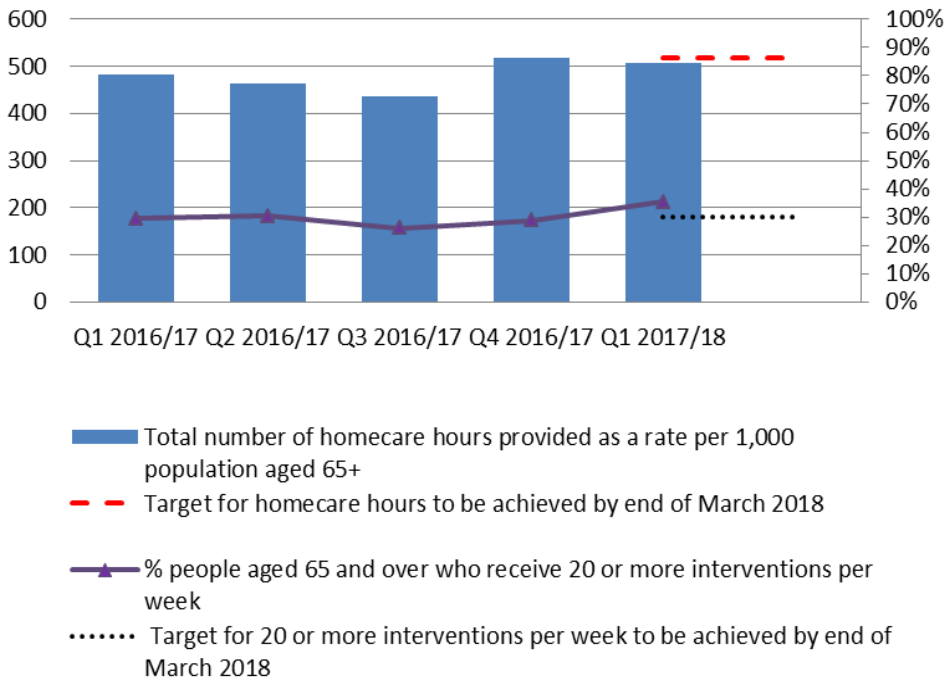
1,932 people had an Anticipatory Care Plan (ACP) in place in Qtr1 2017/18. This figure now includes both GP-led and ACP Support Nurse ACPs.

Number of people aged 75+ receiving Telecare - Crude rate per 100,000 population



1,629 people aged 75 and over received a Telecare service at the end of Qtr1 2017/18.

Homecare hours and interventions

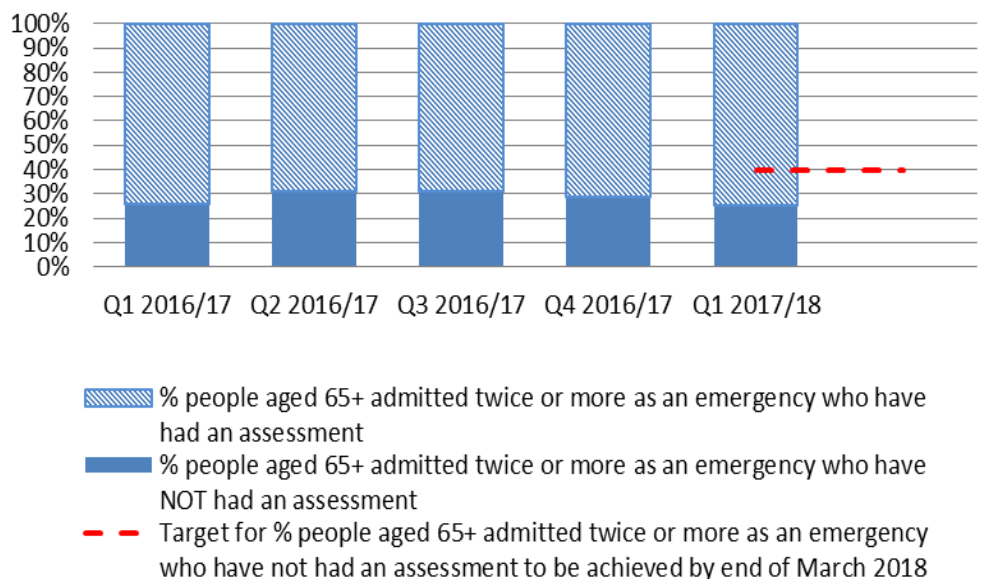


8,197 hours of homecare per week were provided to 1,328 people aged 65 and over in Qtr1 2017/18. This equates to a rate of 506 hours per 1,000 population. 470 people received 20 or more interventions per week (35.4%) in Qtr1 2017/18.

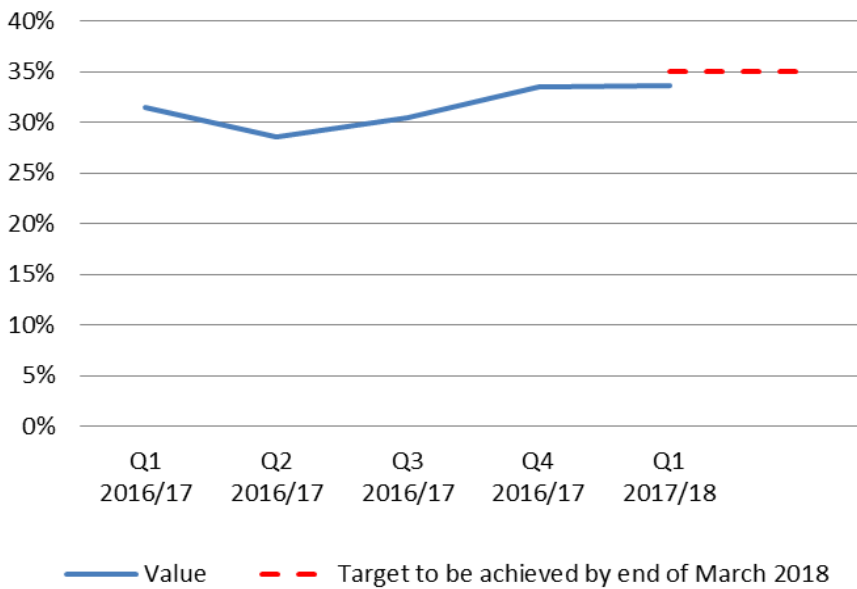
654 people (74.5%) aged 65 and over admitted to hospital twice or more received an assessment of their needs in Qtr1 2017/18.

224 people (25.5%) did not have an assessment.

Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment



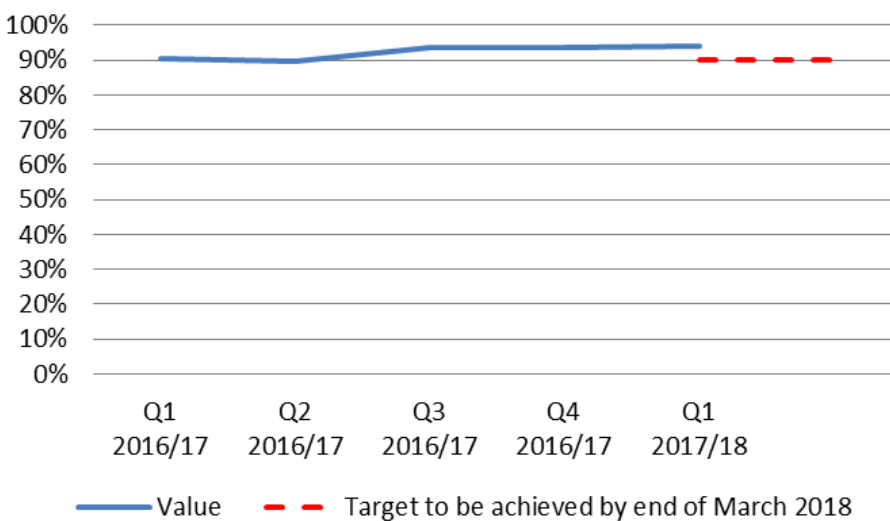
Percentage of people with intensive needs 65+ receiving care at home (10+ hrs) *



286 people aged 65 and over with intensive needs received 10 or more hours of care at home in Qtr1 2017/18.

This indicator is published by the Local Government Benchmarking Framework and measures volume rather than appropriate targeting or alternative supports which may augment homecare such as telecare.

Percentage of care at home clients (65+) receiving personal care



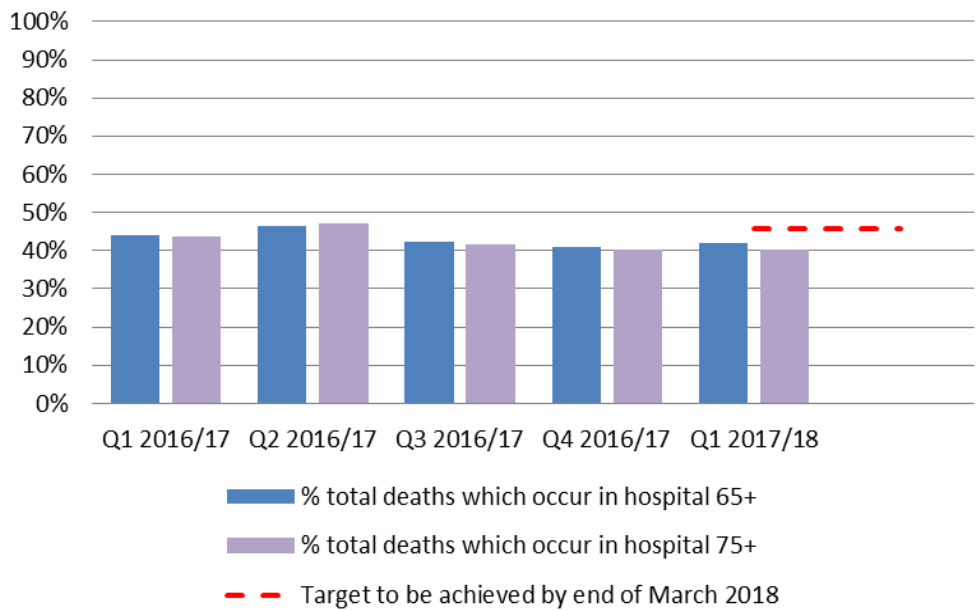
1,247 of 1,328 people (93.9%) aged 65 and over received personal care at home in Qtr1 2017/18.

*A change in the 2015/16 guidance for the collection of Continuing Care data will affect comparability with previous figures. Scottish Government are currently examining options to resolve this and this may result in an update to the data presented here.

42% of all people aged 65 and over who died in Qtr1 2017/18 died in hospital .

40.1% of those aged 75 and over died in hospital: the lowest percentage since January 2011.

Percentage of total deaths which occur in hospital



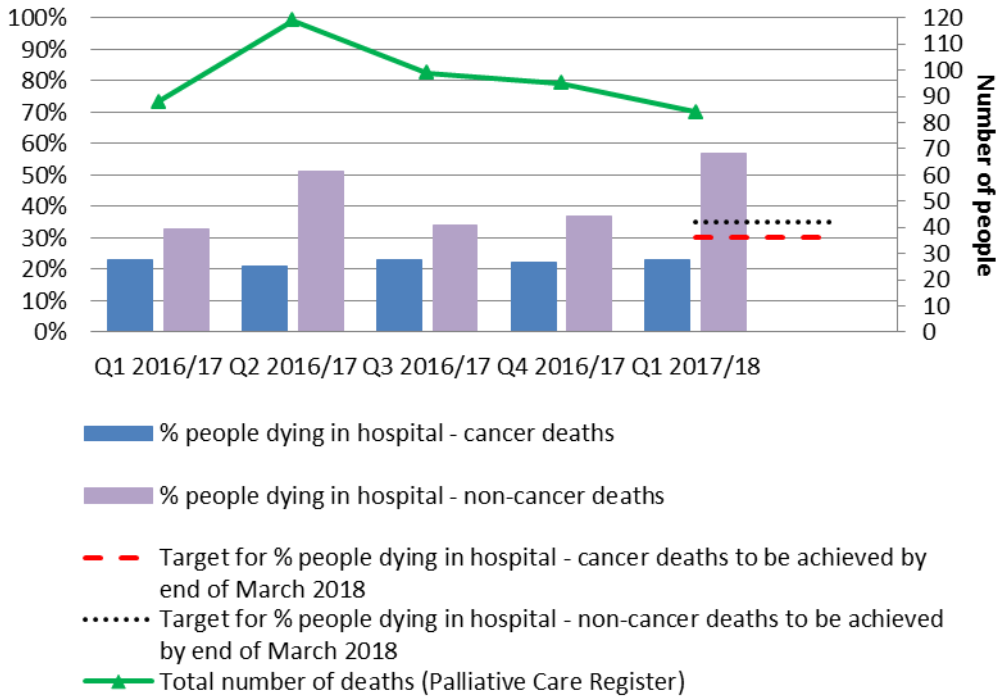
832 people (97.7%) aged 65 and over with complex needs were living in a homely setting in Qtr1 2017/18.

Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting *



*A change in the 2015/16 guidance for the collection of Continuing Care data will affect comparability with previous figures. Scottish Government are currently examining options to resolve this and this may result in an update to the data presented here.

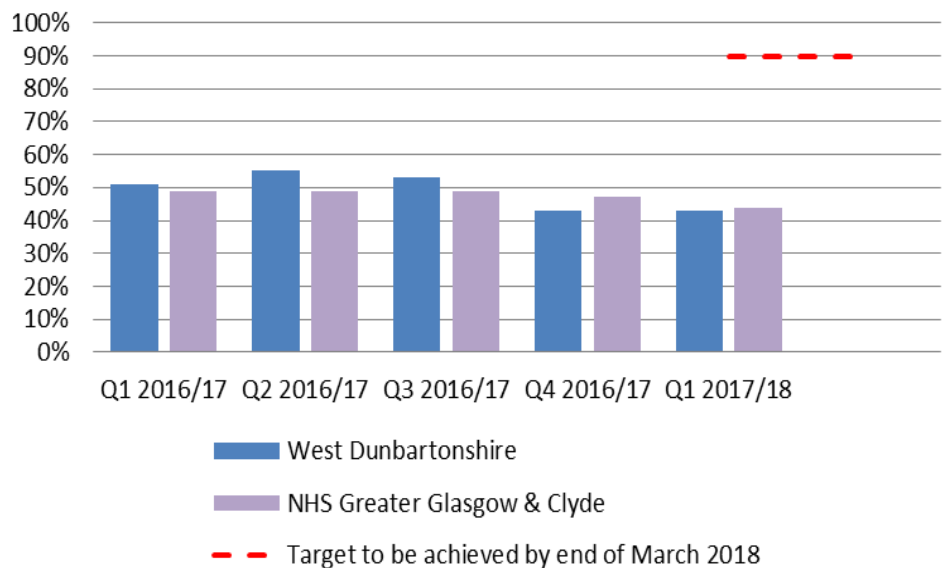
Percentage of people on the Palliative Care Register dying in hospital



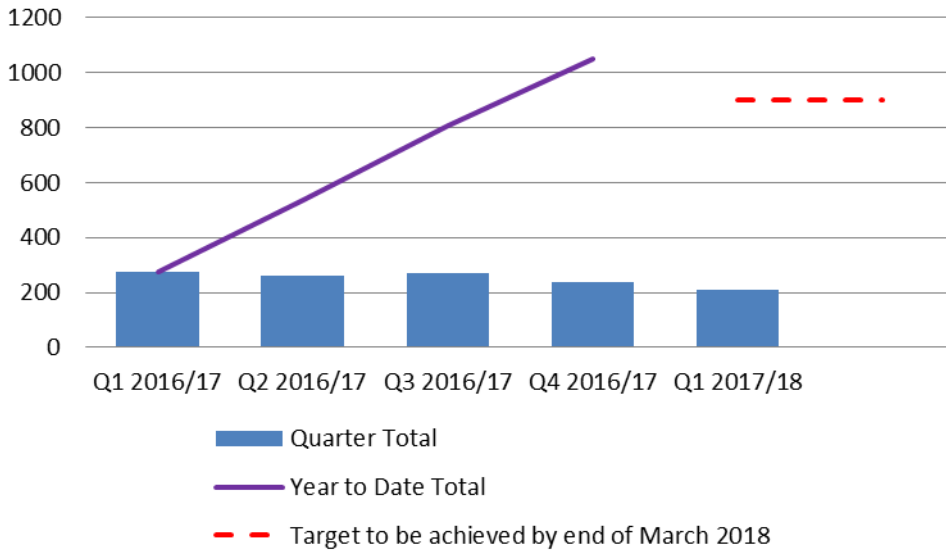
84 people on the Palliative Care Register died in Qtr1 2017/18, 62% of whom were supported to die at home.

Percentage of people seen within 4 weeks for musculoskeletal physiotherapy (MSK) services

1,640 people from West Dunbartonshire and 17,650 from across NHS Greater Glasgow & Clyde were referred to the MSK service in Qtr1 2017/18.

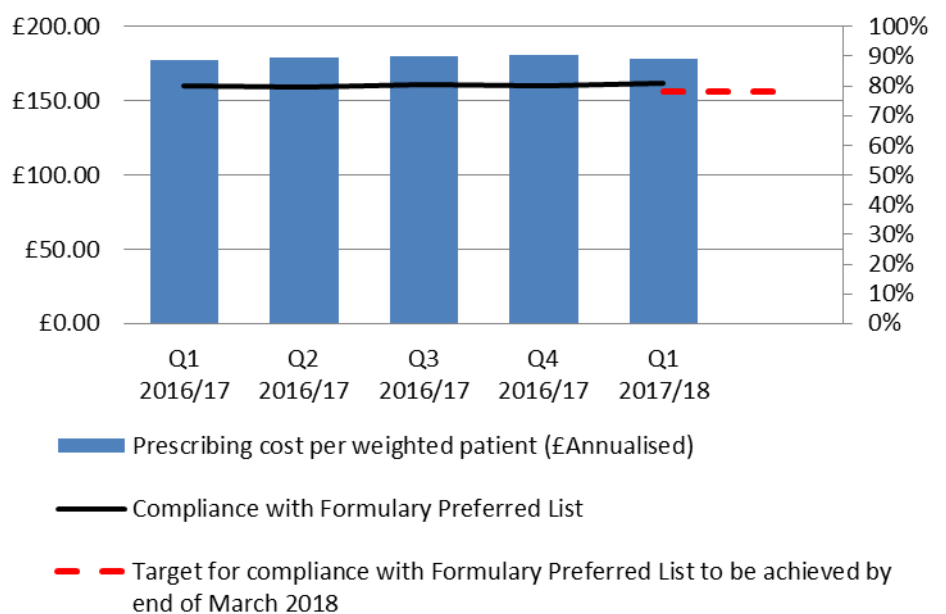


Number of people receiving Homecare Pharmacy Team support



423 people were referred to the Homecare Pharmacy Team in Qtr1 2017/18. 97 people declined the support and 92 people were being supported by other service teams.

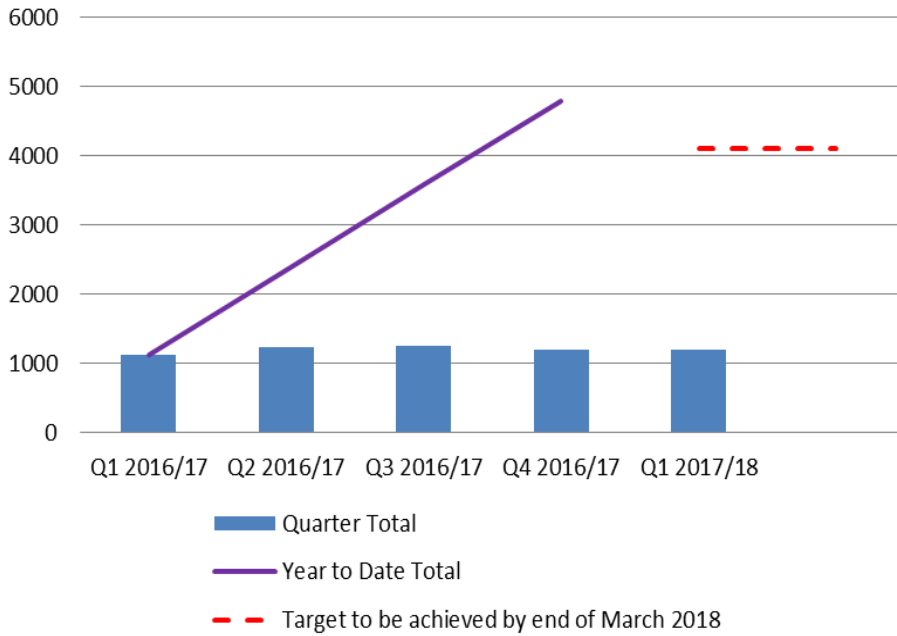
Prescribing cost and compliance with Formulary Preferred List



Compliance with the Formulary Preferred List was 81.1% in Qtr1 2017/18.

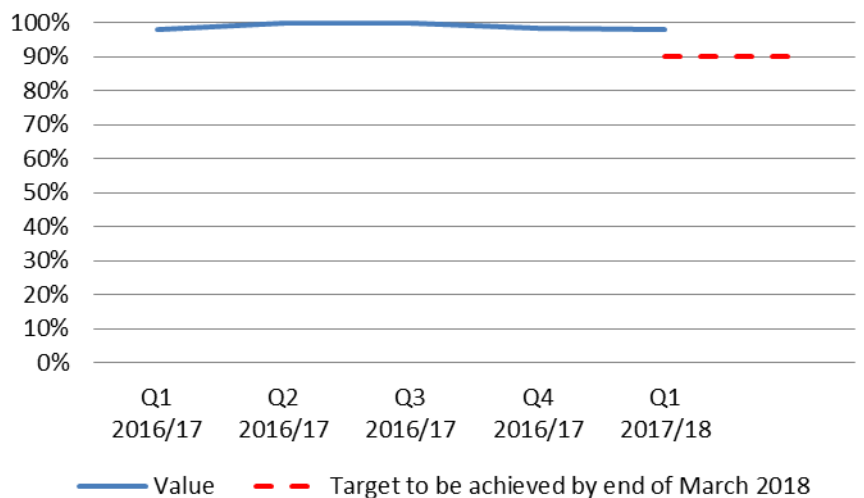
WDHSCP's prescribing cost target is the average cost across NHS Greater Glasgow & Clyde as calculated at the end of March 2018.

Number of respite weeks provided to all client groups



346 people received respite in Qtr1 2017/18. Targets have been reviewed in light of a revised methodology for inclusion of respite which must now be clearly identified in the cared for person's care plan.

Percentage of carers who feel supported to continue in their caring role

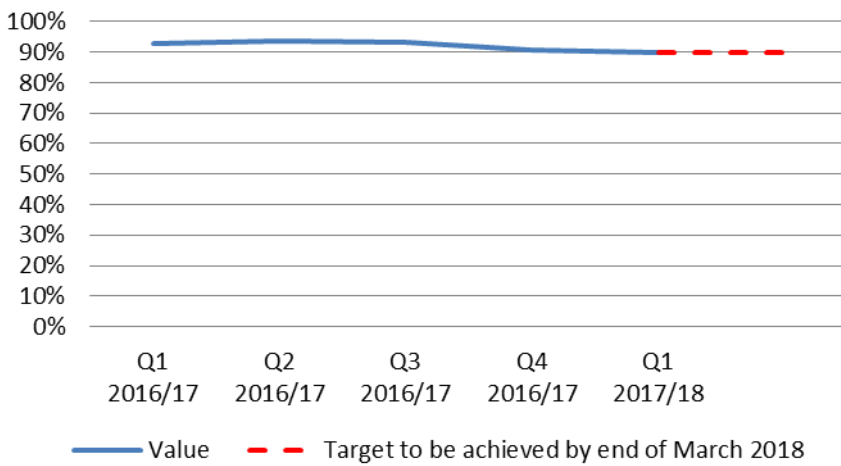


48 of the 49 carers asked felt supported to continue in their caring role during Qtr1 2017/18. *

* Sample data from Carer Support Plans completed during Qtr1 2017/18.

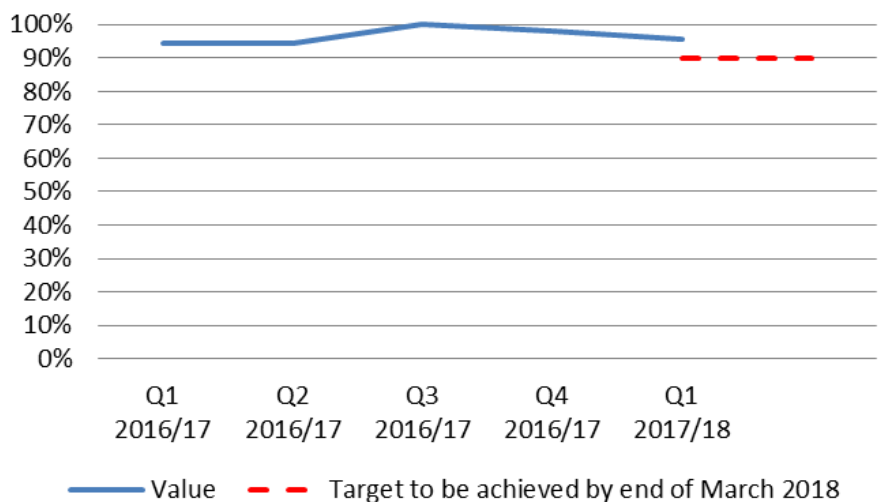
Supporting Safe, Strong and Involved Communities

Percentage of people waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery



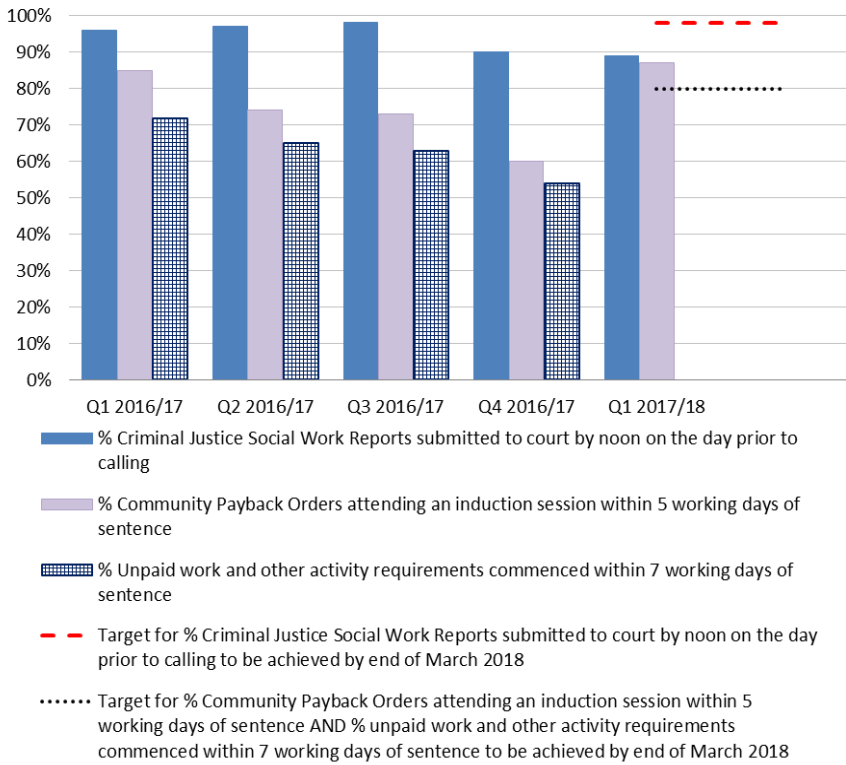
194 of 216 people (89.8%) received treatment within 3 weeks of referral in Qtr1 2017/18. This figure is likely to increase in subsequent publications as additional waiting times data is gathered by National Services Scotland.

Percentage of people who started Psychological Therapies within 18 weeks of referral



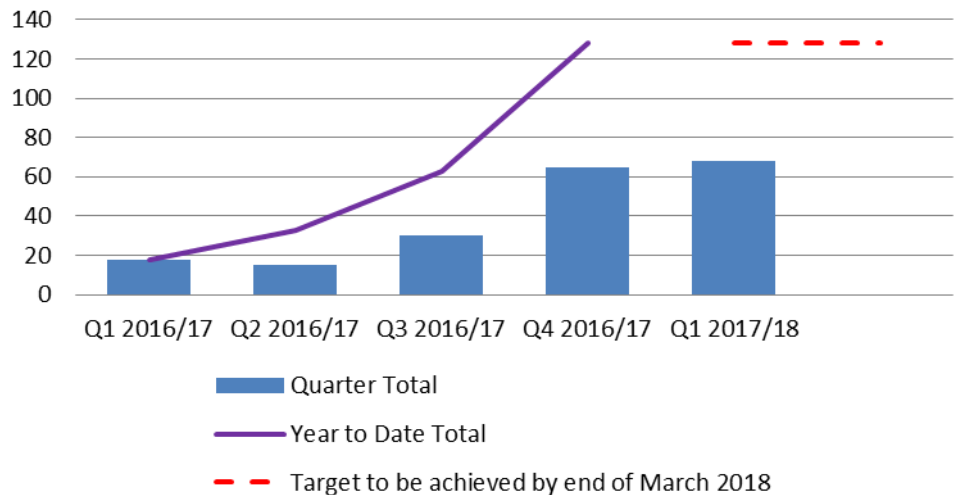
66 of 69 people (95.7%) started Psychological Therapies treatment within 18 weeks of referral in Qtr1 2017/18.

Criminal Justice



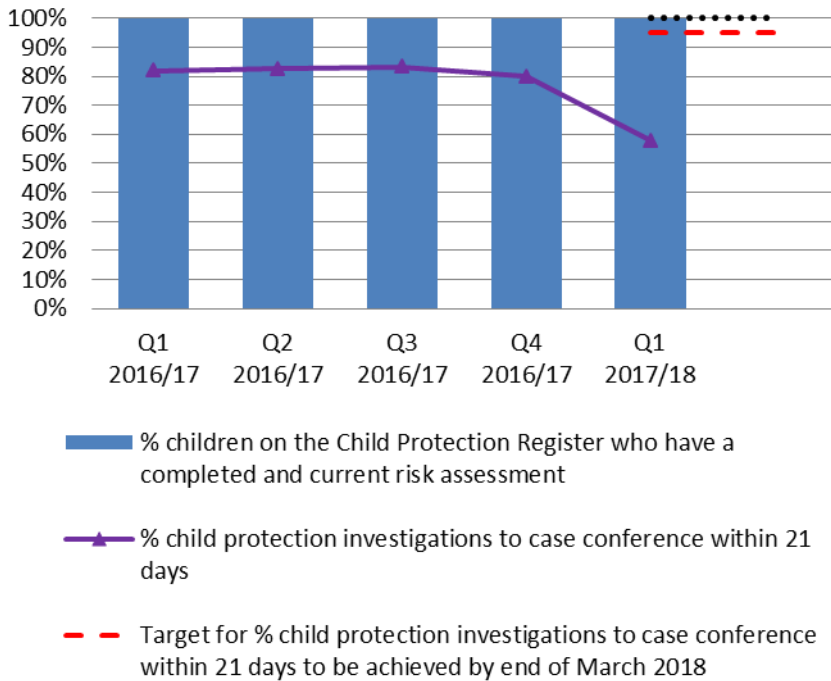
162 of the 183 (89%) Social Work Reports were submitted on time in Qtr1 2017/18.
 98 of the 113 (87%) new Community Payback Orders attended induction within the timescale in Qtr1 2017/18.
 0% of unpaid work orders were commenced within 7 days in Qtr 1 2017/18. Work is underway to understand and address this poor performance. A high volume of new unpaid work orders and 2 vacant posts may have been contributing factors.

Number of referrals to the Scottish Children's Reporter on offence grounds



32 children were referred to the Scottish Children's Reporter (68 referrals) on offence grounds during Qtr1 2017/18.

Child Protection

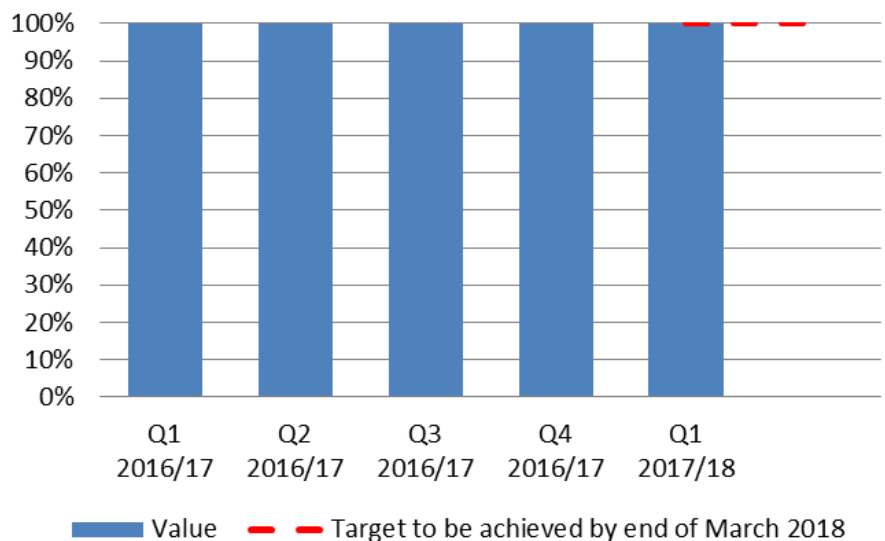


There were 60 children on the Child Protection Register at the end of Qtr1 2017/18.

37 out of 64 (57.8%) case conferences were carried out within 21 days during Qtr1 2017/18. Performance is being closely monitored to address any impact of higher registration numbers.

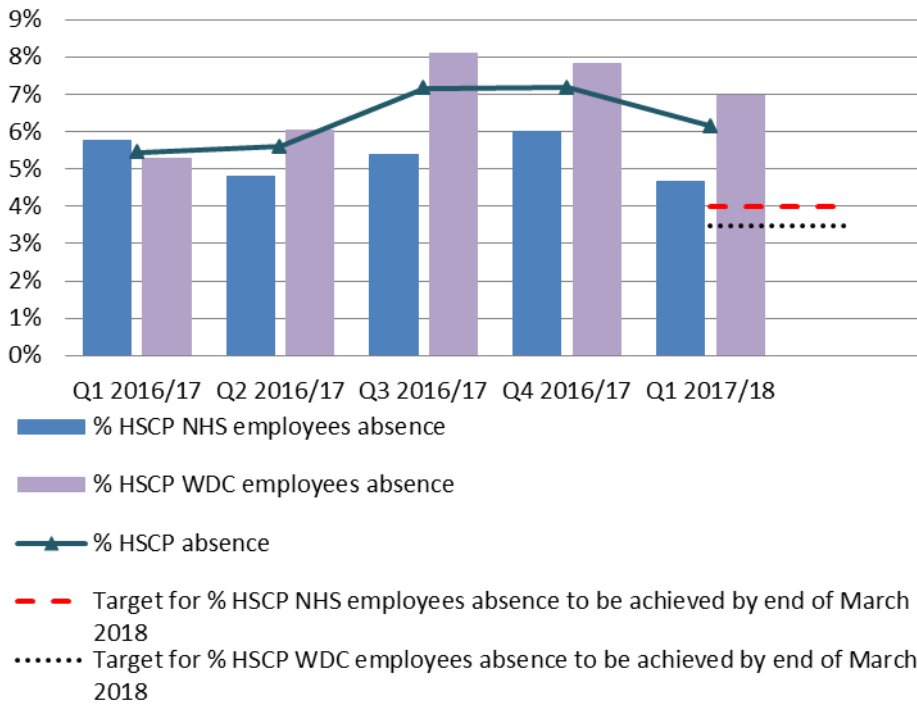
% Adult Support and Protection clients who have current risk assessments and care plan

All 6 Adult Support and Protection clients had a current risk assessment and care plan in Qtr1 2017/18.



Our Staff

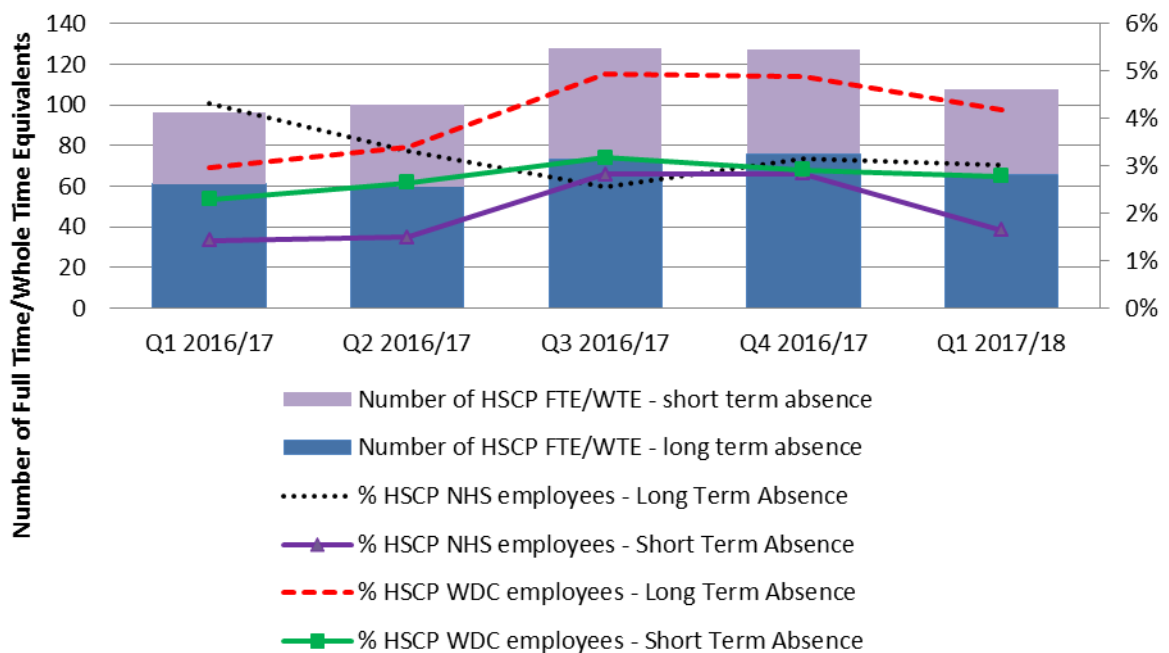
HSCP staff absence



There were 739 NHS employees (617.67 Whole Time Equivalent) and 1,432 WDC employees (1,134 Full Time Equivalent) working within the HSCP during Qtr1 2017/18.

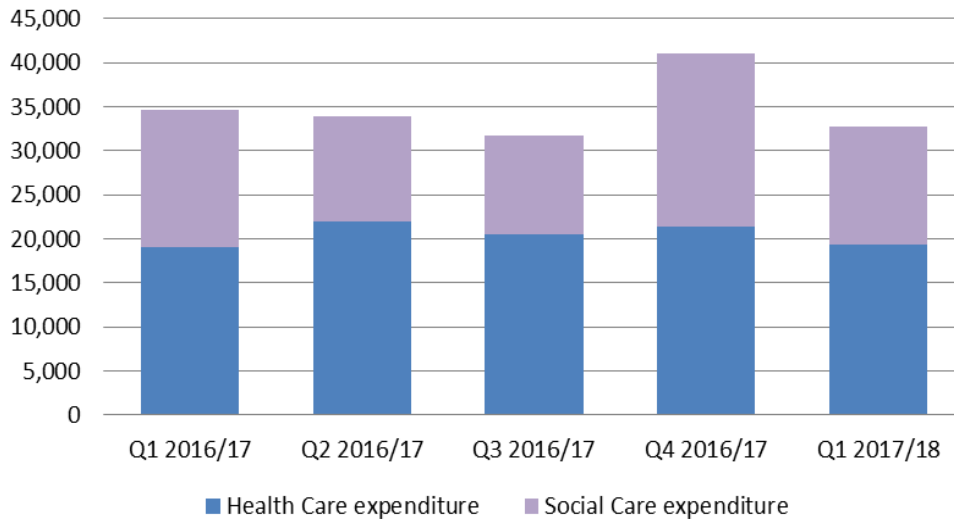
Overall HSCP absence was 6.14% in Qtr1 2017/18: 6.95% WDC employees and 4.65% NHS employees.

Long term and short term absence

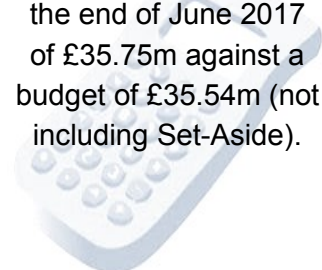


Our Finance

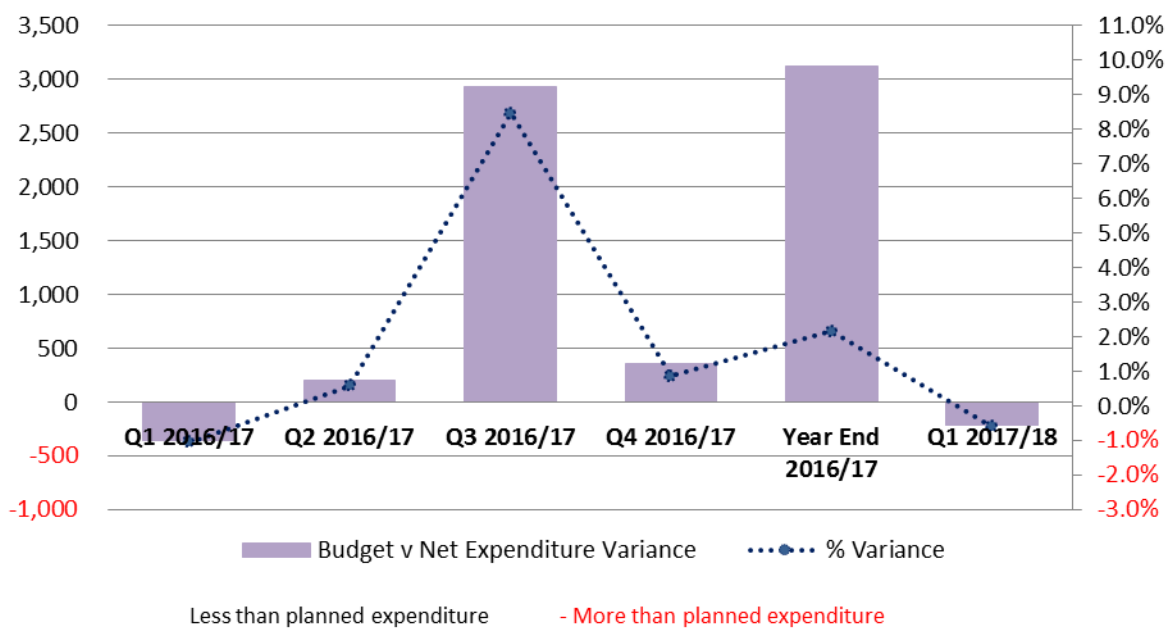
Health and Social Care Net Expenditure £000's



HSCP Expenditure to the end of June 2017 of £35.75m against a budget of £35.54m (not including Set-Aside).

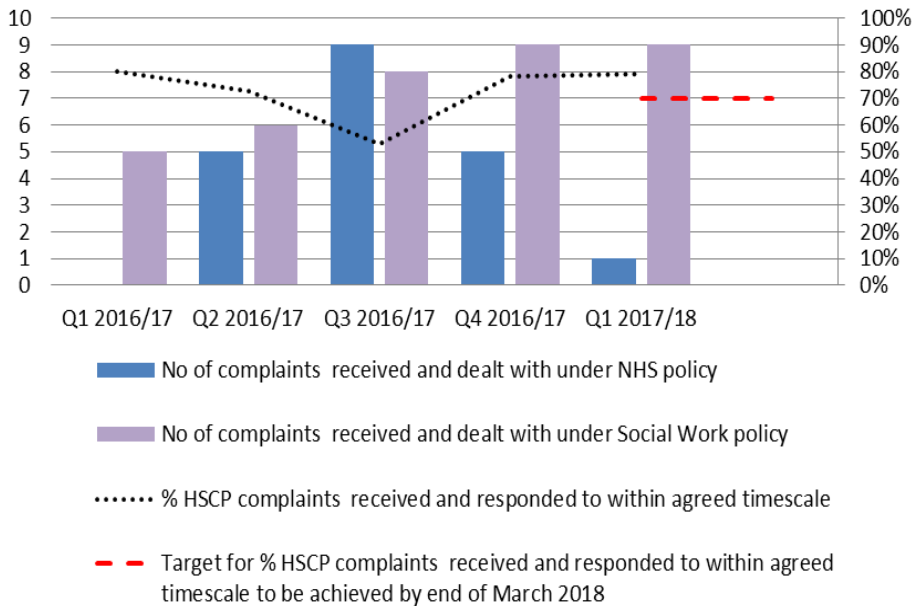


Budget v Net Expenditure Variance



Complaints

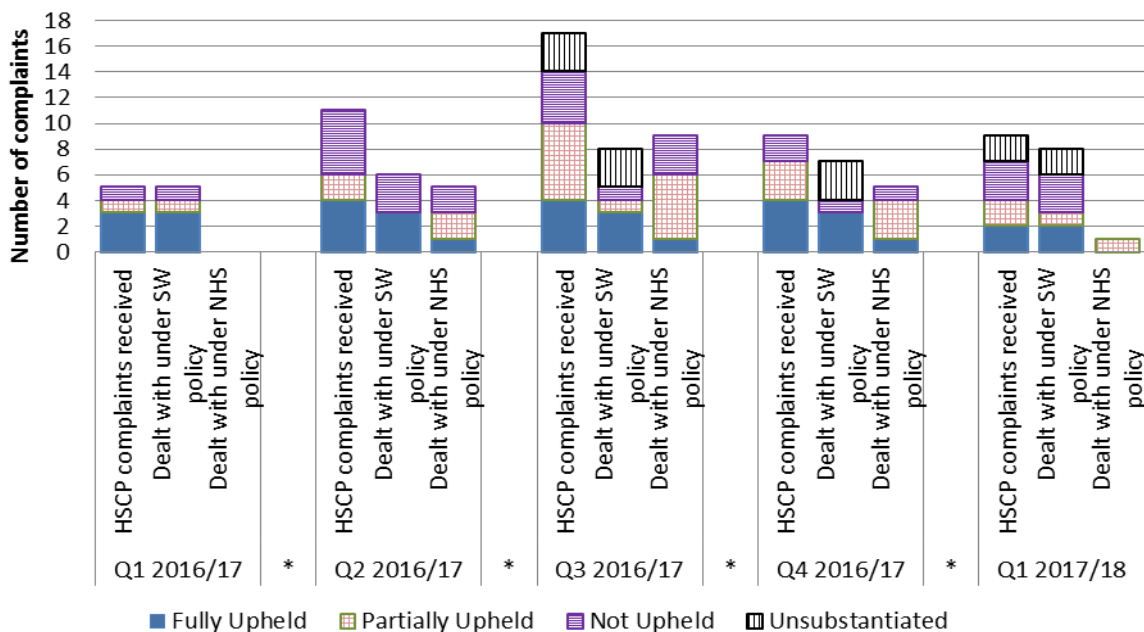
Complaints responded to within agreed timescales



9 complaints were dealt with through the Social Work Complaints policy and 1 through the NHS policy in Qtr1 2017/18.

3 complaints were responded to outwith the timescales. These were between 4 and 8 days late and were due to administrative delays.

Complaints



Both of the upheld complaints in Qtr1 2017/18 concerned Administrative Processes. Any learning from these complaints is being considered within the relevant service areas.

Service Improvement Linked to Performance

SEARCH (Support and Education for Alcohol)

Through the success of the SEARCH Project, carers living in West Dunbartonshire affected by alcohol misuse are now better identified, supported, more confident and skilled in their caring role, with improved mental and physical health enabling them to sustain caring for their loved ones. Achieving wider recognition, SEARCH has been shortlisted for the NHSGGC Chairman's Awards and the national Herald Society Awards. SEARCH was developed after Carers of West Dunbartonshire (CWD) and WDHSCP developed a



shared concern that people with alcohol and addiction issues and caring responsibilities were not receiving the support they required: with low numbers of these carers identified, in disparity to the apparent scale of the problem locally. It focuses on two at risk groups of younger adults (18-25 years) who are at risk of using alcohol as a coping mechanism for carer related stress and older adults (65+) emerging as a 'hidden' group with alcohol related issues.

CWD and WDHSCP have improved identification and support of these carers through increasing awareness, skills and knowledge regarding alcohol related issues. A CWD SEARCH support worker is co-located with WDHSCP Addictions and Hospital Discharge Teams, targeting supports and resources with bespoke individual and group support, including for those caring for someone affected by alcohol related issues (75%) and those affected themselves. SEARCH has reduced use of alcohol as a coping mechanism and created safer communities through education and support.

National Health & Social Care Standards

Scotland's new [National Health and Social Care Standards](#) were launched in June 2017. Underpinned by five principles of **Dignity & Respect, Compassion, Being Included, Responsive Care and Support & Wellbeing**; they set out what we should expect when using health, social care or social work services in Scotland. These Standards are very much welcomed by WDHSCP Board, as they reflect and reinforce our own established core values, and the good practice of HSCP services. This was reflected in our second [Annual Public Performance Report](#), which highlights numerous varied areas of good and emerging practice.

For more information on our services and their performance please visit
<http://www.wdhscp.org.uk/about-us/public-reporting/>

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 22nd November 2017

Subject: Moving Forward Together: NHSGGC Health and Social Care Transformational Strategy Programme

1. Purpose

1.1 To advise the Partnership Board of work being carried out by NHS Greater Glasgow and Clyde to develop a Transformation Strategy for services within the Health Board area.

2. Recommendation

2.1 The Partnership Board is recommended to:

2.1.1 Note this report.

2.1.2 Agree to ongoing involvement of officers from the HSCP in work to develop the Moving Forward Together Strategy.

2.1.3 Delegate authority to the Chief Officer to identify an appropriate member(s) to represent the Partnership Board and HSCP on the Stakeholder Reference Group

3. Background

3.1 There are a number of local, regional and national drivers around development of a Transformation Strategy for NHS Greater Glasgow and Clyde. These include:

- Conclusion of the acute services review for Glasgow in May 2015, with the opening of the new Queen Elizabeth University Hospital.
- The clinical services strategy for NHS Greater Glasgow and Clyde (previously reported to the Partnership Board).
- National strategies published by the Scottish Government, including the national clinical strategy, strategies for mental health, major trauma services, cancer services and the health and social care delivery plan (the latter previously reported to the Partnership Board).
- Emerging work around regional planning across health boards in the west of Scotland (separately reported to this meeting).
- The Public Bodies (Joint Working) (Scotland) Act 2014, and the establishment of 6 Integration Joint Boards within the NHS Greater Glasgow and Clyde area, with responsibility for the strategic planning of, as a minimum, social care, primary and community healthcare and unscheduled hospital care for adults.

3.2 In 2016, the Audit Scotland report 'NHS in Scotland' identified a set of key messages for the NHS in Scotland, as outlined below:

- There have been significant improvements both in population health and healthcare over the last decade.
- The demands on health and social care services are escalating and NHS funding is not keeping pace.
- NHS boards are struggling to meet the majority of national standards and it is increasingly difficult to balance the demands of hospital care alongside providing more care in the community.
- There are significant workforce pressures due to an ageing profile and difficulties in recruitment and retention.

3.3 The report goes on to recommend that NHS Boards should '*take ownership of changing and improving services in their local area and, working with partner agencies, develop long term workforce plans and work with the public about the need for change*'

3.4 The Scottish Government published a response to this report with three main aims:

- Reducing inappropriate use of hospital services.
- Shifting resources to primary and community care.
- Supporting capacity of community care.

3.5 In response to the drivers outlined above, NHS Greater Glasgow and Clyde have initiated work to develop a health-board wide Transformation Strategy. A paper considered and approved by the NHSGGC Health Board on 17th October 2017 is appended to this report.

4. Main Issues

4.1 The aim of the Moving Forward Together work programme is to develop a medium term transformational plan for NHS Greater Glasgow and Clyde (to be known as the Moving Forward Together Strategy). The scope of this work will include development of a system wide strategic framework, with associated implementation plans for acute, primary care and community health services.

4.2 It is anticipated that this work will be carried out in four phases, with completion expected in mid-2018:

- Phase 1 - Establishing baseline position, and mapping against current strategy / work streams and gap analysis.

- Phase 2 – Establishing gaps and commissioning work streams to inform those gaps. Clinical discussion on principles leading to the development of plans to implement new models of care and the quantification of the impact of those changes.
- Phase 3 - Drawing together and quantifying the impact of predicted demand changes and new models of care to describe options for a new service. configuration across primary, community, secondary and tertiary care
- Phase 4 - Engagement, consultation and revision.

- 4.3** A number of functions which may be considered 'in scope' for the Moving Forward Together Strategy are delegated to the six IJBs within the Greater Glasgow & Clyde area - therefore statutory responsibilities for decision making in relation to the Strategy may rest with both those six IJBs and Health Board. While governance arrangements are currently under discussion, it is expected that Executive-level governance will be carried out by a programme board, chaired by the NHSGGC Chief Executive and with membership comprising Executive Directors, Chief Officers, Acute Services, clinical leads and Regional Planning representation.
- 4.4** The programme board will review outputs and provide guidance to the project team and will report to the NHS Greater Glasgow and Clyde Senior Management Team, Health Board and the six Integration Joint Boards.
- 4.5** Project activity will be undertaken by a system wide core transformation team comprising cross system clinical, managerial, HSCP, planning, public health, communications and public engagement, data analysis, finance and estates. This team will be responsible for developing the project plan and taking forward the four phases of the programme.
- 4.6** The role of HSCP officers on the core transformational team, and of Chief Officers on the Programme Board, will be to provide support, advice and scrutiny of development of the Moving Forward Together Strategy from an HSCP perspective. This will include for example, articulating the aims of the strategic plans of the six IJBs and how the Moving Forward Together Strategy can align with these, and describing the scale of the financial challenge facing IJBs and the extent of the transformation work already underway within Partnerships.
- 4.7** The core transformational team had their first meeting in early September and have begun initial activity to take forward Phase 1 of this project. Further updates will be provided to the Partnership Board in due course.

5. People Implications

- 5.1** No immediate impacts, however the outcome of the completed programme could recommend changes to the workforce.

5.2 A range of individuals have been co-opted to the core transformational team on a temporary basis, including a number of officers from HSCPs representing primary and community care. This includes West Dunbartonshire HSCP's Head of Strategy, Planning & Health Improvement.

6. Financial Implications

6.1 As the Chief Financial Officer has reported to the Partnership Board, within both the Council and the Health Board there will be significant financial challenges for 2018-19 and beyond, and those challenges will have implications for their allocations to the Partnership Board.

6.2 The focus of the Moving Forward Together programme is to develop future services which are optimised for safe and effective, person centred care that meets the current and future needs of our population, but is sustainable and deliverable within the allocated resource envelope. This transformation programme will then potentially be an important vehicle for the identification of future savings and efficiencies. The intent is that it will ensure that the quality of service is maximised in process for the delivery of future savings and efficiencies.

7. Professional Implications

7.1 No specific implications associated with this report.

8. Locality Implications

8.1 No specific implications associated with this report.

9. Risk Analysis

9.1 Failure to deliver the scale of transformation required across the health and social care system over the medium term would present a significant risk to the Partnership Board discharging its statutory duty of delivering future Strategic Plans within available budgets.

10. Impact Assessments

10.1 No immediate impacts arising from this report. It is expected that the final draft Moving Forward Together Strategy will be subject to a full Equality Impact Assessment by the Health Board..

11. Consultation

11.1 To support wider engagement in development of the Moving Forward Together Strategy, a Stakeholder Reference Group will be established. The purpose of this group will be to:

- Act as a sounding board for testing plans, and materials

- Advise on the development of information for wider public use
- Communicate back to stakeholder groups
- Strengthen and play a significant role in wider public communication

11.2 Membership of the Stakeholder Reference Group is currently under consideration by the core transformation team, however it is expected that representation from each of the six IJBs in the NHS Greater Glasgow and Clyde area will be sought. The Partnership Board is therefore asked to delegate authority to the Chief Officer to identify an appropriate member(s) to represent the Partnership Board and HSCP on the Stakeholder Reference Group.

12. Strategic Assessment

12.1 The Moving Forward Together Transformational Strategy Programme supports the direction of travel of the local Strategic Plan.

Author: Soumen Sengupta - Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Care Partnership

Date: 06 November 2017

Person to Contact: Soumen Sengupta - Head of Strategy, Planning & Health Improvement, Garshake Road, Dumbarton.
E-mail: soumen.sengupta@ggc.scot.nhs.uk
Telephone: 01389 737321

Appendices: NHSGGC Board Report (October 2017): Moving Forward Together - NHSGGC'S Health and Social Care Transformational Strategy Programme

Background Papers: None

Wards Affected: All

NHS Greater Glasgow & Clyde

NHS Board Meeting

Chief Executive and Medical Director

17 October 2017



Paper No: 17/52

MOVING FORWARD TOGETHER: NHS GGC'S HEALTH AND SOCIAL CARE TRANSFORMATIONAL STRATEGY PROGRAMME

Recommendation:-

The Board is asked to approve the plan and associated timescales set out below to develop a Transformational Strategic Programme for NHSGGC Health and Social Care Services; Moving Forward Together, in line with Scottish Government national and regional strategies and requirements and the projected needs of the NHSGGC population.

Purpose of Paper:-

To seek Board support for and approval of the development of a Transformational Strategic Programme for NHSGGC Health and Social Care Services: Moving Forward Together.

The paper also includes an Annex which highlights areas of transformational change already delivered across health and social care in NHSGGC.

Key Issues to be considered:-

The requirement for NHSGGC to develop an implementation plan, for the National Clinical Strategy and the National Health and Social Care Delivery Plan.

Any Patient Safety /Patient Experience Issues:-

No issues in the immediate term, however the outcome of the completed Programme will contribute to NHSGGC's delivery of the Scottish Government aim of Better Care.

Any Financial Implications from this Paper:-

No issues in the immediate term, however the outcome of the completed Programme will contribute to NHSGGC's delivery of the Scottish Government aim of Better Value.

Any Staffing Implications from this Paper:-

No issues in the immediate term, however the outcome of the completed Programme could recommend changes to our workforce.

Any Equality Implications from this Paper:-

No issues.

Any Health Inequalities Implications from this Paper:-

No issues in the immediate term, however the outcome of the completed Programme will contribute to NHSGGC's delivery of improved health equality.

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-

No.

Highlight the Corporate Plan priorities to which your paper relates:-

Develop a new five year Transformational Plan for the NHS Board working in partnership with other key stakeholders and taking cognisance of the key local and national strategies, including the Health and Social Care Delivery Plan

Author – Transformational Team

Tel No – 0141 201 4611

Date – 10 October 2017

MOVING FORWARD TOGETHER: NHS GGC'S HEALTH AND SOCIAL CARE TRANSFORMATIONAL STRATEGY PROGRAMME

PART ONE: NHSGGC Strategic Background and National Strategies/Plans and Requirements

NHSGGC strategic background

NHS services in general and NHSGGC acute services in particular have gone through a period of ongoing change since the millennium. The delivery of the Glasgow Acute Services Review first approved in 2002 and the South Clyde Strategy (2006) and the North Clyde Strategy (2009) have seen changes across services in what is now Greater Glasgow and Clyde. The achievement of the various infrastructure and service improvements embedded within these strategies culminated in the opening of the new Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children in May 2015.

In addition, in 2012 the NHSGGC Board commissioned a strategic review of clinical services to ensure their fitness for future demands. This work was completed and approved by the NHSGGC Board as the Clinical Services Strategy in January 2015. This Clinical Services Strategy was also adopted by the emergent Health and Social Care Partnerships as a framework for planning clinical services. That position remains extant.

National and regional strategic background

Since 2015 there have been a number of National Strategies published by the Scottish Government, including the National Clinical Strategy and Health and Social Care Delivery Plan as well as strategies for mental health, major trauma, cancer services, maternity and neonatal care, primary care, intermediate care and realistic medicine.

The Scottish Government have confirmed that by 2021 there will be Diagnostic and Treatment Centres (DTC) across the country, in addition to the enhancements to the current Golden Jubilee National Hospital. This investment is to build capacity for diagnostics and planned surgery away on dedicated sites away from the emergency and trauma centres and units. The precise configuration of these centres is yet to be fully defined but in planning for the future, it is essential that NHSGGC and West of Scotland plans influence and take account of this development.

The Health & Social Care Delivery Plan (HSCDP) reaffirms the need for planning regionally a range of clinical services on a population (cross geographical boundaries) basis. The West of Scotland Regional Planning Group is therefore developing its strategic planning programme in line with these requirements, with all component NHS Boards, including therefore, NHSGGC. This too must include forward planning towards establishment of the DTCs as well as within estates, capital and revenue planning.

Under the Public Bodies (Joint Working) (Scotland) Act 2014, Integration Authorities are responsible for the planning, commissioning and delivery of a range of services across the boundaries of primary, community and secondary care. There are six Integration Joint Boards within the NHSGGC Board area and each has in place a strategic plan and supporting commissioning intentions.

In its first report on Health and Social Care Integration in 2015, Audit Scotland emphasised the significant opportunities associated with integration for improving outcomes for individuals and communities and argued that a measure of success would be the extent to

which integration provides a vehicle for Health Boards, Councils and IJBs to move to a more sustainable health and social care service, with a greater emphasis on anticipatory care and less reliance on emergency care.

In 2016, Audit Scotland set out a range of findings and recommendations for Scottish Government and for NHS Boards and Health and Social Care Integration Joint Boards, summarised (by Audit Scotland) as below.

“The NHS is going through a period of major reform. A number of wide ranging strategies propose significant change, including the National Clinical Strategy, integration of health and social care services and a new GP contract. These need to be underpinned by a clear plan for change. Some progress is being made in developing new models of care, but this has yet to translate to widespread change in local areas and major health inequalities remain.”

Recommendations

The Scottish Government should:

- provide a clear written plan for implementing the 2020 Vision and National Clinical Strategy, including: – immediate and longer-term priorities, including a public health strategy to help NHS boards focus on preventing ill health and tackle health inequalities – support for new ways of working and learning at a national level – long-term funding plans for implementing the policies – a workforce plan outlining the workforce required, and how it will be developed – ongoing discussion with the public about the way services will be provided in the future to manage expectations*
- set measures of success by which progress in delivering its national strategies can be monitored, including its overall aim to shift from hospital to more community-based care. These should link with the review of national targets and align with the outcomes and indicators for health and social care integration*
- consider providing NHS boards with more financial flexibility, such as three-year rolling budgets rather than annual financial targets, to allow better longer-term planning*

The Scottish Government, in partnership with NHS boards and integration authorities, should:

- model the cost of implementing its National Clinical Strategy and how this will be funded, including the capital investment required*
- share good practice about health and social care integration, including effective governance arrangements, budget-setting, and strategic and workforce planning*
- in line with the national policy on realistic medicine: – work to reduce over-investigation and variation in treatment – ensure patients are involved in making decisions and receive better information about potential treatments*

NHS boards, in partnership with integration authorities, should:

- *take ownership of changing and improving services in their local area, working with all relevant partner organisations*

In response the Scottish Government published the Health and Social Care Delivery Plan (HSCDP) which is predicated on a “Triple Aim” of Better Health, Better Care and Better Value. It also described these aims in terms of reducing inappropriate use of hospital services; shifting resources to primary and community care and supporting capacity of community care.

It is against this national strategic background that this Programme – Moving Forward Together - is proposed so as to ensure NHSGGC health and social care services keep pace with best available evidence and ongoing transformational change nationally and regionally to meet the needs of the people of Scotland, ultimately delivering the Triple Aim set out in the HSCDP – Better Health, Better Care, Better Value.

The Aim and Objectives of the Moving Forward Together Programme

The aim of this transformational strategic programme is:

- to develop and deliver a transformational change programme, aligned to National and Regional policies and strategies that describes NHSGGC’s delivery plan across the health and social care services provided by our staff, which is optimised for safe, effective, person centred and sustainable care to meet the current and future needs of our population.

The objectives are:

- to update the projections and predictions for the future health and social care needs of our population
- to produce a clinical case for change
- to review existing National, Regional and NHSGGC published strategies and model the impact of their delivery on our population
- taking the information above, to develop new models of care delivery which provide safe, effective and person centred care which maximises our available resource, provides care in the most efficient and effective way and makes the best use of innovation and the opportunities presented by new technology and the digital age
- to support the subsequent development of delivery plans for these new models of care, which describe the required changes in workforce, capital infrastructure and procedures and processes which ensure the intended and projected benefits are realised.

A detailed description of the programme is set out in the accompanying paper. The Board is invited to consider and confirm its approval to proceed to develop Moving Forward Together as outlined. This will see the delivery of a comprehensive transformational change plan to come forward to the Board by June 2018.

MOVING FORWARD TOGETHER: A TRANSFORMATIONAL STRATEGY FOR HEALTH AND SOCIAL CARE SERVICES ACROSS NHS GREATER GLASGOW AND CLYDE

PART ONE: National Policy Strategic Context

The strategic landscape set for NHS Scotland in which NHSGGC must operate can best be described as an agreed and supported direction of travel which is founded on evidence based good practice and sound principles. Audit Scotland highlighted both the imperative to continue to pursue this direction of travel, but also recognised the challenges which face us in delivering the changes which are required to move us forward together.

The high level picture for our nation is one of changes to the demographic composition of our population and the challenges which that brings. It is to be celebrated that our people are generally living longer and healthier lives due to the range and quality of past and present prevention programmes and the care services that the NHS in Scotland has and is delivering.

It is also recognised, however, that these positive changes place increasing demands on health and social care services, who in turn work within allocated resources to provide the care needed for local residents. This has resulted in the need to look at the future needs of our population and to develop and support the changes needed to keep pace with demand now and over the coming years. Modern health and social care practice is developing through the growing evidence base which describes what best meets those future needs through new and developing technological advances, but also in terms of what our population expect of their health and social care services in the modern world.

This changing and challenging environment drives a requirement to review and where necessary redesign our health and social care services for the future.

2020 Vision

The 2020 Vision remains the pinnacle of NHS Scotland Health and Social Care policy and it clearly has relevance beyond 2020.

The Vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system where:

- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self management
- When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

The Quality Strategy

If the 2020 Vision is the pinnacle of the policy frameworks then the Quality Strategy is what underpins the frameworks.

The Quality Strategy (2010) is the approach and shared focus for all work to realise the 2020 Vision.

The Quality Strategy aims to deliver the highest quality health and social care to the people of Scotland, to ensure that the NHS, Local Authorities and the Third Sector work together and with patients, carers and the public, towards a shared goal of world leading healthcare.

The Quality Strategy is based on the Institute of Medicine's six dimensions of Quality.

It is also shaped by the patient engagement feedback received from the people of Scotland when asked what they wanted from their healthcare system.

This is summarised as a system which is caring and compassionate and has good communication and collaboration. A system where care is delivered in a clean environment and that gives continuity of care and achieves clinical excellence.

Out of these criteria three Quality Ambitions were developed:

- **Safe**
There will be no avoidable injury or harm to people from healthcare and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all time
- **Person Centred**
Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision making
- **Effective**
The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit and wasteful or harmful variation will be eradicated.

Integration and the National Health and Social Care Outcomes

Legislation requiring the integration of Health and Social care came into effect in April 2016 and the new Integration Authorities now have responsibility for over £8 billion of funding across Scotland for the delivery of services which was previously managed separately by NHS Boards and Local Authorities. The Scottish Government considers this to be the most significant change to the way care is provided for people in their communities since the creation of the NHS.

In addition to the Public Bodies (Joint Working) Act, Health and Social Care Services are required to develop in response to other legislation, including:

- The Social Care (Self Directed Support) Act 2013, which makes legislative provisions relating to the arranging of care and support, community care services and children's services to provide a range of choices to people for how they are provided with support.
- The Children and Young People (Scotland) Act 2014, which reinforces the United Nations Convention on the Rights of the Child; and the principles of Getting It Right For Every Child.

- The Community Empowerment (Scotland) Act 2015, which provides a legal framework that promotes and encourages community empowerment and participation; and outlines how public bodies will work together and with the local community to plan for, resource and provides services which improve outcomes in the local authority area.
- The Carers (Scotland) Act 2016, which aims to ensure better and more consistent support for both adult and young carers so that they can continue to care in better health and to have a life alongside caring.

The measure of success in integration is making the necessary changes which put people at the centre of decisions about their care and improves and brings closer together the range of services available to make them near seamless and more responsive to the people who use them.

Hospitals should and will provide clinical care that cannot be provided anywhere else, but most people need care that can be provided in settings other than hospitals which are more appropriate to the specific individual needs and are better placed to support health and wellbeing. This thinking meets the expectation that people would rather receive support and care at home or in a homely setting when they do not require the acute care that can only be delivered in a hospital.

Integration aims to provide care built around the needs of the person, which can support them to remain at home or closer to home, connected to their families and their communities. At a strategic level the benefits of Integration are founded on delivery of 9 outcomes, which are monitored through a range of measureable indicators. These are:

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

What does this mean for NHSGGC?

Metrics to monitor the delivery and impact of these nine outcomes have been described separately by Scottish Government. In terms of impact for NHSGGC, taking outcome 5 as an example, the Board will wish, in due course, to be able to define its contribution to reducing health inequalities across its population, particularly as there is continuing evidence of a widening gap in health inequalities within the City of Glasgow.

We will

- ensure that appropriate health inequalities impact assessments are a core component of the Moving Forward Together programme proposals for change

The National Clinical Strategy

The National Clinical Strategy (NCS) was published in February 2016. It is evidence based and sets out the drivers for the required transformational change in the delivery of clinical services. It follows an approach that looks across the whole patient pathway from primary care, community care, to secondary/tertiary care and includes palliative and end of life care and the approach to Realistic Medicine. It uses the known projections and predictions in terms of changes in demographic profile, technological advances available resource to consider the wider implications of those changes for NHS Scotland for the next 10 to 15 years and beyond.

The NCS lists the key drivers for transformational change as:

- demographic changes in Scotland's population
- the changing patterns of illness and disability
- the relatively poor health of the population and persisting inequalities in health
- the need to balance health and social care according to need
- workforce issues
- financial considerations
- changes in the range of possible medical treatments
- remote and rural challenges to high quality healthcare
- opportunities from increasing information technology (e-health)
- a need to reduce waste, harm and variation in treatment

The NCS uses national and worldwide evidence of successful change to indicate the potential impact of such changes in terms of improved outcomes and better experiences for individuals.

The NCS recognises the current challenges to the delivery of these changes in NHS Scotland which are reflective of those facing NHSGGC:

- increasing need for support for an ageing population with increasing levels of multi-morbidity
- multi-morbidity arising approximately a decade earlier in areas of deprivation

- A need to
 - improve care and outcomes via an expanded, multidisciplinary and integrated primary and community care sector, despite current workforce constraints
 - to increase co-production with patients and carers, create high quality anticipatory care plans and to support people in health improvement and self management
 - embrace the changes required for effective integration of health and social care and ensure that it makes a transformational change in the management of patients despite the current demand and supply challenges also faced by social services
 - reduce the avoidable admission of patients to hospital whenever alternatives could provide better outcomes and experiences
 - dramatically reduce the problem of discharge delay and thereby the risk of avoidable harm and adverse impact on the maintenance, or re-establishment of independent living
 - make better use of information and make better informed decisions about both individual and collective care
 - ensure that services become sustainable in the face of considerable workforce and financial constraints by giving careful consideration to planning of more highly specialist provision
 - provide healthcare that is proportionate to people's needs and where possible their preferences, avoiding overtreatment and over medicalisation and at the same time prevent undertreatment and improving access to services in others
 - provide services of greater individual value to patients
 - move to sustainable expenditure so that we maintain high quality services and can also avail ourselves of medical advances as they arise, and
 - integrate the use of technology into service redesign and to consider how IT could transform service delivery and help meet future challenges.

The potential impact for the delivery of health and social care services provided by NHS GGC will cut across the whole range of services from primary through community, acute care and beyond. This programme – Moving Forward Together – is aimed looking forward to the transformational changes that will be required for meeting the assessed future needs of our people. Taking as an example the principles of service planning, these will potentially significantly change in terms of both the “Once for Scotland” approach in, for example, shared diagnostic services and also the changes in planning regionally for populations, across board and geographical boundaries.

In planning regionally for the West of Scotland population of 2.7 million people this will likely lead to changes in the organisation of our hospitals. There will be a need in future to work as joined up networks providing the full range of planned care needed across specialist services, linking to and working alongside, primary care clusters and community care services to ensure a coordinated, seamless experience for those individuals who cannot be cared for at home or in a homely setting.

The NCS sets out evidence based examples of those services best provided locally, regionally and nationally. This evidence based configuration linked to population size will be a foundation principle for both WoS regional planning and Moving Forward Together.

We will

- maintain open dialogue with delivery partners, e.g. HSCPs, National Services Division, WoS Regional Planning leads and our workforce across all services and service sectors to ensure planning is joined up and cohesive across all relevant NHS Boards and partners.
- bring forward a forward plan that is developed together with all such partners and is agreed by them as a sustainable way forward.

Health and Social Care Delivery Plan

The Health and Social Delivery Plan (HSCDP) sets out in greater detail the outcomes required in the delivery of integrated health and social care services. It represents what Scottish Government expects NHS Boards, Local Authorities and IJBs to deliver in partnership with the voluntary sector, patients, carers, families and our wider population.

The HSCDP focuses on three areas, which are referred to as the “Triple Aim” -

Better Care

- ❖ To improve the quality of care for people by targeting investment at improving services, which will be organised and delivered to provide the best, most effective support for all

Better Health

- ❖ To improve everyone’s health and wellbeing by promoting and supporting healthier lives from the earliest years, reducing health inequalities and adopting an approach based on anticipation, prevention and self management

Better Value

- ❖ To increase the value from and financial sustainability of care, by making the most effective use of the resources available to us and the most efficient and consistent delivery, ensuring that the balance of resource is spent where it achieves the most and focusing on prevention and early intervention.

The HSCDP goes on to describe how transformed Health and Social Care services will benefit individuals and communities and will impact on regional and national services.

National and Regional Approach to Service Planning

The National Clinical Strategy introduced the requirement to plan services on a population basis whether regionally or nationally (Once for Scotland) determined by evidence of those services that can best be delivered at local, regional or national level.

The West of Scotland (WOS) now has a nominated Chief Executive lead and the Director of WOS Regional Planning is building a team of co-opted senior executives from NHSGGC and other boards and seconded managers to take forward the WOS regional planning agenda.

The stated requirement is to develop a regional transformation plan by September 2017 which sets out how the region will support delivering the HSCDP with board local development plans setting out their contribution both to the regional and national plans.

By March 2018 each region is expected to have a plan setting out how services will evolve to deliver the NCS and further develop the efficiency of secondary care.

NHSGGC plays a full part in the leadership of and support to various work streams in the development of the West of Scotland planning process.

The plans will need to consider how services will be evolved over the next 15-20 years to support the transformation of health and social care and ensure the longer term investment in services and estate is committed to the right areas to deliver the aims of the national clinical strategy and HSCDP.

This WOS planning will run alongside the NHSGGC Moving Forward Together Programme and as it develops the interdependency and alignment will be continually monitored and necessary adjustments made through the maintenance of a close working relationship between the two teams.

Primary Care

The national Primary Care Outcomes Framework sets out a clear vision for the future primary care at the heart of the healthcare system, linking to the 2020 Vision, Health and Social Care Integration, the National Clinical Strategy and Health and Social Care Delivery Plan.

NATIONAL OUTCOMES				
Our children have the best start in life and are ready to succeed	We live longer, healthier lives	Our people are able to maintain their independence as they get older	Our public services are high quality, continually improving, efficient and responsive	
We start well	We live well	We age well	We die well	
PRIMARY CARE VISION				
Our vision is of general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multidisciplinary teams will deliver care in communities and be involved in the strategic planning of our services.				
HSCP OUTCOMES				
Services mitigate inequalities	People can look after own health	Live at home or homely setting	Positive Experience of Services	Services improve quality of life
Carers supported to improve health	People using services safe from harm	Engaged Workforce Improving Care	Efficient Resource Use	
PRIMARY CARE OUTCOMES				
We are more informed and empowered when using primary care	Our primary care services better contribute to improving population health		Our experience as patients in primary care is enhanced	
Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care	Our primary care infrastructure – physical and digital – is improved		Primary care better addresses health inequalities	

This vision applies across the four primary care contractor groups and the wider multi-disciplinary team working in primary care.

General practices are central to this vision for primary care with Scotland's GPs as the *Expert Medical Generalist in the community; focussed on complex care, undifferentiated presentation and local clinical leadership*.

A new GP contract is under development with changes expected from April 2018. The contract, alongside additional focus and investment in the wider context of primary care, is expected to achieve a move towards that vision and the creation of extended multi-disciplinary teams in every locality.

A key part of the vision is the establishment of clusters of GP practices. These are now in place across Scotland with a clear remit to provide leadership on quality improvement across practices and with wider services.

The Scottish Government review of Out of Hours primary care services was published in February 2017. It seeks to ensure that services are

- Person centred, sustainable, high quality, safe and effective
- provide access to relevant urgent care when needed
- deliver the right skill mix of professional support for patients during the out of hours period

Four theme based task groups were set up to examine workforce matters; how data and technology can enable improvements; explore new models of care and explore what a quality out of hours service would look like.

The Scottish Government also committed £1m to testing the Review Chair's recommended new model of urgent care with seven pilot sites throughout Scotland testing various aspects of this model.

The results of this Initial Testing Programme will inform the National Delivery Plan for the Transformation of Urgent Care, for which £10 million is committed in 2017. It is intended that this will deliver both national and local initiatives over the immediate and longer term towards enabling improvements in urgent care services.

We will

- continue to support the 39 clusters across NHS GGC as a cornerstone of future developments in primary care.
- work together with primary, community and secondary care partners to drive and support action to put in place the Review recommendations for urgent/out of hours care.

The vision for Pharmaceutical services in Scotland includes a commitment to increasing access to community pharmacy as the first port of call for managing self-limiting illnesses and supporting self-management of stable long term conditions, in-hours and out-of-hours, and to increasing access to GP practice based pharmacy, integrating pharmacists with advanced clinical skills and pharmacy technicians in GP practices to improve pharmaceutical care and contribute to the multidisciplinary team.

The Community Eyecare Services Review sets out a clear role for Community Optometrists in the transformation of primary care and ongoing development of community based care; ensuring that patients see the most appropriate professional and further developing eyecare in the community.

The Oral Health Improvement Plan currently under development will set out the steps to support NHS dental services to have an increasing focus on prevention.

Mental Health

The Scottish Government published a ten year strategy for mental health in March 2017. It is wide ranging and cross cutting across, for example, education, prison, secure care, children, young people and adults, including also measurement and data requirements to fulfil the 40 actions set out. It will be reviewed at the halfway stage – in 2022 – to assess its delivery and impact.

In terms of NHSGGC, it is not the purpose of this document to set out a range of specific actions required. That will take time given the complexity of the overall actions required, but it is vital that this programme considers and sets out the needs for people who need mental health and associated support services, whether provided by the statutory or the voluntary sector.

We will

- Work with health and social care partnerships and relevant sectors, including education and secure sector as required, to ensure that NHSGGC is prepared for and will deliver a range of services necessary to meet the needs of our population both in Greater Glasgow and across the WoS as required. These plans will be an important part of the final proposals to be brought forward to the Board in June 2018.

Maternity and Neonatal

The Review of Maternity and Neonatal Services in Scotland was published by Scottish Government in January 2017. Its aim was to ensure that every mother and baby continues to get the best possible care from Scotland's health service, giving all children the best start in life. The Review examined choice, quality and safety of maternity and neonatal services, in consultation with the workforce, NHS Boards and service users.

A summary of the recommendations:

- Continuity of Carer: all women will have continuity of carer from a primary midwife, and midwives and obstetric teams will be aligned with a caseload of women and co-located for the provision of community and hospital based services.
- Mother and baby at the centre of care: Maternity and Neonatal care should be co-designed with women and families from the outset, and put mother and baby together at the centre of service planning and delivery as one entity.
- Multi-professional working: Improved and seamless multi-professional working.
- Safe, high quality, accessible care, including local delivery of services, availability of choice, high quality postnatal care, colocation of specialist maternity and neonatal care, services for vulnerable women and perinatal mental health services.
- Neonatal Services: proposes a move to a new model of neonatal intensive care services in Scotland in the short and long term.
- Supporting the service changes: recommendations about transport services, remote and rural care, telehealth and telemedicine, workforce, education and training, quality improvement and data and IT.

Implementation of these recommendations is overseen by a national Implementation Group chaired by Jane Grant, Chief Executive, NHSGGC.

As is the case with mental health services, the NHSGGC plans for the future in this area are being developed and it is intended that the Moving Forward Together Programme assesses the impact of these recommendations and necessary changes and brings forward appropriate actions to address any changes required in line with the national requirements both in terms of the women and babies within NHSGGC but also as required across WoS as well as any actions taken so far and their impact.

Major Trauma Services

In January 2017 a new National Trauma Network was launched which sees four major trauma centres backed up by a range of co-ordinated trauma units across Scotland. One of these major trauma centres is based in Glasgow, at the QEUH. The national trauma network is commissioned and run by National Services Division while the local configuration of hospitals and, vitally, the clinical pathways for people suffering trauma are determined regionally and locally to best support and meet need. NHSGGC and WoS planning leads are working together to ensure the most appropriate configuration of trauma units and, along with Scottish Ambulance Service (SAS) and NHS 24, among others, to see necessary changes made so as to save more lives.

This work will continue to be driven by the Major Trauma Network and associated partners, however it is essential that the clinical needs of people with trauma are taken into account in determining the future patterns and pathways of care across NHSGGC.

We will

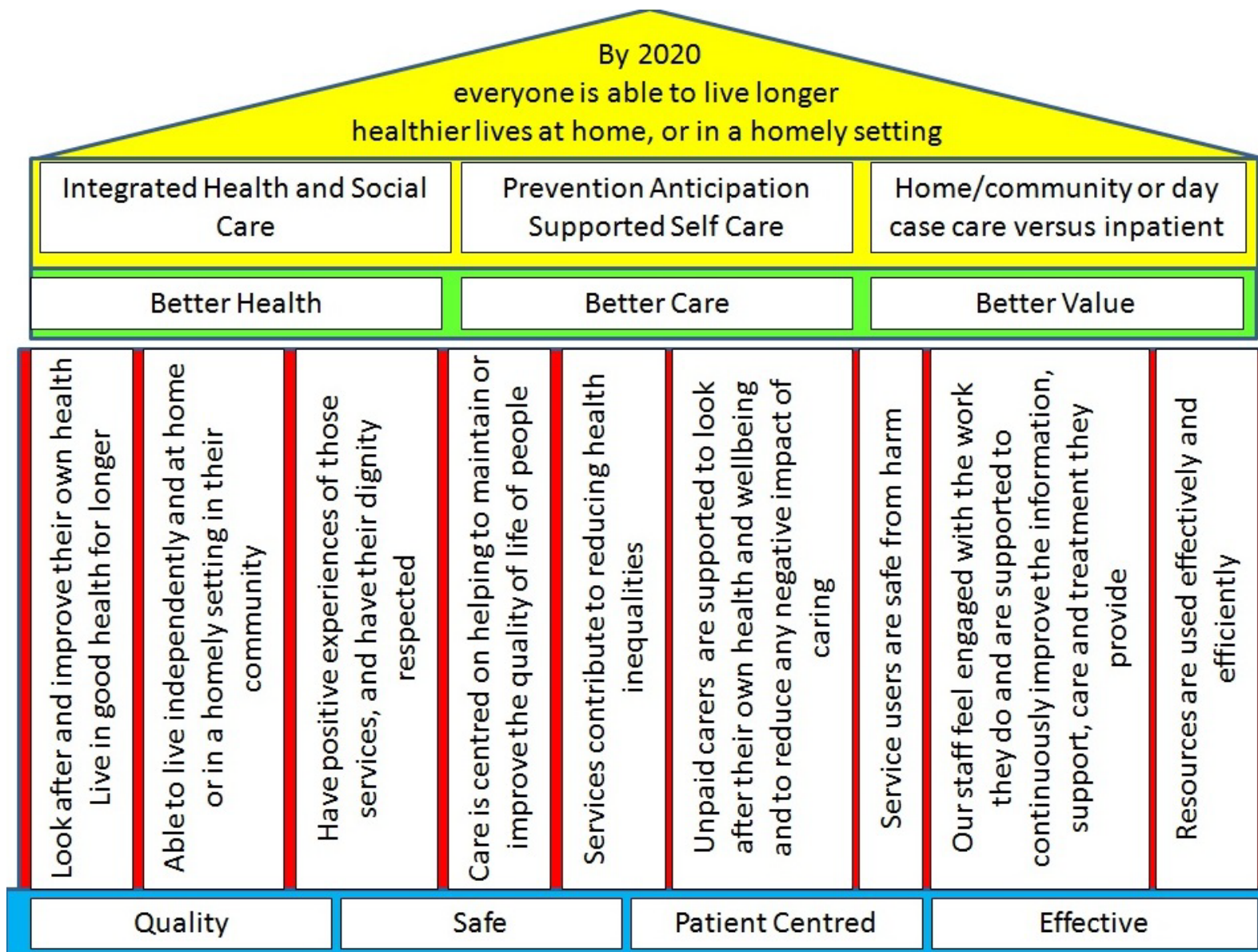
- ensure that the Major Trauma Network and planning for the appropriate configuration of Trauma Units is taken into account in planning for the future needs of our population.

Summary of the National Strategic Context

As highlighted in this section there are a number of national and regional policies, strategies and influences which will shape the NHSGGC Health and Social Care Transformational Strategy. However there is a coherent and clear direction set out across the documents. The diagram below seeks to summarise this direction.

The 2020 Vision is the pinnacle of the strategic framework. Its delivery for our population rests on the triple aim and the success of the integration agenda which is supported by the 9 pillars of the National Health and Social care outcomes and the Primary Care outcomes. Everything is underpinned by the Quality Strategy. Clinical services will be developed in line with the National Clinical Strategy and other relevant Scottish Government strategies.

Pictorially we are representing this as a “Cathedral of Care” – set out below.



PART TWO: NHSGGC Strategic Background and the Clinical Services Strategy (CSS)

NHSGGC Clinical Services Strategy

The 2015 CSS provides the extant framework within which NHSGGC plans and delivers health and social care.

Although it predates the National Clinical Strategy the two documents are coherent in terms of the overall principles and the direction of travel across primary, secondary and tertiary care and the shift in care from an emphasis on hospital care towards care provided at home or in a homely setting via primary and community care planned and delivered via health and social care partnerships and, for example, clusters of GP practices working cohesively as a multi-disciplinary team to meet the needs of patients.

The CSS Case for Change

As with the NCS the CSS first identified the case for change based on an evidential review and predictions of our future population needs.

The summary of the final case for change is described by 9 key themes shown below.

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

CSS System Wide Challenge

The CSS recognised the challenging demand pressures across a system in which 'hospital' and 'community' services were largely seen as separate, with often poor communication and lack of joint planning across the system. It was recognised that the future demand pressures could not be met by continuing to work in that way.

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

The CSS proposed working differently at the interface between community and hospital which may involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system.

Enablers

The CSS identified that changing the system at scale would require a series of enabling changes to support delivery of the new health care system.

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

CSS projected benefits

It was anticipated that the successful achievement of the new system of health care would result in:

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

Moving Forward Together – making it happen

The Moving Forward Together Programme will be delivered by a central hub of a core project team from across NHSGGC and with skills and experience covering all aspects of health and social care. The core team will work using the spokes of their various clinical and managerial networks in order to fully utilise the experience innovation and drive of the full range of staff who deliver health and social care services. The core team report into a cross system programme board populated by our most senior executives.

The Moving Forward Together Programme is not starting from first principles. Rather it builds on and drives forward known actions and commitments already recognised as necessary – but it will also update and supplement these in light of more recent evidence and national strategic needs.

The CSS Future Health System described a series of key characteristics of clinical services. These are also key features of the future for NHS Scotland and NHSGGC in particular in terms of the national strategic picture.

Much of the proposed change in the CSS remains what needs to be and must be done to deliver sustainable high quality health and social care which meets the future needs of our population.

However, if NHSGGC is to continue to meet the needs of our population, this Transformational Programme needs to take the CSS principles and the national context requirements on to a transformational delivery platform . It needs to describe transformational change in the context of integration and bring together health and social care to deliver a new health and social care system that not only provides the best quality of care possible but also supports people to manage their own care where appropriate, through maximising the use of digital technology and community support to improve access for advice and support, such as through community pharmacists. We need to develop the actions which will deliver the changes described in the National context but delivered locally, regionally and nationally for our population.

The actions that this programme recommends will need to:

- Support and empower people to improve their own health
- Support people to live independently at home for longer
- Empower and support people to manage their own long term conditions
- Enable people to stay in their communities accessing the care they need
- Enable people to access high quality primary and community care services close to home
- Provide access to world class hospital based care when the required level of care or treatment cannot be provided in the community
- Deliver hospital care on an ambulatory or day case basis whenever possible
- Provide highly specialist hospital services for the people of Greater Glasgow and Clyde and for some services, the West of Scotland

Delivery of the Moving Forward Together Programme will see improvements in care and outcomes for everyone.

What does the future look like?

➤ In Primary Care

A system underpinned by timely access to high quality primary care both in and out of hours, providing a comprehensive service that deals with the whole person in the context of their socio-economic environment:

- building on universal access to primary care.
- focal point for prevention, anticipatory care and early intervention.
- management where possible within a primary care setting.
- focus for continuity of care, and co-ordination of care for multiple conditions.

➤ In Community Care

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

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

➤ In Unscheduled Care

Co-ordinated care at crisis/transition points, and for those most at risk:

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

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

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

➤ **In Scheduled (Planned) Care**

Planned care which is locally accessible on an outpatient and ambulatory care or day case basis where possible, with:

- wider range of specialist clinics in the community, working as part of a team with primary care and community services.
- appropriate follow up.
- diagnostic services organised around assessed individual needs.
- interventions provided as day case where possible.
- rapid access as an alternative to emergency admission or to facilitate discharge.

Aligned with regional and national direction our service planning will cater for the needs of our population, as well as for the wider regional or national population as required. In this planning highly specialised and complex care will be provided in relevant properly equipped specialised units with an appropriately skilled workforce. These services will be designed to meet the current and projected needs based on population and the planning will be shaped by clear evidence on the relationship between outcomes for patients and activity volume when delivered by colocated multi disciplinary teams.

➤ **In e-Health**

Since 2012 when the Clinical Services Strategic review was commissioned NHSGGC has already achieved considerable benefit from e-Health investment which has transformed many aspects of healthcare already. The main themes in the past five years have been:

- implementing board-wide cornerstone electronic health record systems (Trakcare, Clinical Portal and EMISWeb), including a single patient index across the Health Board using CHI as the main identifier.
- making a wide range of clinical and care information available for clinicians and social care practitioners at the point of need within and increasingly across social care and Health Board boundaries
- digitising incoming hospital and community referrals with SCI Gateway and sending return correspondence with EDT, replacing postal letters (2.5 million items annually)
- centralising laboratory and radiology information systems
- replacing paper notes in outpatient clinics with access to digital patient information
- digitising in-patient workflow and support services

NHSGGC eHealth has an ambitious work plan for the next 12 months which is focussed on patient safety and care integration.

- finalise Full Business Case and, subject to approval, begin implementation planning for a Board-wide Hospital Electronic Prescribing and Medicines Administration system
- implement a new medicines reconciliation system and discharge letter process, creating a single patient-centred medication list
- complete roll out of a single Board-wide maternity electronic record system
- complete data sharing in Portal between all HSCPs and health board
- improve interoperability between key EPR systems such as document sharing from EMISWeb into portal and GP data summary into Portal
- develop a Patient Portal proof of concept digital platform and associated business case that will inform national strategy

Strategic aims of e-health that will help transform care by 2025 include

- Improved healthcare safety for medicines and deteriorating patients giving better situational awareness for clinicians
- Better interoperability of and workflow between cornerstone systems right across community and primary care helping break down professional and organisational silos
- Support for virtual consultations and care coordination reducing need for patients to travel, improving oversight of long term conditions and maximising clinic utilisation
- Digital patient engagement including patient portals to help self care, multimodal access for patients with text or webchat
- Better use of smart informatics at the clinical front line to help decision making by summarising the large amount of health and care data that now exists on individuals
- Providing technology such as the Microsoft Office 365 collaboration suite that will enable more agile and flexible working

Our Starting Point and Transformation in Action

Although there has not been the transformational change since 2015 that would have seen the full implementation of the CSS new health care system, NHSGGC has not stood still.

There are a number of service reviews currently under way which will produce transformational change proposals which may be delivered during this programme or will be incorporated into the final change proposals in the new clinical and service models coming out of this programme and the wider West of Scotland regional approach to planning.

These reviews include:

- GP Contract Arrangements
- Out of Hours Services
- Mental Health Services
- Unscheduled Care
- Older People's Services
- Planned Care Capacity
- Beatson West of Scotland Cancer Centre
- Modern Outpatient Programme
- Stroke Services
- Orthopaedic Services
- Breast Services
- Urology Services
- Gynaecology Services

There are also a great number of changes which showcase the opportunities and benefits that can be realised if transformational change is achieved at scale across our health and social care services.

Annex A to this paper highlights small scale but transformational change that has been achieved and which clearly aligns to the direction set out by the CSS.

The challenge of the Moving Forward Together Programme is to take these advances from isolated demonstrations of success on to where they become common practice and then on to become business as usual across NHSGGC.

PART THREE: Proposed Approach: Moving Forward Together

Our Approach

The Moving Forward Together Programme takes a phased approach to delivery.

There is a central Core Team who have dedicated time each week to take forward the work of the Programme. It is composed of senior managers and clinicians from across the HSCPs and Acute Sectors.

The Programme plan has been divided into 4 phases which are described below.

Phase 1 – October to November 2017 - Establishing baseline and modelling known changes

The Core Team members reach back to their base networks to ensure engagement and to use the knowledge and experience base of those networks in a hub and spoke methodology.

We will

- Review the current range of relevant National and Regional Strategic Documents;
 - o eg National Clinical Strategy , Health and Social Care Delivery Plan (2016) Cancer and Mental Health Strategies
- Review the outputs of the GGC Clinical Services Strategy for comparison with National and Regional Guidance to create and amalgamated set of principles on which Transformation Strategy will be based
- Update the predictions on population changes to develop a demand picture up to 2025
 - o Using the same methodology as WOS work with ISD to ensure alignment
 - o Work at a specialty and condition level using population based approach
 - o Include primary and community care demand
- Review and quantify the impact of the delivery of the IJB strategic plans and commissioning intentions
- Carry out a stakeholder analysis and develop engagement plan
- Highlight the gaps where further work should be commissioned.

Phase 2 – December 2017 to February 2018 - Clinical discussion on principles leading to the development of plans to implement new models of care and the quantification of the impact of those changes

We will

- Prepare the Phase 1 principles framework, case for change, care stratification model and evidence base to enable a structured discussion with small clinical groups from and then across primary community secondary and tertiary care
- Prepare a review of all local and regional work on clinical services, as well as the GGC Clinical Services Review (CSR) and national strategies and model the predicted impact on the current services in GGC for discussion in clinical groups
- Commission either SLWG or current groups to review Phase 1 predicted service demand and produce proposals for future service requirements, the impact of which can be modelled.
- With clinical groups produce a matrix of stratified clinical interdependencies for each service which will inform options development and a plan for enabling changes and/or supporting services which are required to sustain the new service models
- Model the impact of these proposed changes on the demand and activity profile to inform the options development
- Commission further evidence base reviews and review other service models as required to support the development of options

Phase 3 – March to April 2018 - Drawing together and quantifying the impact of predicted demand changes and new models of care to describe options for a new service configuration across primary community secondary and tertiary care

The Core Team will draw together all of the various pieces of work from Phase 1 and 2 and analyse the outputs of the commissioned work streams.

We will

- review current WOS planning, GJNH and other Health Board strategic intentions and assess the impact on GGC options
- describe the required changes, supporting and enabling work and outline delivery plans with options where relevant
- use this basis to prepare an outline of the strategic delivery plan with options to be discussed during the wider clinical and public engagement programme through an open and transparent effective dialogue process supported by a series of wide ranging conversations

Phase 4 – May to June 2018) Amendments following engagement and Approval

The outcomes of the engagement process following the initial options proposal at the end of Phase 3 will be used to finalise proposals. The details of this Phase will be determined by the guidance given by the NHSGGC Board, IJBs and Scottish Government.

We will

- bring forward finalised proposals for the future of health and social care services delivered by NHSGGC for their population to the Board for approval in June 2018.

Communication and Engagement

It is proposed that during the programme there is a comprehensive and transparent engagement process with the widest possible range of stakeholders.

This will include wide spread staff and partnership engagement and inclusion through the hub and spoke methodology for clinical engagement following the principles of Facing the Future Together.

We will

- engage with and take advice from all the various Board advisory groups and committees
- work together with the WOS Regional Planning Team.
- engage with neighbouring health boards and national partner Boards including the Scottish Ambulance Service, NHS24 and the Golden Jubilee Foundation
- engage with patients and carers at the earliest opportunity and throughout the process by establishing a Stakeholder Reference Group with wide representation across the demography and the geography of our population.
- produce and implement an inward and outward facing communications programme which supports the delivery of our key messages to our staff, partners and population using the range of available effective means.

SUMMARY

The Moving Forward Together Programme is NHSGGC's seminal transformational programme to deliver the National Clinical Strategy, Health and Social Care Delivery Plan and other associated National Strategies.

The Programme will describe a new health and social care system that is optimised for safe, effective, person centred and sustainable care to meet the current and future needs of our population.

The Programme will develop in cooperation and cohesion with the developing work in the West of Scotland for planning of a Regional basis.

The Programme will provide an overarching framework for change across primary, community and secondary care both in the short term during the conduct of the programme and thereafter as a result of it's recommendations.

The Programme will support the subsequent development of delivery plans for the developed new models of care, which describe the required changes in workforce, capital infrastructure and procedures and processes which ensure the intended and projected benefits are realised.

NHSGGC Examples of Transformation in Action

The following section highlights small scale but transformational change that has been achieved and which clearly aligns to the direction set out by the NCS HSCDP and CSS.

The challenge of the Moving Forward Together Programme is to take these advances from isolated demonstrations of success on to where they become common practice and then on to become business as usual across NHSGGC.

Primary Care: Transformation in Action

<p>House of Care CSS New System Characteristic Building on universal access to primary care. Focal point for prevention, anticipatory care and early intervention. Management where possible within a primary care setting. Focus for continuity of care, and co-ordination of care for multiple conditions.</p>	
<p>Previous State: Disease specific task based review in primary care for patients with Long Term Conditions guided by former Quality and Outcomes Framework; limited patient empowerment.</p>	<p>Transformed State: Participating GP practices use the ‘House of Care’ process and framework when recalling patients for their annual review. The House of Care (HoC) ethos places the person at the centre of their care supporting a collaborative conversation between the individual and the professional. Changes in the process include a two-step review:</p> <ul style="list-style-type: none"> • The first is to gather information and carry out disease specific surveillance and to prepare the patient for the second appointment (carried out by the HCSW where possible). • The second, a longer time with the clinician to have a conversation about the impact of the condition and reflect on what matters to the individual (carried out by the Practice Nurse in most cases). <p>A further change is that the patient receives the results from their tests in between the two appointments. They also receive information and are asked to think about/note what matters to them and given prompts for discussion. The second appointment is then intended as a meeting of equals and experts to review how things are going; consider what's important; share ideas; discuss options; set goals; develop a care and support plan. A ‘More than Medicine’ approach is considered and local services to support this are identified.</p>
<p>Benefit Realised</p> <p>Patients being in control of their care and empowered to share decisions about it. The person is more likely to act upon the decisions they make themselves, rather than those made for them by a professional. Clinicians and other staff at all stages having the necessary information about the patient, with care better tailored to the patient’s needs.</p> <p>Biomedical impact - in 19 trials involving 10,856 participants, care planning has led to:</p> <ul style="list-style-type: none"> • Better physical health (blood glucose, blood pressure) • Better emotional health (depression) • Better capabilities for self-management (self-efficacy) 	

New Ways Inverclyde – Transforming Primary Care Programme

CSS New System Characteristic

Building on universal access to primary care.

Focal point for prevention, anticipatory care and early intervention.

Management where possible within a primary care setting.

Focus for continuity of care, and co-ordination of care for multiple conditions.

<p>Previous State 16 practices in Inverclyde working to standard national GMS contract within a context of significant pressures on primary care, including rising workload and complexity.</p>	<p>Transformed State In September 2015, Inverclyde HSCP was approached to consider the opportunity to work in partnership with NHSGGC, Scottish Government and the British Medical Association (BMA) to explore new ways of working and inform the development of the new GP contract; and devise the future role of the GP, envisaged to be that of a senior clinical decision-maker in the community who will focus upon:</p> <ul style="list-style-type: none"> • Complex Care in the Community. • Undifferentiated Presentations. • Whole System Quality Improvement and Clinical Leadership. <p>Following initial engagement sessions led by Inverclyde HSCP, NHSGGC, Scottish Government and the BMA, all 16 Practices in Inverclyde (at that time) signed up to participate in the pilot.</p> <p>A number of tests of change were developed:</p> <ul style="list-style-type: none"> • Aiming to reduce musculoskeletal presentations to the GP by making an advanced physiotherapist practitioner available. • Introduced a Drop-In Community Phlebotomy (drawing blood for testing) clinic. • Introduced Advanced Nurse Practitioners (ANP) working within the Community Nursing Service and responding to exacerbations of chronic illness and minor illness/injuries as well as undertaking Home visits. • Having Specialist Paramedics to reduce home visits for GPs by using this role to deal with unscheduled requests. • Piloting an extension of the Prescribing Team’s clinical and medicines management activities to embed Pharmacists and technicians in GP practices doing pharmacist led clinics, the authorisation of special requests for prescribed medicines and review of immediate discharge letters from acute hospital and outpatient letters. • Pharmacy First Pilot - Inverclyde Pharmacy First Service is a test service that extends the Minor Ailments Service (MAS) to all patients and adds a small range of common clinical conditions. The objective is to provide timely and appropriate assessment and treatment of these common conditions and identify patients who require onward referral to other services.
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Benefit Realised

There is now an expanded multi-disciplinary team in primary care; conditions for further change, due to development of relationships and new ways of working; and increased resilience.

<p>GP Cluster working CSS New System Characteristic Building on universal access to primary care. Focal point for prevention, anticipatory care and early intervention. Management where possible within a primary care setting. Focus for continuity of care, and co-ordination of care for multiple conditions.</p>	
<p>Previous State: 238 individual GP practices across NHSGGC area, often working in isolation. Quality improvement approaches focused on contractual mechanisms e.g quality and outcomes framework and enhanced services.</p>	<p>Transformed State: 238 GP practices across NHSGGC area now grouped into 39 clusters each with a cluster quality lead. Clusters have a role in identifying and driving quality improvement both within clusters and practices and in the wider system. The roles are defined as:</p> <p><u>Intrinsic</u> Learning network, local solutions, peer support. Consider clinical priorities for collective population. Transparent use of data, techniques and tools to drive quality improvement - will, ideas, execution. Improve wellbeing, health and reduce health inequalities.</p> <p><u>Extrinsic</u> Collaboration and practice systems working with Community MDT and third sector partners. Participate in and influence priorities and strategic plans of IJBs. Provide critical opinion to aid transparency and oversight of managed services. Ensure relentless focus on improving clinical outcomes and addressing health inequalities.</p> <p>HSCPs have aligned several existing and new teams to clusters to improve co-ordination of care and multi-disciplinary working: for example neighbourhood older people's teams. Clusters are at an early stage of development and there is significant further potential.</p>
<p>Benefit Realised Supports better joint working between practices and with wider community services. Has enabled alignment of community teams to groups of practices.</p>	

Optometry First Port of Call and Acute Referral Centre CSS New System Characteristic Building on universal access to primary care. Focal point for prevention, anticipatory care and early intervention. Management where possible within a primary care setting. Focus for continuity of care, and co-ordination of care for multiple conditions.	
Previous State: Patient with eye problems routinely attending GP practices. For urgent care patients went to eye casualty and waited to be seen by ophthalmology staff.	Transformed State: Optometry practices now first port of call for eye problems including urgent issues. GPs signposting to optometrists, and optometrists can refer to secondary care using SCI gateway if required. Urgent care now triaged first by optometrist in the community and then by telephone triage by a specialist nurse at the hospital. The patient is then given a next day planned appointment or advised to attend the hospital immediately if triaged as urgent
Benefit Realised Patients going to the service with the most appropriate skills and equipment directly, resulting in a reduction in steps in the pathway and unnecessary referral though GP practice; faster appropriate response and treatment. Patients access care according to urgency on a semi planned basis. Optometrists are able to ascertain the status of electronic SCI Gateway referrals. Utilisation of existing systems (SCI Gateway) maximises benefit of previous investment in people, systems and equipment.	

Enhanced Anticipatory Care Planning CSS New System Characteristic Comprehensive Primary Care Service Community Services and care planning in place to respond to crisis	
Previous State: Anticipatory Care Plans should be in place for 30% of GP patients at highest risk of emergency admission.	Transformed State: Extension of anticipatory care planning to a larger number of patients than that required within target groups. Practices were paid an item of service for each ACP completed or updated. Additional work was undertaken to improve awareness and use of eKIS among health care colleagues involved in emergency care and home care, for example training junior hospital doctors and extending access to eKIS to Community Nurses
Benefits Realised <ul style="list-style-type: none"> • 700+ new KIS and 400+ updates performed on vulnerable groups. • Care homes, dementia and learning disabilities targeted. • Information in ACP supported decision making for patients admitted as an emergency 	

<p>Revised Heart Failure Diagnostic including direct access for GPs to BNP blood tests</p> <p>CSS New System Characteristic</p> <p>High Quality Primary Care Management where possible within a primary care setting Diagnostic services organised around patient needs</p>	
<p>Previous State:</p> <p>Patients with suspected Heart Failure were referred to the Heart Failure diagnostic pathway where they went through a series of investigations. Over 90% of patients referred were found not to have HF. The volume of patients referred into secondary care drove delays in patients with confirmed HF going through the diagnostic pathway and being given an appropriate treatment plan</p>	<p>Transformed State:</p> <p>There was a successful pilot, in the Renfrewshire area, in which GPs were given direct access to BNP blood tests for patients with suspected Heart Failure. It is now planned to roll out this access to all GP practices in the Greater Glasgow and Clyde NHS board area from September 2017. This will mean a change in the Heart Failure diagnostic Pathway that before referring a patient with suspected heart failure a GP will be able to request the relevant blood test from primary care</p>
<p>Benefit Realised</p> <p>Providing access to BNP blood testing in primary care improves the patient journey, immediately reduces delays in excluding HF as a diagnosis and reduces referrals and the number of secondary care attendances for these patients. It reduces waiting times for echo, cardiology diagnosis, improves the diagnosis of heart failure and other cardiac pathology for these patients and reduces the risk of emergency admission prior to commencing treatment</p>	

Community Care: Transformation in Action

West Dunbartonshire Care at Home CSS New System Characteristic:	
<p>Single point of access, accessible 24/7 from acute and community settings. Focused on preventing deterioration and supporting independence. Multi-disciplinary care plans in place to respond in a timely way to crisis. Working as part of a team with primary care providers for a defined patient population.</p>	
Previous State	Transformed State
<p>The traditional model of care at involved separate referral routes and care planning, contributing to unnecessary delays in the right assessment and service being provided, with a propensity for duplication of service provision.</p>	<p>West Dunbartonshire HSCP has established an integrated care at home service, bringing together the co-ordinated provision of Care at Home and District Nursing services to more timeously and effectively identify and respond to risk and avoid unnecessary admissions to hospital, both “in” and out-of-hours. This community service links directly to out-of-hours GP services and all HSCP-managed and independent sector care homes.</p> <p>The multi-disciplinary work together to ensure improved shared information and communication at an earlier stage. Single sharable assessments and information sharing leads to better targeting of resources, more skilled and confident staff working towards shared objectives.</p> <p>In addition, the innovative use of Technology Enable Care (TEC) and dedicated reablement services support better outcomes, by maximising the individual’s long term independence and quality of life; and appropriately minimising structured supports.</p> <p>The team consistently receives unsolicited excellent feedback from services users; and encourages a culture where all feedback is used to - including challenge - provides an opportunity to critically review and improve services.</p>
Benefit Realised	
<p>People living in West Dunbartonshire are better able to live independently at home, recover well from hospital stay or injury and are safer and more independent through the dedicated work of West Dunbartonshire’s Care at Home Team.</p> <p>The West Dunbartonshire HSCP Care at Home Service was awarded the Scottish Association of Social Work (SASW) Award 2017 for the ‘Best example of collaboration in an integrated setting’.</p>	

Reconfiguration of rehabilitation services in North East Glasgow CSS New System Characteristic Rapid transfer to appropriate place of care, following assessment. In-patient stay for the acute period of care only Early supported discharge to home or step down care.	
Previous State: Older people had extended stays in acute hospitals which were not seen as a homely setting. Patients attended day hospital for regular but infrequent appointments over long periods Patients attended for clinic appointments on sites without access to the full range of supporting services	Transformed State: Early intervention from specialists in the acute care of older people focussed on immediate multidisciplinary assessment of frailty and clinical need; Rapid commencement of multidisciplinary rehabilitation within acute facilities for patients who require immediate access to the full range of investigations and specialist advice; New HSCP inpatient and community services to enable patients who do not require care in a full acute hospital to:- Be discharged directly home after assessment or a short stay in a full acute hospital; Access local intermediate care in community rehabilitation beds provided in a homely local setting; Have rehabilitation at home with support from additional community rehabilitation services; Acute day hospital services, which deliver assessment and intervention on a more focussed and intense one stop basis, to enable the discharge of patients home or to the ongoing care of local HSCP services; Outpatient services in a setting where there is access to other clinical services enabling a one stop approach.
Benefit Realised Patients benefit from shorter periods in acute hospitals and a more focussed period of rehabilitation and re-ablement with a focus on returning them to their home. When they are not ready to return home but do not require acute care they can access community based intermediate care nearer to home and family	

Hepatitis C Outreach CSS New System Characteristic Planned Care Locally Accessible; Hospital Assessment – Right Time Right Place; Coordinated Care at Time of Crisis	
Previous State: Patients with Hep C Infection have high rates of non-attendance at hospital clinics	Transformed State: Community outreach clinic established at Bridgeton Health Centre combining Liver Clinics with Community Addiction Services and Opiate Substitution Therapy Prescription Management
Benefit Realised Better access to services, promoting better health through a joined up approach across relevant acute and community services supporting the patient. Higher levels of attendance at new patient appointments. Reduces barriers to healthcare for historically hard to engage patients	

**East Renfrewshire Medicines Reconciliation and Support Service
CSS New System Characteristic:**

Focused on preventing deterioration and supporting independence.
Working as part of a team with primary care providers for a defined patient population.

Previous State

Individuals and families/carers unclear about medicine failure to comply, leading to exacerbation of condition and re-admission to hospital.

Transformed State

The East Renfrewshire HSCP's Medicines Reconciliation and Support Service is a pharmacy technician led service which:

- Provides medication advice and support for patients and carers upon return home after hospital discharge to ensure any medication changes are understood and actioned.
- Assessed compliance with medication and offers support where compliance issues are known.
- Completes an enhanced medicines reconciliation liaising with relevant members of the multi-disciplinary team to ensure current medication is correct.
- Rationalises dosing times to minimise need for unnecessary homecare input for medicines prompts.

Benefit Realised

By understanding their medication better and by having interventions such as compliance aids and inhaler technique provided, patients have been able to get better results from their prescribed medication.

Reduction in additional medication prompts also supports other HSCP community services, as reduced homecare prompts consequently reduces pressure on the homecare service. The Medicines Reconciliation and Support Service has improved patients' healthcare journeys; promoted a joined up approach to patient care; and by close working with the voluntary sector, provided links to local community supports and opportunities.

East Dunbartonshire Health and Social Care Intermediate Care Unit (ICU) CSS New System Characteristic: Focused on preventing deterioration and supporting independence. Working as part of a team with primary care providers for a defined patient population.	
Previous State No opportunity for services users to have additional assessment and rehabilitation post discharge from hospital.	Transformed State East Dunbartonshire HSCP commissioned a pilot step down intermediate care unit within Westerton Care Home in November 2016. The pilot incorporated a model of GP provision, care management and rehabilitation. Eight beds were planned to allow service users to transition from the hospital setting when medically fit for discharge to a homely environment, allowing them time for additional recovery; rehabilitation; and to enable a comprehensive assessment of their longer term health and social care support needs. The skill mix for the unit comprised: <ul style="list-style-type: none"> • Social workers from the Hospital Assessment Team (HAT) and Allied Health Professionals from the Rehabilitation Assessment Link Service (RAL) who are part of the Community Rehabilitation Team employed from the HSCP. • A nursing/support worker component from the care home. • GP contracted to do 2-3 clinical sessions weekly.
Benefit Realised	
<p>There was improvement in delayed discharge figures against heavy demographic demands for admissions to hospital. The unit offered a new service for East Dunbartonshire HSCP's portfolio of services for people who had complex needs who required an opportunity for further interventions and time to reflect on future plans. The pilot consolidated the essential role of rehabilitation in the interface between the acute and the community.</p> <p>The unit has been very beneficial to clients and their families as it provides opportunities for further assessment and rehabilitation. The service helped to get people out of hospital whilst also giving them breathing space to make decisions for the longer term.</p>	

<p>Out of Hours Community In-reach Service: CSS New System Characteristic</p> <p>A comprehensive range of community services, integrated across health and social care Early supported discharge to home or step down care. Early involvement of primary and community care team in planning for discharge</p>	
<p>Previous State: The Rapid Response team of the Renfrewshire Rehabilitation and Enablement Service (RES) offered access to Physiotherapy Occupational therapy, nursing, dietetic and technical assessment and support to patients referred urgently by their GP or hospital. It operated 0830-1900 Mon-Fri.</p>	<p>Transformed State: The Out of Hours Community Inreach Service aimed to support key points of transition both in and out of hours. Community social workers coordinated a range of supports to prevent admission and support discharge, working alongside the Rapid Response team. Key additions were the provision of a transport and resettlement service (including transport of equipment) and the extension of hours of working (1330-2000 Mon-Fri and 0900-1700 weekends). The team worked within the multi-agency discharge hub following its establishment in Feb 2015.</p>
<p>Benefit Realised</p> <p>Provided assistance to Older Adults Assessment Unit, Emergency complex and wards with discharges. This was an essential component for OAAU in terms of facilitating early discharge and reducing length of stay. Consultant estimated reduction to length of stay for patients discharged from OAAU is 1.75 days. Delivered benefits of joint working between health and social care and co-location</p>	

<p>Renfrewshire Development Programme CSS New System Characteristic: Single point of access, accessible 24/7 from acute and community settings. Focused on preventing deterioration and supporting independence. Multi-disciplinary care plans in place to respond in a timely way to crisis. Working as part of a team with primary care providers for a defined patient population.</p>	
<p>Previous State: Traditional models of working and relationships between acute, primary and community care in Renfrewshire.</p>	<p>Transformed State: The purpose of the Renfrewshire Development Programme (RDP) was to develop and test new service models proposed by the NHSGGC Clinical Services Strategy. It involved Renfrewshire HSCP, the 13 GP practices in Paisley and the Royal Alexandria Hospital. Its aims were to:</p> <ul style="list-style-type: none"> • Improve quality, including patient experience. • Improve care at interface between hospital and community. • Reduce avoidable admissions. • Maintain/improve re-admission rates. <p>There were six component parts:</p> <ul style="list-style-type: none"> • Chest Pain Assessment Unit. • Older Adults Assessment Unit. • Out of Hours Community Inreach Services. • Enhanced Pharmacy Service. • Enhanced Anticipatory Care Planning.
<p>Benefit Realised</p> <p>There were reduced lengths of stay associated with Chest Pain Assessment Unit and Older Adults Assessment Unit, with fewer patients requiring overnight stay and high patient satisfaction.</p> <p>There were Increased numbers of Anticipatory Care Plans completed for patients in target groups.</p>	

<p>Glasgow City Home is Best CSS New System Characteristic: Focused on preventing deterioration and supporting independence. Multi-disciplinary care plans in place to respond in a timely way to crisis. Working as part of a team with primary care providers for a defined patient population</p>	
<p>Previous State Hospital facing social work and community health resources organised and managed separately across the NHS and Social Work and the 3 geographical localities within the city.</p>	<p>Transformed State Development of a singularly managed, multi-disciplinary hospital facing community health and social work team for the whole city, with separate hubs facing into north and south acute sectors. This team will have an unequivocal responsibility for improving HSCP performance in relation to diversion from admission (front door focus), delayed discharges (back door focus) and utilisation of HSCP beds management (e.g. intermediate care, former HBCC, and AWI). The team will co-ordinate activity across all relevant HSCP teams/ disciplines, including social work, rehabilitation and occupational therapy. Essential to its success will be effective interfaces with the Acute system at both front door and discharge points. It will also work closely with Cordia, HSCP integrated neighbourhood teams (as above) and independent service providers (such as care homes).</p>
<p>Benefit Realised</p>	
<p>More coherent and efficient deployment of hospital facing HSCP resources. A singular community health and social work team, managed by one Service Manager across the city (rather than multiple managers as at present). Simplified accountability and system performance management arrangements. Simplified interface with the HSCP for the acute system. Ultimately the intention is that this team will perform a key role in meeting whole system unscheduled care performance targets and further improvement in Glasgow's delayed discharge performance. It is also expected to lead to more efficient utilisation of expensive HSCP resources such as intermediate care.</p>	

Unscheduled Care: Transformation in Action

Dedicated Frailty Units and Comprehensive Geriatric Assessment CSS New System Characteristic In-patient stay for the acute period of care only	
Previous State: Elderly patients were admitted to emergency medical wards without routine access to geriatric assessment of their rehabilitation needs.	Transformed State: Dedicated frailty units have been established to deliver a consistent Comprehensive Geriatric Assessment to patients who have been identified as frailty positive using the standard ED Frailty triage tool. Early identification for appropriate patients provides fast track access to elderly care assessment nurses and geriatricians. With targeted specialist resource provided by the frailty team, which consists of Acute Community and Social Care services, can ensure that wherever possible the patients needs can be met and are returned home or to their place of care within 24-48 hours and avoid extended periods of inpatient care that can result in further deterioration for frail elderly patients.
Benefit Realised Patients gain rapid access to an integrated multi skilled specialist team focussed on supporting the patients safe return to home or a homely setting as soon as possible, thus avoiding unnecessary extended hospital stays	

Ambulatory Emergency Care Pathways CSS New System Characteristic In-patient stay for the acute period of care only	
Previous State: Patients presenting with conditions which did not require an extended stay were admitted in order to assess and access diagnostic tests as there was no appropriate alternative to admission. This resulted in short stays which took bed capacity and prevented patient flow through the emergency receiving beds.	Transformed State: A number of high volume pathways have now been established for ambulatory care pathways. For COPD the community respiratory team provides support at home to manage and respond to exacerbations and provide alternatives to hospital care. For chest pain there is now a consistent pathway which has been adopted by both EDs and AUs across all sites and enables streaming of patients based on clinical scoring algorithm to avoid unnecessary admission. There is a DVT clinic delivered by specialist nurses via an appointment based system triggered after first referral to complete the treatment plan and educate of condition management There is now a cellulitis pathway that reviews patients after first episode of admission and identifies those suitable to have their treatment converted to planned care delivered by the medical day units
Benefit Realised Patients avoid admission to hospital and are treated either on a planned basis or on an ambulatory basis through the hospital or in a day hospital or community based service	

Acute Assessment Units CSS New System Characteristic Senior clinical decision makers at the front door In-patient stay for the acute period of care only	
Previous State: Acute departments were not routinely manned by specialty consultants. These senior decision makers were available but on request and decisions were routed through junior staff.	Transformed State: The establishment of Assessment Units with access to professional advice either via senior nurse or specialty specific telephone systems. Work undertaken to improve access to specialty advice with the option to review management plan and/or defer patient attendance to the following day to a hot clinic.
Benefit Realised More rapid access to senior specialist opinion allows treatment plans to be established more rapidly	

Discharge Flow Hubs CSS New System Characteristic Better coordination of patient flow	
Previous State: The elements which are required for discharge; medicines, transport and care packages were not well coordinated and put pressure on ward staff	Transformed State: The Flow Hub concept brings together the combination of discharge lounges and transport hubs. The most advanced version of this is in the RAH with HALO (hospital ambulance liaison officer) supporting patient transport management and discharges, working alongside pharmacy service provision for patients awaiting medication/scripts which are provided in the hub rather than the ward areas. These hubs also manage outpatient transport services Pharmacy provision to the hub is being rolled out across sites.
Benefit Realised Discharge is better coordinated and is earlier in the day, improving patient flow and bed availability	

Exemplar Wards CSS New System Characteristic Better coordination of discharge planning	
Previous State: Patient discharge planning dependent on senior medical review. Decisions often taken later in the day resulted in delays.	Transformed State: More frequent and earlier decision making with the use of daily 'board rounds'. Discharge decisions delegated to nursing staff where appropriate. Better systems for coordination of Immediate Discharge Letters and Pharmacy.
Benefit Realised More patients discharged earlier in the day allowing beds to be available when needed for acute admissions	

Planned Care: Transformation in Action

Ortho Opt-in CSS New System Characteristic Hospital Assessment – Right Time Right Place	
Previous State: All patients referred by their GP with a specific range of joint related conditions would be sent a hospital outpatient appointment and seen in a consultant clinic.	Transformed State: Patients referred by their GP with that specific range of conditions go through an extended triage carried out by Specialist Nurses and Physiotherapists/ Podiatrists. Patients are sent information about their condition and asked to phone in for advice or to opt-into an outpatient appointment.
Benefit Realised	
To date 156 patients have been through this opt-in process. 67% made no contact with the department following the information being sent out. 30% requested a face to face clinic appointment and 3% called for advice in self care. This system reduces unnecessary outpatient appointments and empowers the individual to make a more informed decision about their referral into the department	

Virtual Lung Cancer Clinic CSS New System Characteristic Hospital Assessment – Right Time Right Place	
Previous State: All patients referred by their GP with Urgent Suspicion of Cancer (USOC) would be sent a hospital outpatient appointment for a fast track consultant clinic. A significant proportion of patients attending fast track clinic appointments were found to not have a diagnosis of cancer.	Transformed State: USOC referrals are now vetted by a Respiratory Consultant and directed to either a fast track outpatient clinic or to a Virtual Lung Cancer Clinic. In the Virtual Lung Cancer clinic referral information, lung functions test results and CT results are reviewed by two Respiratory Consultants resulting in either a routine clinic appointment or a fast track appointment, referral to another specialty or discharge. Written communication is provided to the patient after the virtual clinic.
Benefit Realised	
Of 354 patients referred for a USOC appointment, 144 were seen by Virtreduced clinic times, or required no physical appointment and were given early reassurance and discharge, allowing resource to be focused on the management of cancer cases. 81% of patients who responded to a questionnaire evaluation of the Virtual Lung Clinic were satisfied with receiving their results by letter. Benefits – timely reassurance of results; improved time to first face to face appointment for those needing one; better use of fast track USOC appointments for patients needing this type of service.	

Virtual clinics in Clyde Gastroenterology CSS New System Characteristic Coordinated care at crisis/transition points and for those most at risk	
Previous State: Inflammatory Bowel Disease Patients attended at regular interviews for Consultant Return appointment putting pressure on the return demand of the service	Transformed State: Virtual consultations - review of all 174 IBD patients on Biologics undertaken with Gastro Consultant, IBD Specialist Nurses over 3 x weeks resulted in an individual care plan in place for each patient on a Biologic drug
Benefits Realised	
No longer required to attend secondary care for appointment Individual care plan in place – shared with IBD specialist nurse team and General Practice Suite of patient self management support materials developed for use Biologic tapering / withdrawal – medicines review – not taking medicines unnecessarily IBD patients and relatives have telephone / email access to IBD Clinical Nurse Specialist Advice in event of a flare Protocols defined for CNS use – Nurse Led Return Clinics established for IBD IBD Consultant – aim is to see patient once then discharge with a clear care plan Reduced unnecessary OP returns to clinic Some require 2 or 5 Yearly scans – discharged in between Detailed Plan provided to GP for each patient Agreed pathway to enable quick access back into service if necessary	

Redesign of Bowel Screening Processes CSS New System Characteristic Diagnostic services organised around patient needs	
Previous State: Bowel screening (national programme) 3 samples required limited uptake	Transformed State: Introduction of more specific test requiring only 1 sample anticipated increased uptake (starting Oct 2017)
Benefit Realised	
Improved uptake for bowel screening therefore earlier diagnosis and better outcomes in bowel cancer treatment	

Access to Stroke Diagnostics CSS New System Characteristic Diagnostic services organised around patient needs	
Previous State: Limited ability/delay in patients receiving Imaging whilst attending a TIA clinic	Transformed State: Ring fenced slots for CT/MR where possible for patients attending TIA clinics
Benefit Realised	
Patients receive a diagnosis as part of a one stop clinic	

Primary Care Access to Lab Testing CSS New System Characteristic Diagnostic services organised around patient needs	
Previous State: Primary care did not order or receive test results electronically	Transformed State: Introduction of GP ordercoms (ICE) for Laboratory Medicine
Benefit Realised All Lab tests ordered electronically and reports available directly to GPs, faster response and more robust system.	

GP direct access to MRI CSS New System Characteristic Diagnostic services organised around patient needs	
Previous State: GP could not refer patients directly for MRI	Transformed State: GPs can now refer patients for MRI knee following the approved protocol
Benefit Realised Reduced need for patients to be referred to secondary care	

Mental Health: Transformation in Action

Redesign of Matched Care in Primary Care MH Teams CSS New System Characteristic Routine Patient Outcomes Monitoring	
Previous State: Primary Care Mental Health Teams are designed to provide brief, prompt care for people with common mental health problems. Patient “flow” in such systems is critical, but there was no agreed system for tracking care which patients required.	Transformed State: CORE-Net (Clinical Outcomes in Routine Evaluation) is an electronic patient outcome measure suitable for PCMHT use, and is completed electronically. Scores are entered by patients or their clinicians and the system visualises progress over time.
Benefit Realised Outcomes for patients, clinicians and teams can now be readily visualised, and support not only individual care plans, but also assist teams in managing overall demand, and team capacity. CORE-net is being rolled out to other community teams in MH.	

Redesign of provision of Cognitive Behavioural Therapy (CBT) CSS New System Characteristic Introduction of Computerised CBT (cCBT) across NHS GGC & Partnerships from Nov 2017	
Previous State: CBT is a fundamental mode of evidence-based psychological treatment in MH, but typically requires intensive therapist input. cCBT is recommended by NICE and SIGN and the program used (<i>Beating the Blues</i>) has a strong evidence base and has been proven to work in Scotland.	Transformed State: cCBT is used for the treatment of patients suffering from mild to moderate depression and/or anxiety. Treatment consists of 8 x 1 hour sessions completed weekly via the internet either in the patient’s home or at a community location such as a library.
Benefit Realised Referrals can be made via SCI Gateway from primary care with only minimal contact information required. Patients will typically be provided with access to the cCBT program within 5 working days from receipt of referral. NHS GGC/Partnerships has a target of 980 referrals in the first year, and this will increase treatment options for GPs, reduce referrals to secondary care MH services and support continued delivery of the Psychological Therapies HEAT target.	

E-health: Transformation in Action

West of Scotland Portal to Portal Development	
<p>The West of Scotland portal to portal project has provided a technical solution built in Clinical Portal to enable boards to launch their respective portal systems seamlessly without requirement to enter an additional username and password.</p>	
<p>Previous State:</p> <p>Patient care is increasingly being delivered in regional models across the West of Scotland. This is due to large populations located across NHS Board boundaries</p> <p>The viewing of patient records and clinical information across Health Boards within the West of Scotland involved accessing multiple sources of information from different systems, may have required telephone contact or even the transfer of paper case notes between Boards.</p>	<p>Transformed State:</p> <p>The project set out to make it simple for clinicians to find the information they wanted, while also addressing security and confidentiality issues.</p> <p>NHSGGC now has 2 way portal to portal with the following boards:</p> <p>NHS Lanarkshire</p> <p>Golden Jubilee National Hospital</p> <p>NHS Ayrshire & Arran</p> <p>NHS Dumfries and Galloway</p> <p>This functionality is available to all clinical staff in GGC and the participating boards. It will be extended to GGC administrative staff in November 2017</p> <p>Information governance and other key documentation was created once and then agreed by each of the health boards. A minimum data set was agreed that included demographics, GP details, lab results, encounter history and clinical documentation. A full audit trail is available of all user activity in each portal system.</p>
Benefit Realised	
<p>Data sharing is immediate and safe using the patient CHI number to identify and match the patient. Clinical risk is reduced significantly as up to date information can now be queried at source which further assists decision making.</p> <p>Obtaining patient information is efficient and simple, which is a significant time saving for clinical staff. Baseline analysis completed ahead of the project underlines this point. It found that doctors could spend 70 minutes per day looking for information about patients</p> <p>Feedback from clinicians is overwhelmingly positive, the regional portal is being well-used; already, clinicians are accessing 3-4,000 cross board records every week, and there have been more than 50,000 log-ons so far this year.</p>	

Community Nursing System Integration

Ability to view the following data sets from the community nursing information system (CNIS and EmisWeb) within Clinical Portal.

- Risks
- Allergies
- Open Referral Information
- Associated Professionals (GP, named nurse)
- Associated People (Next of Kin, Carer)
- Malnutrition Universal Screening Tool (MUST) data
- Summary of last 10 Visits
- Care Plans

The Community Nursing service will move to EMIS Web in 2018/19 this data will transfer from being viewed from CNIS to EMIS Web, further consultation will be undertaken to look at sharing additional fields.

Previous State:

District Nurses have regular contact with patients often seeing them on a daily basis this means the data they record in the electronic patient record is the most up to date. Previously this was not viewable to anyone other than Community Nurses.

When a patient was admitted to hospital there was a lack of information on any community care they were receiving.

These patients are often elderly and may be confused at the time of admission restricting their ability to provide accurate medical information.

Transformed State:

With the above data fields now being viewed in Clinical Portal other directorates can view important data relating to community nursing patients.

The ability to see contact details for patient's district nurse and next of kin is particularly useful when patients cannot provide this information themselves or for when a patient being discharged from hospital and will require district nursing care.

GP's can view when the patient was last visited by a district nurse rather than contacting the district nurse in person.

Other Specialist Nurses, eg Tissue Viability nurses can see view care plan data relating to any pressure ulcers the patient may have.

Benefit Realised

Improved sharing of patient information and more effective communication between primary, secondary and community care staff leading to patient safety benefits and improved care.

Community Care HSCP Partnership Information

Access across partner agencies to patient/client information via an adapted version of Clinical Portal.

<p>Previous State:</p> <p>No electronic means for two-way sharing of shared patient/client information between social work and NHS staff.</p> <p>Their only option was to phone round/message often multiple partnership colleagues to get what they needed.</p> <p>Clear impact on efficiency, and potential impact on patient/client safety.</p>	<p>Transformed State:</p> <p>Portal links created for each of the two social work IT systems in use.</p> <p>Depending on the access rights of a user, information accessible can include demographics, key contact details, alerts/ concerns, encounter summary and a variety of assessments.</p> <p>Piloted and now live between NHSGGC and West Dunbartonshire.</p> <p>Good early reviews from users. Feedback is that they want to implement wider.</p> <p>Roll-out now underway, plus planning for possible future extension.</p>
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Benefit Realised

Availability and sharing of information between partner agencies leading to improved patient safety and quality of care benefiting patients and carers. More efficiency for staff involved in patient's care as information is available and relevant.

Neurology Advice Only Headache Pilot

Pilot of advice referral using SCI Gateway from Primary to Secondary care.

<p>Previous State:</p> <p>Patients presenting to GP's with symptoms routinely referred to Neurology and placed on waiting list until seen by the Service.</p>	<p>Transformed State:</p> <p>Early intervention with the service via the Advice referral highlighted 25% of the pilot referrals were dealt appropriately through this process which negated the need for the patient to attend an outpatient appointment.</p> <p>16% of referrals resulted in an urgent referral being made to the patient.</p> <p>While the project was taken forward as a pilot, the system and process has been left on, with wider communication to GP practices due to the potential benefits to patients and to the service.</p> <p>Further work will be undertaken to assess what developments are required to support a full scale implementation for other services.</p>
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Benefit Realised

Primary care clinicians in requesting advice for patients to decide on best treatment plan, and if a referral is required to secondary care.

Secondary care clinicians in being able to vet an advice only referral and upgrade this to an outpatient appointment if appropriate, therefore reducing the number of appointments required.

Copy of advice message placed into the EPR to form part of the patient record. Structured advice message within SCI Gateway utilising agreed terminology, allowing appropriate triage. Patient benefits from triaged advice and avoiding an unnecessary appointment.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP**Health & Social Care Partnership Board: 22nd November 2017**

Subject: Regional Planning with Regard to the Scottish Government Health and Social Care Delivery Plan**1. Purpose**

- 1.1** To advise the Partnership Board of work being led by the Chief Executive of NHS Ayrshire and Arran in their capacity as Regional Implementation Lead (West of Scotland) to develop a regional plan for the West of Scotland in accordance with the national Health and Social Care Delivery Plan.

2. Recommendation

- 2.1** The Partnership Board is recommended to:

2.1.1 Note this report.

- 2.1.2** Agree that the Chief Officer engage with regional planning arrangements on the Partnership Board's behalf and keep the Partnership Board apprised of progress.

3. Background

- 3.1** As Members will recall, over the past eighteen months two key documents – the Health and Social Care Delivery Plan and the National Clinical Strategy – have been published providing the national policy direction and setting out the way forward in Scotland in terms of health and care
- 3.2** The National Health and Social Care Delivery Plan (2016) describes the approach to be followed to ensure that Health and Social Care is transformed in the next few years. It sets out a significant list of deliverable objectives which include a focus on regional and national planning of services where appropriate.
- 3.3** The National Clinical Strategy (2016) also calls for regional planning of many hospital services to improve patient outcomes; to make maximum use of highly trained clinicians; to fully utilise complex services supported by expensive technology such as robotic surgery; to standardise care to avoid unwarranted variation; and to make services financially sustainable for the future.
- 3.4** At regional level, the Scottish Government has commissioned Regional Delivery Plans to be developed, encompassing a whole-system approach to the delivery of health and social care for each of three regions: North, East and West. The national NHS Boards are also developing a single plan that

sets out the national services where improvement should be focused, including, where appropriate, a 'Once for Scotland' approach in areas such as digital services, clinical demand management and support services.

- 3.5** West Dunbartonshire lies within the West of Scotland regional area. West of Scotland regional planning is concerned with improving the health and care of a population of 2.7m people covered by five NHS Boards, 16 Local Authorities and 15 Integration Joint Boards, as well as the Golden Jubilee Foundation.
- 3.6** To take forward the national and regional approach, five NHS Chief Executives have been appointed to the role of National or Regional Implementation leads. The appended paper has been prepared by Chief Executive of NHS Ayrshire and Arran in their role as Regional Implementation Lead (West of Scotland) to describe the collective ambition of the West of Scotland to improve the health and care for people across the Region.

4. Main Issues

- 4.1** The regional planning approach proposed for the West of Scotland has been framed in respect of the following principles:
- Prevention is better than cure
 - Care should be designed around the needs of the whole population removing boundaries in planning and delivering care
 - Focus on reducing health inequalities by working together on the wider determinants of health
 - Care should be provided as locally as possible and only centralised where absolutely necessary
 - Care should be integrated across health and social care working in true partnership with patients, carers and the voluntary sector
 - We should make the best possible use of resources achieving value for patients, communities and the tax payer.
- 4.2** Recognising the importance of all the key stakeholders in developing a plan for the future in the West of Scotland work, the Regional Implementation Lead began working with NHS Boards to begin to create a shared agenda. It has been acknowledged that further work is required to engage with and include Local Authorities, Integration Joint Boards and the third sector in the development of this plan (particularly around the social care element of this work). The appended paper confirms that this will be progressed over the next few months.
- 4.3** Recognising the existing governance arrangements and accountabilities of the NHS Boards, Integration Joint Boards and Local Authorities, work will be progressed to consider how each of the organisations can work effectively together to deliver their local plans but also to optimise the opportunities from working regionally to create sustainable care models for the local populations. To achieve this ambition a common purpose has been developed, i.e. we are working together as a region towards four aims: improving health and

wellbeing; increasing care and quality; delivering on finance and efficiency; and better workplace with a focus on staff.

4.4 The appended paper also recognises that while the stakeholders involved will be united as a region in addressing this common purpose, not all of the work to plan or deliver these objectives will be done at a regional level. For example, the Integration Joint Boards have primary responsibility for joining up health and social care in their communities, while there are national programmes who are planning for shared services across the nation. Existing Board Strategies and Health and Social Care Strategic Plans set out work that will continue to be progressed locally. This work will influence and be influenced by the development of the regional delivery plan.

4.5 The Regional Implementation Lead (West of Scotland) is now taking forward work to put in place the following governance arrangements:

- NHS Board Chairs form an assurance and scrutiny group. It is anticipated that this group will develop to include representation from Integration Joint Board chairs.
- West of Scotland Health and Social Care Delivery Group. This group is chaired by the Regional Implementation Lead. Membership includes NHS Chief Executives, Health and Social Care Partnership Chief Officer, Employee Director Representation, and leads for Nursing, Medical and Human Resources. Engagement is now taking place with COSLA/SOLACE on including representation from Local Authorities.
- Work is being undertaken to explore the establishment of a Clinical Board/Senate whose scope could include deepening and owning the case for change; providing clinical input into care model decisions; and providing clinical leadership to the process and signal clinical backing of the regional work.

5. People Implications

5.1 No specific implications associated with this report.

6. Financial Implications

6.1 No specific implications associated with this report.

7. Professional Implications

7.1 No specific implications associated with this report.

8. Locality Implications

8.1 No specific implications associated with this report.

9. Risk Analysis

9.1 In developing this plan, one of the challenges will be defining the role of the region in care that is delivered outside of hospital. The appended paper acknowledges that there are likely to be tensions that emerge and will have to be worked through between organisations within the region as partners try to balance achieving individual organisation goals and regional goals.

10. Impact Assessments

10.1 None required for this report.

11. Consultation

11.1 None required for this report.

12. Strategic Assessment

12.1 The Regional Delivery Plan will support both the local delivery of Health and Social Care Partnership Strategic Plans across the West of Scotland; and taken together with these plans will describe a strategy for the health and social care for the Region's population as a whole.

Author: Soumen Sengupta - Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Care Partnership

Date: 06 November 2017

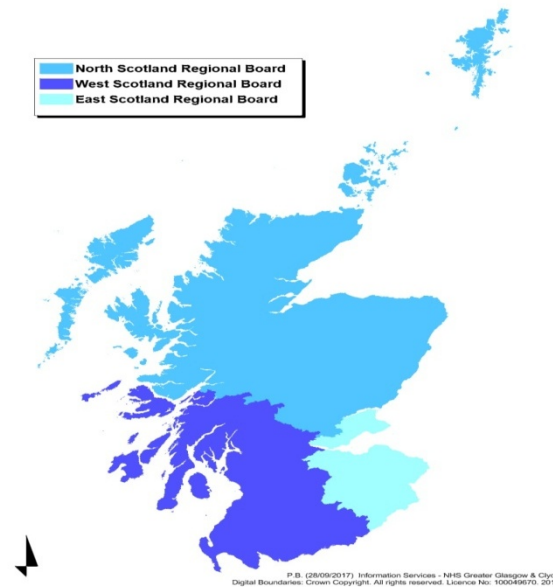
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Appendices: West of Scotland - Developing a Regional Plan
Position Paper and Discussion Document
(September 2017)

Background Papers: None

Wards Affected: All

West of Scotland



Developing a Regional Plan

Position Paper and Discussion Document

September 2017

1. Introduction

This paper describes the collective ambition of the West of Scotland to improve the health and care for people across the Region. It has a particular focus on keeping people well, early intervention and developing better, more integrated care organised around the individual needs of the patients we serve. It builds on the many examples of excellent care already provided across the Region and reflects our local aspiration to deliver the *National Health and Social Care Delivery Plan* providing better health, better care and better value.

The paper is structured as follows:

- Summary of our overall approach
- Our guiding principles
- The leadership of the Programme
- The national policy context
- The regional context
- The case for change
- The emerging common purpose
- Early thinking on new models of care
- The regional plan to take this work forward to March
- Next steps
- Statements of intent

Delivering this vision will require action at every level of the health and care system across the Region. Our starting point is to recognise that circa 90% of care is provided in an out of hospital setting. Our approach will therefore build first and foremost on the needs of local communities whilst also recognising the need to plan for the most seriously ill who will require more specialised hospital based services.

Our approach is to collectively plan to improve the health and wellbeing of our 2.7m population, reducing inequalities and improving health outcomes for our citizens. It will be grounded in effective and meaningful partnership between health care, local authority services, primarily social care, the third sector, patients and communities. The Regional Delivery Plan will support both the Local Delivery and Health and Social Care Strategic Commissioning Plans and taken together with these plans will describe a strategy for the health and social care for the Region's population as a whole.

2. Executive Summary

Regional planning in the West of Scotland with the focus on acute and tertiary services has served us well for many years. These arrangements are no longer fit for purpose, as the task to prepare a Regional Delivery Plan requires a different and more inclusive approach. Therefore, we are putting in place new arrangements to co-ordinate planning across the Region.

The NHS in the West of Scotland has demonstrated significant improvements over the last 20 years; however there is further work to be taken forward to meet the challenges of the next 20 years. Preventable illness is widespread and health **inequalities deep-rooted**.

New technologies and treatment options are emerging, and **patients' needs are changing**. We face particular pressures in providing care to an increasingly older population recognising they will need more joined up integrated care to stay well and lead a full life.

In the West of Scotland, we have a shared understanding of the challenges we face and have developed a **compelling Case for Change** as a basis for action.

We have developed a **shared vision and a common purpose** which describes our future offer for our patients and communities. Our ambition is to join up care around the patient breaking down traditional barriers in how care is provided between family doctors and hospitals, between physical and mental health and between health and social care. This future will see far more care delivered locally nearer to people's homes but with some services in specialist centres.

We are committed to **Local Care Models** based on a deep understanding of the different needs of segments of the population, a consistent set of clinical standards and with services integrated and co-ordinated from a patient view.

Whilst most people can be cared for by better more joined up local care, we recognise the most seriously ill need more specialised hospital care. We are committed to developing a region-wide framework to support the development of **New Models of Acute Care** based on a stratified network of services.

To deliver this vision we have put in place comprehensive programme arrangements including **System Leadership through a Regional Programme Board** and have set out a **Forward Programme Plan** (October to March) to deliver the first strategic plan in March 2018.

3. Guiding Principles

In drafting this document and developing the plan, we are proposing to apply the following principles:

- Prevention is better than cure
- Care should be designed around the needs of the whole population removing boundaries in planning and delivering care
- Focus on reducing health inequalities by working together on the wider determinants of health
- Care should be provided as locally as possible and only centralised where absolutely necessary
- Care should be integrated across health and social care working in true partnership with patients, carers and the voluntary sector
- We should make the best possible use of resources achieving value for patients, communities and the tax payer.

4. Leadership of the Programme

The West of Scotland comprises a number of partner organisations supporting the provision of health and care services including 5 Territorial Boards, 15 Health and Social Care Partnerships, 16 Local Authorities, 5 National Boards and a number of Third Sector Organisations.

West of Scotland Partners

Health and Social Care Partnerships (15) / Local Councils (16) ¹	<ul style="list-style-type: none">• Inverclyde• East Renfrewshire• West Dunbartonshire• North Ayrshire• North Lanarkshire• Dumfries & Galloway• Falkirk• Glasgow City	<ul style="list-style-type: none">• Renfrewshire• East Dunbartonshire• East Ayrshire• South Ayrshire• South Lanarkshire• Stirling & Clackmannanshire¹• Argyll and Bute
NHS Territorial Boards (5)	<ul style="list-style-type: none">• Ayrshire & Arran• Forth Valley• Lanarkshire	<ul style="list-style-type: none">• Dumfries & Galloway• Greater Glasgow & Clyde
NHS National Boards (5)	<ul style="list-style-type: none">• Scottish Ambulance Service• NHS 24• Golden Jubilee Foundation	<ul style="list-style-type: none">• National Education Scotland• National Shared Services

¹ Local Councils are typically 1:1 with HSCPs with the exception of Stirling and Clackmannanshire which has 2 Councils and 1 HSCP
Source: Regional Team

Recognising the importance of all the key stakeholders in developing a plan for the future in the West of Scotland work, we began working with Boards and their executive and non executive members, the Integrated Joint Board chief officers and their voting members, and other senior managers and senior clinical leaders' to begin to create a shared agenda. We recognise that we have further work to do engage with and include Local Authorities, Integration Joint Boards and the third sector in the development of this plan, particularly around the social care element of this work. This will be progressed over the next few months.

Some of this work has been facilitated by external organisations to encourage a more transformational approach both to developing the regional delivery plan and the ways in which we will need to work across the different parts of the system to achieve success, learning from experience both within the United Kingdom and across other parts of the world.

Stakeholder Engagement

Our first set of meetings aimed to set out the question we believe we needed to answer as a region. This can be described as:

How do care services need to be configured in the West of Scotland to be safe, sustainable, equitable, effective and affordable to meet the needs of the 2.7m population going forward to 2035 and support the delivery of the Health and Social Care Plan?

The workshop engaged more than 65 people in shaping approach



An engagement session on the 20th September 2017 saw representatives from the NHS Boards, the Integrated Joint Boards come together to consider the emerging story for the region. The session set out for consideration and discussion:

- the key messages arising from the population needs assessment;
- the key messages from the gap analyses on workforce, demand and performance analyses, finance and infrastructure;
- the case for change;
- the common purpose that unites us as a region
- the potential interventions in care models and a stratified model for designing services
- the programme structure to support the development of the Regional Delivery Plan
- the approaches we need to adopt to communication and co-production as we go forward to prepare the first regional delivery plan for March 2018, including the approach to governance and sign off prior to submitting the plan at the end of March 2018.

This session allowed key regional stakeholders to come together to consider and agree the vision for the region and the guiding principles and behaviours that will be crucial to develop and maintain the relationships across the region and to create the arrangements and necessary conditions to engender a whole system approach to achieve the collective goal.

5. National Policy Context

Over the past eighteen months 2 key documents – the Health and Social Care Delivery Plan and the National Clinical Strategy- have been published providing the policy direction and setting out the way forward in Scotland in terms of health and care of our population on top of the existing Quality Strategy that sets out an ambition for quality.

National Health and Social Care Delivery Plan¹, launched in December 2016, describes the approach to be followed to ensure that Health and Social Care is transformed in the next few years. It is action orientated, and sets out a significant list of deliverable objectives which include a focus on regional and national planning of services where appropriate. The delivery plan draws on preceding strategies, pulling them together and setting out the direction of travel and expectation of a modern health and care system to achieve the aspirations mentioned in the strategies.

- 2020 Vision – people live longer, healthier lives at home or in a homely setting
- Health and Social Care Integration² which promotes prevention, anticipation and supported self management; working across health and social care to improve patient care
- Daycase treatment as the norm
- Highest standards of quality and Safety (Quality Strategy 2010)
- Person centred care
- Health and Social Care Workforce Plan³– considering workforce planning and development
- Investment - matched to reform and transformation
- Digital Strategy⁴ - promoting technology and information supporting both patients and care professionals to provide modern models of care

The National Clinical Strategy⁵ published in February 2016 set out areas for change:

- Planning and delivery of primary care services around individuals and their communities
- Planning hospital networks at a national, regional or local level based on a population/ availability of appropriately skilled workforce paradigm
- Providing high value, proportionate, effective and sustainable healthcare (linked with Realistic Medicine)
- Transformational change supported by investment in eHealth and technological Advances

The National Clinical Strategy also calls for regional planning of many hospital services to improve patient outcomes; to make maximal use of highly trained clinicians; to fully utilise complex services supported by expensive technology such as robotic surgery; to standardise care to avoid unwarranted variation; and to make services financially sustainable for the future.

¹<http://www.gov.scot/Resource/0051/00511950.pdf>

²www.shiftingthebalance.scot.nhs.uk/downloads/1305042182-Integration(Summary position paper)

³Integration across Health and Social Care Services in Scotland – Progress, Evidence and Options: www.gov.scot

⁴<http://www.ehealth.nhs.scot/strategies/the-person-centred-ehealth-strategy-and-delivery-planstage-one/>

⁵www.gov.scot/Publications/2016/02/8699

The King's Fund has considered the evidence of benefit from reconfiguration of acute services and notes that while reconfiguration can lead to improvements in services:

“Reconfiguration is an important but insufficient approach to improve quality. It should be used alongside other measures to strengthen delivery of care and to instil an organisational culture of improvement.”⁶

Other national policies and strategies influencing the development of the regional delivery plan include:

- Best Start (*Maternity and Neonatal Services Strategy – 2017*)
- Primary Care Transformation
- Implementing the GP contract
- Mental Health Strategy
- Cancer Strategy (March 2016)
- Getting it Right for Every Child (GIRFEC)
- Realistic Medicine
- Review of Health and Social Care Targets
- Public Health Strategy

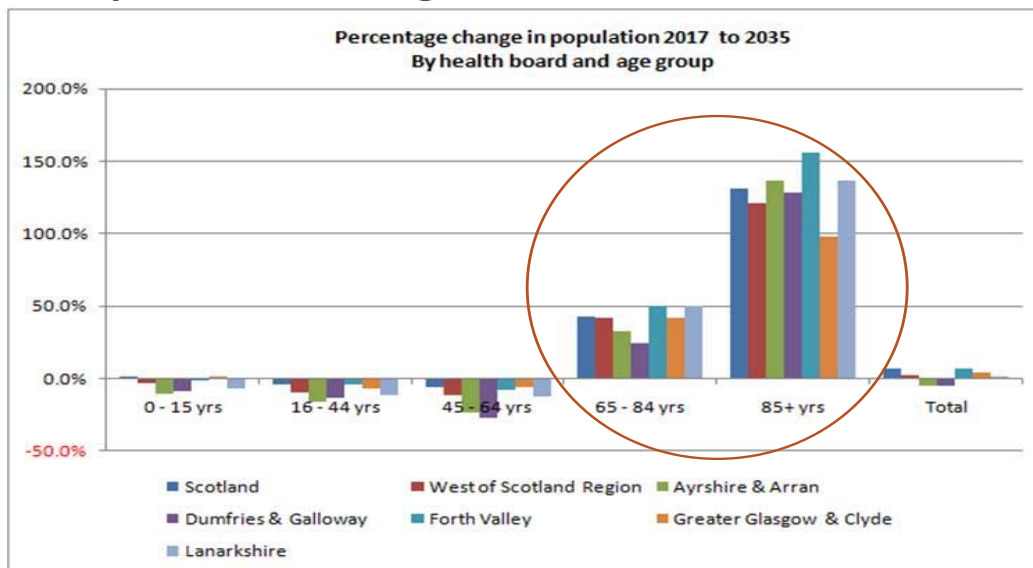
⁶ The King's Fund: *Reconfiguration of Clinical Services: What is the evidence?* Candice Imison. November 2014

6. Regional Context

6.1. Understanding the Population

The West of Scotland serves a population of circa 2.7m, covering a wide geographic area of 8,777 square miles, consisting of urban, rural and island communities. A Health Needs Assessment for the West of Scotland is currently being progressed. A significant number of analyses have been identified and undertaken which will support the work over the coming months to consider the service model and provision for health and care services for the region. Beyond the work to consider the population age, gender, deprivation levels and the implications of this both in relation to health and social care provision, use and funding levels, work is considering the use of services, life expectancy and health outcomes; reviewing the trends in this over the last decade or longer.

Population Changes in West of Scotland



Population Needs Assessment: Emerging Findings

- The West of Scotland has some of council areas with highest proportions of oldest residents in terms of population percentage over 65.
- It also has most of the most deprived council areas in terms of summary SIMD score (Glasgow city, West Dunbartonshire, Inverclyde, Renfrewshire, North Lanarkshire, East Ayrshire) and the bulk of the population residing in the most deprived deciles and quintiles.
- Both social deprivation and agedness of the population place major demands on the health and care systems
- The challenges of equitable service provision based on need rather than demand in a geographic area that also has considerable sized areas of affluence results in smaller National Resource Allocation Committee (NRAC) and Scottish Allocation Formula (SAF) shares for hospital & community services.

- Hospital admission rates are observed to be higher in the West of Scotland based on the crude rates. Work is underway to age, sex, deprivation adjust this position to assess the level of over-utilisation. This poses the question - does the proximity to hospital facilities encourage access particularly where they are relatively well provided for in terms of hospital beds and consultant provision?
- Plateauing of the life expectancy at birth is seen for Scotland as a whole, which is particularly clear for Scottish males, and evidence of unexpected downward shifts in the life expectancy trajectory are visible in some areas within the region. Stalling of rises in life expectancy defying the expectation of ongoing improvements in longevity. This is likely to be multi-factorial
 - including the effects of the high prevalence of obesity, the rising prevalence of Type 2 Diabetes, the stalling decline of smoking prevalence, the contribution made by the rise in alcohol-related deaths, etc
 - the role of austerity and level of investment in health and social care may be impacting, as well as the current organisational model that may hinder the achievement of optimal efficiency.
 - falling access to primary and secondary health services, and social care, for some sections of the population in both remote/ rural areas and urban areas.

All of these threaten to reverse the progress made by improving structural determinants of health over the past century and increased health service provision over the past 15 years.

- Consistently clear improvements in most health parameters, as well as preservation of, or improvement in, the relative position in the national health league table, are being seen for the residents of the most deprived health board in the West of Scotland, namely Greater Glasgow & Clyde, in terms of standardised death rates from all causes, and standardised mortality ratio for all causes, SMR for cancer mortality for all types, and specifically for the commonest cause of death, namely heart disease.
- Despite having less social deprivation than GG&C, Lanarkshire's relative position in the standardised mortality (all causes) league table has worsened somewhat in recent years and its relative position in the cancer mortality league table for all types combined and for lung cancer in females has also worsened.
- Perhaps more surprisingly, more rural areas in the West of Scotland, even those characterised by relative affluence such as Dumfries & Galloway and Argyll & Bute, have unexpectedly lost ground and those with historical health deficits, such as parts of Ayrshire & Arran, appear to have deteriorated further in very recent years. Age/sex standardised death rates (all causes), standardised mortality ratios (all causes of death), and/or SMR for cancer (all types combined) appear to be rising in recent years, for these three board/council areas, the starting points of the rises varying with the area. Even the more affluent Forth Valley, appears to have lost ground with respect to its relative position in the cancer (all types) SMR league table, since its enviable position before 1990.

To ensure that the limited resources available are used equitably, that is, determined by genuine need, and fairly distributed against both geographical and socio-economic gradients, it will be important to consider the service provision across the region.

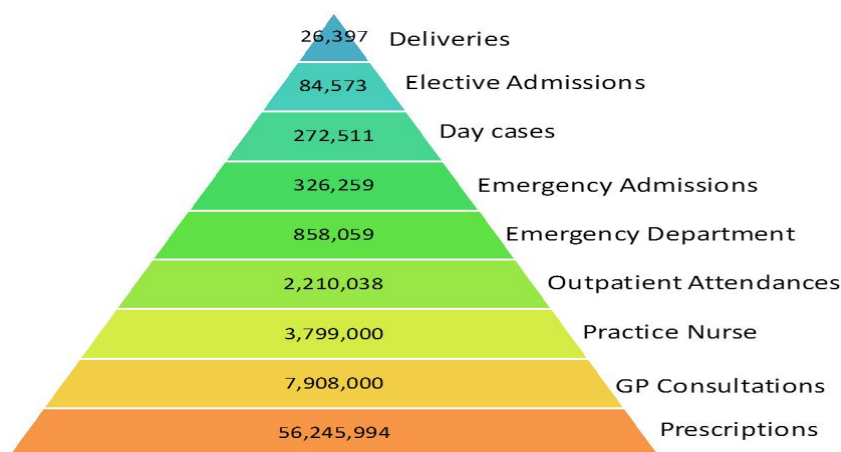
6.2. Demand Capacity Review

As with the Health Needs Assessment, analyses are being undertaken to consider the demand for and use of services. The focus to date has been primarily on health but this will be extended to include the social care provision for the plan submitted in March. This work has been reviewing a number of areas including analyses of: activity by admission category and by specialty; changes in activity; beds, bed days used and length of stay; projected position by 2020, 2025 and 2035; performance data including waiting times and waiting list information, outpatient measures and day case rates.

Information setting out the position for the West of Scotland is available in a supporting paper however some of the high level messages of this work to date are set out below:

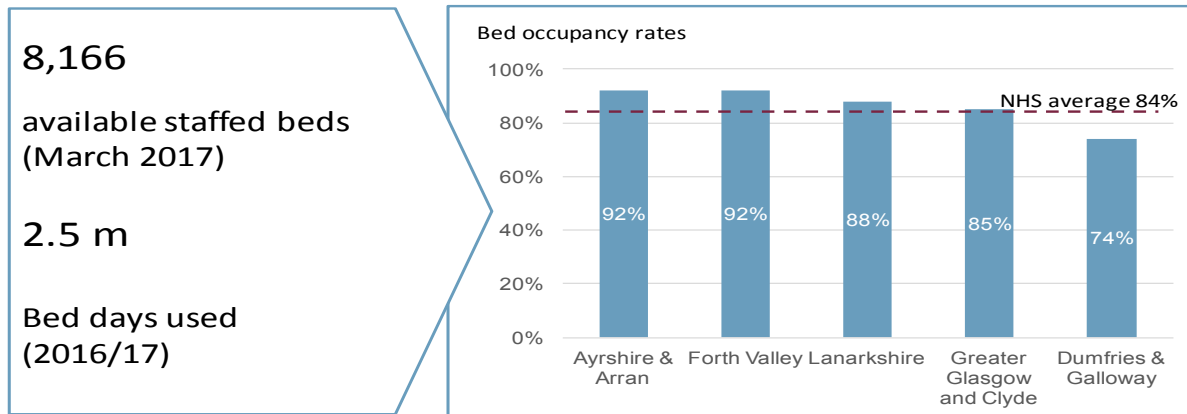
West of Scotland Activity

The diagram below sets out some of the key areas of activity, indicating the different levels of activity, providing some context in terms of where the services are provided.



Work has also been undertaken to consider the bed numbers and bed days being used to support the hospital service provision across the region. The inserted information below shows the current position based on the expected percentage growth of the population based on how the current service is used by different age bands of the population and the potential future scenarios if there is no change.

Current acute bed status in West of Scotland

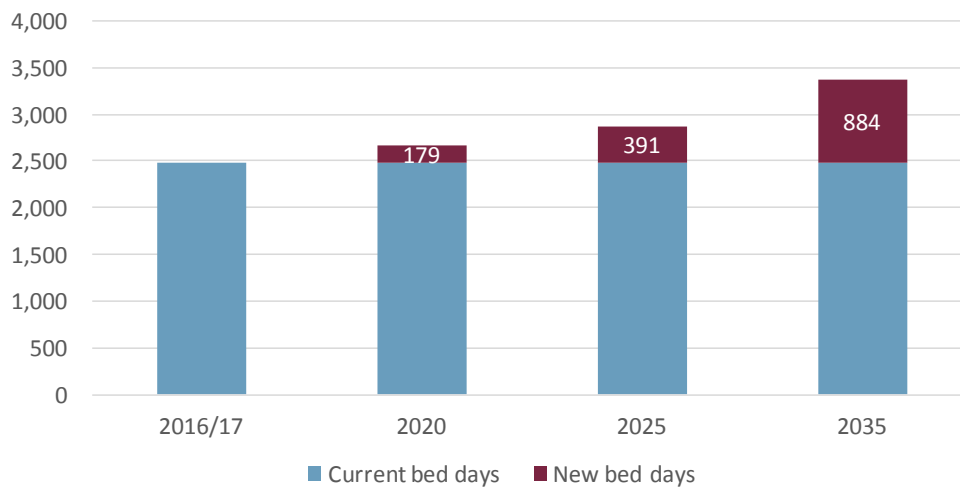


Projected changes in activity and bed days, based on demographic growth only

Of particular note is the rise in bed days in addition to the 200,000 currently to be saved. With the current model of care, we expect there to be demand for an additional 880,000 acute bed days by 2035– 2,850 beds assuming an 85% occupancy rate.

Projected changes in occupied bed days due to demographic changes only

Bed days, Thousands



Source: Regional team analysis

6.3. Workforce Challenges

The NHS in Scotland must adapt its workforce models to be in the best position to deliver excellent and sustainable treatment and care in a rapidly changing Health and Social Care landscape. Workforce planning must take account of the national workforce planning work and consider the workforce challenges across the health and social care sector. West of Scotland Health Boards have been working together to develop a position which accurately describes the workforce within the region and identifies the principle workforce issues which must be addressed in order to deliver new regional models of clinical care:

- Workforce availability
- Workforce adaptability

- Workforce affordability

The West of Scotland Health Boards currently employ 62,630 wte / 72,620 head count, which accounts for approximately 45% of the NHS workforce in Scotland. Each Board has reviewed the ISD dataset to identify specific factors, where applicable, in terms of risks and challenges, opportunities and options to create an overall high level regional workforce position.

A supporting paper on the work to date is attached in the appendix. The high level message is that there are five key 'hot spot' job families/professions across the region:

- Medical – challenges in demand, supply and sustainability across a spectrum of grades, specialties and including general practice;
- Nursing – specifically challenges in smaller branches/cohorts associated with the overarching demography of the workforce and the potential risk this presents in terms of retirement profiles e.g. health visitors, district nurses, paediatrics, midwifery, mental health and associated issues with demand and supply. The demand for Advanced Nurse Practitioners (ANPs) was also specifically flagged. This mirrors the medical position both in acute settings but also increasingly within GP practices. There remain questions about the capacity of higher education institutes to meet demand;
- Radiographers – mismatch in supply of radiographers compounded by the increasing demand for services and existing problems with radiology staffing;
- Pharmacy technicians – significant increase in demand not being matched by supply;
- Healthcare science – demographics of the workforce, particularly in senior roles, are influencing the current provision couples with longstanding national issues with supply;

Issues informing the need for change are currently being quantified in terms of medical staffing as this proves challenging in providing equitable access to specialist opinion to support care in a number of Boards and specific specialties within the region. Currently there are circa 269 vacancies at consultant level (119 vacant for 6 months or more). This exercise will in time cover all staff groups.

It is recognised that the workforce of the future will not be “more of the same”. The workforce will be older and have a greater reliance on Advanced Practitioners and roles with extended scope. All staff groups will be required to work to the “top of their licence” with work aligned to their skills. It is likely that the workforce may require to be re-profiled to match the increased workload demand in the community and the higher acuity in acute care. The Directors of Nursing are leading work through the West of Scotland Advanced Nurse Practitioner Academy to ensure consistency of competency and level of practice across the West of Scotland, sharing resources where appropriate. This is enabling the West of Scotland to get assurance with regard to growth of this important senior group. They are also looking at non-medical care models to develop new and extended Advanced NMAHP roles such as caseload holders, clinical leads as alternatives to medical models for particularly hard to fill specialties.

As part of the development of the first plan for March 2018 work will be undertaken to understand the total workforce supporting health and care services within the West of Scotland.

6.4. Infrastructure

Based on the report prepared by Health Facilities Scotland the West of Scotland faces significant challenges in relation to the infrastructure within health. The Report indicates that around 50% of the estate is modern, offering good functional accommodation however 50% of the estate has significant challenges. This is summarised below:

Modern estate

- Queen Elizabeth University Hospital & Royal Hospital for Children
- Stobhill and Victoria ACHs Glasgow
- New Dumfries and Galloway Hospital
- Forth Valley Royal Hospital
- 2 PFIs / PPP facilities – Hairmyres, Wishaw (Lanarkshire)
- Golden Jubilee Hospital
- New community care estate such as Eastwood Health and Care Centre and other similar primary care facilities

Estate with significant challenges

- Backlog maintenance around 1/3rd of national total
- Physical condition, age and functional suitability challenges a number of sites
- 3 similarly sized hospitals south west of Glasgow, with a growing need for investment RAH, Crosshouse Hospital and Ayr Hospital
- East side of Glasgow - GRI and Monklands will struggle to provide functionally appropriate accommodation. There are also challenges around the need to improve engineering services infrastructure to support these sites.
- Outlying areas of the region need investment in buildings and engineering services; specifically IRH, Vale of Leven and Falkirk Community Hospital
- Some GP practices

The current position offers both a challenge and an opportunity to build the future infrastructure based on the needs of the population organizing care in the most appropriate setting and using the workforce to best effect to provide the right care level within the hospital or community settings.

- £1bn - £2.5bn investment required
- Investment strategy combining replacement, refurbishment and rationalisation likely to offer most effective and affordable solution
- Health and Care Facilities and requirements as well as national work on primary care being undertaken by Health Facilities Scotland will also be included in the March 18 plan
- Medical Equipment and technology investments are currently being reviewed

- Offers new opportunities to consider different infrastructure to support future services
The Regional Delivery Plan must bring a co-ordination to the planning of and investment in infrastructure that supports the care models developed.

6.5. Finance

The financial plans submitted by the West of Scotland Health Boards for 2017/18 show a combined recurring deficit of £237m.

	Greater Glasgow & Clyde £m	Ayrshire & Arran £m	Forth Valley £m	Lanarkshire £m	Dumfries & Galloway £m	Total £m
New Resources:						
Baseline increase	31.1	10.0	7.3	23.5	4.2	76.1
Social Care Fund	(23.7)	(7.7)	(5.3)	(13.4)	(3.0)	(53.1)
New Medicines Fund	(7.9)	(2.6)	(1.5)	(3.7)	(1.8)	(17.5)
Income from other Boards	2.4					2.4
Other (including NRAC)	0.0	1.5	5.4		1.7	8.6
Total new resources	1.9	1.2	5.9	6.4	1.1	16.5
Additional Expenditure:						
Recurring over/(under) commitment b/fwd	29.6	17.7	7.5	9.5	4.8	69.1
Pay inflation estimate	20.0	4.8	3.3	7.2	3.6	38.9
Other Costs (incl medical staffing)	6.0	3.1	4.4	8.7	4.5	26.7
Supplies inflation estimate	6.0	5.0	4.7	4.8	0.4	20.9
Primary Care prescribing	8.5	5.6	2.9	1.4	1.2	19.6
Acute prescribing	21.0	0.3	2.4	8.6	0.7	33.0
Other prescribing			2.5			2.5
Capital charge inflation	1.0					1.0
Apprentice levy	8.0	1.5		2.0	0.8	12.3
Rates revaluation	11.0	0.3	1.2		0.5	13.0
Pension cost (RRL to AME)	3.5					3.5
National services	1.5	0.4	0.1	0.3		2.3
Premises costs	3.2	0.9				4.1
Out of Hours and other regional costs	5.0	0.4	0.9			6.3
Total additional expenditure	124.3	40.0	29.9	42.5	16.5	253.2
Financial gap to be closed	(122.4)	(38.8)	(24.0)	(36.1)	(15.4)	(236.7)

Work is currently under way to complete a forward look for the next three years but this is difficult given uncertainties around future funding assumptions regarding Scottish Government funding uplifts and pay policy. To set a context for the financial parameters of the regional plan, a three year forward projection is being developed based on the following assumptions:

- **Annual Scottish Budget allocations** – assumes that the basis in which funding was allocated for 2017/18 continues for 2018/19 and 2019/20 (annual uplift to meet cost pressures <1%).
- **Transfer resource** – share of the transfer of £250m from Acute to IJBs in line with national target to reduce bed days by 400,000. This will also provide 50% of the commitment to increase primary care funding by £500m by the end of the current parliamentary term. The other 50% being funded directly by Scottish Government Commitment to 50:50 split between primary / community care and acute costs by end of the current parliamentary term also factored into three year forward projections.
- **Projected Cost Base** – assumes 10% inflationary increase (3%pa) on 2016/17 budgets over the next three years (conservative estimate).

- **Earmarked allocations** – assumes that these will be spent of new commitments and therefore no net benefit to overall financial position.
- **New medicines and diagnostic costs** - assume increase for secondary care medicines and diagnostics in line with recent historic patterns
- **Capital**– no change in formula funding allocation to be prioritised towards backlog maintenance and essential equipment replacement.
- Changes to pay policy will impact future modelling

7. Case for change

Everyone deserves to lead a full and healthy life and to receive the best possible care when they become ill. The West of Scotland has many areas of excellent care of which we should be proud of but we know that we could do more both to prevent ill health and to improve outcomes.

Over the last few years we have seen improvements in the services and infrastructure for patient care. For example:

- We opened the Queen Elizabeth University Hospital and Royal Children's Hospital in Glasgow. We will shortly open a new hospital in Dumfries and Galloway.
- We have reorganised our community services, placing responsibility for local health and social care services under the joint leadership of the NHS and Local Authorities.
- We have successfully provided a number of regional services such as interventional cardiology, based in 2 facilities at Hairmyres in Lanarkshire and the Heart and Lung Centre at the Golden Jubilee Foundation; Forensic medium-secure care at Rowanbank Clinic, Glasgow. The Beatson West of Scotland Cancer Centre on the Gartnavel Campus in Glasgow which we have recently extended by developing a satellite cancer unit at Monklands in Lanarkshire; and most recently the Regional Robotic Prostatectomy Service at the Queen Elizabeth Hospital.
- There is ongoing work to reorganise and improve specialist services across the West of Scotland including major trauma, systemic anti-cancer therapy, urology and ophthalmology. Each of these services seeks to improve patient outcomes by organising care in the most effective way; providing the timely access to specialist care and through standardising approaches to optimise care.
- Integrated Joint Boards have progressed change in local care through the Integrated Care Fund and Primary Care Transformation.

Staff work hard so that we can continue to care for people under greater and growing pressures on the services. Despite all of this work, there is an emerging set of facts that we believe will not make it possible for the care services to stay on the current path without causing significant issues for our patients and staff as well as circumstances which we believe will make the current service model unsustainable even in the short term. This set of emerging facts, tested with senior colleagues involved in leading care services in the West of Scotland, who have confirmed their support for this, can be grouped around 8 major themes:

- **Our population is changing and so are their care needs** - Our population is getting older quicker, partially as a result of work we have done to improve how long

people live. This brings its own challenges as older people generally need more health and social care. Particularly of significance is the growth in over 85's albeit we are seeing that life expectancy is remaining flat and for some areas reducing.

- **We need to improve people's health** – In the West of Scotland we have high levels of obesity, smoking, drinking and drug use. There is also widespread poverty in parts of the Region. There is strong evidence that these factors contribute significantly to people's need for care, in how long people live and in how many of these years are lived in good health.
- **Hospital is not always the best place for care** – People are currently in hospitals who need care that would be better provided outside of hospitals. There is strong evidence that people staying in hospital longer than necessary makes them deteriorate and lose their independence. In some parts of West of Scotland we lack co-ordination of care for people who require multi professional input, particularly those with long-term conditions, mental health and older people and this also results in unnecessary visits or admissions to hospitals. Our care staff in the community do not have access to specialised services and this means they have no choice but to refer people to hospitals.
- **We want to provide the best possible care**– There are differences in how we deliver care across the region and variation in practice. It is important that we use the learning from each part of the service to support us to deliver the best care models and address variation in morbidity and mortality rates. This is partially because our most experienced and highly specialised staff are spread too thinly across the West of Scotland reducing the experience given to junior staff in the management of complex cases that allow them to build up the skills to provide the most appropriate level of support in emergency care. Hospitals are also struggling with waiting times for operations and treatments. This is in part because due to emergency care pressures which can impact on the provision of planned care in the same hospital resulting in elective cancellations reducing the capacity available to support planned care.
- **We need to use our workforce effectively** - There are difficulties in recruiting and retaining staff at all levels and settings of care making it hard to provide the best levels of care. The age profile of our staffing in some professions and general practice also gives cause for concern in terms of maintaining sustainable services. Some local organisations already have high levels of vacancies and are using temporary staff which is proven to cause clinical risks as well as costing the care services more.
- **Our buildings are not fit for purpose**– About half of the hospital buildings in the West of Scotland need major repair work or replacement that would cost somewhere between £1-2.5 billion. At the same time, much of the care that could be provided in the community does not have suitable locations or accommodation to provide these services.
- **Opportunities afforded by technology** – Technology has changed many industries for the better and there are many opportunities for the West of Scotland to use technology to improve our service, both in terms of how we organise and deliver care and in the interventions we offer.
- **We need to make the best possible use of available health and social care funding** – This year we expect to have a deficit of £237m across the West of

Scotland. Whilst some Boards will manage this in 2017/18 we must address the underlying issues and transform our service model to deliver quality and sustainable services.

In bringing these 8 themes together it is clear that status quo is not an option in terms of providing sustainable and safe services across the region. Leaders of the West of Scotland care systems believe we must make radical changes in how we provide care or we will fail our population and our staff. There is recognition that regional working across Board boundaries with our citizens to develop service models that meet the populations' needs is essential. This approach will be important to make most effective use of the resources, particularly workforce, if we are to ensure the population have access to the appropriate level of care and to use the funding available to best effect.

Evidence from other systems demonstrates the need to have upfront investment to support delivering the service transformation. In considering the way forward the region recognises the importance of: developing digitally enabled services to modernise how care is delivered; and ensuring adequate capital investment is available to create the most effective configuration of facilities across the health and care system to provide the right models of care to support transformation.

Recognising the existing governance arrangements and accountabilities of the NHS Boards, the Health and Social Care Partnerships/ Integrated Joint Boards and Local Authorities, work will be progressed to consider how each of the organisations can work effectively together to deliver their local plans but also to optimise the opportunities from working regionally to create sustainable care models for the local populations. To achieve this ambition a common purpose has been developed. The next section sets out what our common purpose might be as region to address this case for change.

8. Developing the Way Forward

8.1. Shared Vision and Common Purpose

We are working together as a region towards four aims:

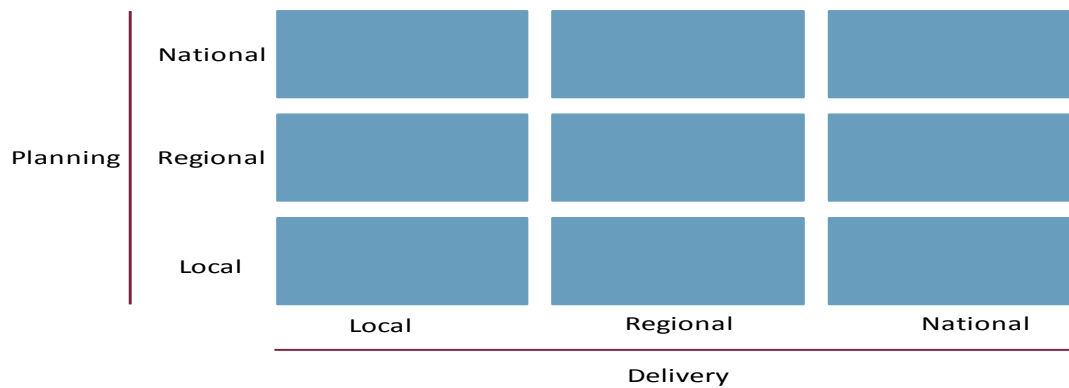
- Improving health and wellbeing;
- Increasing care and quality;
- Delivering on finance and efficiency; and
- Better workplace with a focus on staff.

In the submission in March, we will set out a shared vision and common purpose for the West of Scotland to achieve these aims and directly address our case for change. Our current draft of this is:

Case for change	Common purpose
Our population is changing and so are their care needs	We will design our care around the specific needs of individuals and different segments of our population rather than around existing organisations and services (Population Health Management).
We need to improve people's health	We will proactively engage people to have better lifestyles, develop independence and self-care.
Hospital is not always the best place for care	Design and deliver care services around population segments that are closer to home, particularly those that require joined-up care.
We want to provide the best possible hospital care	We will design our future hospital services around the new and expanded local services, with different levels of service provided in different hospitals.
We need to use our precious workforce effectively	Develop regional workforce strategy, which includes addressing key gaps and the ability to flex across region.
Our buildings are not fit for purpose	Create regional estates strategy that makes best use of existing estates to support out-of-hospital and hospital care models and determines investment needed.
Technology has changed but we are not taking full advantage	We will make better use of the technology we have already invested in and make more investments in technology that allow us to improve care and reduce the cost of the care services.
We need to make the best possible use of tax payers money	Develop comprehensive regional plan that addresses drivers of financial pressure (incl. balance of care, productivity, workforce, back-office, estates)

While we will be united as a region in addressing this common purpose, not all of the work to plan or deliver these objectives will be done at a regional level. For example, the Integration Joint Boards (IJBs) have primary responsibility for joining up health and social care in their communities, while there are national programmes who are planning for shared services across the nation. Existing Board Strategies and Health and Social Care Strategic Commissioning Plans set out work that will continue to be progressed locally. This work will influence and be influenced by the development of the regional delivery plan. By March we will define how this common purpose will be planned and delivered at local, regional and

national levels with a guiding principle that we should be as local as possible and as regional as necessary where there is a compelling case for regional or national work.



In developing this plan, one of the challenges will be defining the role of the region in care that is delivered outside of hospital. From discussions amongst leaders of the care system we believe there will be a regional role in facilitating sharing of best practices, developing common and consistent elements of care models across the region, determining how best to ensure the money is available to implement these new ways of care, and making sure the IJBs are supported with the necessary workforce, facilities and technology to do their work.

Inevitably there will be tension between organisations within the region as we try to balance achieving individual organisation goals and regional goals that may sometimes pull in opposite directions. If we are to achieve this common purpose as a region, our service leaders will need to role model behaviours that will support the different organisations to work together successfully. Our workshop participants on the 20th identified behaviours they felt would be important including trust, respect, acting with principle and integrity, acting collegiately and ultimately working for the best interests of all the 2.7m people who live in the West of Scotland.

8.2. Care Models

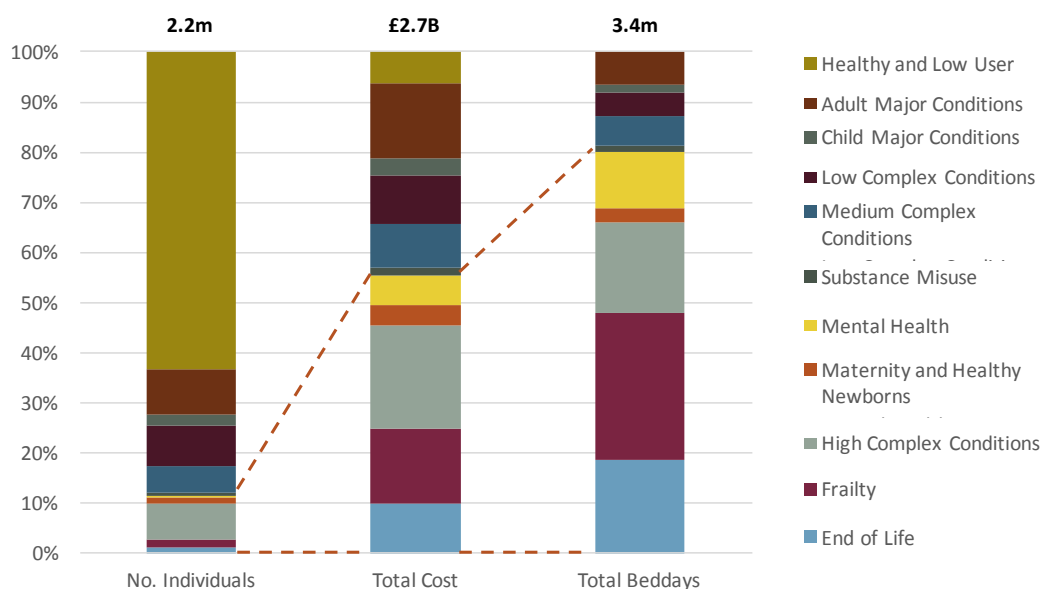
In the West of Scotland we intend to develop our future care models in four ways, outlined in the exhibit below.

Understanding the needs of different segments of the population	Addressing as much care as possible proactively and locally	Designing hospital care to deliver safe and sustainable services	Putting in place the key enablers
<ul style="list-style-type: none"> Use ISD data to have fact-based discussion on population segments Identify specific patients and segments to make targeted interventions to care plans and care models 	<ul style="list-style-type: none"> Integrated services covering primary care, community care, social care, mental health, access to specialist diagnostics Services integrated and co-ordinated from patient view Increased funding and capacity outside hospital Effective multi-disciplinary team working 	<ul style="list-style-type: none"> Establishing clear standards for safe delivery of services <ul style="list-style-type: none"> Interdependencies Workforce Volumes Establishing different levels of hospital services Networking hospitals for sustainable high-skilled services 	<ul style="list-style-type: none"> Digital Workforce Estates Organisational development Financial Allocation Model Governance Communications & engagement

Understanding the needs of different segments on the population

ISD Scotland have developed data that shows how different segments of the population use the care services in very different ways. For example, people with serious mental health needs are estimated to cost £19k in hospital care per person per year, people with frailty issues cost £11K per person per year while mostly healthy people cost £115 per person per year.

In the West of Scotland 12% of the population consume over 55% of the health spend and 80% of beddays



Source: ISD

Individuals and groups of our population clearly have very different needs and we in the West of Scotland are committed to organise the system around these different needs.

Addressing as much care as possible proactively and locally

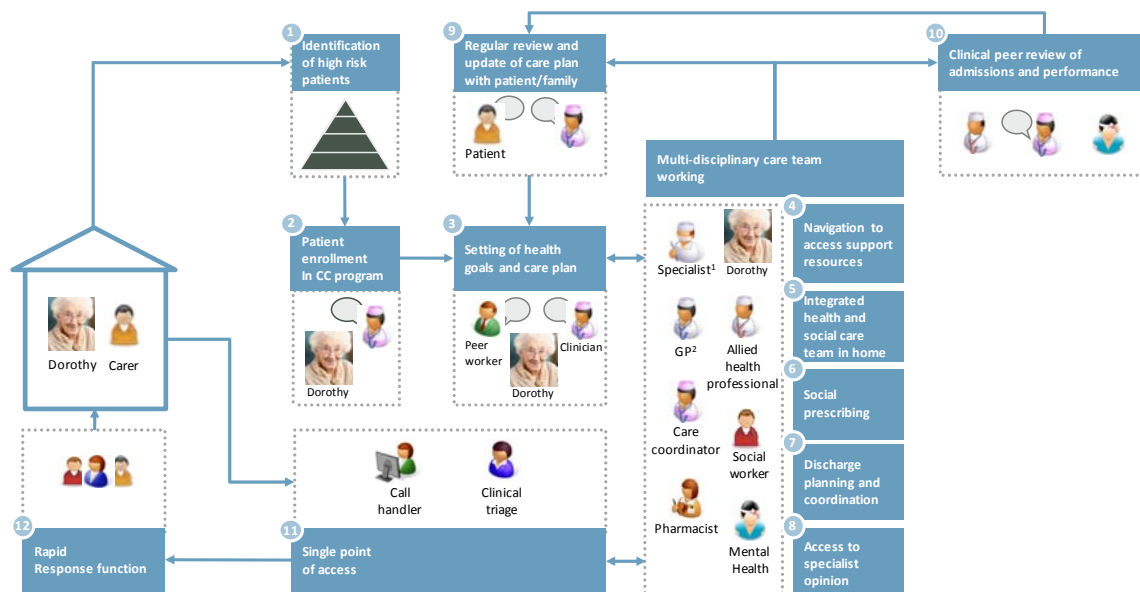
Integration Joint Boards have primary responsibility for this area and are making progress in developing and delivering on their plans. At a regional level we are exploring the potential for some common elements of care models that can be described regionally and delivered locally. For example, one region in England made this offer of local care to its older population with complex needs:

- **Care planning and navigation** – People will be supported to develop a personalised care and wellbeing plan. Dedicated professionals from a variety of health and social care backgrounds will co-ordinate the care and support from the rest of the multi-disciplinary team (MDT) and the wider health, social care and voluntary sector.
- **Supporting people to improve their health and wellbeing** - Supporting people and carers to improve and maintain health and wellbeing by building knowledge and changing behaviours through proactive prevention / engagement.

- **Healthy living environment** – Ensuring a healthy living environment to preserve long-term health & wellbeing (e.g. falls prevention, housing improvements and alterations).
- **Integrated health and social care multi-disciplinary team** – Providing person-centred, coordinated multi-disciplinary care services, wrapped around GP practices and community services providing care to people who have personalised care plans based on their needs.
- **Single point of access** – A number called by the person, the GP, community services and acute staff, or indeed any other professional, to support people with their care by gaining more efficient, coordinated access to services.
- **Rapid response** – The ability within an MDT to respond rapidly to people with complex needs who are experiencing urgent health or social care needs that left unattended would result in a hospital admission.
- **Discharge planning and reablement** – A pro-active, anticipatory service designed to target those people who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating and to support their recovery.
- **Access to expert opinion and timely access to diagnostics** - The ability for primary care professionals to access a specialist opinion in the community setting and where appropriate, a specialist triage for diagnostics. Access to full and timely diagnostic services and diagnostic results will reduce the need for multiple outpatient appointments.

Such a model for anticipatory care could look like the following chart:

Example flows of an anticipatory Local Care model



1 Specialists in both inpatient or outpatient settings
 2 Includes primary care physicians, advanced practice nurses, physicians assistants
 Source: Carnall Farrar

It is important to recognise that this type of local care model will require a mix of different primary care professionals working as a multidisciplinary team and is in part designed to

make best and most sustainable use of the GP as the expert generalist to improve outcomes. The chart below draws out the range of skills that may be needed.

We are exploring ways to strengthen the teams around GPs, particularly for population segments that need coordinated care in the community

Multi-disciplinary team model for older people with complex needs



In the regional workshop, we agreed that we would seek to put a model or models like this in place across the West of Scotland recognising that there could be significant variation in how we might implement it locally. As a region, we intend to as a minimum:

- Share best practice across Integration Joint Boards
- Estimate the impact of local care models so that we can design the future need for beds
- Agree on the regional need for investment to make the business case together
- Ensure the enablers of local care in place, including workforce, technology and facilities
- Communicate to the population of West of Scotland an expectation of what can be provided locally and where hospital care is needed.

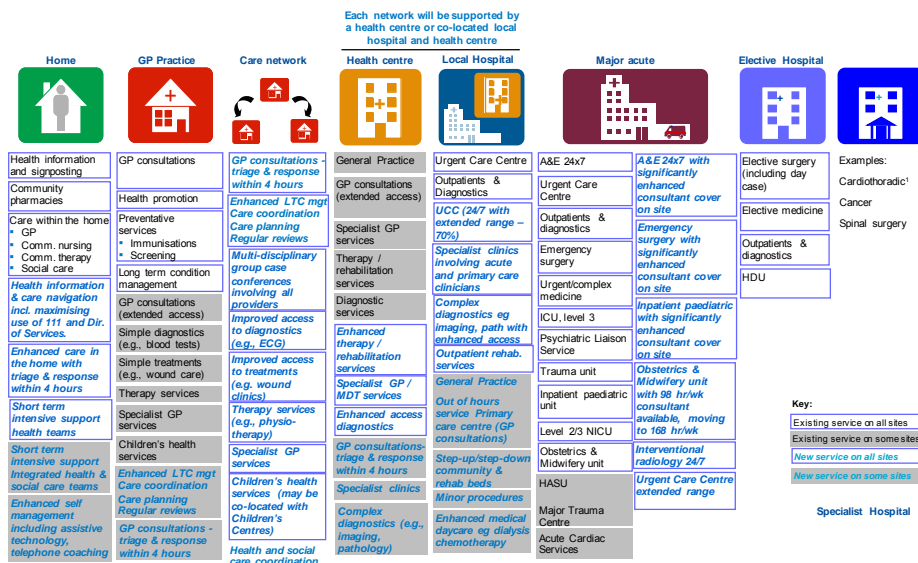
Designing hospital care to deliver safe and sustainable services

As a region, we have explored taking a tiered approach to hospital care, with clearly defined services at each site based on the needs of the population, meeting clinical standards, having the minimum volumes needed to build and maintain staff skills, and the availability of skilled staff for each specialty.

In practice, this would mean moving low volume specialties around different hospital sites; with some higher level hospitals will specialist services. Other hospitals would not have every service but would work through networks.

An example of how a tiered approach might look in the acute sector, as well as how some care services currently provided in acute may move to other models or setting of care models is outlined in the exhibit below.

Illustration of region-wide framework for local and acute care models



In the engagement workshop, it was agreed to explore this approach for the March submission and detail the factors and process that would be considered in such a decision, including assessing different options for clinical safety, availability of workforce, the amount of time it would take patients and families to get to services, capital investment needed, and operating costs.

Putting in place the key enablers

To deliver these care models, many enablers will need to be in place. The exhibit below outlines our early thinking on the different enablers that will need to be planned for in our March plan:

1	Workforce	People will be at the heart of the system that we are building, they are our greatest asset. The new care model will require staff and partners to work differently and will also require new roles to be developed.
2	Organisational development	Training, upskilling and behavioural change are crucial to enable leaders, professionals and teams to work together differently to deliver the new care model.
3	Estates	Estates resources need to be understood. The new care model will be enabled by the creation of a regional capital strategy, considering additional space required; repair, repurposing or disposal of existing space. Exploration of estate and infrastructure for both health and local authorities will be essential to optimise use of facilities and capital funding investment.
4	Information	The new care model will need to be enabled by integrated patient data to allow clinicians and care professionals to plan, and deliver the care needed for our population. Information is also crucial to enable long term, innovative solutions and drive productivity improvements.
5	Financial model	The current financial models and service level agreement arrangements across organisations within the region require to be reviewed as they contribute to the fragmentation in the system, and do not support integrated population based care. A new approach is needed to align organisations around a common purpose, provision of services across the region, nurture collaboration, drive cost savings and support system-wide decision making.
6	Governance	To support the integrated system and achieving a shared vision, appropriate governance is essential to enable the organisations to work together effectively as the system transitions into a new delivery model. This will require clear roles and responsibilities, with engagement from the right stakeholders.
7	Comms and engagement	The public and staff need to be engaged throughout and consulted appropriately. A detailed and robust internal and external communications and engagement plan is required, backed up by the resources to execute it.

Taken together, we believe these proposals for designing our care models are consistent with the National Clinical Strategy, particularly when planning local services around individuals, population segments and their communities, and planning hospital networks at the appropriate level recognising availability of skilled workforce.

9. West of Scotland Structure and Planning Approach to Deliver the Regional Plan

To deliver our regional plan by end-March, we have developed a workplan that covers:

- Governance
- Building the regional team
- Communications and engagement
- Designing the care models
- Understanding enablers required
- Setting the financial framework

This work and the timeline is illustrated below and detailed further in the rest of this section.

	October	November	December	January	February	March
Governance	Establish & mobilise governance of programme (Programme Board, Clinical Board, Workstream Groups)	Engaging meetings on programme and clinical boards (monthly) and workstreams oversight group (every 1-2 weeks) to provide oversight and progress planning				Board approval for plans
Building regional team	Establish PMO and analyst support team	Support programme governance Boards and workstreams with papers, drafting, logistics and analysis.				
Communications and engagement	Develop comms plan	Engagement (Care & council leaders, clinicians and staff, elected reps, patient groups, policy makers)	Stakeholder workshop	Engagement event: Case for Change	Public engagement on service models Policy-makers engagement	Stakeholder Workshop
Designing the care models	Population needs assessment Population segmentation Review IJB care plans	Design local care model Design acute care model		Preliminary analysis of implications (financial, activity, outcomes of care models)		
Understanding enablers required		Stocktake of current position of workforce, estates, technology, financial models, organisation development		Develop plans for enablers to support care models		
Setting the financial framework	Build/confirm financial baseline and Do Nothing scenario	Develop strategic financial framework model for West of Scotland		Model different options & scenarios to allow robust financial underpinning of plan		

9.1. Governance

We are putting in place the following governance arrangements:

- NHS Board Chairs form an assurance and scrutiny group. It is anticipated that this group will develop to include representation from IJB chairs.
- West of Scotland Health and Social Care Delivery Group. This group is chaired by the Regional Implementation Lead. Membership includes CEOs, Chief Officers, Partnership, Employee Director Rep, and leads for Nursing, Medical, HR. We are also engaging with COSLA/SOLACE on including representation from Local Authorities.
- We are exploring the establishment of a Clinical Board/Senate whose scope could include: 1) deepening and owning the case for change, 2) providing clinical input into care model decisions and 3) providing clinical leadership to the process and signal clinical backing of the regional work.

9.2. Building the regional team

Developing the plan and preparing for implementation is going to require building a regional team to support this, the scale of which will depend upon the final scope of work agreed for the region.

The overall effort will be led by the Lead Chief Executive (John Burns) and the Director of Regional Planning (Sharon Adamson). We will be mobilising 5 strategic work streams led by a Chief executive or joint leadership with a Chief Officer to develop detailed plans for each area:

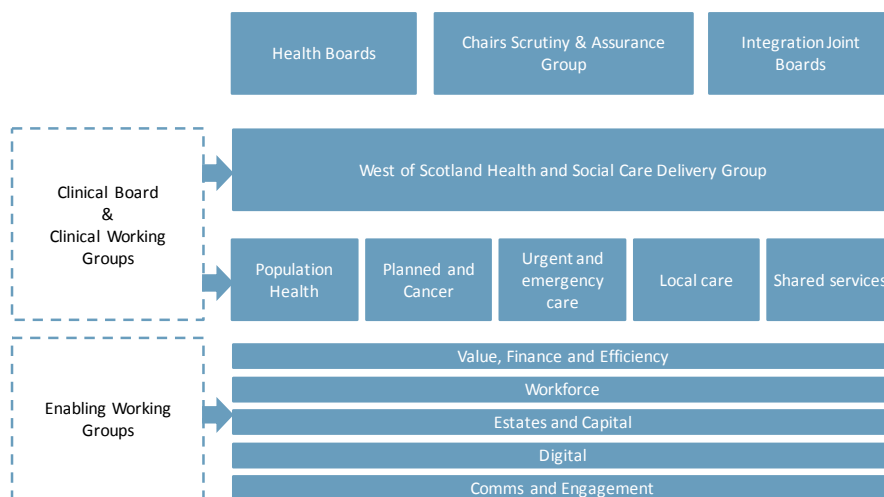
- Population Health
- Planned and Cancer Care
- Urgent and Emergency Care
- Local care
- Shared Services (including links to National Work e.g., Once for Scotland)

Supporting this work is a number of enabling work groups:

- Finance
- Workforce
- Estates and Capital
- Digital
- Communications and Engagement

The chart below maps out our current thinking on the arrangement of governance and workstreams for the West of Scotland:

West of Scotland Region – Programme Structure



Furthermore, there is work underway from the previously agreed regional priorities that will continue and will inform the new regional delivery arrangements, including reviews of:

- Urology
- Ophthalmology
- Trauma and Orthopaedics

- Major Trauma
- Maternity and Neonatal
- Systemic Anti- Cancer Therapy Provision
- Interventional radiology

9.3. Communications and Engagement

All of the areas outlined above need to inform the change in conversations across the system with the public, with the various staff involved, the different organisations and the roles that we all need to play in achieving this, thereby setting the expectations of how we will behave and act to encourage success.

There has been considerable engagement work undertaken by the Health and Social Care Partnerships in developing their Strategic Commissioning Plans. Engagement findings from the National Clinical Strategy and through the National Conversations work also offer views that can inform the approach we are taking and can be built upon as we develop the regional delivery plan.

Critical to success is describing the functional relationships required to progress this and achieve success, recognising the importance of conversations rather than plans in driving change. As part of this we need to provide an environment that supports the enacting of change.

Initial Engagement will look at:

- Developing and sharing key messages around regional planning and the case for change; considering what Scottish Government will lead and what will be regional and local
- Ongoing Engagement
 - Identifying key stakeholders – internal and external, targeting our approaches to support different stakeholders needs
 - Setting out the messages around the population health need, considering service models and the views of the public on service requirements
 - Setting out the emerging thinking on the future service models and implications to provision

9.4. Designing the Care Models and Understanding the Enablers Required

As outlined in section 8.2 above we believe there are four elements to designing interventions that will be transformative and allow us to meet our four aims as a region:

- Understanding the needs of different segments of the population (both now and how it will change over time) in order to identify those that need targeted interventions to care models.

- Addressing as much care as possible proactively and locally in primary, community and social care.
- Designing our acute and community hospitals around the need for safe and sustainable acute care following the local care intervention.
- Putting in place the enablers to allow these interventions to be successfully implemented.

We have quite rich data from ISD around population segmentation and are working with public health colleagues on a population needs assessment for the region. Based on this work, we propose to do a quick effort to prioritise population segments where we would look for better care models to improve their care.

We will then look to produce with IJB colleagues, informed by their existing plans as well as local and international best practice, the common elements of local care models that the population of the West of Scotland can expect to be delivered by IJBs. We expect to have by end-March a clear description of how local care models will be experienced by people in the West of Scotland, an analysis of activity shifts between acute and local care, a business case for the system from these investments, as well as an implementation plan for these models of care.

In parallel with this local care model work, we will be building activity and financial models that will allow us to understand the implications of local care models on the bed requirements and service configuration in the acute sector. By end-March, we expect to have a view on what this will mean in terms of:

- Centres of excellence, particularly for low-volume, high-complexity care
- Organisation of elective and emergency services
- A model for different levels of hospitals and the services they will provide
- An alternative model for providing excellent urgent and emergency care

When designing care models, we will also develop a view on the implications for enablers of these care models, including:

- The implications for estates and infrastructure across the public services, including how best to use the existing estate across hospital sites, primary care and social care.
- Understanding the skills and competencies, as well as numbers, of staff required to support the emerging models, creating a position to influence training and education for the future.
- Understanding of how the future developments in technology might influence the care and models required to better inform the planning beyond 2025 and the potential impact on the different parts of the system. This will consider the opportunities digital health offers, linking with national work.

9.5. Setting the financial framework

In parallel with the care model work, we intend to build a regional financial framework that will:

- 1) set out the current baseline for the region and the do nothing scenario over a longer period than we have currently projected.
- 2) allow us to model the impact of care model interventions and changes to key revenue and cost assumptions.
- 3) Determine a different approach to the finance models to support more effective cross system working
- 4) outline the business case for interventions at a locality level, board level and regional level.

10. Next steps

With the other regions and the National Boards, we have identified a set of next steps that we should also address collaboratively which the national boards will lead to support the development of the regional delivery plans.

10.1. Collaborative Contribution from the National NHS Boards

As part of developing our regional delivery plans we will also consider the services, functions and support that are best delivered on a national basis; and which can contribute towards the management of demographic financial and workforce pressures. To that end we will work closely with the National Boards over the next few months to refine, develop and prioritise the initial propositions that they have set out.

10.2. Service Transformation – Demand Management

With NHS24 and the Scottish Ambulance Service we will develop plans to

- implement, at scale, the proposals for practice level GP Triage
- reduce the volume of out of hour callers to NHS24 and 999 callers requiring further support from primary and secondary care;
- develop a triage service for return appointment patients and outreach telehealth clinics;
- roll out computerised CBT and improved pathways for those contacting NHS24 and the Scottish Ambulance Service in mental distress.

10.3. Supporting Recruitment, Retention and Improving the Employment Experience

We will work with NES, NSS and others to co-ordinate national and international campaigns to promote careers in health and care in Scotland and to link careers advice and marketing support to the new NHSScotland national recruitment system.

We will also continue to work to improve the employment experience for all our workforce; including rolling out the arrangements to reduce the number of employers of Doctors and Dentists in Training.

We will work with NES, NSS, SSSC, the Care Inspectorate and others to develop an accessible, user designed data platform which provides access to data on the existing and the 'in-training' workforce and to analytical tools which can help to inform the development of different workforce scenarios supporting local, regional and national planning.

10.4. Digital Transformation

It is essential that we transform our digital landscape to enable the public and healthcare staff to access information, resources and services from smart phone technology in the same way as they access retail, transport, and similar services in other spheres of their lives. Part of the work we will progress is to ensure that we can use technological advances in robotics and artificial intelligence to meet the challenges that face us now, and in the future.

Working with the National Boards we will seek to create clarity about technical and usability standards that will support intuitive applications that are capable of delivery across boundaries and which support the scale up and spread of proven innovations to ensure the benefits of technology are accessed across the whole system at pace.

10.5. Once for Scotland

We will continue to work with the National Boards to develop new models of delivery for services such as procurement, radiology, aseptic pharmacy, laboratories and clinical engineering.

We will also work with the National Boards to implement the strategy for NHSScotland Business Systems, which is predicated on moving to Cloud based, Software as a Service models for a joined up approach to Finance, HR and Payroll (moving away from legacy systems and from managing these systems in individual silos). This will provide a core infrastructure which will facilitate the development of shared business services in our regional structures.

11. Statements of Intent

In advance of the submitting the regional delivery plan in March 2018, we intend to:

1. Develop and publish a clinical case for change.
2. Come together as regional leaders of our health and care system and set out a comprehensive programme to deliver our vision and common purpose.
3. Develop a region-wide planning process that will describe what will be planned and delivered by whom at national, regional and local level.
4. Assess the care needs of our population, taking into account the different needs of individuals and segments of the population.
5. Develop local care models for the highest priority population segments and model the impact of these interventions on future acute capacity requirements.
6. Develop a stratified model of local and acute care setting out the different levels of service provision in the different facilities across the region; understanding the implications for future service configuration.
7. Hold engagement sessions with our population, frontline staff and policy-makers to inform them of the regional delivery plan and allow them to shape and coproduce it with us.
8. Develop a view of the impact of this plan on the future capital investment requirements for the region, including hospital and out-of-hospital infrastructure.
9. Assess the impact of this plan on our workforce and outline our future workforce strategy; informing future training and education requirements.
10. Evaluate the impact of the implementation of this strategy on finance and activity and outline a financial plan to support implementation.

Appendices

1. Population Health Needs Assessment Summary Information
2. Demand and activity
3. Workforce
4. Communications and Engagement Plan

Appendix 1

Population Health Needs Assessment Summary Information

Understanding the Population

A Health Needs Assessment for the West of Scotland is currently being progressed; a significant number of analyses have been identified and undertaken which will support the work over the coming months to consider the service model and provision for health and care services for the region. Beyond the work to consider the population age, gender deprivation levels and the implications of this both in relation to health and social care provision, use and funding levels, work is considering the use of services, life expectancy and health outcomes; reviewing the trends in this over the last decade or longer.

Population Needs Assessment: Emerging Findings

- West of Scotland has some of the council areas with the highest proportions of oldest residents in terms of population percentage over 65; as a whole it differs significantly from the Rest of Scotland (RoS) by having a slightly greater percentage of young people aged 0-15 years and a considerably smaller percentage of the very elderly aged 90+ (appendix Table1).

Table1: Age distribution for a recent year, 2016, for Scotland, NWoS, RoS, and component areas of the NWoS. Source: NRS.

	% of population by age group				
	0-15 yrs	16-64 yrs	65+ yrs	75+ yrs	90+ yrs
Scotland	16.9%	64.6%	18.5%	8.2%	0.76%
GG&C	16.7%	66.8%	16.4%	7.6%	0.72%
FV	17.4%	64.1%	18.5%	8.0%	0.70%
Lan	18.0%	64.3%	17.7%	7.6%	0.59%
D&G	15.8%	59.5%	24.7%	11.0%	0.98%
A&A	16.8%	61.5%	21.7%	9.4%	0.85%
A&B	15.2%	60.1%	24.7%	10.7%	0.99%
NWoS	17.0%	64.6%	18.4%	8.2%	0.73%
RoS	16.9%	64.5%	18.6%	8.2%	0.79%
RoS/NWoS ratio	99.1%	99.9%	101.1%	100.6%	108.9%
NWoS/NoS ratio	100.9%	100.1%	98.9%	99.4%	91.8%

- It also has most of the most deprived council areas in terms of summary SIMD score (Glasgow city, West Dunbartonshire, Inverclyde, Renfrewshire, North Lanarkshire, East Ayrshire) and the bulk of the population residing in the most deprived deciles and quintiles. Appendix Table 2 and Figure 1.

Figure 1: Map of Scotland, showing the three regions and the distribution of 2016 SIMD quintiles, by datazone. Source: P Barton, NHS GG&C.

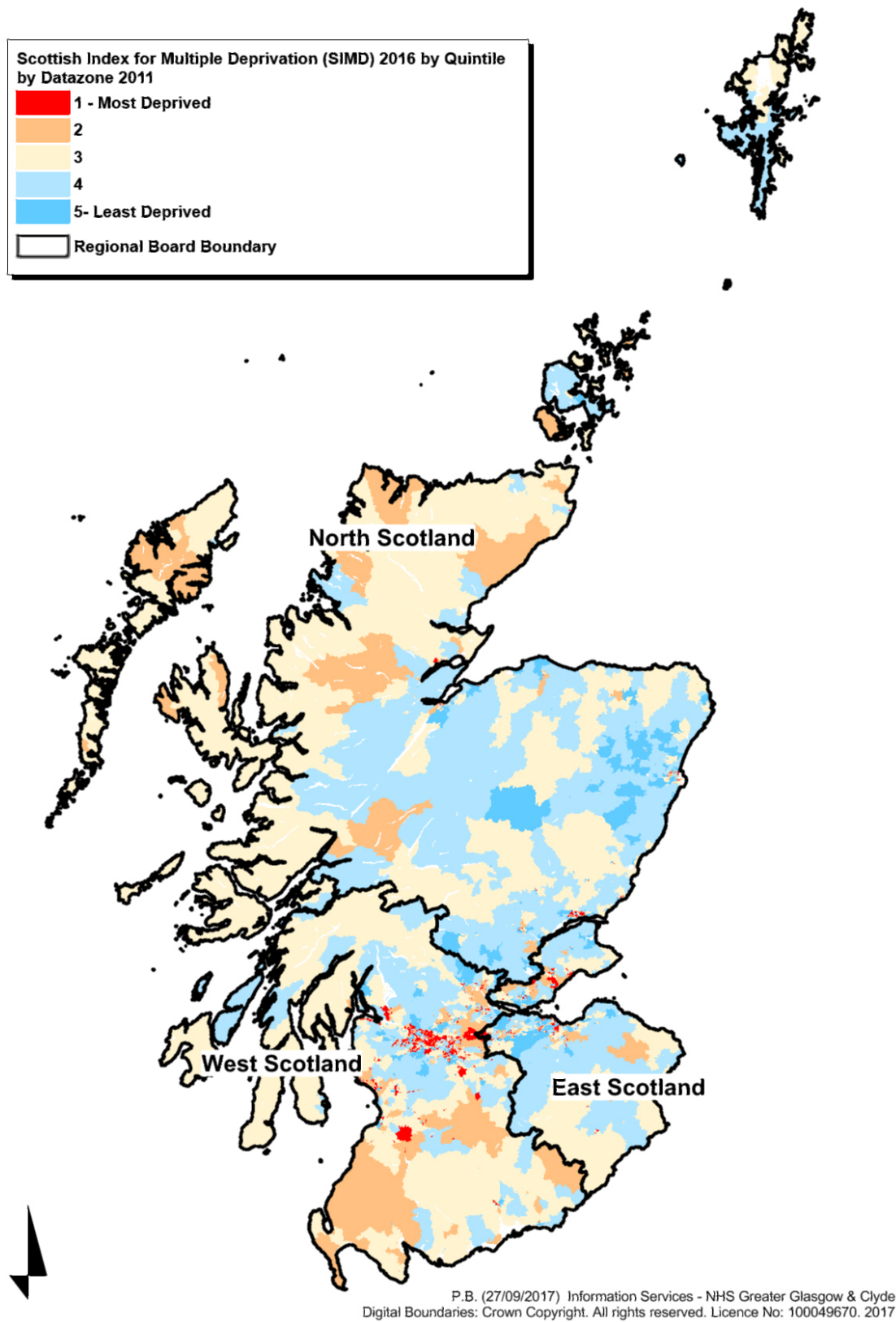


Table 2: Distribution of the Scottish population by SIMD decile and region using ISD weighted population. All figures are based on SAPE 2016 and SIMD 2016. Source: M Grimmer, NHS GG&C.

Decile	Total Population				Percentage of Area Population			
	East Scotland	North Scotland	West Scotland	Scotland	East Scotland	North Scotland	West Scotland	Scotland
1 (most deprived)	72,238	47,996	420,087	540,321	5.3	3.7	15.4	10.0
2	121,262	64,881	352,690	538,833	8.9	5.0	12.9	10.0
3	137,275	93,302	307,082	537,659	10.1	7.1	11.3	9.9
4	136,167	110,211	292,832	539,210	10.0	8.4	10.7	10.0
5	142,166	145,656	249,297	537,119	10.4	11.1	9.1	9.9
6	131,921	167,475	241,106	540,502	9.7	12.8	8.8	10.0
7	141,408	198,350	204,901	544,659	10.4	15.1	7.5	10.1
8	120,668	191,247	230,667	542,582	8.8	14.6	8.5	10.0
9	139,257	149,726	254,340	543,323	10.2	11.4	9.3	10.1
10 (least deprived)	222,498	141,446	176,548	540,492	16.3	10.8	6.5	10.0
Total	1,364,860	1,310,290	2,729,550	5,404,700	100.0	100.0	100.0	100.0

- Both social deprivation and agedness of the population place major demands on the health and care systems. Analysis of the SMR01 dataset for hospital activity shows that the elderly, who are also deprived, are particularly high users of unscheduled services and considerably outnumber the elderly affluent in key board areas such as GG&C.
- The challenges of equitable service uptake and provision, based on need rather than demand in a geographic area that also has considerable sized areas of affluence, results in smaller National Resource Allocation Committee (NRAC) and Scottish Allocation Formula (SAF) shares for hospital & community services and GMS services, respectively. The challenge to meet the level of the need with the level of the service provided will exacerbate the falling historical and projected crude population share of the region as whole and those of the WoS health boards individually to ensure a considerable drop in the equivalent target shares to 2039. Figure 2 shows the projected population estimates for the WoS and the RoS and Figure 3 shows the falling crude population share for the WoS and the rising crude population share for the Rest of Scotland). The WoS is projected to expand only modestly over the next 20 years whereas the percentage rise in the population of the Rest of Scotland will be 6 times greater. ASHD of the SG has agreed to our request to calculate all NRAC parameters, including historical and projected target shares, for the WoS, EoS and NoS.

Figure 2: Projected populations for the NWoS and the RoS, between the baseline, which was 2014, and 2039. Source: NRS. (Breakdown by Board available)

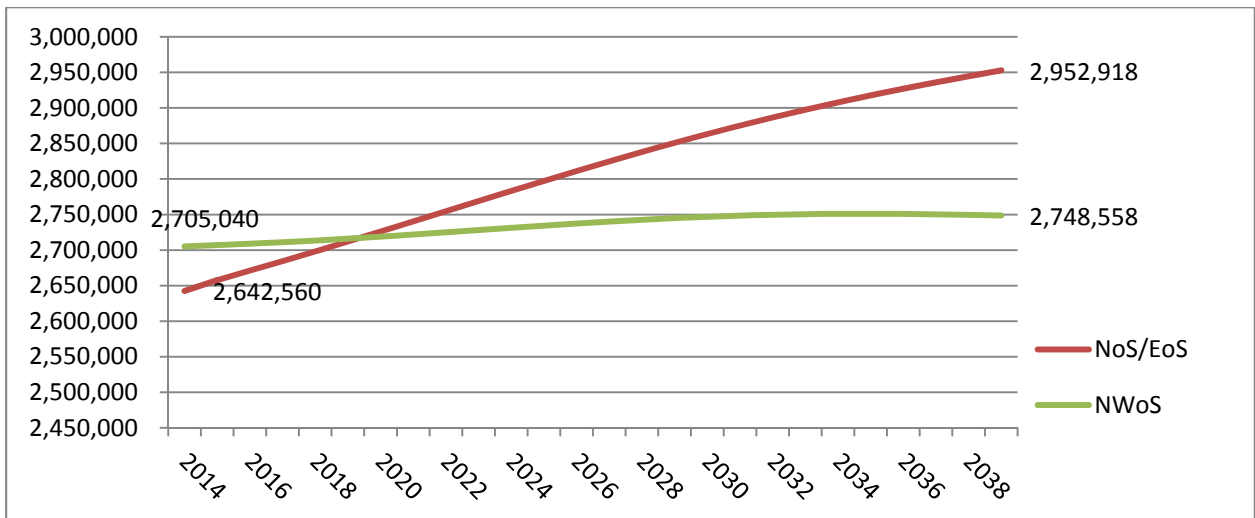
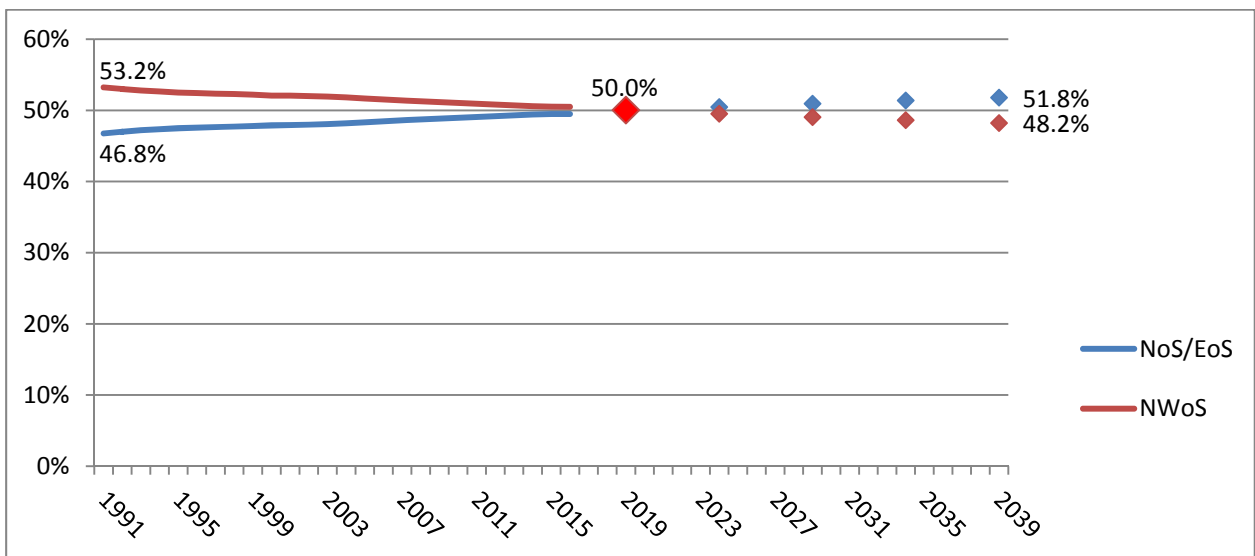


Figure 3: Historical (solid line) and projected (diamond datapoints) for the New West of Scotland Region and the Rest of Scotland (NoS/EoS), 1991-2039. Source: NRS Scotland. (Breakdown by Board available)



- Plateauing of the life expectancy at birth is seen for Scotland as a whole, which is particularly clear for Scottish males (see red arrow in Figure 4), and evidence of unexpected downward shifts in the life expectancy trajectory are visible in some areas within the WoS region (see downward red arrows in Figure 5, which relates to females, which are unprecedented in scale or duration over the entire study period).
- Life expectancy for those who reach 85 years of age appears to have declined since 2009/11, for both genders, but particularly for females (Figure 6). This drop appears to

have occurred earlier for D&G males (after 2009), after 2011 for Lanarkshire males and very recently for A&A, FV and GG&C males (Figure 7).

Figure 4: Life expectancy at birth for Scottish males and females, 2000/2 to 2013/15. Y axis truncated. Source: NRS Scotland.

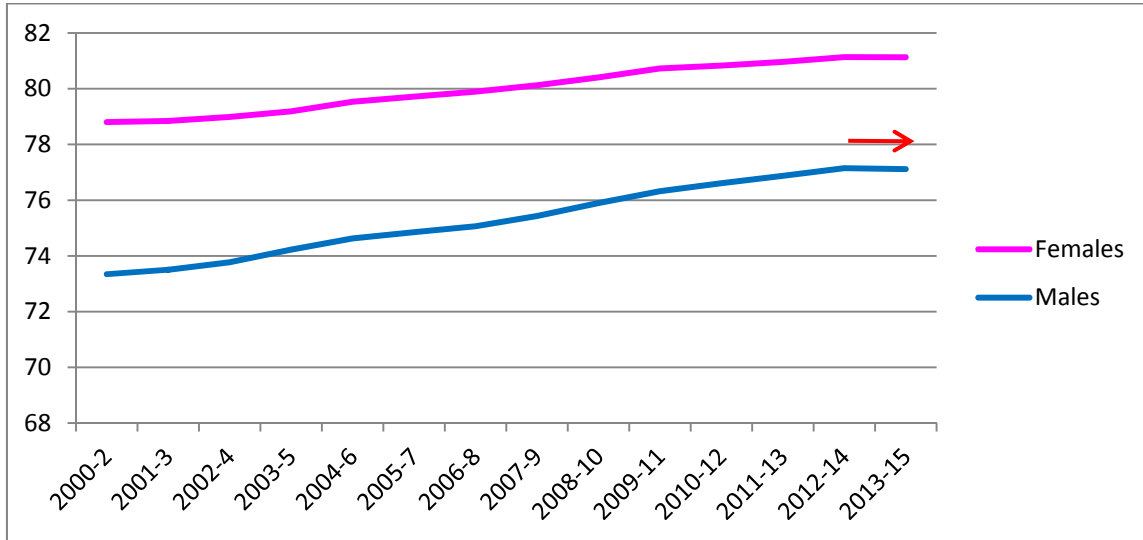


Figure 5: Life expectancy at birth for females by area, 2000/2 to 2013/15. Y axis truncated. Source: NRS Scotland.

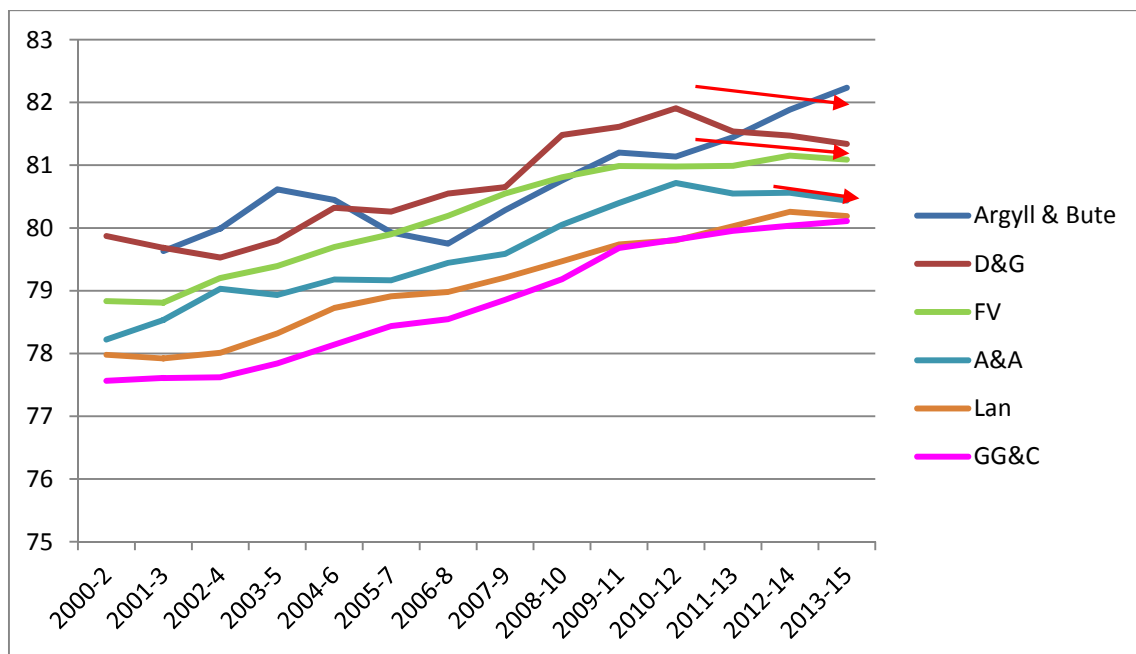


Figure 6: Life expectancy at age 85 years for Scottish males and females, 2000/2 to 2013/15. Y axis truncated. Source: NRS Scotland.

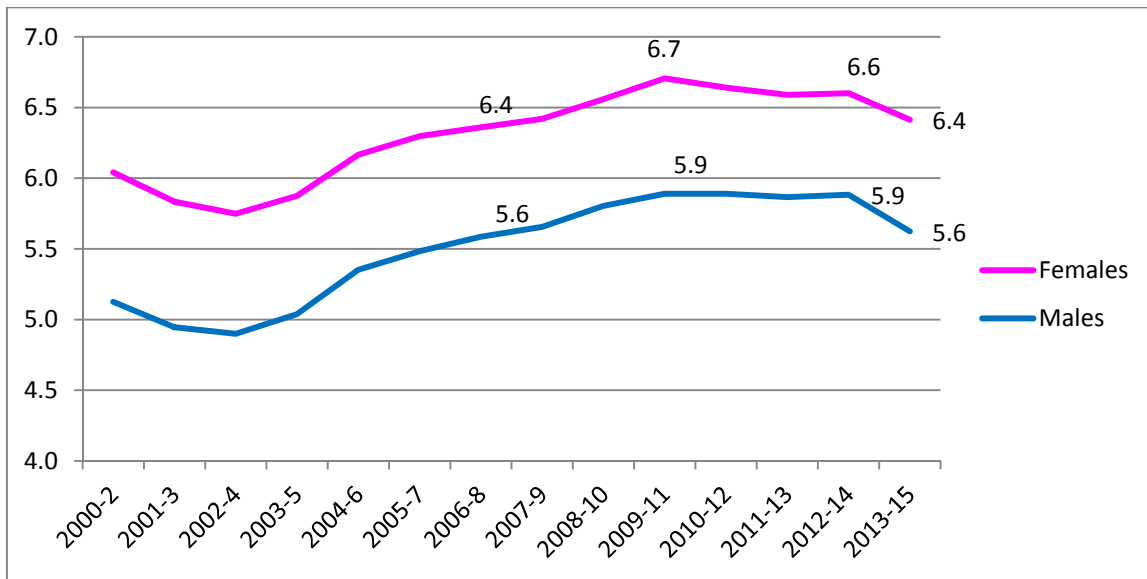
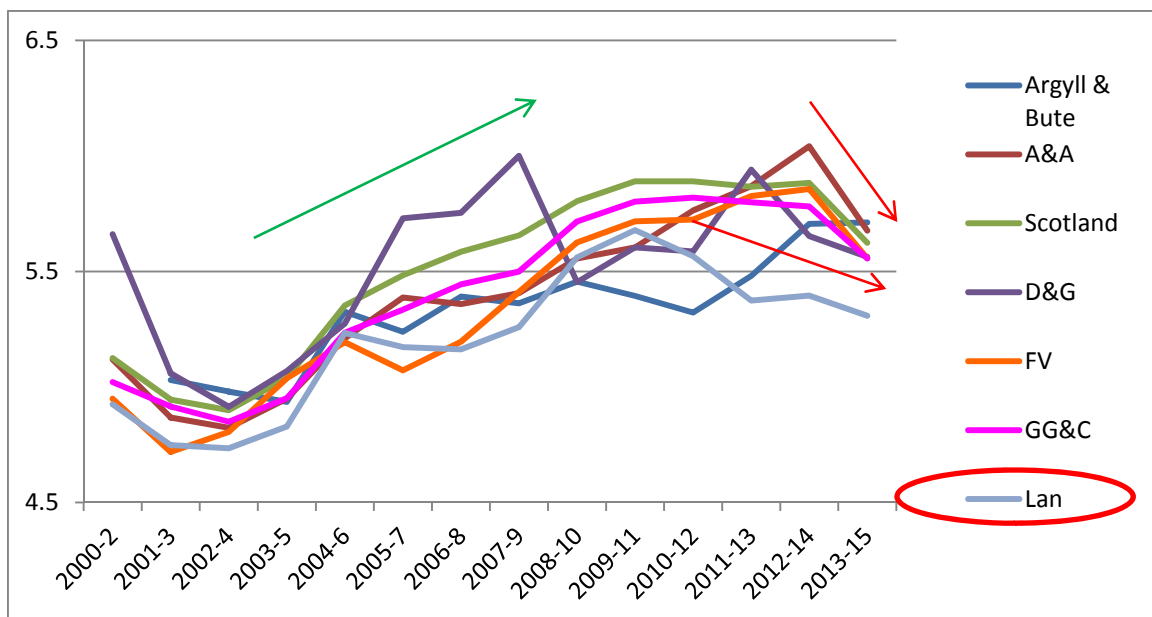


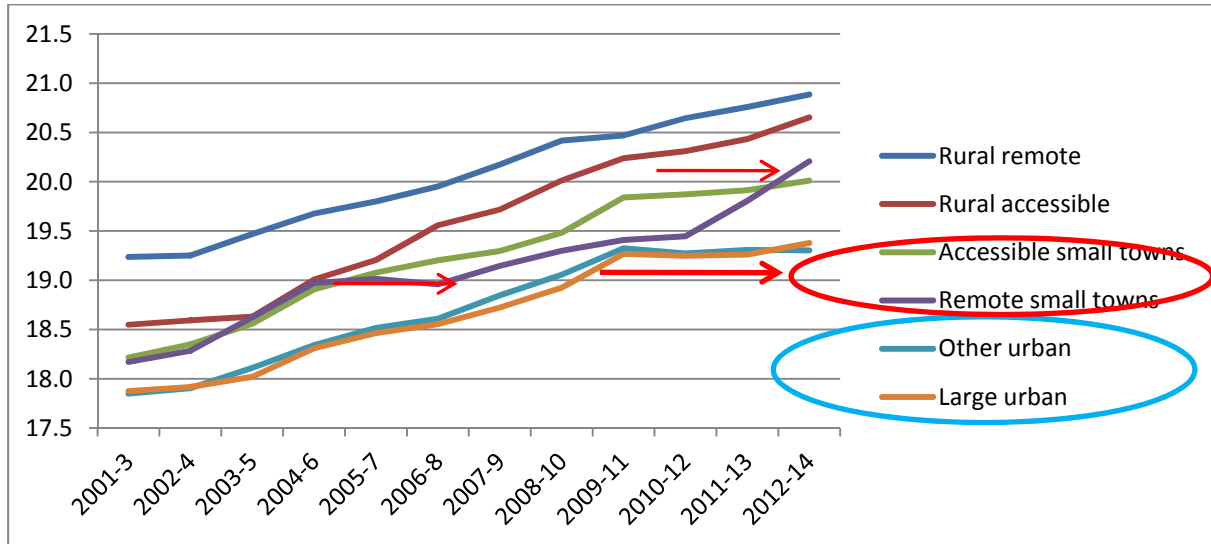
Figure 7: Life expectancy at 85 years for males by area, within the WoS, 2000/2 to 2013/15. Y axis truncated. Source: NRS Scotland.



- Furthermore, when the life expectancy of Scots who reach 65 years of age are categorised using the urban rural classification, some trendlines appear to experience a lengthy plateau including those living in accessible and remote small towns, but also the lines for those living in large and other urban areas, as shown for females at age 65 (Figure 8). This raises the possibility that some of the drop in life expectancy in A&A and D&G as a whole is due to a stalling of LE in older people in accessible (more recent) and remote small towns (after 2004-6). It is interesting to note that the LE is highest and still

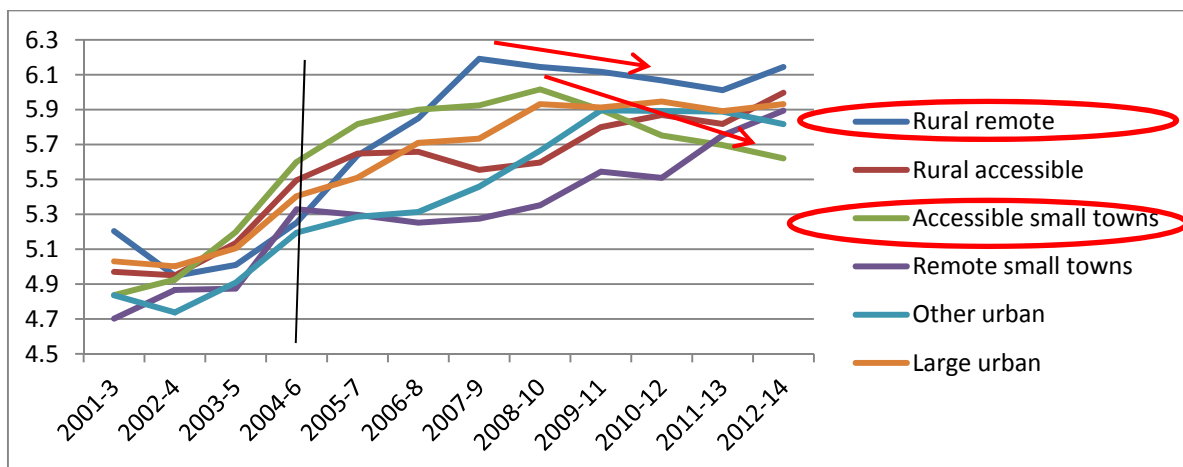
rising for females at age 65 who live in both rural remote and rural accessible areas, suggesting a self-selection effect.

Figure 8: Life expectancy at 65 years, for females, by urban rural classification. Y axis truncated. Source: NRS Scotland.



Nevertheless, any advantage conferred by being elderly and living in rural Scotland appears to diminish for those males in Scotland who reach 85 years of age as shown in Figure 9. There appears to be a prolonged stalling of the previous rise in LE for males at age 85 years living in rural remote areas after 2007-9, despite 7 years of steady improvement.

Figure 9: Life expectancy at 85 years, for males, by urban rural classification. Source: NRS Scotland.



- The stalling of rises, or even clear declines in life expectancy, defy the expectation of ongoing improvements in longevity which are seen in other parts of the world. The cause is likely to be multi-factorial

- the role of the recession in 2008 and exacerbated by recent austerity measures, mediated by
- life style related diseases which include the effects of the high prevalence of obesity, the rising prevalence of Type 2 Diabetes, the stalling decline of smoking prevalence, the contribution made by the rise in alcohol-related deaths, etc
- the relative level of investment in health and social care,
- as well as the current organisational model that may hinder the achievement of optimal efficiency of the current use of resources,
- falling access to primary and secondary health services, and social care, for some sections of the population in both remote/ rural areas and urban areas, as a result of centralisation of acute hospital services, closure/downgrading of community hospitals, falling access to a GP principal who knows the patient (loss of continuity in primary care).

All of these threaten to reverse the progress made by improving structural determinants of health over the past century and increased health service provision over the past 15 years.

- Consistently clear improvements in most health parameters, lesser degree of deterioration, and preservation of, or improvement in, the relative position in the national health league table, are being seen for the residents of the most deprived health board in the West of Scotland, namely Greater Glasgow & Clyde, in terms of standardised death rates from all causes, and standardised mortality ratio for all causes (Figure 10), SMR for cancer mortality for all types (Figure 11a), and specifically for the commonest cause of death, namely heart disease (see Health Needs Assessment report).
- Despite having less social deprivation than GG&C, Lanarkshire's relative position in the standardised mortality (all causes) league table has worsened somewhat in recent years (Figure 10 in Appendix) and its relative position in the cancer mortality league table for all types combined (Figure 11b) and for lung cancer in females has also worsened (Figure 14).
- Perhaps more surprisingly, more rural areas in the West of Scotland, even those characterised by relative affluence such as Dumfries & Galloway (Figure 11c) and Argyll & Bute (Figure 11d), have unexpectedly lost ground and those with historical health deficits, such as parts of Ayrshire & Arran (Figure 11e), appear to have deteriorated further in very recent years. Age/sex standardised death rates (all causes), standardised mortality ratios (all causes of death), and/or SMR for cancer (all types combined) appear to be rising in recent years, for these three board/council areas, the starting points of the rises varying with the area. Even the more affluent Forth Valley, appears to have lost ground with respect to its relative position in the cancer (all types) SMR league table, since its enviable position before 1990 (Figure 11f).

Figure 10: Trends in standardised mortality ratios (all causes of death) for the component parts of the NWoS, 2000 to 2016. Source: NRS Scotland.

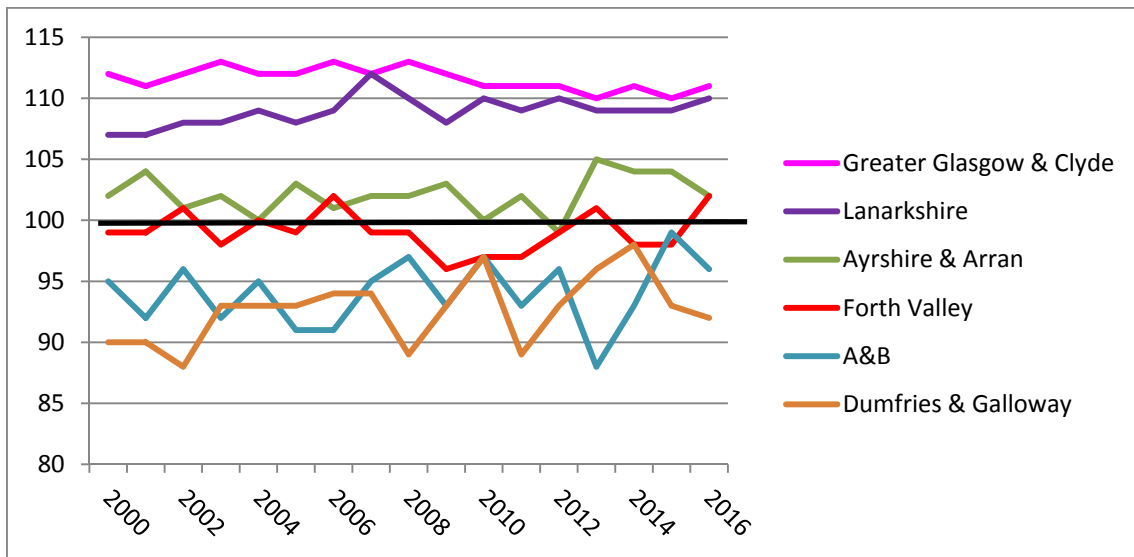
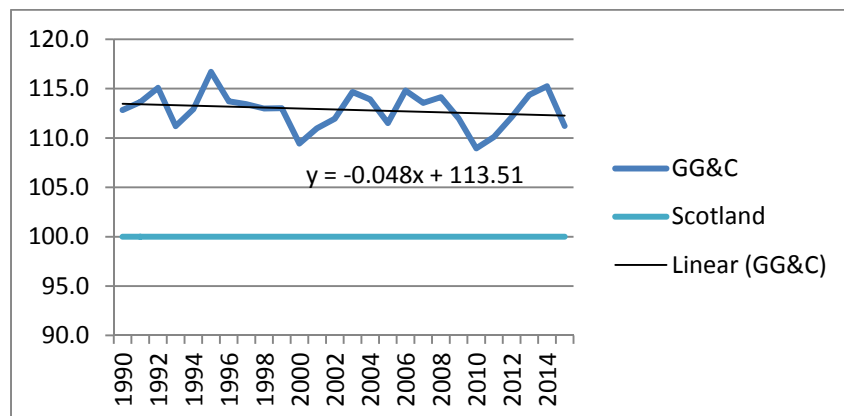
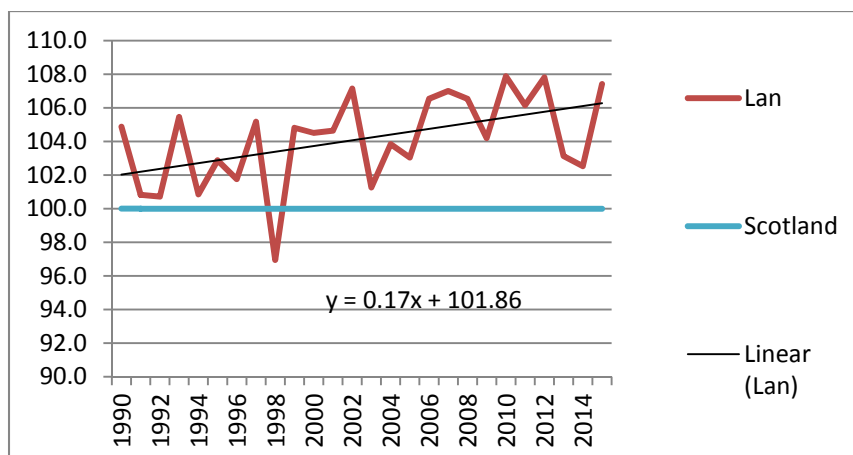


Figure 11: Trends in standardised mortality ratios for cancer (all types combined) for the component parts of the NWoS, 2000 to 2016. Source: NRS Scotland.

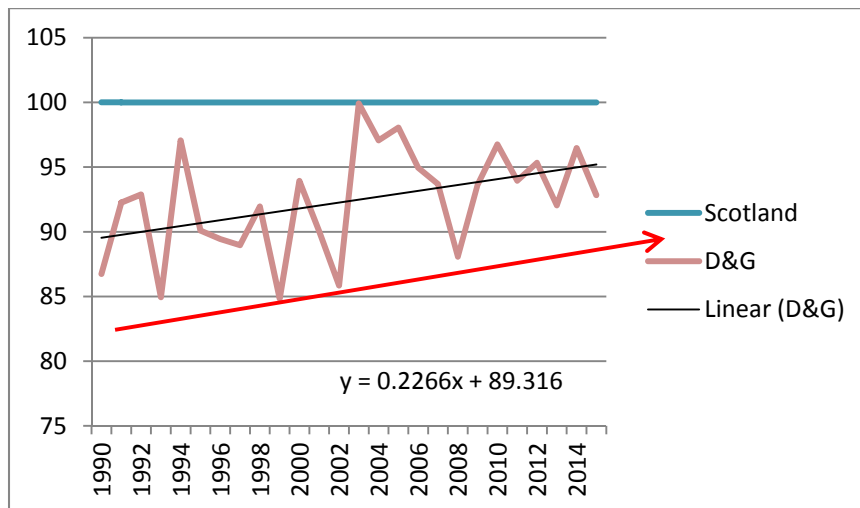
a) GG&C



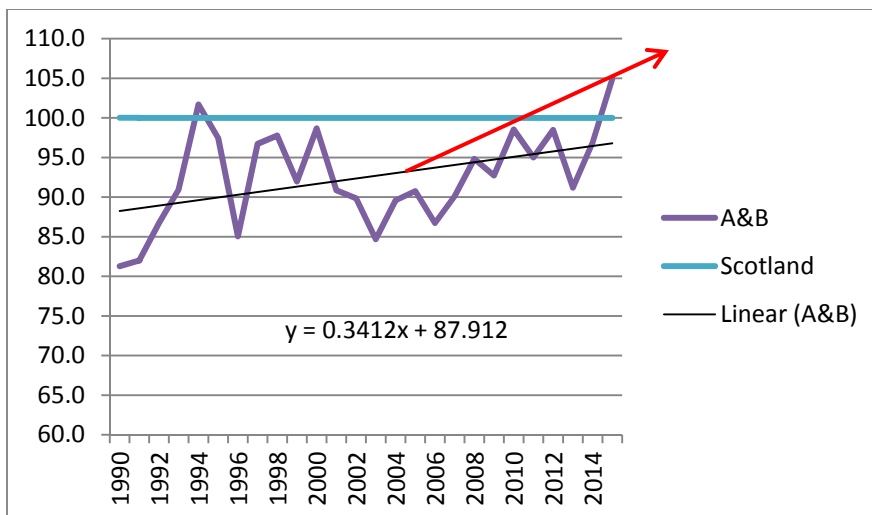
b) Lanarkshire



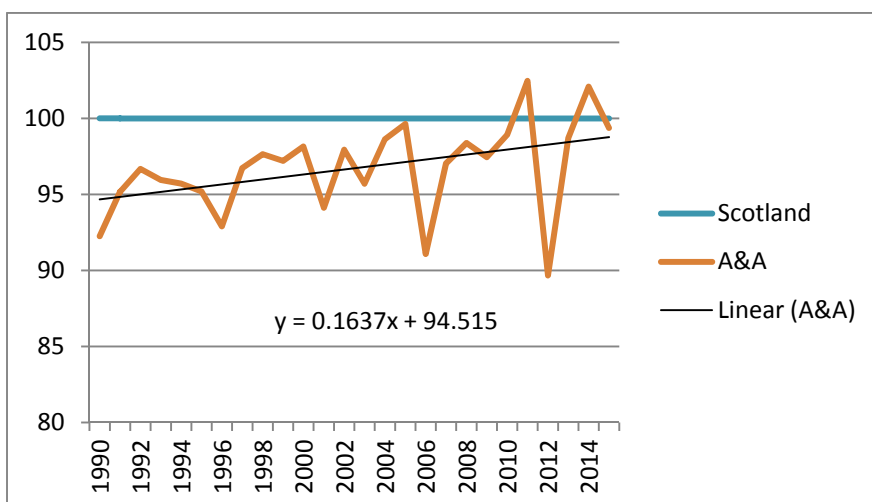
c) D&G



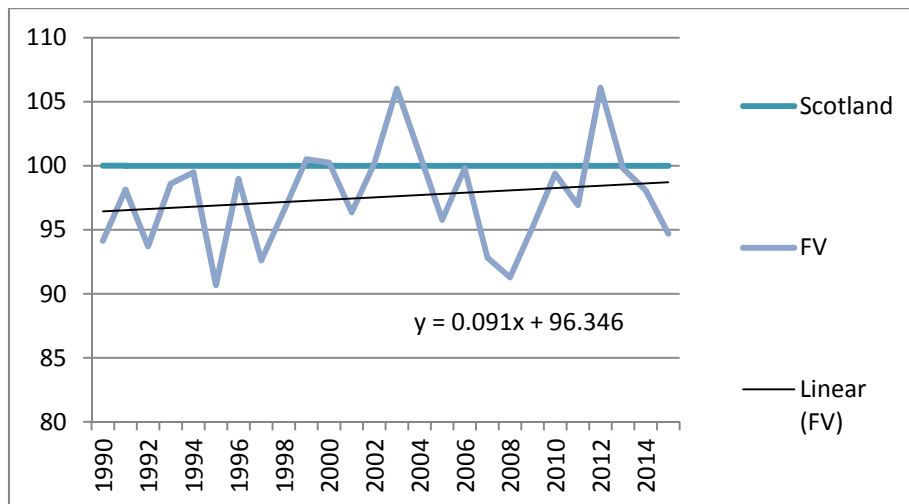
d) A&B



e) A&A

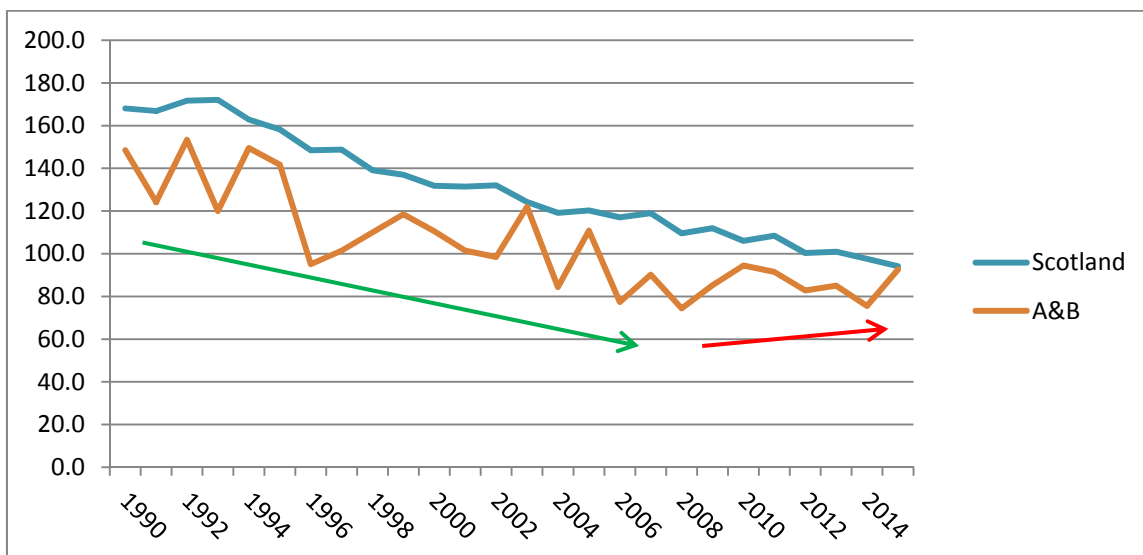


f) FV



- For Argyll and Bute males, the age/sex standardised death rate for lung cancer actually increased between 2008 and 2015, at a time when most observers are seeing dramatic declines in such deaths throughout the western world. By 2015, it had reached the national rates, something it had only achieved once before in 26 years (Figure 12).

Figure 12: Trend in age/sex standardised lung cancer mortality per 100,000 person years, in Argyll and Bute males, using the European Standard Population (2013), by year, 1990-2015.



- For Lanarkshire females, the age/sex standardised death rate for lung cancer increased more rapidly than did the Scottish rates such that by 2015, there was a 10.0 point gap opening up between the two trends (shown with the red arrow) (Figure 13). Meanwhile, GG&C females managed to reduce this gap slightly over this time period, emphasising that GG&C either held its ground or improved on it and rarely lost ground regardless of the parameter under study. This converging picture for GG&C vs Lanarkshire, with

respect to lung cancer mortality in females, is highlighted in Figure 14. By 2015, their lines are coming close to touching for the first time (red circle in Figure 14).

Figure 13: Trend in age/sex standardised lung cancer mortality per 100,000 person years, in Lanarkshire females, using the European Standard Population (2013), by year, 1990-2015.

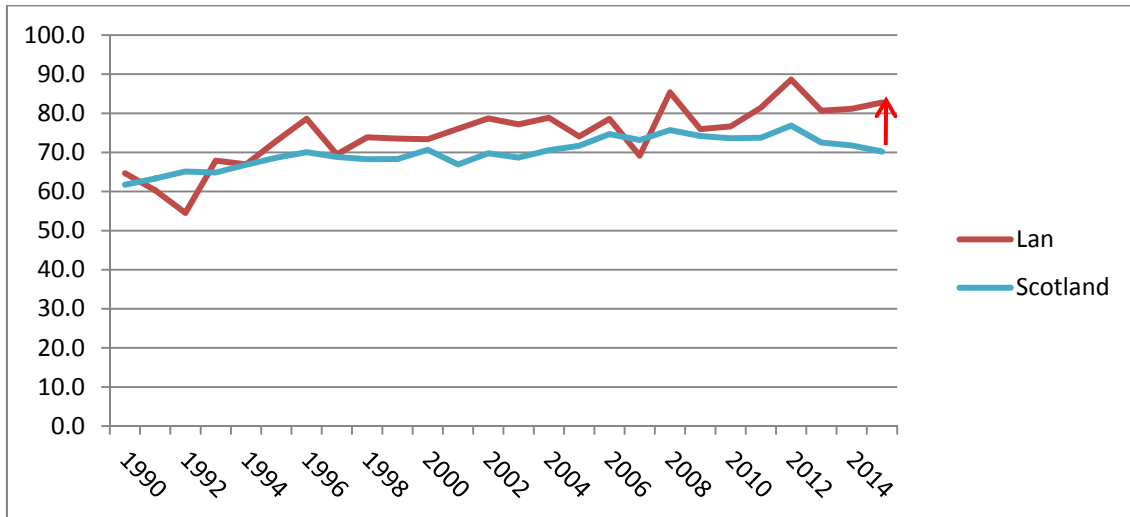
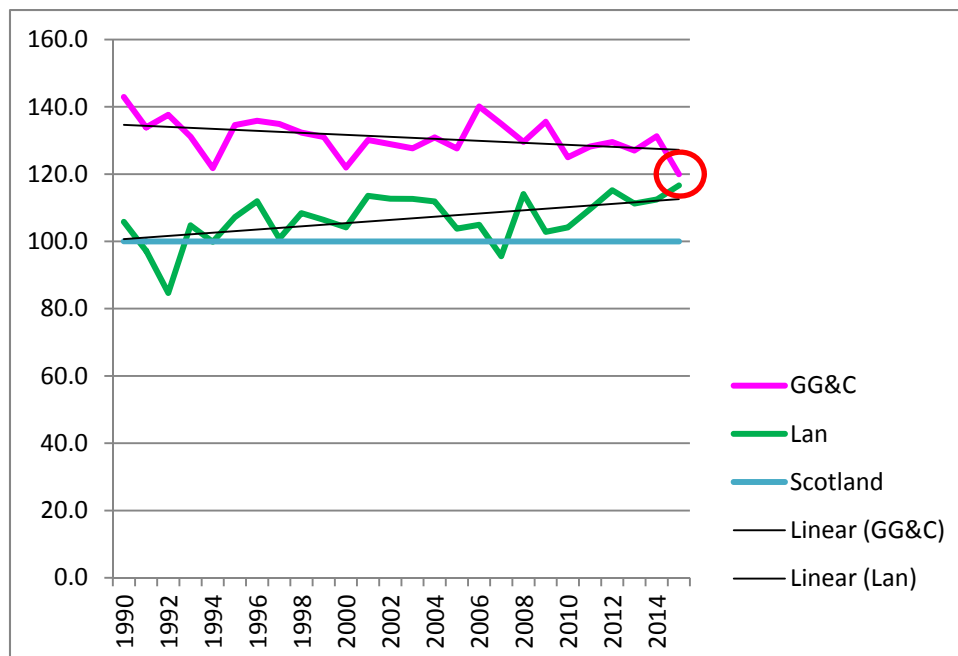


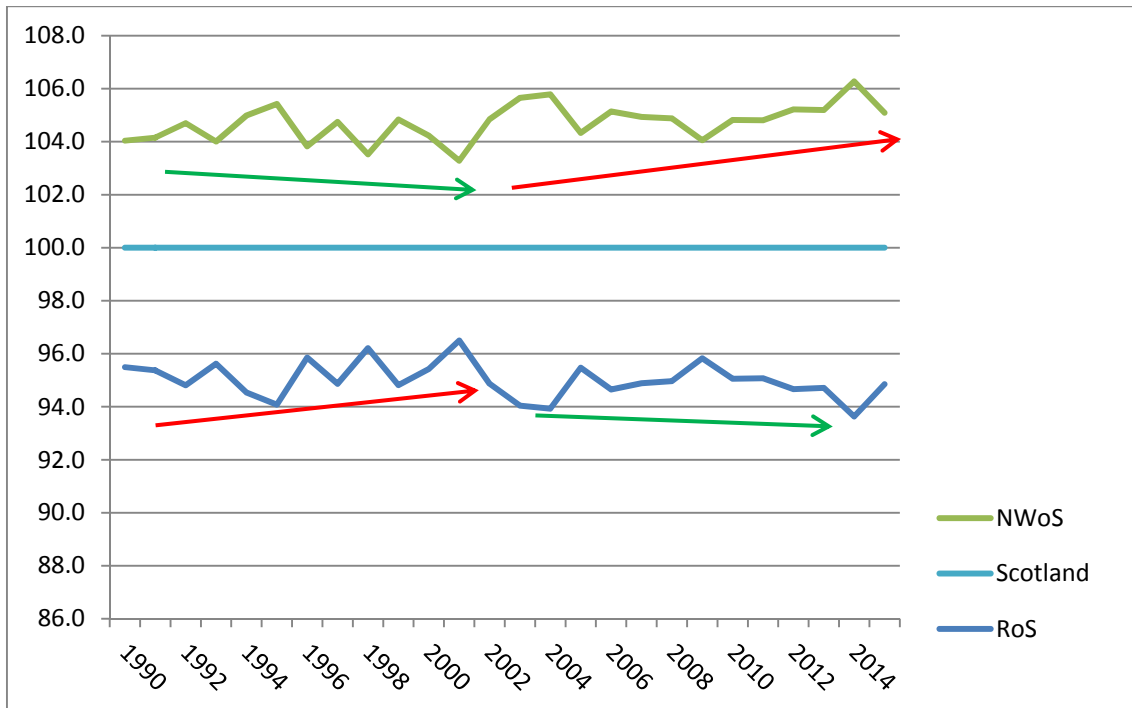
Figure 14: Trend in standardised mortality ratios for lung cancer in females for GG&C and Lanarkshire, showing the relative position compared to the national average (100% for Scotland) by year, 1990-2015.



- A comparative study of the trends of the standardised mortality ratios for cancer (all types combined) for the WoS and the RoS suggests that these changed direction after 2001, starting an upward, worsening trajectory for the NWoS (apart from GG&C

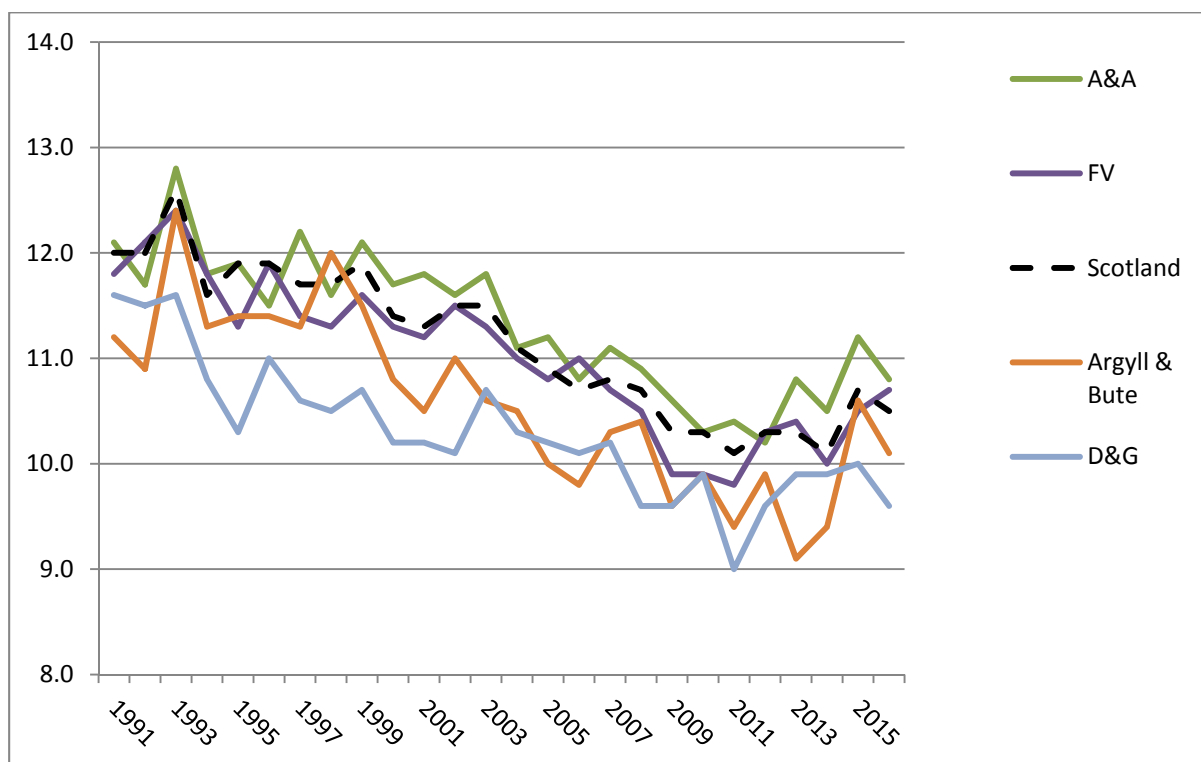
as described above) and a flat or perhaps slightly improving trajectory for the RoS. Identifying what happened after 2001 to cause this worsening relative picture for cancer mortality in 5 of the WoS areas under study is an important aim of the health needs assessment and therefore of any regional plan aimed at improving the targeting and efficiency of service provision (Figure 15).

Figure 15: Trends in standardised mortality ratios for cancer (all types combined) for the NWoS and the RoS, 1990 to 2015. Source: ISD Scotland.



- The only part of the WoS that has improved on virtually every parameter examined is GG&C, well studied for its concentrated social deprivation, and the two obvious mitigating factors to consider are its ability to attract economic investment and its ready access to/supply of health care. The one parameter that showed some loss of ground in GG&C was the age/sex standardised mortality rate for all causes combined, which rose by 2.6% between 2011 and 2016. However, the equivalent rises for the West of Scotland and Rest of Scotland as whole were 4.7% and the 2.1%, suggesting that GG&C behaved more like the Rest of the country (the east half of the country) than its immediate neighbours in the west side of the country . In contrast, the equivalent percentage rises for FV, A&B, D&G, A&A and Lanarkshire for the same 5 year time period were, in decreasing order, 9.2%, 7.4%, 6.7%, 3.8% and 3.6% respectively. The actual trends for the four rural areas that experienced higher percentage rises after 2011 are shown in Figure 16.

Figure 16: Trend in age/sex standardised death rate per 1,000 population, FV, D&G and A&A, both genders combined, using Scotland as the standard population, by year, 1991-2016.



- Extensive analysis (pending) of routinely collected data on the prevalence, incidence, mortality and hospitalisation for both coronary heart disease and all heart disease combined suggests a similar picture, although with ongoing improvements in both GG&C and Lanarkshire and recent small deterioration in the other rural areas under study. The other finding of note is that the overall decline in incidence and mortality for cardiovascular disease in both the WoS and the RoS is only accompanied by a fall in hospitalisation in the RoS. Although higher rates of hospitalisation in the WoS are in keeping with its greater level of social deprivation, a trajectory that is travelling in the opposite direction, ie rising, is difficult to justify.
- Hospital admission rates, for all ICD10 codes (all illnesses and diseases) and types (emergency, elective inpatient and elective day case) are observed to be higher in the West of Scotland than in the Rest of Scotland, based on the crude rates (Figures 17 to 19). The trends are rising for both halves of the country for emergency and elective day case but falling overall for both halves of the country for elective inpatient, in keeping with national directives to move to day case activity. The divergence in the trend lines between the WoS and the RoS over time was greatest for emergency admissions. The temporary plateau in rates for elective inpatient in the RoS between 2011/12 and 2014/15 (Figure 19) was matched with a clear rise in the WoS, which will have exacerbated the ongoing rise in emergency admissions in terms of pressure on what are declining bed numbers.

Figure 17: Emergency inpatient admissions: Crude rate per 100,000 population for NWoS, RoS and Scotland. Source: ISD Scotland.

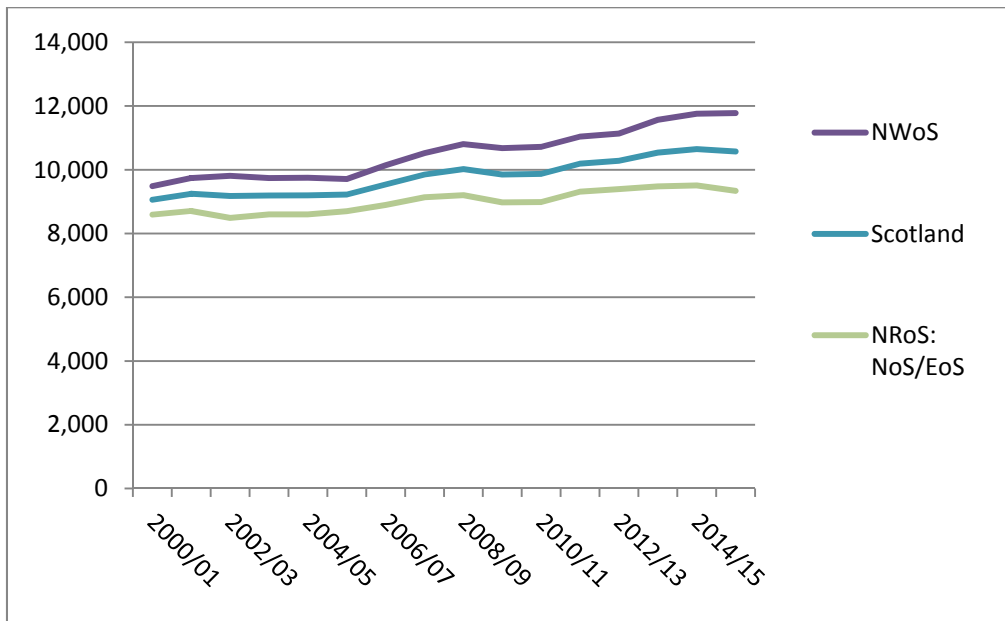


Figure 18: Elective day case activity: Crude rate per 100,000 population, for NWoS, RoS and Scotland. Source: ISD Scotland.

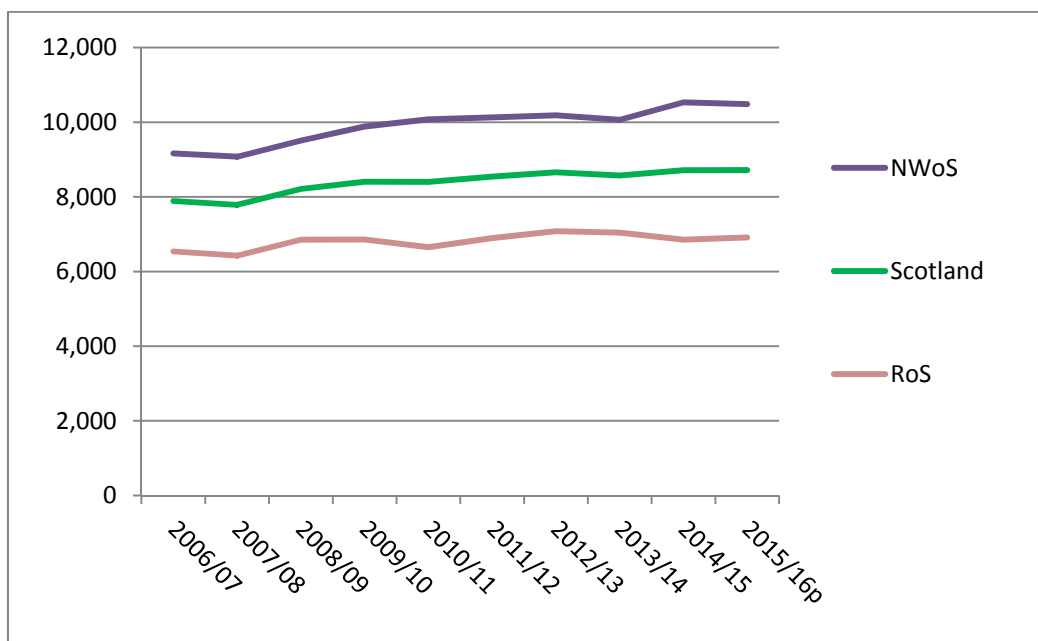
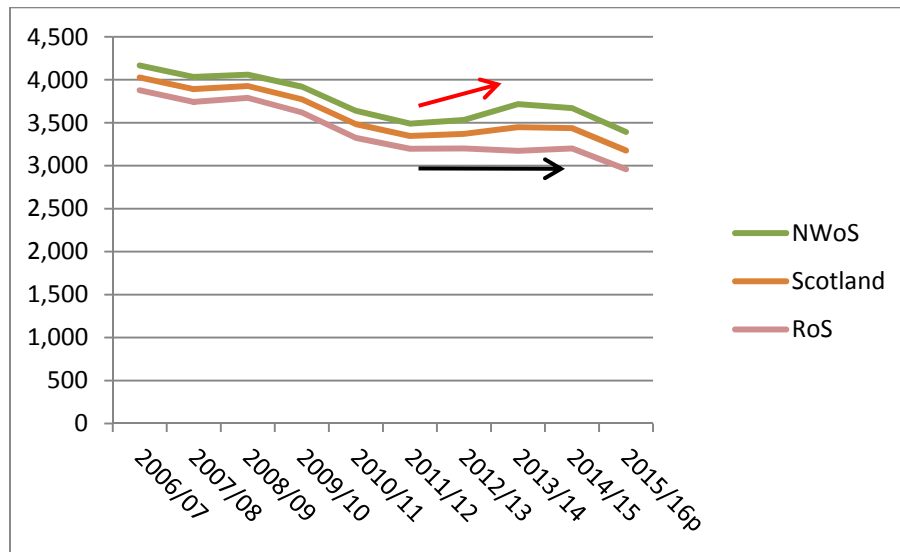
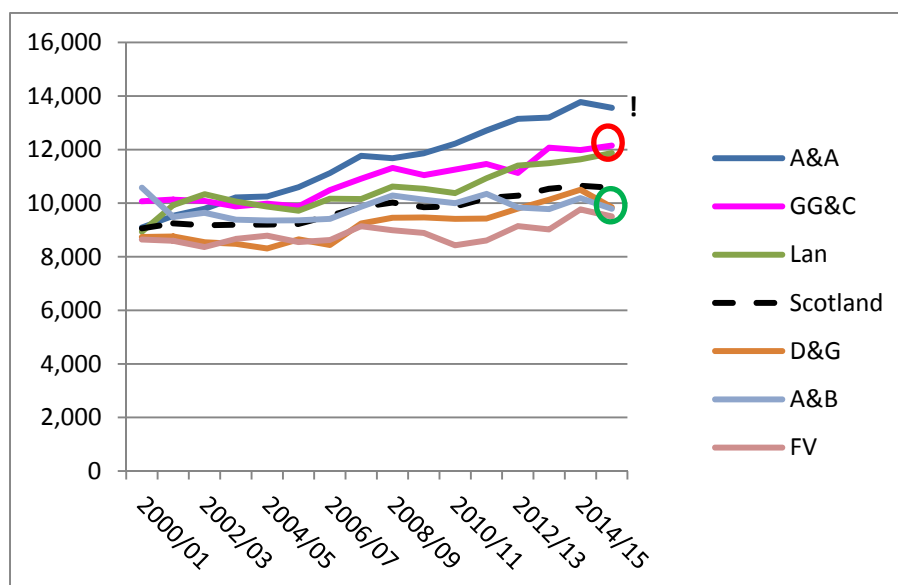


Figure 19: Elective inpatient admissions: Crude rate per 100,000 population, for NWoS, RoS and Scotland. Source: ISD Scotland.



- Furthermore, within the WoS there is considerable variation in rates of emergency inpatient admission with the range expanding significantly over the past 15 years (Figure 20). Work is underway to age, sex, deprivation adjust this position to assess the level of over utilisation in the WoS. This poses several questions - does the proximity to hospital facilities encourage access particularly where they are relatively well provided for in terms of A&E sites, hospital beds and consultant provision? Are there historical cultural factors that lead to increasing dependency on A&E services leading to higher reliance on emergency inpatient admission? Does falling provision of GP principals, and related continuity of care, in primary care have an impact on use of unscheduled hospital care. Do redirection policies at A&E make a real difference to the use of unscheduled care?

Figure 20: Emergency inpatient admissions: Crude rate per 100,000 population, for Scotland and the 6 study areas within the NWoS. Source: ISD Scotland.



- Although the use of elective care varies to a lesser extent within the WoS, based on crude rate trends (Figures 21 and 22), additional questions are raised about why some health board and council areas within that region have such high rates and others have such low rates, even after standardisation for age, sex and deprivation (based on fully adjusted analyses for 2016/17 and age/sex standardised analyses using European standard population for 2013, analyses pending). Why are FV elective day case rates static and equivalent A&A rates falling over time whilst those of the other areas tend to be rising (Figure 21)? Why are A&B rates for elective inpatient admission, though falling, so much higher than elsewhere in the WoS and can this excess be legitimately attributed to its remoteness and rurality, its agedness and the level of deprivation it conceals in its rural neighbourhoods (Figure 22)?

Figure 21: Elective day case activity: Crude rate per 100,000 population for Scotland and the 6 study areas within the NWoS. Source: ISD Scotland.

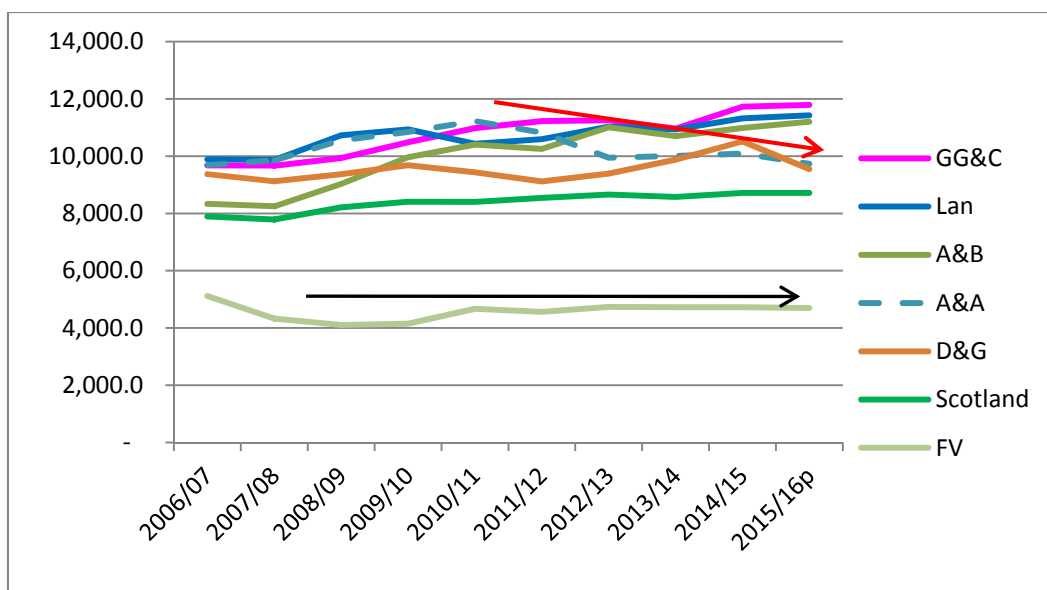
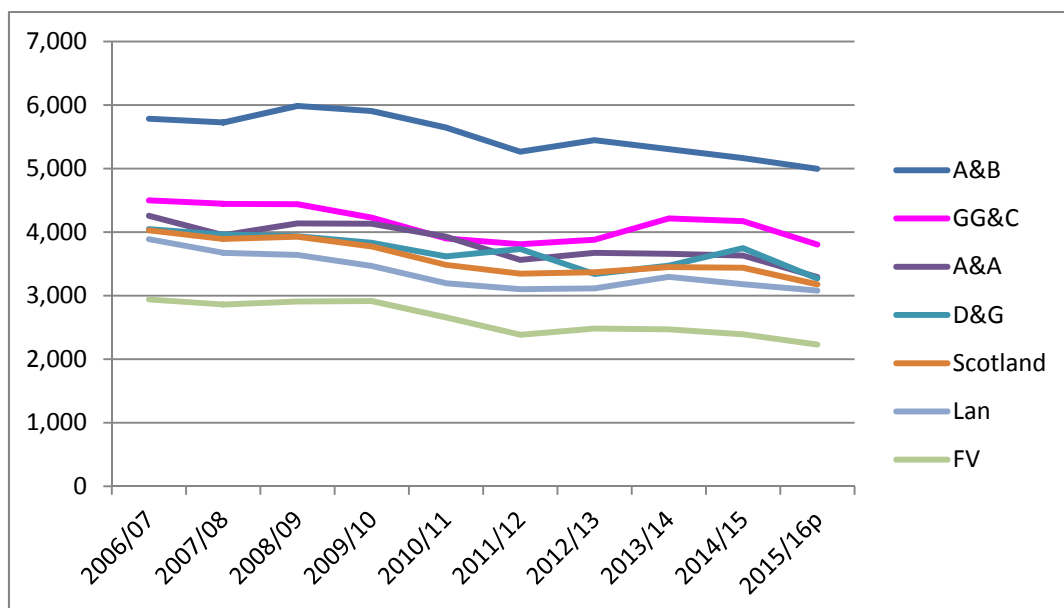


Figure 22: Elective inpatient admissions: Crude rate per 100,000 population for Scotland and the 6 study areas within the NWoS. Source: ISD Scotland.

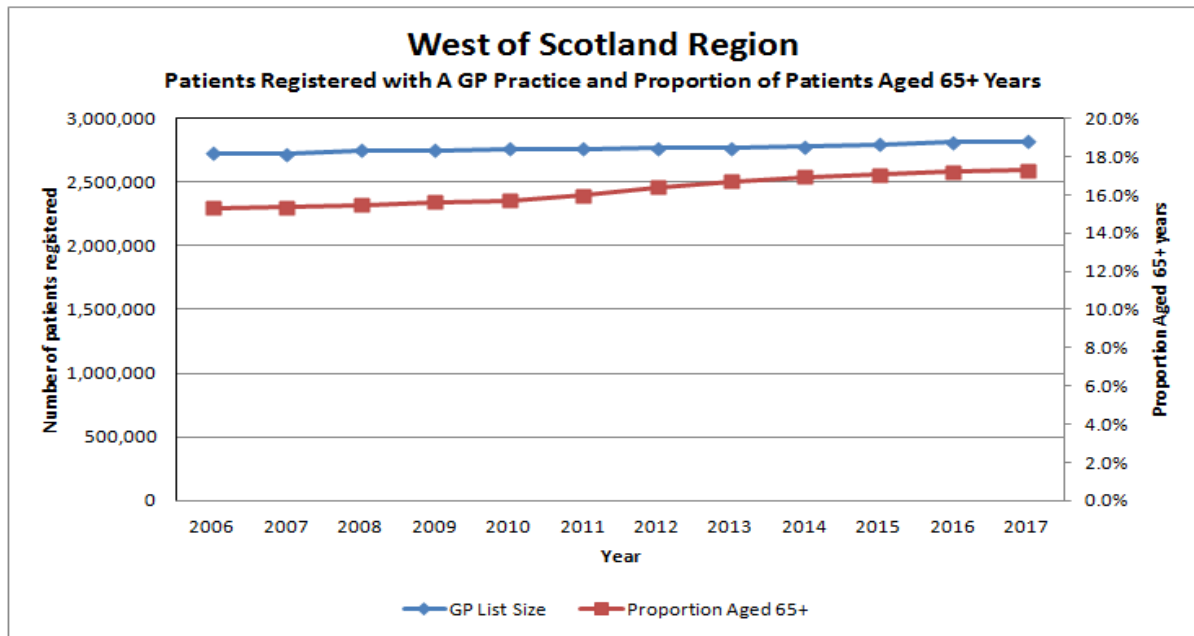


These largely unexplained variations require to be explored with a view to better understanding the drivers of consumption of hospital care and the degree to which current provision is meeting, or indeed exceeding, the needs of the residents of the WoS Region. To ensure that the limited resources available are used equitably, that is, determined by genuine need, and fairly distributed against both geographical and socio-economic gradients, it will be important to consider the service provision and service uptake across the region.

Appendix 2: Demand and Activity

This paper sets out supporting information contained within the West of Scotland Submission. This work was prepared by J Gomez.

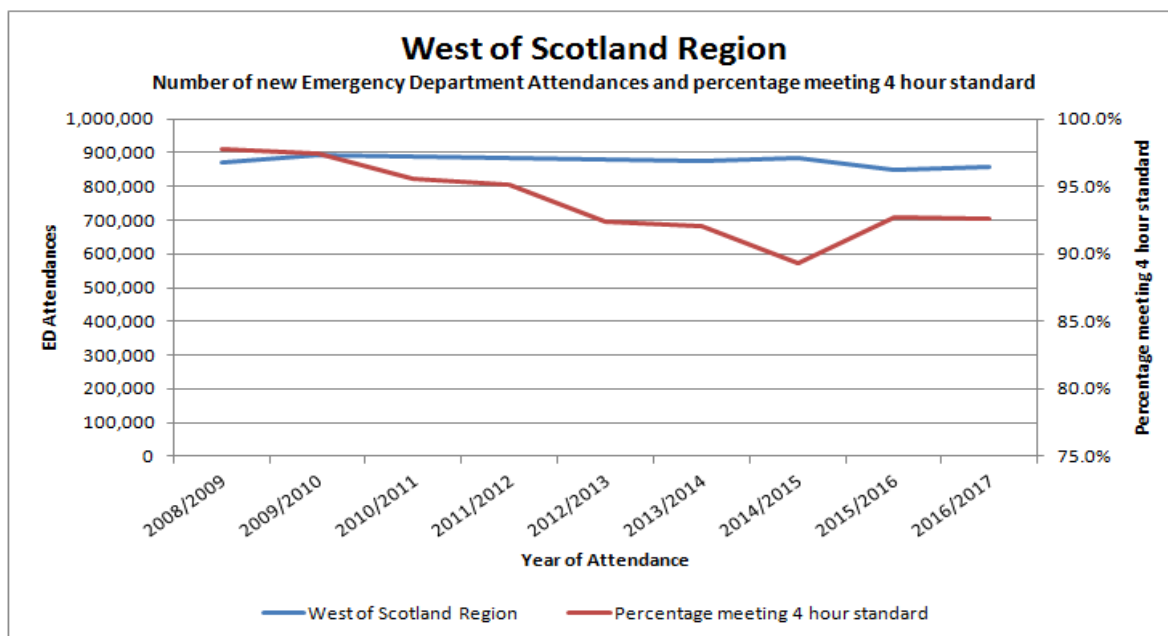
General Practice



- Between 2006 and 2017 the number of patients registered with a West of Scotland GP increased by 3.5 per cent, from 2,725,912 to 2,820,944.
- This represents an average annual increase of 0.3 per cent.
- At the same time the proportion of patients aged 65+ years have increased by 12.9 per cent, an average annual increase of 1.1 per cent.
- ISD have estimated that per annum there would be approximately 7,908,000 GP consultations and 3,799,000 Practice Nurse consultations with 56,245,994 prescriptions dispensed.

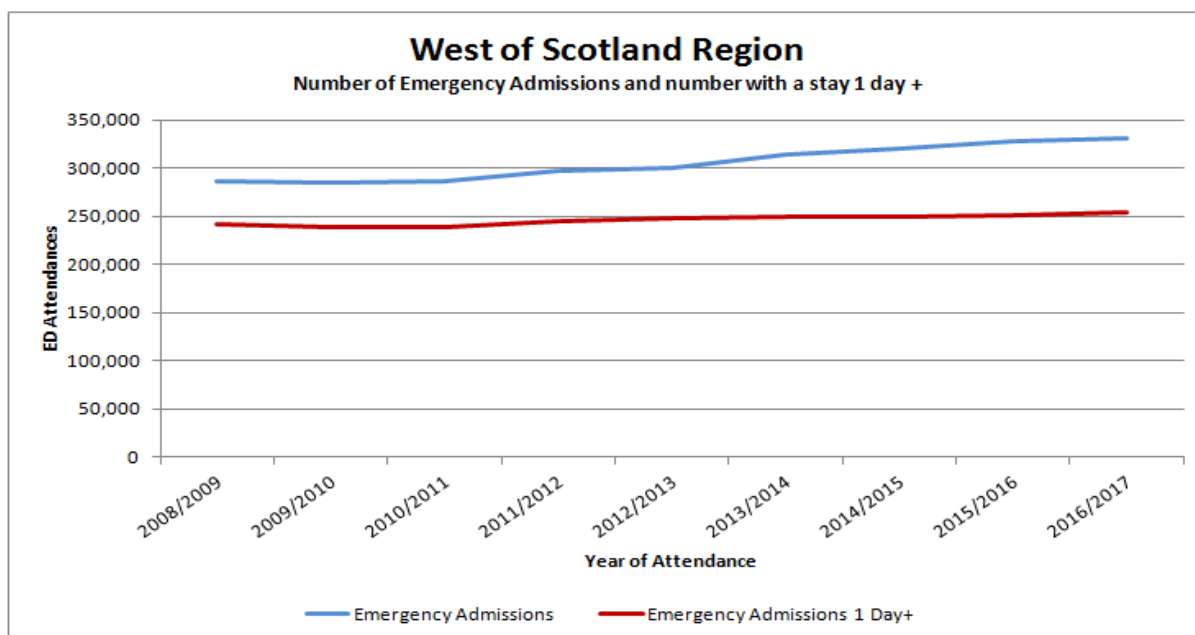
Emergency Care

Emergency Department Attendances



- Between 2008/2009 and 2016/2017 the number of New Emergency department attendances decreased by 1.4 per cent, from 869,960 to 858,059, since 2014/2015 it has decreased by 3.1 per cent.
- This represents an annual average of a 0.2 per cent decrease.
- The percentage of patients meeting the four hour standard decreased by 5.3 per cent, reducing from 97.6 per cent in 2008/2009 to 92.6 per cent in 2016/2017.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population attended Emergency Departments 7.8 per cent more than expected.

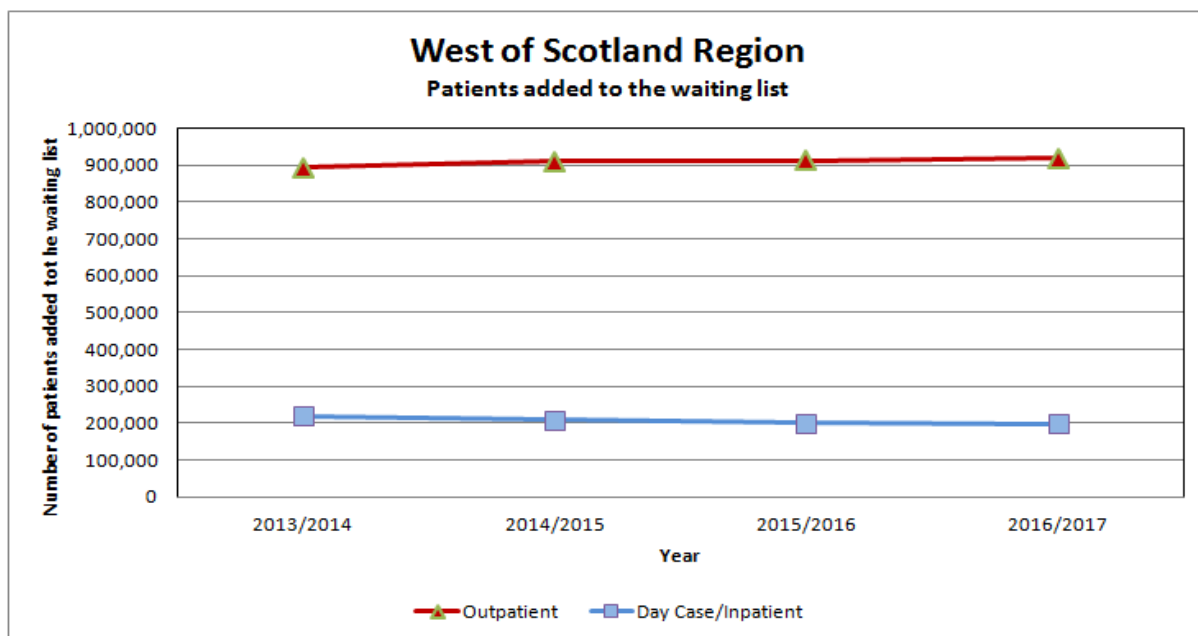
Emergency Admissions



- Between 2008/2009 and 2016/2017 the number of emergency admissions increased by 15.7 per cent, increasing from 286,478 to 331,318, since 2014/2015 it has increased by 3.3 per cent..
- Emergency admissions with a stay of one day or longer increased by 5.1 per cent whilst short stays with no overnight stay increased by 71.8 per cent.
- Zero stay admissions accounted for 15.8 per cent of all emergency admissions in 2008/2009 increasing to 23.4 per cent in 2016/2017.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population were admitted as an emergency 6.3 per cent more than expected.
- In 2016/2017 the case mix adjusted average length of stay was 0.96 which was 0.02 better than NHS Scotland.
- The emergency re-admission rate within 7 days in 2016/2017 was 4.7 per cent compared to NHS Scotland at 4.8 per cent and within 28 days it was 10.1 per cent compared to NHS Scotland at 10.4 per cent.
- Emergency admissions are projected, based on demographic changes alone, to increase by 3.3 per cent (11,250 admissions) by 2020, 8.3 per cent (26,135 admissions) by 2025 and 18.2 per cent (57,494 admissions) by 2035.

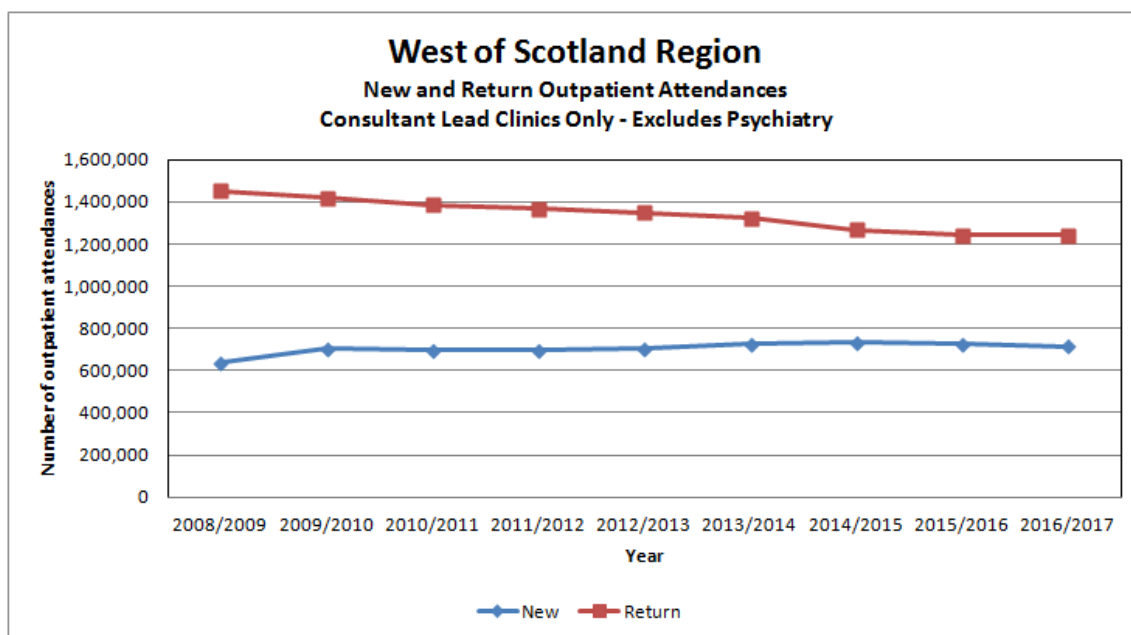
Elective Care

Additions to Waiting Lists



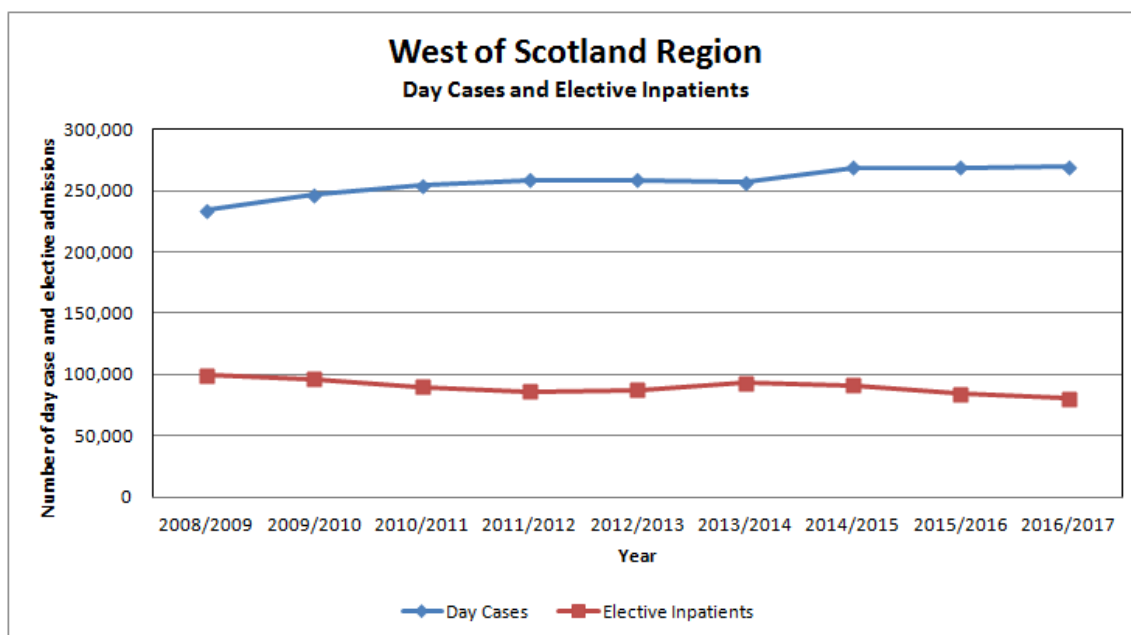
- Between 2013/2014 and 2016/2017 the number of additions to the new outpatient waiting list has increased by 3.0 per cent from 892,805 to 919,244
- This represents an average increase of 1 per cent.
- Patients on the outpatient waiting list have increased by 27.2 per cent from 125,053 in March 2014 to 159,018 in March 2017. Over sixty per cent of this increase occurred in the past year.
- The number of additions to the inpatient or day case waiting list decreased by 9.7 percent, from 219,371 in 2013/2014 to 198,080 in 2016/2017.
- This represents an average annual 3.3 per cent decrease
- Patients on the inpatient or day case list have increased by 37.2 per cent from 24,348 in March 2014 to 33,408 in March 2017. The increase is spread more regularly across the period than the increase in the outpatient waiting list.

Outpatient Attendances



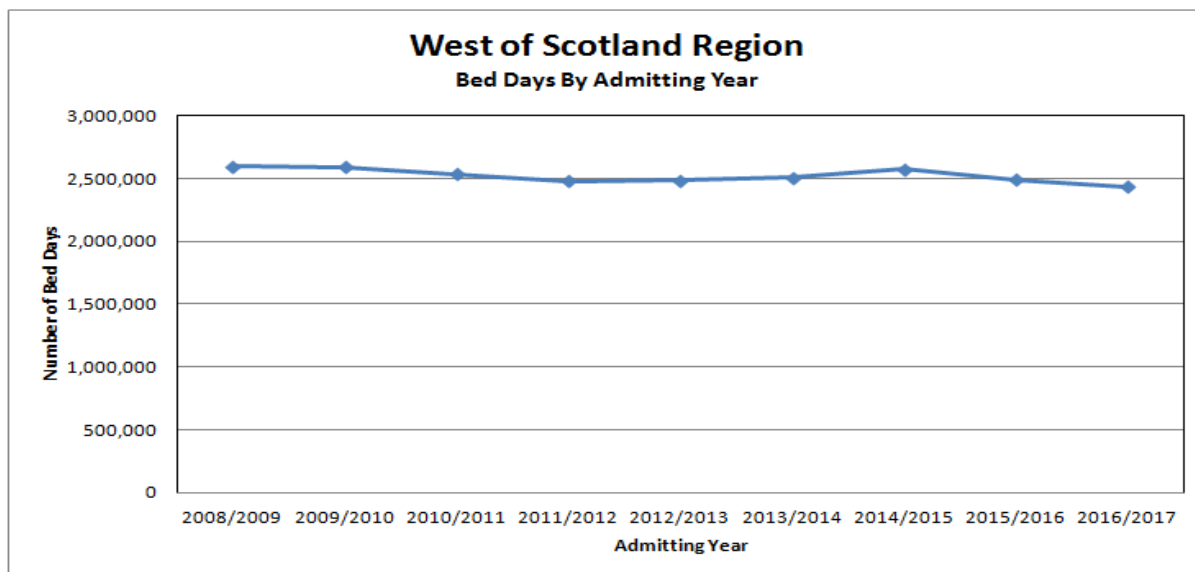
- Between 2008/2009 and 2016/2017 the number of new outpatient attendances at consultant led clinics (excluding psychiatry) increased by 12.1 per cent, increasing from 638,212 to 715,441, since 2014/2015 it has decreased by 2.5 per cent. Over the same period return outpatient attendances decreased by 14.6%.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population attended an outpatient appointment 1 per cent more than expected.
- The percentage of outpatients seen within 12 weeks in 2016/2017 was 83.2 compared to NHS Scotland at 81.5 per cent.
- In 2016/2017 the new outpatient DNA rate was 10.3 per cent compared to NHS Scotland which was 9.4 per cent., the DNA rate for return outpatients was 7.1 per cent for West of Scotland and 8.7 per cent for NHS Scotland.
- The return to new outpatient ratio in 2016/2017 was 1.8 compared to 2.0 for NHS Scotland
- Outpatients are projected, based on demographic changes alone, to increase by 1.9 per cent (14,222 attendances) by 2020, 4.1 per cent (31,105 attendances) by 2025 and 7.4 per cent (56,473 attendances) by 2035.

Elective Admissions



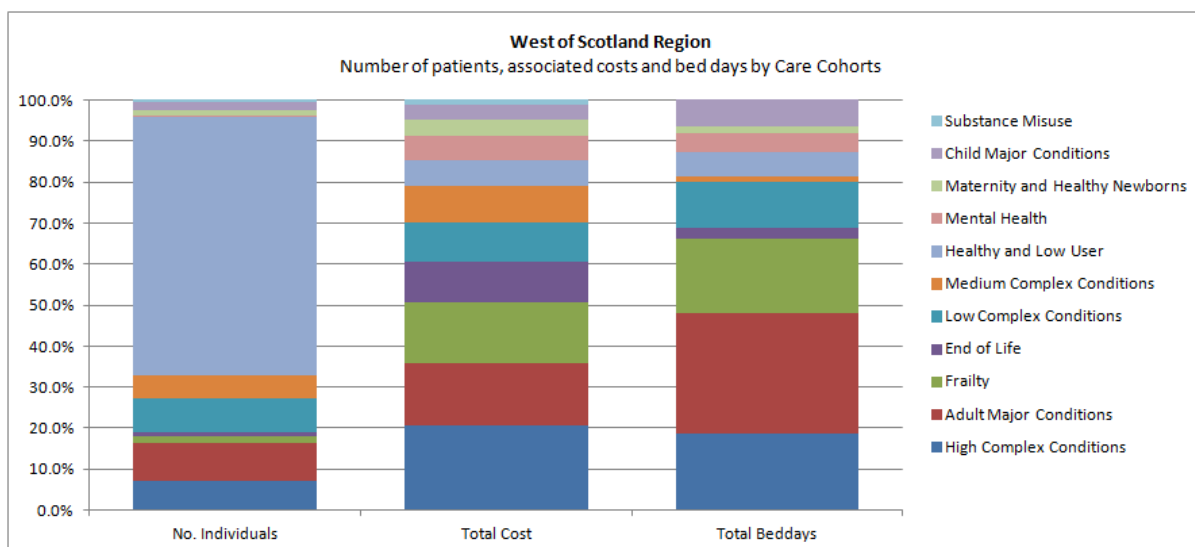
- Between 2008/2009 and 2016/2017 the number of day cases increased by 15.1 per cent, increasing from 233,984 to 269,386, since 2014/2015 it has increased by 0.3 per cent.
- Between 2008/2009 and 2016/2017 the number of elective inpatients decreased by 19.2 per cent, decreasing from 99,530 to 80,437, since 2014/2015 it has decreased by 11.2 per cent.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population were admitted as a day case 16.5 and as an elective inpatient 3.6 per cent more than expected.
- The percentage of day case or inpatients seen within 12 weeks in 2016/2017 was 87.7 compared to NHS Scotland at 87.4 per cent.
- In 2016/2017 the BADS day case rate was 87.0 per cent compared to NHS Scotland which was 85.4 per cent. The overall day case rate for West of Scotland Region was 77.0 per cent and for NHS Scotland 73.9 per cent.
- In 2016/2017 the case mix adjusted average length of stay was 1.03 which was 0.04 poorer than NHS Scotland.
- Day case and elective admissions are projected, based on demographic changes alone, to increase by 3.3 per cent (11,835 admissions) by 2020, 6.9 per cent (24,601 admissions) by 2025 and 12.0 per cent (42,815 admissions) by 2035.

Bed Days



- Between 2008/2009 and 2016/2017 the number of bed days decreased by 6.2 per cent, increasing from 2,597,377 to 2,478,550, since 2014/2015 it has decreased by 5.3 per cent.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population used 3.2 per cent more bed days than expected.
- During the period between 2008/2009 and 2016/2017 the average available staffed bed decreased by 8.7 per cent.
- Bed days are projected, based on demographic changes alone, to increase by 7.2 per cent (178,931 days) by 2020, 16.1 per cent (390,837 days) by 2025 and 36.5 per cent (884,006 days) by 2035.

Activity and Costs for Cohorts of Patients



- Four cohorts, High Complex, Adult Majors, Frailty and End of Life account for 19.1 per cent of individuals but 60.6 per cent of costs and 68.8 per cent of bed days.



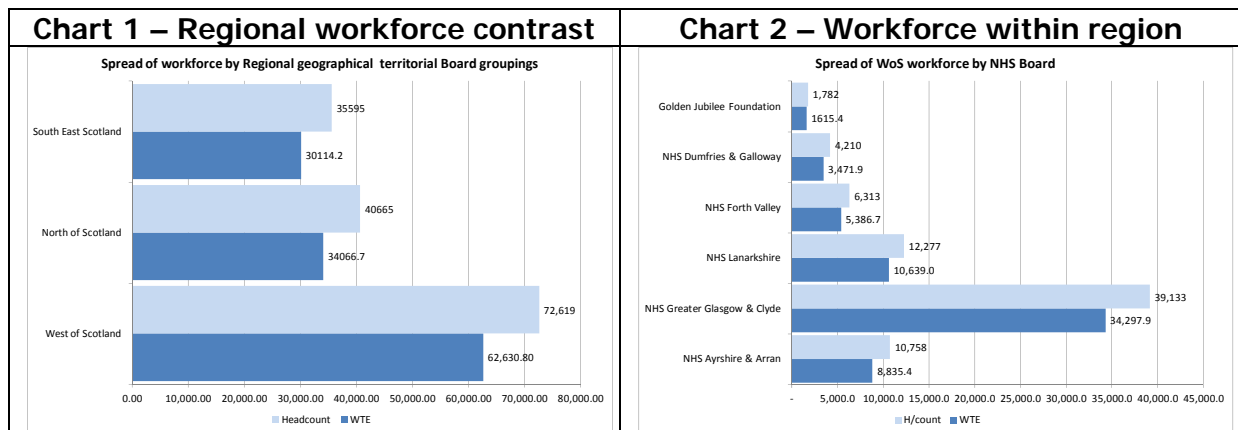
West of Scotland

Developing a Regional Workforce

1. Introduction

West Region Workforce size and scope

The NHS West Region employs approximately 62,630 WTE (72,619 headcount) NHS staff, within five territorial Boards (the Golden Jubilee Foundation being a national Board), representing circa 45% of the entire NHS Scotland workforce as illustrated in the charts below:



In this chapter, the focus is on the NHS workforce as workforce information is more developed. Workforce data from social care will be available from the the Health and Social Care Partnerships as we refine Phase 2 of the national workforce plan.

2. Drivers of Change

- 2.1. Healthcare treatment and provision is constantly advancing and changing, and our workforce must adapt in order to deliver modern, patient quality focused treatment and care. All staff groups at all levels have an important part to play in shaping and delivering future models of care. Staff need to be supported and developed to ensure they can fully engage and commit to new service delivery models.
- 2.2. The future workforce cannot be “more of the same”. The future workforce will need to be based on multi-skilled teams rather than individual practitioners, this will facilitate skill focused effective multi-disciplinary team working.
- 2.3. Hospital based staff will work more closely with community teams and both will need to have a clear understanding and appreciation of each other’s roles to create a culture which supports people with long term conditions and their carers to be the lead partners in decisions about their health and wellbeing.
- 2.4. New developments across the West Region, such as the development of a Regional Elective Centre at the Golden Jubilee National Hospital will bring career opportunities and new work environments which are attractive to staff and may potentially destabilise the staffing in existing and established units.

Workforce planning for new developments must include a risk assessment of unintended consequences for workforce supply and demand.

- 2.5. The ageing population is not the only factor which will impact on service demand; more young people are surviving with long term conditions, the provision of services for people with chronic conditions in mid life, and the increased demand for mental health services for all ages will all impact on the shape of the future workforce.
- 2.6. Changing treatments, interventions and diagnostics will bring opportunities for brand new roles and career pathways.
- 2.7. Sustainability and workforce availability in remote and rural settings is a continuing challenge across all job families but particularly medical , nursing and Allied Health Professions.

3. Regional Pressure Points

Boards have already undertaken work to identify pressure points within the West Region. Common themes which have emerged across the West of Scotland are as follows:

- The Medical Workforce – challenges in demand, supply and sustainability across the spectrum of grades and specialities but significantly at Consultant grade within specialties in acute hospital settings; see Appendix 1 case study examples
- Nursing – an ageing workforce, a significant element of which will retire in the next decade presents particular challenges in key job areas e.g. health visitors, district nurses, paediatrics, midwifery and mental health practitioners. The demand for Advanced Nurse Practitioners (ANPs) is likely to increase, as medical recruitment and retention both in acute and primary care creates additional workforce pressures. New educational programmes and pipelines need to be created to supply this workforce, although recruitment of ANPs will come from an increasingly scarce nursing resource .
- Radiology – demand and supply issues connected to the current radiologist/reporting radiographer position in addition to increasing service demand and enhanced technical solutions requiring different ways of working.
- Pharmacy technicians – a significant increase in demand which is not being matched with supply.
- Healthcare science – demography of the workforce, particularly in senior and specialist roles, as well as longstanding national issues with supply.

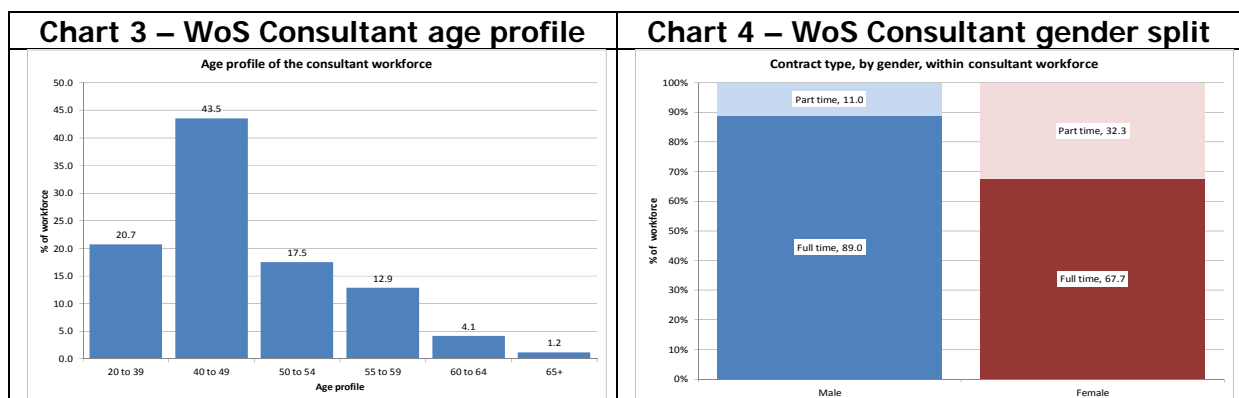
Further work is required to expand on the detail of these pressure areas and potential solutions. For the purposes of this discussion paper, the focus is on medical workforce.

4. Medical Workforce Availability

Recruitment and retention of medical staff within acute and primary care services is increasingly a challenge across Scotland. The available labour market is competitive at inter/intra regional, national, and international levels.

With a growing elderly population and a consequent increase in complex healthcare needs, it is recognised that the current workforce model, with its heavy reliance on a traditional medical model of care is becoming fragile and in some specialties unsustainable in the long term. New workforce models must consider a mixed economy of professions within the workforce working alongside medical staff i.e. advanced practice roles from varying professional backgrounds e.g. Nursing, Allied Health Professionals, Pharmacy, Healthcare Science and Physician Associates.

The charts below illustrate the age profile of the consultant workforce across the West Region and the gender split:



Approximately 126 (headcount) consultants in the West Region are aged over 60. 60.6% of the consultant workforce is male however this is changing as the number of females in the medical workforce continues to expand. This is likely to change the working patterns of the medical workforce as females currently work part time more frequently than males. This will be an important workforce planning consideration in terms of workforce numbers and service capacity.

Table 1, below, illustrates the scale of the challenge faced by the West Region in terms of consultant vacancies, with 46% of all vacancies being vacant 6 months + :

Table 1 – West Region Consultant Vacancies as at 31st March 2017

	Total Vacancies WTE	Vacant 6 months or more
All specialties	260.0	119.8
All medical specialties	254.9	117.8
Emergency medicine	9.0	6.0
Anaesthetics	26.0	9.0
Intensive care medicine	2.0	-
Clinical laboratory specialties	53.0	25.0
Histopathology	13.0	5.0
Chemical pathology	2.0	-
Haematology	5.0	2.0
Medical microbiology & virology	2.0	1.0
Clinical radiology	31.0	17.0
Medical specialties^R	78.5	41.4
General (internal) medicine	12.0	9.0
Cardiology ^R	3.0	3.0
Infectious diseases	3.0	1.0
Dermatology	7.9	2.0
Endocrinology & diabetes	4.0	3.0
Gastroenterology	13.0	7.0
Genito - urinary medicine	3.6	0.6
Geriatric medicine	7.0	3.0
Renal medicine	2.0	1.0
Neurology	5.8	4.8
Palliative medicine	1.0	-
Rehabilitation medicine	2.6	1.0
Respiratory medicine	8.0	5.0
Rheumatology	2.6	-
Clinical neurophysiology	1.0	-
Clinical oncology	2.0	1.0
Public health medicine	1.3	1.3
Occupational medicine	2.0	2.0
Psychiatric specialties	30.4	9.1
General psychiatry	23.7	6.8
Child & adolescent psychiatry	1.8	-
Old age psychiatry	3.3	2.3
Psychiatry of learning disability	0.6	-
Psychotherapy	1.0	-
Surgical specialties	35.7	19.0
General surgery	3.7	1.0
Otolaryngology	6.0	5.0
Neurosurgery	1.0	-
Ophthalmology	8.0	6.0
Trauma & orthopaedic surgery	6.0	1.0
Plastic surgery	2.0	-
Urology	8.0	5.0
Oral & maxillofacial surgery	1.0	1.0
Obstetrics & gynaecology	4.0	-
Paediatrics specialties	13.0	5.0
Paediatrics	13.0	5.0

Attached at Appendix 1 is a case study analysis of three medical specialties with significant staffing challenges for illustrative purposes – clinical radiology, histopathology and gastroenterology.

Across all Boards there are also significant supply challenges at the Trainee doctor level, resulting in either trainee vacancies or appointments of less senior trainee doctors, which present real challenges to Boards across the region to sustain current services and plan for future service provision and contributes to the wider Scotland wide challenges of a lack of future supply of trained doctor for both the secondary and primary sectors.. The changing demography of the medical workforce coupled

with individuals wanting to improve work life balance and/or work part time means that for many it takes longer to complete training, which compounds current fragility of rotas and longer term supply challenges. This will be a key element of the March 2018 Workforce Plan.

Recruitment & Retention

The West Region health boards recognise the importance of being an Employer of Choice which attracts and retains staff, supported by robust implementation of the Staff Governance Standards and the implementation of the Everyone Matters 20/20 Workforce Vision with its five priorities (A Healthy Organisational Culture, A Sustainable Workforce, A Capable Workforce, An Integrated Workforce and Effective Leadership & Management). All health boards have local action plans in place which support the priorities and ensure ongoing engagement with staff.

All boards remain committed to reducing expenditure on agency, bank and locum staff and a number of strategies are currently in place in boards to support this aim.

5. Workforce Affordability

Improve efficiency

To maximise the efficiency of service delivery, several factors should be taken into account in designing the workforce of the future:

- **Avoid duplication** – opportunities to integrate and streamline patient pathways will be considered and where possible generic support workers introduced both across health and health / social care (AHP, nursing, social care).
- **Reduce utilisation of high cost agency staff** – all Boards are committed as far as practicably possible to reduce/eliminate the utilisation of high cost agency staff within nursing and medical job families. The West Region continues to develop its medical bank to not only attract doctors in training but also those seeking additional work at retirement.
- **Work to “top of licence”** (registered and support staff) – roles require to be reviewed with staff supported and developed to work to the “top of their licence”. This offers the potential to increase staff numbers and redistribute the workload to lower banded but appropriately trained staff, thus avoiding an increase in cost.
- **Extended scope** – to streamline the patient journey, certain roles will extend their scope to provide additional care elements and avoid referral to a different healthcare provider or into acute services e.g. community nurses developing Intravenous (IV) therapy skills to allow patients to be cared for in the community; extending psychological care approaches, growing the resilience of people using services to effectively self-care and supporting

concordance with agreed personalised treatment plans reducing demands on unscheduled care.

- **Roles appropriate to skill** – to ensure efficiency, appropriately skilled staff should undertake roles e.g. admin staff undertaking admin roles, not clinicians. Staff developed to conduct proactive engagement with patients, their families and carers about what matters to them and how they feel better supported to access services and to self care when they are able; staff empowered to promote healthy lifestyles and provide support to patients and carers to meet social challenges such as financial security and employment.

In addition, there are other opportunities for efficiency which will support the workforce of the future:

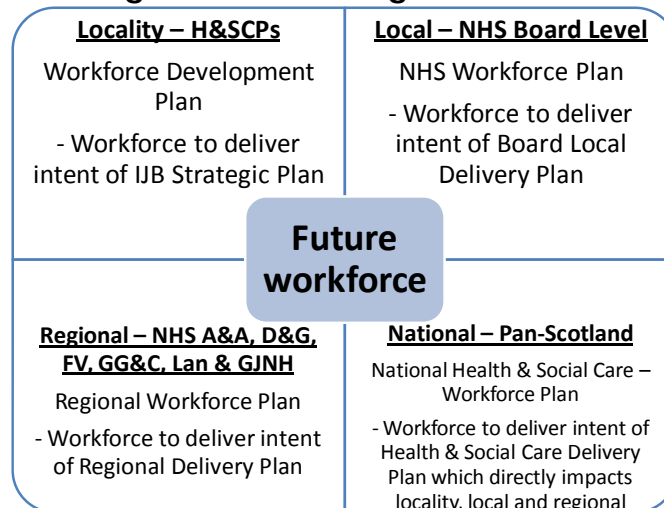
- Agile working arrangements which will support and enable the concept of working across boundaries
- Improvements in technology such as electronic patient records, mobile technology (tablet computers), etc. would support greater workforce productivity and efficiency and will require the workforce to work differently
- Innovative practice using existing technology based platforms (e.g. NHS Inform MATS) and developing other web-based access to services for early advice and self management, influencing a culture of self-efficacy which deflects demand away from healthcare services and into upstream services e.g. leisure, voluntary and third sector services.
- West Region health boards and their partner HSCPs will continue to work with third sector colleagues to focus on supporting and testing out new approaches for the delivery of community-based support for people with complex and multiple conditions.
- Integrate more closely all contractor disciplines such as community pharmacists, dentists, optometrists and care providers to enable patients to better access appropriate care and advice
- Introduce pharmacists in GP practices with advanced clinical assessment skills to support the care of patients with long term conditions and better manage their medications

The workforce of the future will not be “more of the same”. The workforce will be older and have a greater reliance on Advanced Practitioners and roles with extended scope. All staff groups will work to the “top of their licence” with work aligned to their skills. The workforce may require to be re-profiled to match the increased workload demand in the community and the higher acuity in acute care.

6. Regional Workforce Planning

All NHS Boards within the West Region have extant Workforce Plans as required by CEL32(2011) and the new regional approach should robustly complement existing plans as illustrated in Figure 1 below:

Figure 1 – Planning continuum



Critical will be balancing the unique, but mutually dependent, workforce requirements and needs arising from each of the four levels. The key workforce planning considerations required at all levels are the same:

- Detailed qualitative and quantitative profile the current workforce
- Skill profile of current workforce
- Need for a current and future service profile
- Labour market intelligence for staff group/speciality/geographic distribution

The Regional Delivery Plan will present the profile of the West of Scotland population and will recognise significant cross boundary flow from areas of Highland and the Island Boards, and Scotland as a whole due to the provision of some specialist tertiary services for NHS Scotland as a whole within the West Region.

7. Regional Workforce Planning – Way Forward

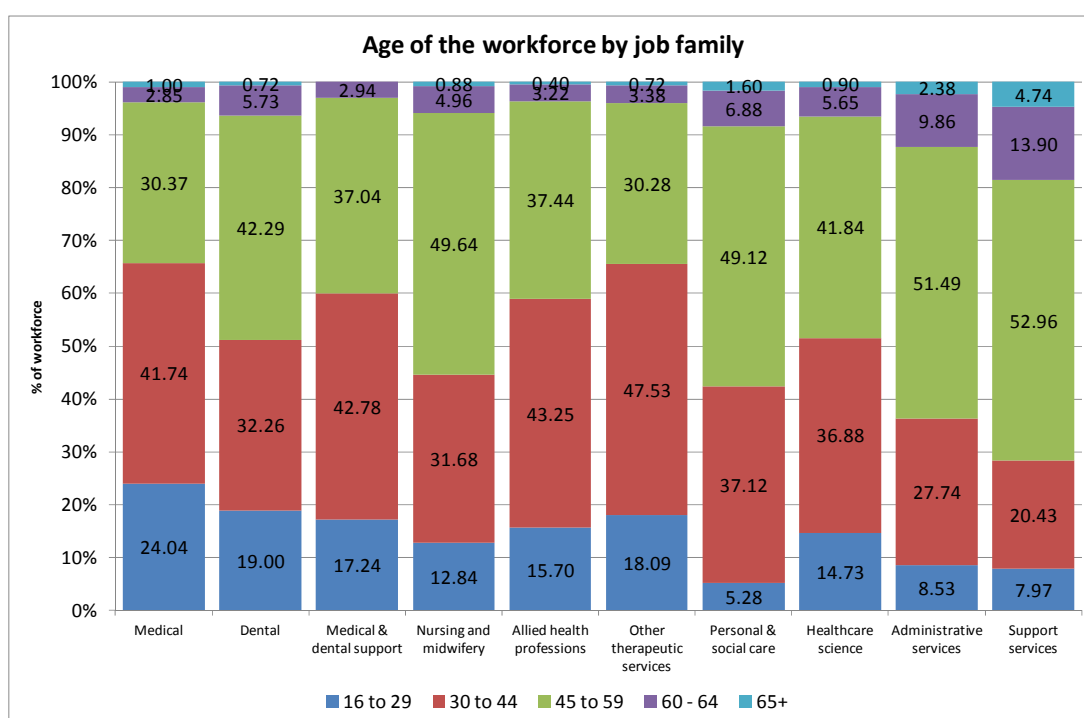
- 7.1. Standardised data collection – workforce information and numerical data should be gathered in a consistent regional format to allow for aggregation into regional documents.
- 7.2. Additional workforce planning capacity – additional resources should be identified for Regional workforce planning, identifying the limitations of the current Board workforce planning capacity.
- 7.3. Quantitative data needs to be augmented with soft, qualitative data to enable decision making and risk assessment to be made with a full picture including gathering information from the frontline.
- 7.4. There is a need for work at national level, via NES and NSS, in partnership and collaboration with the regions to ensure appropriate information and

intelligence is sourced, used and understood consistently in a 'Once for Scotland' manner.

- 7.5. HR Recruitment teams should establish real time labour market intelligence at Board, Regional and National level, which will enable recruitment processes to be intelligence driven and will help inform education need.
- 7.6. Interventions to develop the West Region workforce should be skill focused and matched to the SCQF Framework so each intervention is matched to an education level.
- 7.7. West Region should undertake detailed multi-professional workload and workforce planning to support service redesign and change. Effective use of existing resources will be essential as will gaining an understanding of current utilisation of the workforce and the ongoing implications of retaining and up skilling the existing workforce, many of whom will remain part of the workforce for the next 5-10 years.

The age of the West Region workforce, by job family, is shown in Chart 5:

Chart 5 – Age of WoS Workforce by Job Family



- 7.7.1. The older population is also reflected in our workforce profile, this will affect the availability and fitness of the West Region workforce. An older workforce will bring both challenges and opportunities and all the West Region health boards are developing new approaches which will support older staff to remain in employment longer e.g. less physically demanding roles, reduced hours and flexible working.

7.7.2. Labour markets are changing, this includes the length of service, of our workforce influenced by changing pension provision; for example an employee born in 1981 will not draw their state pension until they are 68 years old (on the assumption there is no change to the state pension age of 68 being introduced by 2039), if they start work or education at 17 this makes their potential working life 51 years long. There are also now five generations in the workplace, ensuring the strengths and skills of each generation is capitalised on will be a core part of regional planning, whilst acknowledging the changing personal circumstances of such a diverse workforce.

With any intervention planning the length of time to train the required workforce should be factored in to preparation timelines, as well as backfill requirements, location and availability of training.

7.7.3. A similar approach will be required to define the generic support worker role and the education needs of this worker. It may not be possible to determine the exact numbers of each role required and so an initial estimate of need should be agreed and used for the purposes of development. Professions should be able to define their unique professional contribution and identify tasks which can be delegated and carried out effectively by support workers.

7.7.4. In a rapidly changing care environment with continual advances in care, there needs to be a cultural shift to accept that there will be a need for roles which may not have existed before. Listening to the workforce and understanding the detail of challenge will support appropriate intervention on careers, development and education. This further strengthens the need for qualitative and consultative intelligence on workforce and labour market availability, skill requirements and career satisfaction.

7.8. West Region health boards should work with Regulators, Scottish Government and Higher and Further Educational Institutions to ensure that the development of education programmes and curriculum are in line with the future healthcare needs, and have sufficient focus on community care. Future skills and treatment interventions will inform education need.

7.9. It is envisaged that Advanced Practice roles will be an integral part of building capacity and capability within the West Region workforce. The development of extended roles and initiatives such as intravenous therapy, advanced practice, non medical prescribing and the extension of the health care support worker role will require engagement with HEIs and the GP community. West Region health boards are fully engaged in the national agenda to develop the roles of community practitioners, ensuring new models meet the needs of people using services.

End.

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

Radiology

Challenges

Vacancies are a growing trend, with a sustained inability to fill advertised posts, of which in some of the West Region Boards these have been enduring vacancies over many years. This mirrors the position across wider NHS Scotland and the UK as a whole

In terms of sub-specialisation within radiology specific pressure points across the region include: GG&C - Neuro Radiology and Neuro Interventional Radiology; Breast Radiology is flagged as a challenge across all West Region Boards.

Predicted CCT, as illustrated in the charts, for 2018 could be absorbed solely by the West of Scotland Region. Attraction and retention is the key issue across all Boards where there is an inability to replace retirees, without considering additionality arising from service development.

The largest pressures are in D&G, FV and A&A as illustrated in the vacancy charts.

Demand

Radiology services in the UK are described by the Royal College of Radiologists as being in crisis. There is a highly competitive labour market, making job design critical to attraction. The ever increasing role of imaging in modern clinical care has led to a high increase in demand, particularly in complex imaging including CT and MR scans which has outstripped the ability of current services to cope.

Existing models of mitigation

- Plain film reporting contracted out in some Boards
- Retired Consultants providing locum / bank capacity however this is limited by SPPA limitations on hours that may be worked (up to 16 hours per week)
- Collaboration on capacity across Boards

Potential future mitigation of risk

- Expansion of Radiographer clinical reporting and initial commenting – further development of Advanced Practice roles to support the service
- Regional concept of model of delivery
- Networks of expertise supporting the West Region
- National Radiology Shared Services implementation and impact

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

Gastroenterology

Challenges

There is a trend of increasing vacancies, compounded by a number of impending vacancies particularly at a lower retirement than may have been expected (mid-50s) have been reported by some Boards.

There are insufficient numbers going through training; in 2018 there is only one expected CCT, in addition to the current number of 13 wte vacancies, a further 8 wte are expected to retire in 2018.

Demand

There is an increased demand for diagnostic gastroenterology, the rollout of Bowel Screening has been the greatest contributor to the increase, as such this demand could have been anticipated.

Media campaigns have increased public awareness of bowel cancer, increasing referrals. Changes in demography and disease incidence is also attributable

National UK studies anticipate a 40% increase in demand, from 2016 to 2020

Existing models of mitigation

- Nurse Endoscopists / Consultant Nurse Specialists / Specialist Nurses
- Planned care review under taken by Advanced Nurse Practitioners
- Direct to test vetting to improve efficiency
- Specialist Nurses

Potential future mitigation of risk

- Review the model of service delivery across the West Region to best capitalise upon economies of scale with existing resource
- Increase Advanced Nurse Practitioner / range and scope of specialist nursing roles to better support delivery of gastroenterology services
- Physician Associate roles open up a new labour market which has as not yet been systematically utilised within the West of Scotland region unlike other regions. The lead in time for Pas being 2 years.

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

Histopathology

Supply

The vacancy rate has increased significantly with workforce demand currently outstripping supply – a number of Boards have had several rounds of advertising with limited success e.g. A&A have had four rounds of recruitment with only one Consultant recruited

There are currently 13 wte vacancies, with a further 2 wte expected in 2018, this is set against a CCT 2018 supply of 6 headcount, effectively the West Region could subsume the entire CCT output and this would still result in a staffing deficit.

Demand

Pathology is involved in 70% of all diagnostics. Rising disease prevalence and increased incidence of cancer is the primary driver for the demand increase.

The demand is anticipated to steadily increase, with the predicted pattern of retirement there will be a shortage of Consultant Pathologists.

Existing models of mitigation

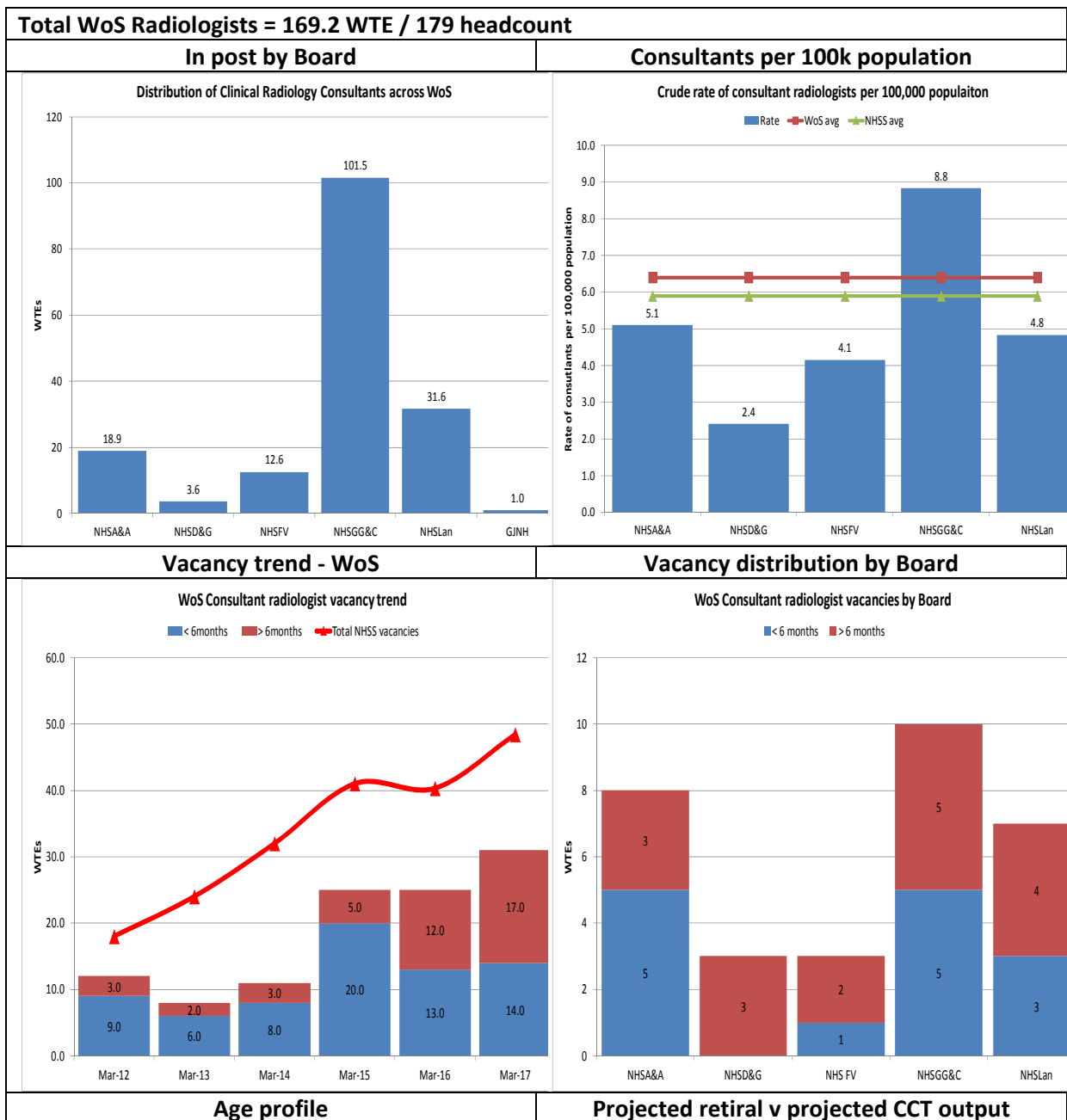
- Bio-medical scientists undertaking dissection
- Out-sourcing of some reporting

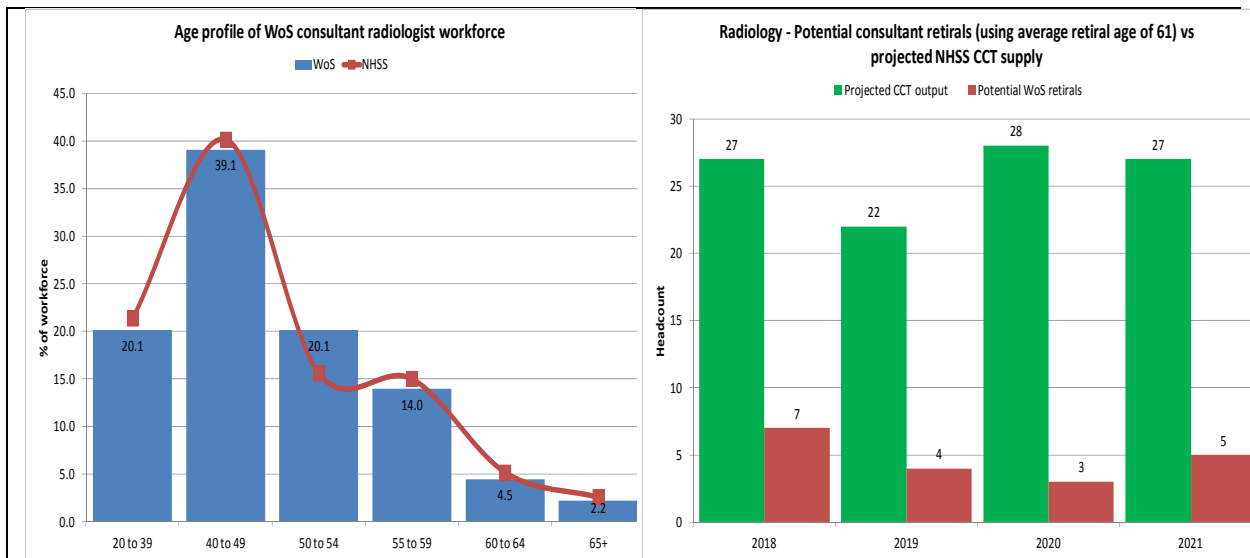
Potential future mitigation of risk

- Out-sourcing of service
- SLA with other Boards in the West Region
- Physician Associate roles open up a new labour market
- Bio-medical science reporting – in its infancy at a national level
- Roles for clinical scientists

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

Clinical Radiology detail

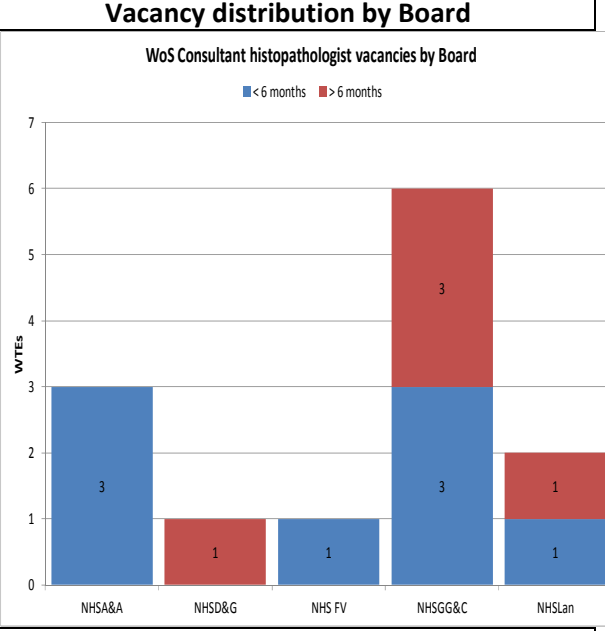
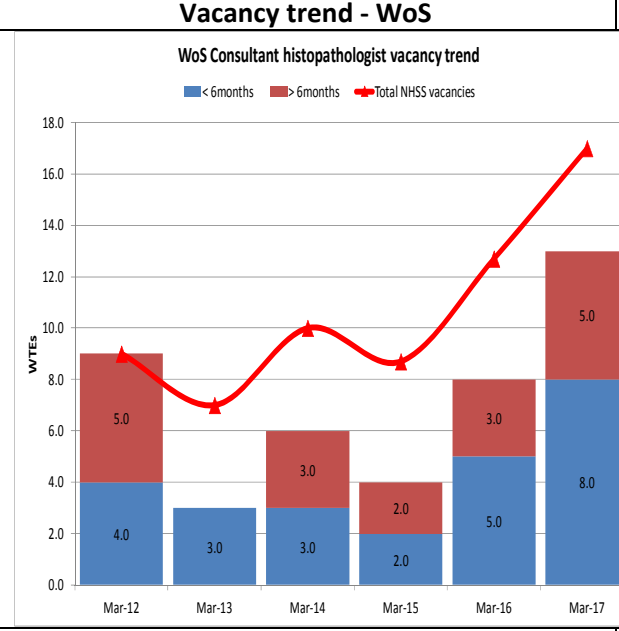
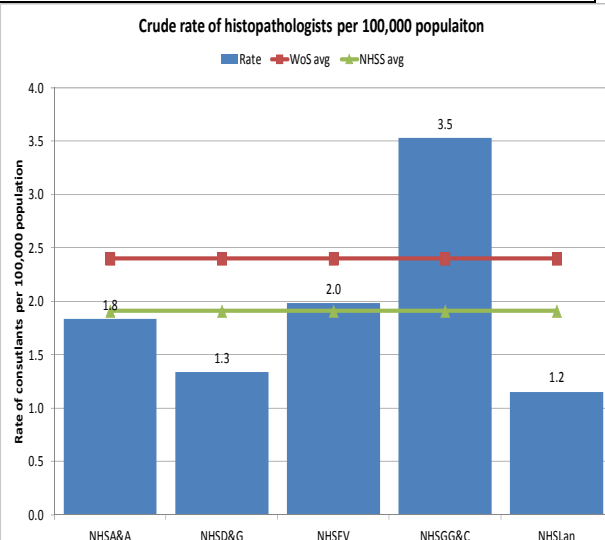
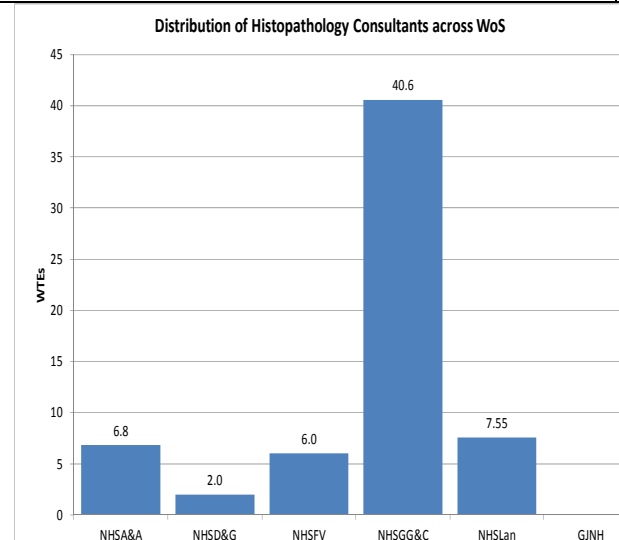
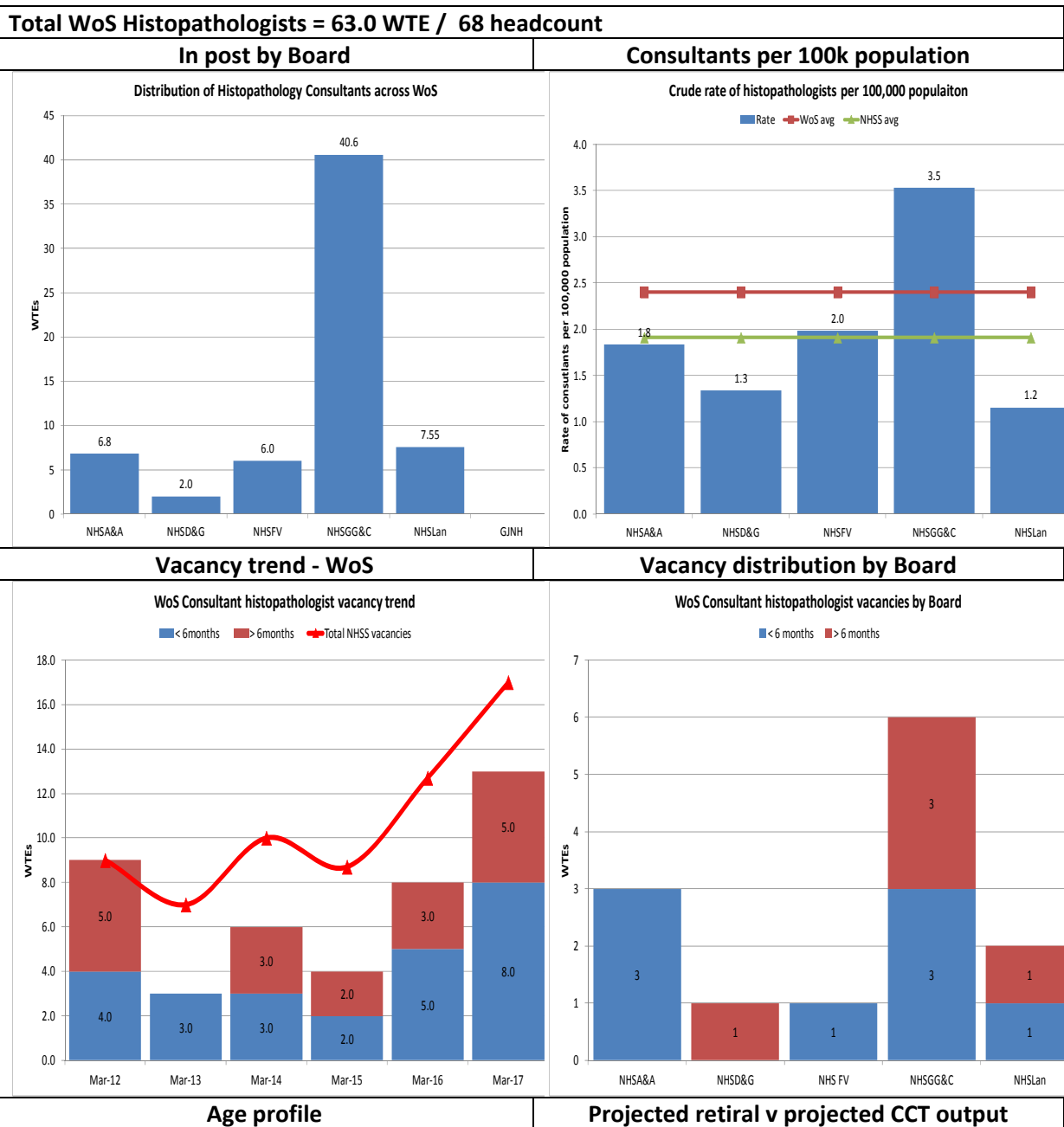




Clinical radiology – narrative summary

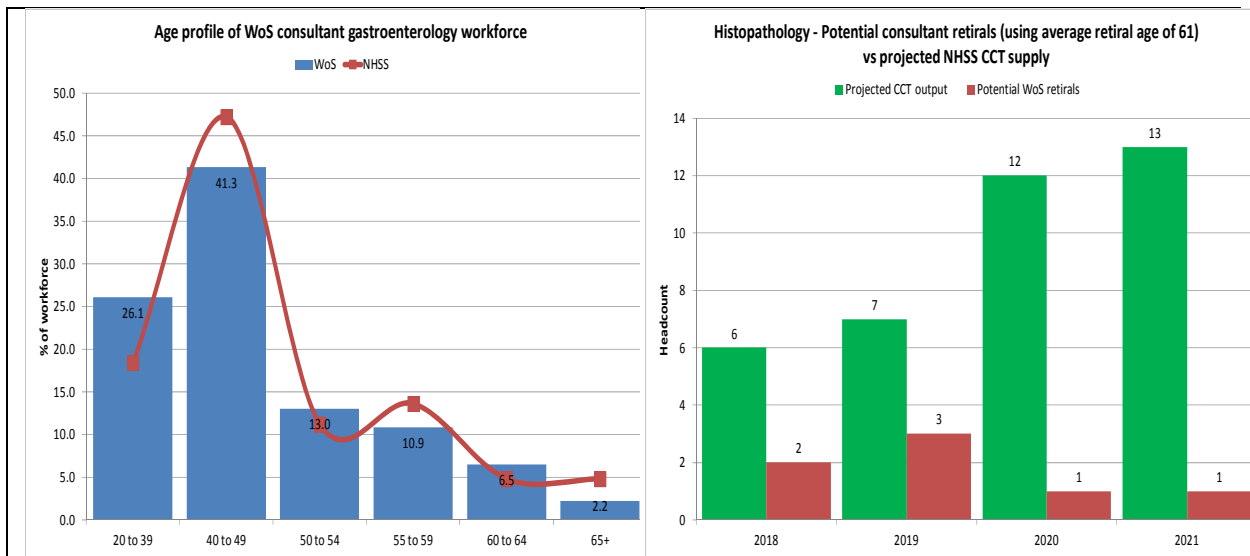
Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

Histopathology detail



Age profile

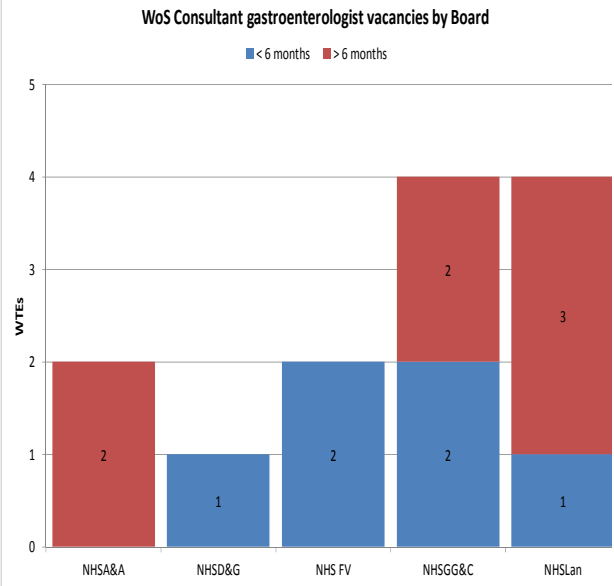
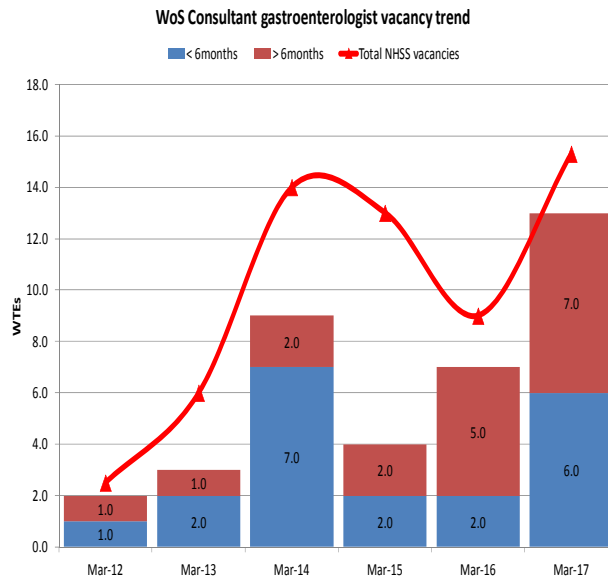
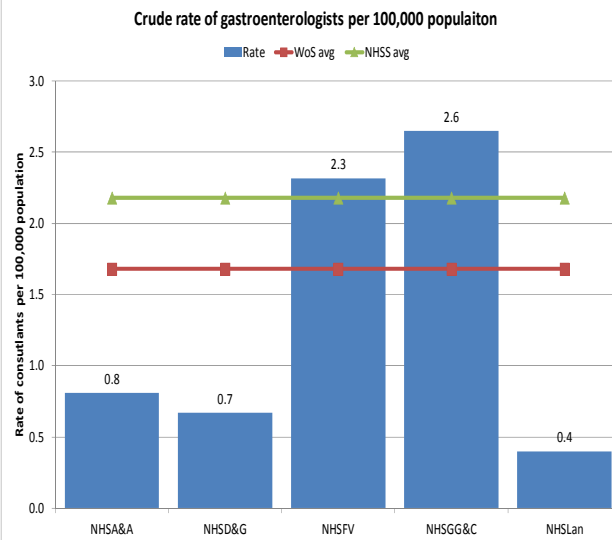
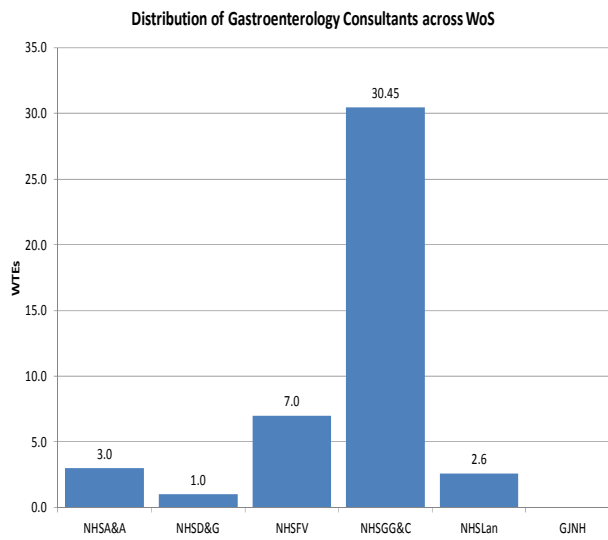
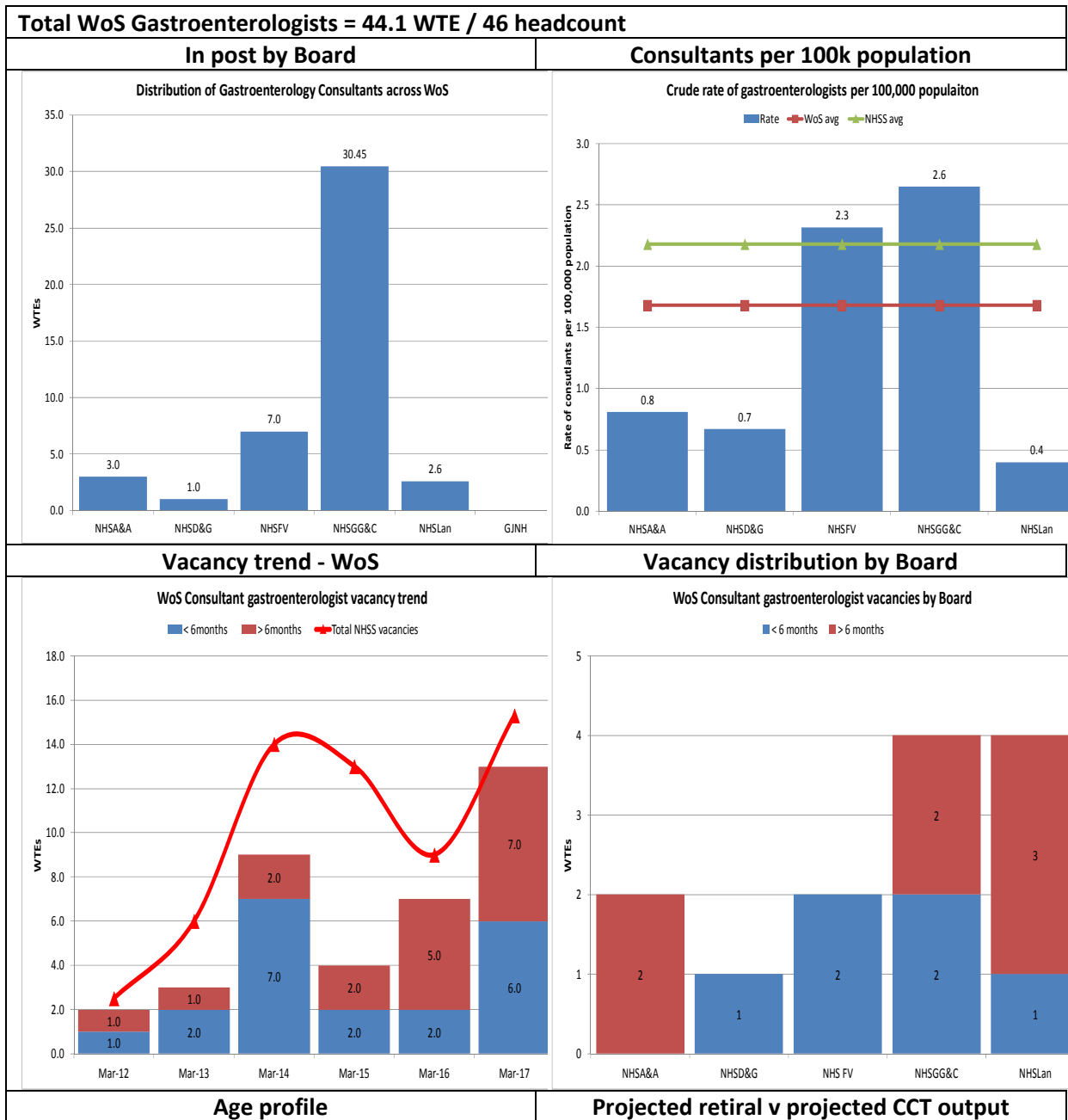
Projected retiral v projected CCT output



Histopathology – Narrative summary

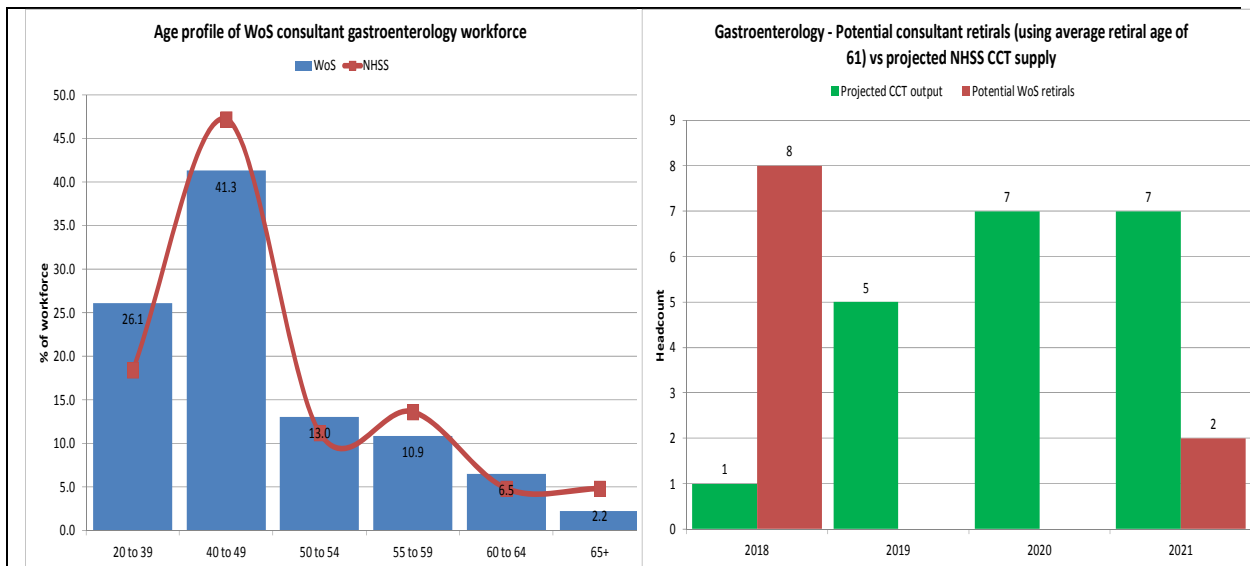
Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

Gastroenterology detail



Age profile

Projected retiral v projected CCT output



Gastroenterology – narrative summary

Planning and delivering care and treatment across the West of Scotland

Communications plan

1. Introduction

1.1 This communications plan has been developed to support the implementation of the West of Scotland Delivery Plan. It sets out the approach that will be taken to engage with key stakeholders on the plan, to communicate the national and historical context within which the plan has been developed and to highlight the benefits that will be realised for patients, communities and staff.

1.2 It also outlines the measures that will be taken by the West of Scotland Communications Teams to ensure consistency of message, co-ordination of timescales and a single 'once for the West of Scotland' approach to maximise effective use of resources and avoid duplication.

2. Background

2.1 The Scottish Government published the Health and Social Care Delivery Plan in December 2016, which sets out the importance of delivering:

- better care;
- better health; and
- better value.

2.2 The Health and Social Care Plan outlines the need to look at services on a population basis and to plan and deliver services that are sustainable, evidence-based and outcome-focussed. By working more collaboratively, NHS Boards, Integration Joint Boards and other partners can plan and deliver services more effectively, so as to provide better patient outcomes and more efficient, consistent and sustainable services.

2.3 At regional level, the Scottish Government has commissioned Regional Delivery Plans to be developed, encompassing a whole-system approach to the delivery of health and social care for each of the three regions (North, East and West).

- 2.4 For the West of Scotland, this involves planning for the population of 2.7 million, which is covered by five NHS Boards, 16 Local Authorities and 15 Health and Social Care Partnerships, as well as the Golden Jubilee Foundation.
- 2.5 The national NHS Boards are also developing a single plan that sets out the national services where improvement should be focused, including, where appropriate, a ‘Once for Scotland’ approach in areas such as digital services, clinical demand management and support services.
- 2.6 To take forward the national and regional approach, five Chief Executives have been appointed to the role of National or Regional Implementation Lead.
- 2.7 The West of Scotland partners are required to produce a first Regional Delivery Plan by March 2018, and seek the support of Health Boards and Integrated Joint Boards to work collaboratively to achieve the best outcomes delivered sustainably for everyone across the West of Scotland.

3. Positioning our communications: national and historical context

- 3.1 The one constant in the NHS is change. The 70th anniversary of the NHS is a fitting backdrop to demonstrate to our communities just how much change has already taken place and how modern healthcare will continue to evolve, providing better care and better outcomes.
- 3.2 This is a key theme within the communications and engagement strategy created by the Scottish Government to support the delivery of the National Delivery Plan. That strategy provides a national framework to which all regional activity can be aligned.
- 3.3 All our communications will reflect the language and positioning of change as recommended within the national communications strategy, including:
- the use of language of evolution and development to explain change rather than the terms ‘radical’ or ‘transformational’;
 - acknowledging people’s affection for their NHS and mentioning the things that are important to them;
 - emphasis on the benefits/advantages for people; and,
 - change and development to be framed within the continuation and improvement of a much loved service.
- 3.4 The regional plan will also be based on the values and principles of the national strategy:



- Meaningful engagement with our staff - where our staff will be our primary audiences, learning first-hand about the Regional Delivery Plan as it affects them
- Meaningful involvement of our communities from the outset as plans develop
- Inclusiveness – reflecting the full diversity of our workforce and our communities
- Openness and transparency
- Collaborative

3.5 Key messages shared by everyone involved in the dialogue will be essential for clarity. Our key messages are:

- Working so the people of West of Scotland can live longer, healthier lives at home or in a homely setting and we have a health and social care system that:
 - is integrated;
 - focuses on prevention, anticipation and supported self-management;
 - will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
 - focuses on care being provided to the **highest standards of quality and safety, whatever the setting**, with the person at the centre of all decisions; and
 - ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.
- Healthcare / health and social care / the NHS in Scotland has been **continually evolving over the years** as new treatments, technology and service developments have emerged. Our health and social care system **will always evolve to deal with society's health challenges and to provide excellent care.**
- Health and social care provision is different in Scotland. We have found our own solutions to the challenges we face which give us a solid foundation from which to build. We must **continue to develop to provide the highest quality of health and social care** to the people of Scotland.

3.6 These messages will continue to develop as the regional delivery plan evolves.



4. Our audiences

4.1 The following audiences have been identified although this may be further segmented when the messages evolve.

- **Internal:**
 - NHS Boards - Chairs, Non-executive members and Employee Directors
 - Chief Executives and executive teams - Medical Directors, Nursing Directors, Directors of Finance, Directors of Public Health, Chief Operating Officers, HR Directors, Workforce and Planning Directors
 - Integrated Joint Boards
 - Area Partnership Forum, Trades unions,
 - GPs, Pharmacists and Dentists
 - Staff directly affected by the changes
 - All other staff

- **External:**
 - Patients and carers
 - Third sector organisations
 - Elected members: local councillors, MSPs and MPs
 - Community Planning Partners
 - Media
 - General Public

5. Our approach

5.1 Within the West of Scotland we have a well-established Communications Group which works collaboratively to deliver effective communications across a range of issues. This removes duplication and makes best use of the resources available. We will take the same approach with this communications plan. A single point of contact will liaise with the Regional Implementation Lead to develop content and regular updates for use across the region by all boards.

5.2 The Regional Implementation Lead will agree with his fellow Chief Executives on a 'once for the region' approach to communications, with a single authorisation for all communications.

5.3 The Group will collaborate to produce a range of resources that can be used by all boards to help communicate the plan including:

- Case studies – case studies and people stories will be crucial to evidence that changes is constant and successful and is benefitting patients across the west of Scotland
- FAQs
- Digital resources including animations and infographics



- Core content as newsletters and as editorial copy to be used in local communications

5.4 Each board will use its existing and well-established channels to communicate the regional updates with its own audiences:

- Staff communication channels
- External communications channels:
 - Print publications
 - Public websites
 - Social media
 - Third sector organisations
 - Patient groups
 - Media releases, editorial, events

5.5 As far as is practical, all boards will co-ordinate the publication of updates so that information is being shared with audiences within the same timescales.

5.6 Engagement activity with communities will be co-ordinated locally by each board with their established networks and in conjunction with Health and Social Care Partnerships. This will build on the work that the HSCPs have undertaken to inform their Strategic Commissioning Plans which is informing the development of the Regional Delivery Plan. The expectation is that the Boards and HSCPs will be responsible for gathering feedback to inform the draft plan.

5.7 All boards will keep a record of communications activity, including engagement activity, as evidence of engagement and consultation.

6. Budget and costs

This has yet to be determined

7. Timeline

This has yet to be finalised.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 22nd November 2017

Subject: Chief Social Work Officer's Annual Report 2016 - 2017

1. Purpose

1.1 The attached report presents the West Dunbartonshire Chief Social Work Officer's Annual Report for the period 1st April 2016 to end of March 2017.

2. Recommendations

2.1 The Partnership Board is recommended to:

- i) Receive for its interests the Chief Social Work Officer's Annual Report with its associated appendices.
- ii) Note that Chief Social Work Officer's Annual Report with its associated appendices was presented to the Council on the 25th October 2017.

3. Background

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

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

3.3 At its August 2015 meeting, it was confirmed that the CSWO would provide a separate annual report on care governance to the Partnership Board. The West Dunbartonshire Chief Social Work Officer's Annual Report for the period 1st of April 2016 to 31st March 2017 is attached. This report was presented to the full meeting of the Council on 25th October 2017.

4. Main Issues

4.1 It is a statutory requirement that every local authority should appoint a professionally qualified Chief Social Work Officer. This requirement and the statutory guidance was initially set out in the Social Work (Sc) Act 1968. The particular qualifications are set down in regulations. Revised and updated

National Guidance was published in July 2016 and sent to all Chief Executives.

- 4.2** With respect to governance of social care, the Chief Social Work Officer reports to the Council on the delivery of safe, effective and innovative social work services and the promotion of values and standards of practice. The role of the CSWO is to provide professional governance, leadership and accountability for the delivery of social work and social care services, not only those provided directly by the HSCP but also those commissioned or purchased from the voluntary and private sector. Social work services are delivered within a framework of statutory duties and powers and are required to meet national standards and provide best value.
- 4.3** The Scottish Government's Clinical and Care Governance Framework states that all aspects of the work of Integration Authorities, Health Boards and local authorities should be driven by and designed to support efforts to deliver the best possible quality of health and social care. The national framework directly informed the development of the Clinical & Care Governance sections of the approved Integration Scheme for West Dunbartonshire.

5. People Implications

- 5.1** The National Clinical & Care Governance Framework reaffirms the regulatory frameworks within which health and social care professionals practice and the established professional accountabilities that are currently in place within the NHS and local government; and that all health and social care professionals remain accountable for their individual clinical and care decisions. The Health & Social Care Partnerships local arrangements place a clear emphasis on clinical and care governance being led by and within operational service areas.

6. Financial Implications

- 6.1** Financial implications arising from the issues identified in the CSWO report will be included in future reviews of the Partnership Board's and the Council's long term financial strategies. Some aspects of Scottish Government legislation and policy initiatives come with some financial uncertainty due to potential demands associated with new or extended policy initiatives.

7. Professional Implications

- 7.1** The CSWO reports to the Council on the delivery of safe, effective and innovative social work services and the promotion of values and standards of practice. The Integration Scheme for West Dunbartonshire confirms that:
- The CSWO will provide appropriate professional advice to the Chief Officer and the Partnership Board in relation to statutory social work duties and make certain decisions in terms of the Social Work (Scotland) Act 1968.

- In their operational management role the Chief Officer will work with and be supported by the CSWO with respect to quality of integrated services within the Partnership in order to then provide assurance to the Partnership Board.
- The CSWO will provide an annual report on care governance to the Partnership Board.

7.2 There are several areas that concern specific professional issues within the attached Annual Report. These principally include the need for staff and managers to ensure professional registrations are kept up to date and the need to deliver services that comply with national standards.

8. Locality Implications

8.1 There are no locality implications in respect of this report.

9. Risk Analysis

9.2 Effective clinical and care governance arrangements need to be in place to support the delivery of safe, effective and person-centred health and social care services within integrated services. To this end the current structure of the Clinical and Care Governance functions of the HSCP are being reviewed to ensure they are effective.

9.3 There is a risk to both the Council and the Partnership Board if social work functions are not delivered to an appropriate standard. Members need to be satisfied that proper arrangements are in place to ensure sound governance of social work functions. It has previously been agreed that consideration of the Chief Social Work Officer's Annual Report would give Members the opportunity to satisfy themselves that the delivery of social work functions is being properly conducted within local organisational arrangements.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 The Chief Social Work Officer's Annual Report has been compiled with contributions from and reflects the commitment of the staff across the Health & Social Care Partnership.

12. Strategic Assessment

12.1 The key messages and learning from the work detailed within the Chief Social Work Officer's Annual Report reflect a consideration of the progress and impacts of delivering the Strategic Plan; and will directly inform the on-going development of the next Strategic Plan.

Author: Jackie Irvine - Chief Social Work Officer
West Dunbartonshire Council & HSCP

Date: 10th October 2017

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Appendix: West Dunbartonshire Chief Social Work Officer's Annual
Report 2016 -2017

Background Papers: None

Wards Affected: All



Chief Officer: Beth Culshaw



WEST DUNBARTONSHIRE

CHIEF SOCIAL WORK OFFICER'S ANNUAL REPORT 2016 - 2017

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Foreword

It is my pleasure to provide my fifth Chief Social Work Officer's report in West Dunbartonshire. I would like to acknowledge all the colleagues who have supported me in the provision of relevant material for inclusion in this report.

The requirement for each Council to have a Chief Social Work Officer (CSWO) was initially set out in the Social Work (Sc) Act 1968 and further supported by Section 45 of the Local Government etc (Scotland) Act 1994. The role of the CSWO is to provide professional governance, leadership and accountability for the delivery of social work and social care services, not only those provided directly by the Council or HSCP but also those commissioned or purchased from the voluntary and private sector. Social work services are delivered within a framework of statutory duties and powers and are required to meet national standards and provide best value.

The purpose of this report is to provide Council with information on the statutory work undertaken on the Council's behalf during the period 1st April 2016 to 31st March 2017. This report will be posted on the Council website, the Health and Social Care Partnership website and will be shared with the Chief Social Work Advisor to the Scottish Government.

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1. Chief Social Work Officers Summary or Performance, Key Challenges, Developments and Improvements.

- 1.1 In the first full financial year as a Health and Social Care Partnership (HSCP) the focus has been on further embedding the principles, reporting and governance requirements necessary in respect of meeting the duties laid out in the Scottish Government's Public Bodies (Joint Working) Act (Scotland) 2014.
- 1.2 West Dunbartonshire was well placed in making this transition given the significant integration already realised under the Community Health and Care Partnership (CHCP) established in October 2010.
- 1.3 Further progress has also been made in the operational delivery of health and social care services in line with the benefits and the efficiencies to be achieved from integration.
- 1.4 It is acknowledged by the Senior Management Team of the HSCP that West Dunbartonshire has benefited from the history of partnership and integrated working. In this regard a significant amount of joint arrangements were already in place in terms of;
 - single financial accounting – of the Council and the NHS budget management and oversight;
 - aligned and merged Human Relations management and associated policies;
 - a Joint Staff Forum representing all of the Unions representing staff across health and social care delivery;
 - joint service delivery teams particularly in relation to adult and older peoples services.
- 1.5 In terms of overall demand we have seen child protection and child welfare referrals rise considerably within the period that this report covers. Further detail of this rising demand is provided in Section 7.7 Child Protection page 25.
- 1.6 Whilst the response to this demand clearly illustrates good practice, in that the children and families teams are responding to those in need of care and support it also causes a likewise impact on the need for resources in the form of accommodating children and staff time.
- 1.7 This relationship between demand and resources can be illustrated by some of our areas of financial pressure as experienced in 2016 to 2017.
 - In relation to Kinship Care, which allows children to be cared for by a relative or friend within their own community, we have seen a rise from 127 children in kinship placements in 2015/16 to 158 in 2016/17. In terms of budget this takes the total cost to £1,012,168 for 2016/17. As we are encouraged through policy directives and good practice to place

children within their own communities with Kinship carers this demand and cost pressure is likely to rise.

- For Children's Residential Care and Care in the Community spend rose by £188,000 in 2016/17
- Similarly due to rising demand for Care at Home Services (Home Care) there has led to a rise in expenditure of £256,000.

1.8 Section 8 of this report provides detail of our overall performance and there are a number of high performing areas across the services provided by the HSCP and evidence of service user satisfaction in the quality and type of services they receive with clear evidence of clear improvements and successes.

2. Local Authority Overview and Delivery Landscape

Integration

- 2.1 The Health & Social Care Partnership Board is responsible for the operational oversight of West Dunbartonshire Health & Social Care Partnership (WD HSCP), which is the joint delivery vehicle for those services delegated to the Integration Joint Board; and through the Chief Officer, who is responsible for the operational management of the Health & Social Care Partnership. These arrangements for integrated service delivery have been conducted within an operational service delivery framework established by the Health Board and Council for their respective functions, ensuring both organisations can continue to discharge their governance responsibilities.
- 2.2 West Dunbartonshire HSCP, as was the case with the previous construct of the CHCP, brings together the full complement of service including Children's Social Work and Criminal Justice Services. This is variable across the rest of Scotland and indeed within the Greater Glasgow and Clyde Health Board.
- 2.3 The Strategic Plan for 2016-2017 is one of the main requirements of the HSCP Integrated Joint Board and was developed in consultation with community representatives and key stakeholders. The Strategic Plan describes the priorities for the HSCP and sets out clearly the agreed outcomes and priorities for action, resource allocation and spend against the national health and well-being indicators.
- 2.4 As Chief Social Work Officer, I fully support and endorse the work that has been undertaken in establishing a clear construct for the HSCP and in the development of a comprehensive integration scheme and Strategic Plan for 2016-2017.
- 2.5 In addition it is my professional view that this full complement of services within the HSCP is essential both from a collaborative point of view but also ensures all services are mindful of the contribution they make across the range of public protection requirements which are a statutory function in respect of social work delivery.

Demographics

- 2.6 West Dunbartonshire lies north of the River Clyde encompassing urban and rural communities. According to the National Records for Scotland, the 2016 population for West Dunbartonshire is 89,860; an increase of 0.3 per cent from 89,590 in 2015. The population of West Dunbartonshire accounts for 1.7 per cent of the total population of Scotland.
- 2.7 In West Dunbartonshire, 17.5% of the population are aged 0-15 which is slightly higher than Scotland which sits at 16.9%. In the next age group 17.2 per cent of the population are aged 16 to 29 years. This is smaller than Scotland where 18.2 per cent are aged 16 to 29 years. Persons aged 60 and

over make up 24.4 per cent of West Dunbartonshire which matches the proportion of people aged 60 and over in the Scotland population.

2.8 National and local evidence indicates that the population of West Dunbartonshire is ageing due to a combination of factors: that the number of births within the area is dropping; the number of people migrating to other council areas within the 15 – 44 age group is increasing; and the number of deaths registered annually is falling.

2.9 West Dunbartonshire's Social and Economic Profile 2017 shows that we have seen relatively large increases in our share of the 20% most deprived data zones in Scotland, showing the biggest increase in relative deprivation from 2012. Our Strategic Needs Assessment reflects that we have high levels of people with long term and complex conditions, often linked to the history of heavy industry in the area, with related diseases affecting people at a relatively young age. Because of this, our commitment to work together in shifting the balance of care and support is delivered to people from hospital to community settings and most importantly in people's homes; thereby supporting a whole population approach to improved health and wellbeing.

Commissioning

2.10 WDHSCP cements together both NHS and local authority responsibilities for community-based health and social care services within a single, integrated structure; this partnership has been expanded to establish a Market Facilitation Consortium model of market analysis 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.

2.11 The Market Facilitation Consortium is grounded in the fundamental principles of ensuring a comprehensive partnership approach across all sectors providing health and social care services; a commitment to provide enhanced delivery of service to individuals and communities and a need to create diversity within the market place based on population needs.

2.12 This Consortium approach provides a robust framework for all partners, across age groups and care groups; with clarity of roles, responsibilities, expectations and opportunities for each sector partner described within the context of market facilitation.

2.13 The purpose of the Consortium is to:

- Create, develop, maintain and grow high quality service delivery in and around West Dunbartonshire in order to service the needs of local people and communities; especially those who are most disadvantaged;
- Create and deliver flexible and holistic service packages which are joined up and responsive to need and demand;

- Augment provision through the ability of service providers to maximise resource efficiency and support the development of sustainable community capacity.

2.14 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.

2.15 During 2016/17 the Partnership Board approved its commissioning objectives to improve unscheduled care for residents of West Dunbartonshire. At the heart of these comprehensive commissioning intentions is a commitment to invest, redesign and deliver an effective infrastructure of community services.

3. Partnership Working – Governance and Accountability Arrangements

Role and Function of the CSWO

- 3.1 It is a statutory requirement that every local authority should appoint a professionally qualified Chief Social Work Officer. This requirement and the statutory guidance was initially set out in the Social Work (Sc) Act 1968. The particular qualifications are set down in regulations. A recent review took place in respect of the National Guidance and this was published in July 2016.
- 3.2 The revised statutory guidance was issued to local authorities by Scottish Ministers under section 5 of the 1968 Act. This guidance is for local authorities and is also relevant to bodies and partnerships to which local authorities have delegated social work functions. In recognising the democratic accountability which local authorities have clarity and consistency about the role and contribution of the CSWO are particularly important given the diversity of organisational structures and the range of organisations and partnerships with an interest in the delivery of social work services.
- 3.3 The role of the Chief Social Work Officer relates to all social work services, whether they be provided by the local authority or purchased from the voluntary or private sector, and irrespective of which department of the Council has the lead role in providing or procuring them.
- 3.4 The recent guidance is intended to support local authorities in effectively discharging their responsibilities for which they are democratically accountable and to help local authorities maximise the role of the CSWO and the value of their professional advice – both strategically and professionally. It is also aimed at assisting Integrated Joint Boards (IJBs) to understand the CSWO role in the context of integration of health and social care brought in by the Public Bodies (Joint Working) (Sc) Act 2014.
- 3.5 There is a small number of duties and decisions, which relate primarily to the curtailment of individual freedom and the protection of both individuals and the public, which must be made either by the Chief Social Officer or by a professionally qualified social worker to whom the responsibility has been delegated by the Chief Social Work Officer and for which the latter remains accountable. These include:
 - Deciding whether to implement a secure accommodation authorisations in relation to a child, reviewing such placements and removing a child from secure accommodations if appropriate;
 - Transferring a child on a supervisions order in cases of urgent necessity;
 - Acting as a guardian to an adult with incapacity where the guardianship functions relate to personal welfare of the adult;
 - Decisions associated with the management of drug treatment and testing orders;
 - Carrying out functions as the appropriate authority in relation to a breach of a supervised release order, or to appoint someone to carry out these functions.

Partnership Working – Systems and Structures

- 3.6 As CSWO I chair the following area wide meetings; Child Protection Committee (CPC), the Children and Families Delivery and Improvement Group (DIG) and the Violence Against Women Strategy Group (VAWSG), the latter of which I currently chair on behalf of West Dunbartonshire and Argyll and Bute local authorities as a joint strategy group.
- 3.7 In order to ensure that I am effective in carrying out my duties with respect to assurance and accountability of the full range of social work functions I also attend the following meetings: the Community Planning Management Group, the Public Protection Committee, The Safe and Strong Delivery and Improvement Group, the Integrated Joint Board (IJB), the Audit Committee of the IJB and the Clinical and Care Governance Senior Management Team as well as the Clinical and Care Governance Forum.
- 3.8 I attend Council when providing specific advice or support in the form of a report to Council and I am aware of the Agenda for Council in advance so that I can consider areas that may require additional advice in my role as CSWO.
- 3.9 It is important to note the voluntary and third sector is represented at most of these partnership groups and as such the vehicle for engagement with the Third Sector is via West Dunbartonshire Community Voluntary Services (WDCVS).

Community Justice Reform

- 3.10 With effect from April 2016 responsibility for planning and delivery of community justice is the responsibility of local community justice partners. The statutory partners are:
- Local Authorities;
 - Health Board;
 - Police Scotland;
 - Scottish Fire and Rescue Service;
 - Skills Development Scotland;
 - Integration Joint Boards established by virtue of section 9 of the Public Bodies (Joint Working) (Scotland) Act 2014;
 - Scottish Courts and Tribunals Service;
 - Scottish Ministers (Scottish Prison Service, Crown Office and Procurator Fiscal Service).
- 3.11 Statutory partners were required to produce a local plan for community justice, a Community Justice Outcomes and Improvement Plan. The focus of partners in 2016-17 was the preparation of a Local Outcome Improvement Plan for 2017-18. Local authorities received funding to support the preparation of a transition plan. This funding was pooled by the then Community Justice Partnership authorities (Argyll and Bute, East and West Dunbartonshire) to create a Transitions Officer to

work across the three authorities for the transition period of a year. This enabled a consistent and efficient approach to the production of local plans.

3.12 As CSWO I was previously the lead for the Community Justice Partnership and in moving to the new structure was familiar with the justice landscape, the strategic and operational relationships between authorities and with statutory partners and other relevant organisations. The rationale driving the national strategy for community justice is that the issues underpinning offending are complex, beyond the power of any single agency to resolve and may have aspects which have particular importance in certain localities, for instance the persistently high levels of reported domestic violence in West Dunbartonshire

3.13 Reporting of progress and key challenges for the West Dunbartonshire Community Justice Partnership will be via the Safe and Strong Delivery and Improvement Group to the Community Planning Management Group. This will include an element of reporting on the performance of the Criminal Justice Social Work Service however performance in relation to this service will in the main be through the IJB given that Criminal Justice is included within the integrated partnership, for which I have lead responsibility as both the CSWO and the Head of Service for this area of social work delivery.

Locality Engagement Networks (LENs)

3.14 We have continued to develop our locality arrangements – in tandem with our support for the development of local primary care quality clusters - to provide forums for professionals, communities and individuals to inform service redesign, transformational change and improvement.

3.15 This includes strengthened development of our Local Engagement Networks (LENs) for each locality area, through engagement with carers, patients, service users and their families. Each LENs looks at issues around distinct community health and social care services and gives people the chance to share thoughts on how the service could be improved. This year's LENs have focused on Frailty, Chronic Obstructive Pulmonary Disease (COPD), services for Care experienced young people and Carers

Quality Assurance

3.16 As CSWO I am able to monitor, influence and improve the quality of social work services through my representation on the above groups, within the local partnership arrangements and through my leadership role. A key role in assuring myself, the Council and the IJB, about the quality and effectiveness of the social work contribution and delivery, is to hear about the experience that partners and users have and to address any deficits in delivery as identified through these processes.

Clinical and Care Governance

3.17 In committing to improving quality, efficiency and effectiveness of our services, the Clinical and Care Governance Framework for the HSCP focuses on ensuring that the care we provide is person-centred, safe, and clinically cost effective. We will continue, through self-assessment and self-evaluation, and performance and service

review, to analyse our long term outcomes and define our success by showing a clear direction of travel and progress across our improvement agenda.

- 3.18 This includes preparing the groundwork for the introduction of the Health and Care Standards for Scotland from 1st April 2018 and the introduction of the public sectors Duty of Candour reporting requirements. The Health,(Tobacco, Nicotine etc and Care) (sc) Act 2016 received Royal Assent on 1st of April 2016 and brings into effect the Duty of Candour under part 2 of this Act as supported by the Duty of Candour (Sc) Regulations 2017.
- 3.19 This introduces a new organisational duty of candour on health, care and social work services as from 1st of April 2018 to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm, as defined in the Act. This duty requires organisations to follow a duty of candour procedure which will include notifying the person affected, apologising and offering a meeting to give an account of what happened. The procedure will also require the organisation to review each incident and offer support to those affected; people who deliver and receive care.
- 3.20 As CSWO I have been instrumental along with the HSCP Senior Management Team in developing Clinical and Care Governance arrangements fit for the new structure of delivering social work services and our local framework works effectively in learning from good practice across the integrated partnership. An example of how this works in practice is that the Clinical and Care Governance Forum brought together all services across the Health and Social Care Partnership (HSCP) to share each services process for quality assurance. This resulted in a robust examination of each process and identification of the benefits of processes across the HSCP to the benefit to areas where quality assurance was less well developed or understood.

4. Resources

4.1 Financial performance is an integral element of the HSCPs overall performance management framework, for both health and Council funding with regular reporting and scrutiny by the Partnership Board and its Audit Committee. The 2016/17 financial performance reports demonstrate that in challenging economic times the requirement to deliver services for best value is being met, whilst maintaining quality and securing continuous improvement.

4.2 The key messages from our first full year of operation during the financial year 2016/17 are:

- On a total budget allocation of £167.693m from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board, including Set Aside and Hosted Services, we ended the year in a positive position.
- Reserve balances were strengthened as a result of 2016/17 favourable outturn position and will be applied in line with the HSCP Board's financial strategy, including transformation projects and underwriting the risk of any future unanticipated events that may materially impact on the financial position of the HSCP Board.
- Approved savings of £0.993m relating to Social Care were delivered in line with the financial plan.
- Approved savings of £1.431m for Health Care were part delivered through Health Board collective savings plans and local savings plans. The balance of £0.909m was funded non-recurrently by Greater Glasgow and Clyde Health Board to allow the HSCP Board to approve savings options at the November 2016 meeting for implementation in 1 April 2017.

4.3 The cost of implementation of the Scottish Living Wage of £8.25 per hour for all adult care workers from 1 October 2016 was calculated at a cost of £0.667m The table below sets out the financial performance of all our services and with the overall position as favourable.

West Dunbartonshire Integrated Joint Board Health & Social Care Partnership	2016/17 Annual Budget £000	2016/17 Net Expenditure £000	2016/17 Underspend/ (Overspend) £000
Consolidated Health & Social Care			
Older People Residential, Health and Community Care	25,966	25,971	(5)
Homecare	12,819	13,075	(256)
Physical Disability	2,742	2,509	233
Children's Residential Care and Community Services (incl specialist)	18,925	19,113	(188)
Strategy Planning and Health Improvement	1,934	1,878	56
Mental Health Services - Adult & Elderly Community and Inpatients	9,872	9,580	292
Addictions	2,961	2,859	102
Learning Disabilities - Residential and Community Services	15,352	15,163	189
Family Health Services (FHS)	23,418	23,418	0
GP Prescribing	19,294	19,294	0
Hosted Services - MSK Physio	6,246	6,064	182
Hosted Services - Retinal Screening	823	745	78
Criminal Justice	46	16	30
HSCP Corporate and Other Services	4,015	772	3,243
Cost of Services Directly Managed by West Dunbartonshire HSCP	144,413	140,457	3,956
Set aside for delegated services provided in large hospitals	17,066	17,066	0
Assisted garden maintenance and Aids and Adaptions	702	702	0
Services hosted by other Integrated Joint Boards within Greater Glasgow & Clyde	11,775	11,775	0
Retinal & MSK Physio Services hosted by West Dunbartonshire IJB for other IJBs	(6,263)	(6,263)	0
Total Cost of Services to West Dunbartonshire HSCP	167,693	163,737	3,956

4.4 The set aside budget for large hospital services is related to the Partnership Board's responsibility for the strategic planning for unscheduled care with respect to the population of West Dunbartonshire. For 2016/17 the reported budget is regarded as "notional" with a corresponding equal "notional" spend. However this will develop in 2017/18 as services are redesigned to shift the balance of care from hospital to community care settings. Good quality community care should mean less unscheduled

care in hospitals, and people staying in hospitals only for as long as they need specific treatment.

4.5 The main financial pressures during 2016/17 were in relation to:

- Homecare (Care at Home Services) – reported a year end overspend of £0.256m as a result of increased demand from our growing older people population requiring more frequent visits to allow them to remain supported at home.
- Children’s Residential Care and Community Care – reported a year end overspend of £0.188m mainly due to an increase in residential and secure placements.

4.6 For 2017/18 and beyond, ongoing financial austerity within the public sector coupled with short term funding allocations make financial planning in the medium term a complex endeavour for the Partnership Board and impacts on the decision making process on how to address funding reductions with the least impact to front line services.

4.7 Service redesign and shifting the balance of care are essential given the projected scale of estimated funding reductions (3%-7%) and demographic challenges in the coming years. The Strategic Plan and its associated commissioning intentions will inform the Partnership Board’s Financial Plan around growing our community based services.

5. Workforce

- 5.1 The first integrated Workforce & Organisational Development Strategy was developed for 2015-18. This included a Support Plan for 2015-16 for the West Dunbartonshire Health & Social Care Partnership and this was endorsed by the Integrated Partnership Board on the 18th November 2015.

The support plan was developed to support the delivery of the overall Strategic Plan. A commitment was provided to the Partnership Board on 18th November 2015 that annual updates would be provided on the Support Plan for the lifetime of the Workforce and Organisational Development Strategy (2015-18). The support plan provides a framework to address priorities and update on progress on the previous year and any areas of concern. As we move forward new guidance for integrated workforce planning for health and social care is expected to be issued in November 2017, which coincides with timescales for an update on our Workforce and Organisational Development (OD) Strategy.

- 5.2 We utilise supervision sessions to discuss career development and learning interventions to support staff which also includes discussions with those interested in becoming the CSWO. Succession Planning is one of the priority areas in the HSCP Workforce and OD support plan and are areas which all Heads of Service in the HSCP are committed to supporting staff development.
- 5.3 There are a few areas which the HSCP has identified through its Workforce and OD Strategy which provide a challenge for recruitment. The ageing workforce within Care at Home Services presents a challenge with over 22% of the workforce over 60, and trend analysis for this group in particular shows staff are choosing to work longer. The Employee Wellbeing Group are looking at strategies to support employee wellbeing and one area they are looking at is how we support older people in the workforce.
- 5.4 The HSCP has introduced a supply list for both Care at Home and Residential Care, which supports service demands but an added benefit is it also allows a route into permanent posts as they become available. Work is underway with Clydebank College to develop a Care Academy and we have had two cohorts of students to date. All students who complete the course are provided with a guaranteed interview for Care at Home or Residential Care supply list.
- 5.5 The other area of workforce risk identified relates specially to Mental Health Officers The HSCP has adopted an approach of a mixture of full-time MHO's and staff who work in a service area and also undertake MHO work on a part-time basis. We currently have one member of staff who is currently undertaking training and two who completed training in 16/17. We will continue to support staff with training to build capacity and capability to meet future

demand and this will continue to be a priority for our Workforce and OD plan for 18/19.

Updates are provided each year to each Head of Services as part of the annual update of the workforce and OD support plan, so we can monitor areas of risk and consider appropriate interventions. The annual update on the Workforce and OD support plan is then presented to the Integrated Partnership Board.

- 5.6 We have established the Workforce Development Group which brings together West Dunbartonshire Council and NHS Greater Glasgow and Clyde Human Relations, Organisational Development, Learning and development and Improvement leads to share learning, identify needs and gaps and plan future interventions. We are looking to expand this group to include staff that are interested in or lead on practice development.
- 5.7 We hold quarterly Clinical and Care Governance Development Sessions with our service managers which facilitates shared of learning and development in respect of practice improvements.
- 5.8 In relation to the Health and Social Care Partnership we are currently supporting a number of staff on leadership programmes both at national level such as Leading for the Future, Collaborative Leadership as well as a number of leadership opportunities which are offered both through the NHS and Council to support staff in frontline leadership and management roles. The managers currently undertaking training are from different levels of management. These courses create opportunities for staff to interface with staff working across other HSCP'S, Local Government and the NHS furthermore it encourages sharing of practice from a range of staff from varying backgrounds and professions and facilitates better understanding of respective roles within an integrated setting.
- 5.9 The Scottish Social Services Council (SSSC) are the main regulatory agency for social care staff. The next group of staff to be registered are the Home Care workforce. The expectation is to ensure these staff achieve the minimum qualification to full fill their registration requirements. This is phased in over time to allow us to support staff to achieve these qualifications within the set time period from the date they register. The Register opens for this group of staff on 2nd October 2017 and work is well underway in preparing and ensuring compliance with the registration of the Home Care Workforce. At present we have approximately 300 staff have already trained to SVQ level 2 and a plan is in place to support the remainder of staff to achieve the qualification requirements for registrations.

Awareness raising sessions are in place to support staff to understand the requirements of registration and this is being undertaken jointly with Joint Trade Unions.

- 5.10 A West Dunbartonshire Council (WDC) Staff Survey was last conducted in November 2015 which included all council staff and social work staff. In response to the survey, the Council Action Plan involves improvements in a number of areas and in October 2016, an HSCP Focus Group was conducted to determine whether HSCP staff are aware of the actions taken by the council.

Within the HSCP all health employed staff are surveyed using a system called iMatter. Staff undertake the survey and results are collated for each respective team and then there is a requirement for the team along with their manager to develop a Team Action Plan. Ownership for the Team Action plans lies with the Teams and is aimed at making improvements to how the team operates and on what is important to the staff.

The decision has been taken that the HSCP will move all staff, including staff with a Council contract but working within the integrated HSCP, to the iMatter system. There are significant benefits to implementation of a single approach to staff engagement across the HSCP, reflecting a further development in integration.

6. Regulation, Inspection and Quality Assurance

Role of the CSWO

- 6.1 As CSWO I have the overall responsibility to ensure that the social work service workforce continues to operate within the standards and codes of practice as set out by the Scottish Social Services Council (SSSC) in order to maintain their professional registration.
- 6.2 The Care Inspectorate's role is to register care services and to inspect all care and social services with the aim of encouraging and driving improvement in those services where they have detailed either recommendations and or requirements in certain aspects of care. All inspection findings and reports are reported to the HSCP Audit Committee along with any details of improvement actions and progress.
- 6.3 We work closely with the Care Inspectorate in discharging our responsibilities to ensure that service provision, both provided and commissioned, are of the highest standard. The Quality Assurance team within the HSCP has a clear role in proactively monitoring the quality of care delivered and ensuring that the response to individual concerns about service delivery are responded to quickly and effectively.

Joint Inspection of Services for children and Young People

- 6.4 The Joint Inspection of Services for Children and Young People took place between 29th August 2016 and 14 October 2016 and reported on the 28th of February 2017. This inspection was in respect of all children's services and agencies providing a service within the Community Planning Partnership. As CSWO and the chair of the Children and Families Delivery and Improvement Group (DIG) I had lead responsibility for this inspection.
- 6.5 We established a partnership wide self-evaluation group in 2014 with the purpose of ensuring that we were in a position to evaluate all service supports and interventions in order to identify areas of good practice and areas where further development or improvement was required. In the main this was for the purpose of achieving our priorities as set out in the Integrated Children's Service Report. However it meant we were in a good position to illustrate to the Inspection Team that we knew ourselves well as a children's services partnership, and we had the evidence to illustrate our performance and areas of development being progressed.
- 6.6 The inspection team covered a wide range of areas and issues in respect of achieving positive outcomes for children and their families; we were awarded grades in respect of specific Quality Indicators. These are as follows:

<i>How well are the lives of children and young people improving?</i>	
Improvements in the wellbeing of children and young people	Good
Impact on children and young people	Very Good
Impact on families	Good
<i>How well are partners working together to improve the lives of children, young people and families?</i>	
Providing help and support at an early stage	Very Good
Assessing and responding to risks and needs	Adequate
Planning for individual children	Adequate
Planning and improving services	Good
Participation of children, young people, families and other stakeholders	Very Good
<i>How good is the leadership and direction of services for children and young people?</i>	
Leadership of improvement and change	Good

6.7 The inspectors identified a number of particular strengths which were making a positive difference to the lives of children and young people:

- *The strength of strategic approaches to targeting key universal health services had achieved some real gains within a very challenging context of high deprivation;*
- *Highly committed staff groups across the partnership demonstrated clear ownership of the strategic vision for children, young people and families and felt clearly connected to improvement planning;*
- *Young people, including the most vulnerable, were meaningfully involved in influencing policy and service development;*
- *There was an evident commitment to early intervention and prevention with very effective help and support processes;*
- *A coherent shared vision was in place and modelled by a mature partnership.*

6.8 In respect of areas for improvement, the inspection team concluded that;

Partners had demonstrated a commitment to continuous improvement and reflective practice and we are confident that partners are well placed to incorporate the opportunities for further improvement highlighted during this inspection within their ongoing activities. In doing so, the community planning partnership should take action to:

- *Demonstrate the difference investments in early intervention and prevention are making for all children and young people through measurement of robust data and progress across strategic plans.*
- *Strengthen strategic plans in recognition of national policy directives on prevention of domestic abuse and local trends in use of kinship care.*
- *Achieve greater consistency in quality of assessments of risk and need and the formulation of plans to meet identified factors by ensuring that approaches to day-to-day quality assurance of operational practice are robust, systematic and deliver intended improvements.*

6.9 The inspection team also identified 3 examples of Good Practice;

- Effective change management –Seasons for Growth
- Leadership by young people for young people – Y Sort It
- Commitment to equality and inclusion – Highly Dependent Learners

Improvement Action Plan

- 6.10 Following the publication of the report all Community Planning Partnerships are required to submit an Improvement Action Plan to set out how the CPP will address the key recommendations of the report as outline at 5.8 above. The Improvement Action Plan was approved at the Community Planning Management Group (CPMG) on the 24th of May 2017.
- 6.11 The Joint Children’s Services Inspection Improvement Plan represents a number of improvement actions and milestones which will in effect be developed and implemented across the various CPP strategic planning fora. This plan is therefore a collection of the actions that will be taken to address the learning arising from the joint inspection of children’s services reported in February 2017 by the Care Inspectorate.
- 6.12 Whilst the overall strategic responsibility lies with the Children and Families Delivery and Improvement Group (DIG) chaired by myself as the Head of Children’s Health and Care and CSWO. There are aspects of the actions assigned to either additional Community Planning Strategic Groups or Key Officers who do not sit on the Children and Families DIG. The expectation is therefore that the actions assigned to both the officers and strategic groups will be reported directly into the Children and Families DIG at regular intervals. From there progress made will be reported to the CPMG and any challenges or barriers to progressing actions will be passed to the CPMG for remedial action if necessary.
- 6.13 We anticipate that the Joint Inspection of Services for Older People in West Dunbartonshire will take place at some point in 2018/19. Preparation is underway in respect of formulating a clear self-evaluation.

Regulated Services - Grades and Outcomes

- 6.14 Our performance in this area across all regulatory services has gone from strength to strength. There has been a strong emphasis and robust approach taken to improving our grades both by the Senior Management Team of the HSCP and the Integrated Joint Board via the Audit Committee. Whilst performance overall is reassuring there can be no place for complacency and there are a few areas where further improvement is still required.
- 6.15 For further details across all inspections and grades, requirements and recommendations carried out between 1st April 2016 and the end of March 2017 please see **Appendix 1** - Regulatory Inspection Outcomes. There are some inspections that have taken place in this period but still require to formally report, therefore they have not been included.

7. Statutory Functions

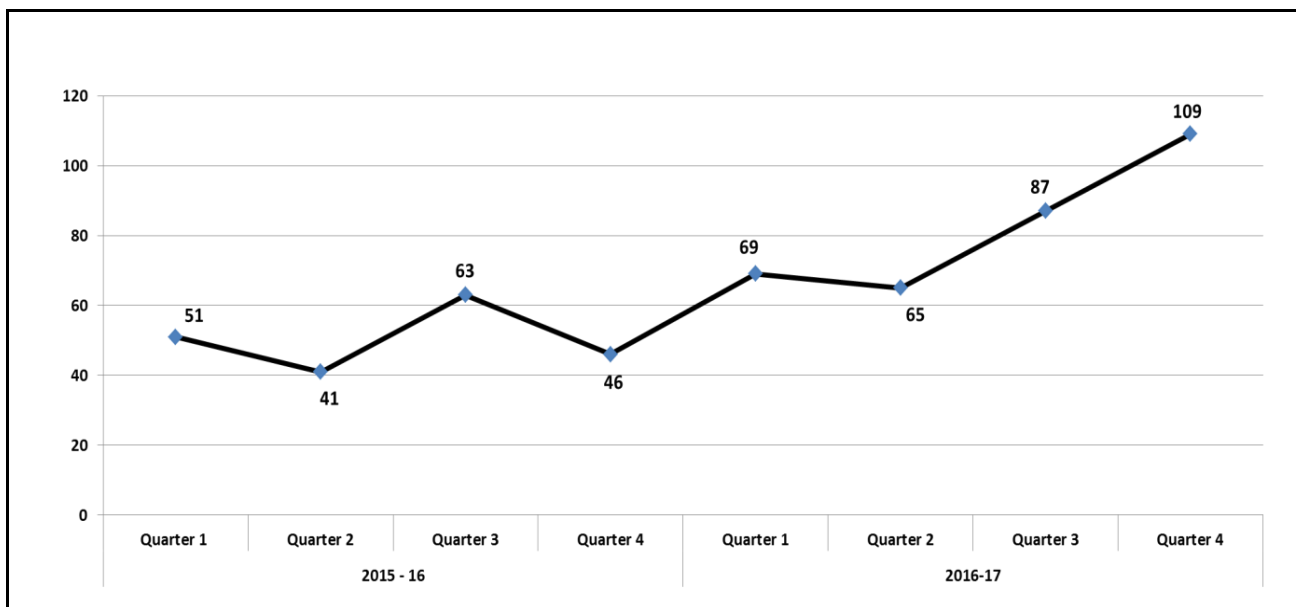
Public Protection Chief Officers Group (PPCOG)

- 7.1 The Public Protection Chief Officers Group (PPCOG) has for some years held regular development sessions in order to learn from elsewhere and to review the purpose and function of the group in terms of assurance and governance.
- 7.2 The Performance and Assurance Reporting Framework, as attached at **Appendix 2**, was developed in 2013. This report is shared with the Child Protection Committee (CPC) and the Adult Protection Committee (APC) however the main purpose of the report is to ensure that the PPCOG can review the outcomes, targets and demand levels on a regular basis. It continues to be presented to each quarterly meeting of the PPCOG and is accompanied by an analysis report prepared by the Chief Social Work Officer. The targets set within this report were reviewed by the PPCOG in April 2016 and in acknowledgement of progress made some of the targets were adjusted to ensure there is continued improvement.
- 7.3 The highest priority in social work is to ensure that, in collaboration with partner agencies, people at risk of harm are afforded effective protection. The PPCOG is chaired by the Chief Executive of the Council with key representation from the Director of Nursing (NHS GGC), the Divisional Commander (Police Scotland) and the Chief Officer (HSCP). The PPCOG is responsible for the strategic co-ordination of all public protection services in West Dunbartonshire.
- 7.4 It is acknowledged that as well as covering the three main areas of public protection; adult protection, child protection and high risk offenders a key cross cutting theme is domestic abuse.
- 7.5 In respect of domestic abuse the prevalence of this significant social issue is stark in West Dunbartonshire. West Dunbartonshire has for a number of years now had the second highest prevalence rates in Scotland, behind the city of Dundee. Domestic abuse prevalence rates and our approach to prevention was a significant factor in the recent Joint Inspection of Children's Services carried out by the Care Inspectorate and as such there was a recommendation in relation to Domestic Abuse (see 6.4 in this report for further detail).
- 7.6 The PPCOG has a Development Plan in place and as such members welcome the work and outcomes from the Scottish Governments Child Protection Improvement Programme and will enthusiastically engage in the work streams going forward, particularly the work in relation to the role and function of Chief Officers. The national Improvement Programme began early in 2016 and reported in December 2016 with various work streams identified from 2017 and onwards.

Child Protection

7.7 Across the past 2 years there has been a noticeable rise in the number of child concern and protection referrals coming into the children and families social work service. These statistics and activity levels have been monitored and analysed on a quarterly basis for a number of years, for the purpose of reporting to the PPCOG and for the CSWO to monitor demand in comparison to resources.

7.8 With regards to the detail of the rise in child protection referrals received by the children and families service in the last 2 years, this has risen from a full year effect of; 201 in 2015/16 to 330 in 2016/17. This represents an increase of 64%. The comparison between the first quarter of 2015/16 and the last quarter of 2016/17 is starker in that there were twice as many referrals; 51 referrals in Quarter 1 of 2015/16 and 109 in Quarter 4 of 2016/17. This is illustrated in the chart below:



7.9 With regards to the number of referrals that led to a child protection investigation this follows a similar upward trajectory which is reassuring in terms of good practice and ensuring that these referrals are assessed and interventions based on the level of risk and need identified.

7.10 Similarly and in line with expectation given the rise in referrals and investigations, children placed on the Child Protection Register (CPR) have also risen. In 2015/16 a total of 57 children were placed on the CPR compared to 123 in 2016/17, a rise of 115%. This is not however a static picture as children are also removed from the CPR throughout the year.

7.11 From analysis it is starkly evident that the reason for registration is predominantly due to 'domestic abuse' and 'neglect' the latter of which

reflects the national picture, however is set in an area where we are the second highest local authority area for reported incidents of domestic abuse.

7.12 From analysis of this rise in referrals and activity we have identified that there are a number of contributing factors:

- i) Poverty – families who may previously not have come to the attention of the statutory social work service and other agencies now are, due to the level of pressure they are experiencing from both reduced income and reduced benefits as well as the impact on occasion of benefit sanctions. On some occasions families are turning to unlawful means to increase their finances;
- ii) The introduction of the Initial Referral Discussion (IRD) process means that we are collectively on a multi-agency basis identifying and agreeing how to proceed with child concern cases, which has contributed to the increase in numbers of cases being considered, however this is identified as good practice and in line with National Guidance. Identifying and allocating the cases which other services have concerns about is extremely important in order that we are able to intervene early and prevent further concern or harm occurring.
- iii) Reflective practice – we have learned by reflecting on both local cases and some of the more high profile national cases, and have made changes to local practice as a result of this. In the main this has led to an increased recognition that children and families need our support earlier and as such we have allocated/opened more cases. This is very appropriate and again reflects good practice.
- iv) A clear focus of the managers now holding the Team Leader role has been to ensure there is more consistent practice across the social work teams by jointly improving our approach to assessment of referrals. Again this reflects good practice and illustrates that we have learnt from past cases, and that this learning leads to a change in practice in order to improve outcomes for children, as expected by the Care Inspectorate. These changes have been supported by other professionals, and there is a reported increase in confidence in the approach of the current Team Leaders, which is reassuring in terms of the quality of our response and the willingness of other agencies to make contact with us when concerned about a child.

7.13 The CPC Improvement Action Plan details the various areas for development and improvement for the CPC. This is a 'live' plan and as such is a standing agenda item on the CPC, to which progress is noted every two months and additional improvement areas or actions are added following either case file audit, reflective case reviews, the outcome of national Significant Case Reviews and through self- evaluation in general. This plan has recently been reviewed and we are in the process of developing a revised three year Improvement Action Plan for 2017 onwards.

Adult Support and Protection (ASP)

7.14 The Adult Protection Committee (APC) continues to meet on a quarterly basis, has an independent chair as required by statute and attendees include a representative from Police Scotland, Trading Standards, Care Inspectorate, Mental Welfare Commission, adult social work services, community Health, Advocacy Services, Scottish Care, Children and Families Fieldwork Manager, CSWO and the Scottish Fire and Rescue Service.

Key issues discussed at the Adult Protection Committee have included:

- Human Trafficking
- Female Genital Mutilation
- Changes to AWI/Graded guardianship
- I am me/Keep safe
- Repeat referrals
- Ways to be more inclusive of service users and carers on the committee.

7.15 Between April 2016 and March 2017 two internal case file audits were completed. As a result of these internal audits there is work being carried out to explore and simplify the route in which chronologies can be accessed on CareFirst and a drive to improve the use and recording of chronologies.

7.16 The ASP training plan is on-going and there continues to be a significant demand for training at Level 1 and Level 2 with 273 people trained in 2016/17. In addition Training for Trainers and Council Officer Refresher Training took place.

7.17 A review of the role, remit and membership of the practice & communication sub-committee took place in order to ensure it remained outcome focused and up to date. As a result of this review, it was agreed that the practice & communications sub-committee should split in to two separate working groups. The newly formed communication working group will now meet twice a year and has multi-agency membership.

7.18 The self evaluation and training working group has merged with the training sub group of the Child Protection Committee. The purpose of the group is to develop a system to review and audit all aspects of Child Protection and Adult Protection work undertaken by each agency involved in order to improve practice and achieve better outcomes for children, young people and adults at

risk of harm. In addition this group develops and maintains a comprehensive multi-agency training strategy to ensure that appropriate training on child protection and adult protection is available to staff from the wide variety of organisations and at different levels of training as appropriate to role and function.

Criminal Justice – the Management of High Risk Offenders

- 7.19 Multi Agency Public Protection Arrangements (MAPPA) is a model of sharing information and creating and reviewing risk management plans. MAPPA places statutory duties on responsible authorities to share information and work together to assess and manage the risk of certain categories of offender. Since the establishment of MAPPA in 2007 the focus has been on registered sex offenders and the small number of restricted patients.
- 7.20 With effect from April 2016 the remit of MAPPA extended to other offenders who are assessed as posing an imminent risk of serious harm to the public. The extension to include this category required an extensive commitment to the training of social workers and front line managers in order to enhance their knowledge and skills in the assessment of risk of serious harm. The number of offenders falling into this category is small but their assessment and management is by definition complex and demanding.
- 7.21 Mental Health Officer Service
The Mental Health Officer (MHO) Service continues to discharge statutory functions on behalf of the Local Authority as delegated to the Health & Social Care Partnership (HSCP). Staffing levels have remained stable, with no unfilled vacancies across the service however two established members of the dedicated core team of MHOs indicated their intention to retire in 2017. This has highlighted the requirement to consider succession arrangements. Authorisation was secured to recruit to one of the post to be vacated in April 2017, whilst similar authorisation will be sought in respect of the second post which will be vacated in November 2017.
- 7.22 In respect of the MHO training programme we had a candidate on the course in 2016 that successfully completed the qualification this year. No candidates will be undertaking the training programme in 2017/2018.
- 7.23 A key development has been a significant increase in the number of referrals relating to hospital discharge cases whereby it has been deemed appropriate for statutory measures to be pursued in order to progress the care plan of an adult who lacks capacity. Whilst the development and introduction of the Adults with Incapacity Authorisation Group (AAG), and the continued use of Section 13ZA, Social Work (Scotland) Act 1968 (as amended), has proved to be an effective and efficient mechanism for progressing many referrals, formal statutory measures are often required. This continues to present a demand challenge for the MHO service, and has been a key area of priority in terms of targeting resources.

- 7.24 A further priority for the MHO service during 2016/2017 was preparing for legislative changes to the Mental Health (Care & Treatment) Scotland Act 2003.
- 7.25 The organisation continues to be represented in relevant national platforms. The Senior Mental Health Officer remains an active member of the Social Work Scotland Mental Health Sub-committee, is chairperson of the Forensic Network Social Work Sub-group, and was an Employer Representative in a Scottish Social Services Council quality assurance exercise.
- 7.26 The Mental Health Officer (MHO) Service has been significantly augmented with the addition of two full-time, dedicated MHO posts which were successfully filled, with two experienced MHOs joining the service in July 2015. One of the posts created has a specific remit for statutory service provision in respect of Older People, in recognition of the developing demography in West Dunbartonshire (as throughout the country), and in response to increasing resource demands in this area of service provision. There are now two MHOs specialising in this service area, and, in addition to enhancing the overall MHO resource, they are also deployed with a view to providing direct support to relevant service partners such as the hospital discharge team.
- 7.27 As a result of the additional posts and ongoing resource alignment, it has also been possible to effectively eliminate the requirement for a waiting list in respect of Adults with Incapacity (Scotland) Act 2000 referrals. Protocols and practices have been developed to support more efficient and effective supervision arrangements under the terms of the 2000 Act, and in response to changes such as the introduction of new regulations surrounding the supervision of private guardians.

8. Service Quality and Performance

Overall Performance

8.1 The following performance reports are attached for information as they cover key requirements in respect of social care performance and Appendices 3 and 4 are reported externally. All performance reports as attached illustrate a wide range of performance indicators. These provide in the main a very positive reflection of the quality of social care service delivery within West Dunbartonshire's Health and Social Care Partnership.

Appendix 1: Regulatory Inspection Outcomes as referred to in Section 5 of this report.

Appendix 2: Performance and Assurance Reporting Framework as developed for the West Dunbartonshire Public Protection Chief Officer's Meeting as previously referred to in section 6.2 of this report.

Appendix 3: HSCP Local Government Benchmarking Framework Indicators for 2015 to 2016.

Appendix 4: WD HSCP Key Performance Indicator Summary 2016 to 2017.

In addition to these performance reports this section will illustrate a few key highlights in terms of service delivery, awards and recognition.

Service Quality and Awards

8.2 The following National Awards included:

- WDHSCP's Prescribing Support Team were recognised as the Self-Management Supporting Health and Social Care Partnership of the Year at the 2016 Health and Social Care Alliance Scotland Awards.
- WDHSCP Care at Home Service were recognised as sector leading in being awarded the Scottish Association of Social Work (SASW) Award for 'Best example of collaboration in an integrated setting' as well as being finalists in the Team of the Year award at the national awards ceremony in March 2017.
- WDHSCP Looked After Children's Team were also finalists in Scottish Association of Social Work (SASW) Team of the Year Award 2016.
- Burnside Children's House received national recognition when it was awarded the Scottish Institute for Residential Child Care (SIRCC)'s Residential Child Care Team of the Year Award 2016 and again in 2017. This was particularly special as young people living at Burnside nominated the staff team for this award.

- WDHSCP's Community Hospital Discharge Team were nationally recognised as finalists in the Integrated Care for Older People category at the Scottish Health Awards 2016.
- WDHSCP Addictions services Blood Borne Viruses team have continued to be recognised nationally, presenting at the Scientific Programme Committee of The International Liver Congress in the Netherlands in April 2017

8.3 West Dunbartonshire HSCP has also seen continued success at West Dunbartonshire Council's annual Employee Recognition Awards 2017:

- Our Day Care Officer Karen McNab was awarded the Council's Community's Award, recognising her outstanding commitment to the health and wellbeing of the older people in her care.
- Commendation for Wendy Jack (Team Leader of the Year award category); and
- Commendation to the Community Paediatric Speech and Language Team (Team of the Year award category).

8.4 At the 2016 NHSGGC Celebrating Success Staff Awards, the Pharmacy and prescribing support unit were awarded in recognition of their work to improve chronic pain management, integrated care pathways and support individuals to manage their pain.

8.5 Also at the 2016 NHSGGC Celebrating Success Staff Awards, the HSCP Children's Services and GG&C Child Protection GP specialist were awarded in recognition of their development work in Child Protection in General Practice; for developing and championing arrangements for strengthened multi-agency co-operation in primary care.

Falls and Frailty

8.6 This is a collaborative approach established between the Health and Care Services and the third sector. The objective of this programme is:

- To improve access to services to people with Frailty
- To improve the experience and outcomes for people identified as frail using the Dalhousie Clinical Frailty Scale following assessment and/or review

The project is underway in the Dumbarton and Alexandria Locality and provides a common language for all health and social care practitioners in

identifying frailty, speaking a common language and improving communication and information sharing between community services, acute and out of hours General Practitioners to support decision making in terms of admission avoidance and support individuals to remain in the community for as long as possible.

Falls Prevention

- 8.7 Falls and Frailty is one of the main reasons for unscheduled admission to hospital. The Community Older Peoples Team lead on the Falls work within West Dunbartonshire and in 2016 to 2017 they established a falls collaborative to deliver actions from the National Strategy in the Prevention and Management of Falls and Fragility Fractures. We have added the level one falls screening tool to all our assessment documentation and implemented this across our integrated health and social care teams. In addition to this we have trained wider community services such as Scottish Fire and Rescue and Community Volunteering Services and introduced the level one screening tool to them and provided improved pathways to our services.

This has led to improved practice and outcomes with 428 level 1 screens undertaken between 1 April and 30 June 2017 and 166 leading to a level 2 multi factorial assessment and interventions such as strength and balance exercises, environmental assessments and medication reviews. Care Home providers meet to support the delivery of the NHS Scotland resource Managing Falls and Fractures in Care Homes for Older People.

Community Older People's Team

- 8.8 COPT receive approximately 1,000 referral per month for a variety of reasons such as assessment, access to respite, day care, rehabilitation, aids and adaptations. The integration of health and social care teams has enabled us to stream line services, reduce duplication and deliver services using inter disciplinary approaches. This has made a significant impact on our waiting times for physiotherapy, occupational therapy and social work allowing for much improved response times and a more planned and co-ordinated approach to care.

Corporate Parenting-Strategy & Action Plan 2017-2020

- 8.9 The Corporate Parenting Strategy and Action plan was developed in collaboration with our care experienced young people from our successful Annual Corporate Parenting Event on 10th October 2016. The theme of this event was "*Dare to Care*" the focus of this event echoed the views of our young people. The strategy, details our collective ambitions and priorities for our looked after children and young people over the coming years and sets out an ambitious plan of how we will achieve, monitor and review progress toward these ambitions.

The Strategy and action plan will be launched at our Annual Corporate Parenting Event in November 2017, following a period of further consultation.

We are developing a Champions Board to provide opportunities for the development of trusting relationships between corporate parents and young people, where opportunities for 'fun' shared activities will allow each to get to know the other out with the normal formal settings. Through regular participation events the young people will be supported to develop skills and confidence to share their care experiences in order to support positive change in the services provided for all looked after young people at both a local and national level.

Progress toward our key priorities includes;

- **Supporting Our Young People to Achieve Their Potential**

As reflected nationally our looked after children, particularly those 'looked after at home' tend to have poorer outcomes. One of our key ambitions is to narrow that educational attainment gap and to improve access to post-school education. This aspiration extends to further and higher education, with the introduction of the Children and Young People (Scotland) Act 2014, colleges and universities now have statutory responsibilities as corporate parents.

- **Building Successful Futures through Good Health and Well-Being**

In West Dunbartonshire, we understand that positive experiences and successful long-term outcomes for our looked after young people depend on each child's physical, mental and emotional health. The Scottish Government's Getting it Right For Every Child (GIRFEC) approach emphasises the importance of wellbeing, with health as a key component. We recognise the scale of this task, and have been working hard to support collective efforts from carers, practitioners and professionals, in making sustained, long-term improvements in the health and wellbeing of our looked after children.

- **Supporting Our Young People to obtain stability through, high quality, affordable housing**

To further improve a care leaver's journey, we understand that the relationship between Throughcare, the young person and Housing is crucial. We have worked hard over the past two years to improve understanding of each agencies roles and the needs of our looked after young people.

This improvement is having a direct impact on the outcomes experienced by our young people. There is now greater consideration to what type of accommodation a young person requires, the location and what supports are required to enable the young person to successfully sustain their tenancy.

This is confirmed through established and robust strategic arrangements and the Local Housing Strategy.

○ **Engagement Activities**

There have been a variety of engagement activities for young people that have taken place throughout 2016/17 including our annual 'It's a knockout' fun day, attended by many care experienced young people, members of staff, colleagues from Police Scotland, our third sector partners, family members and many others. This event is growing in success and creates another opportunity to promote the health benefits of activities such as these.

Engagement and participation of our young people is the key to building a successful foundation for our Champions Board and as such over the recent months staff, managers and young people have taken part in Go-Karting, Fire Reach courses, Inspiring Young Leaders programme and attending the 1000 voices event.

Champions Board and Funding

- 8.10 I am delighted to advise that in July 2017, we submitted a funding bid to Life Changes Trust in relation to establishing and maintaining a successful Champions Board across West Dunbartonshire. This bid was successful and has attracted funding of approx. £240,000 over a period of 3 years. The bid was praised by the Life Changes Trust's Care Experienced Young People Programme committee for its high level of participation from our young people, and they commented that they;

'particularly appreciated the ambition that you showed for care experienced young people, as well as the community dimension within the bid, which demonstrated your commitment to sustainability....'

This is seen as a fantastic opportunity for our care experienced young people to have a further platform to discuss and make positive changes to their future opportunities in West Dunbartonshire and across Scotland, and comes at the time of the 'Root and Branch Review of the care system' which the First Minister, Nicola Sturgeon, announced in October 2016.

Service Achievements – Looked After Children's Services

- 8.11 Burnside Children's House, one of our residential children's houses, was successful in being nominated for, and receiving, the SIRCC Team of the Year award, for a second successive year – a fantastic achievement. In December 2016 Burnside also achieved grades of '6' (excellent) in their inspection for both 'Quality of Care and Support' and 'Quality of Staffing'.

In keeping with this theme our Throughcare and Aftercare service achieved the same grades of '6' for the same areas inspected in February 2017.

Some of Our Young People's Achievements

- 8.12 A number of our care experienced young people have participated in and completed a Fire Reach course over a five day period, at one of our local Fire stations. This ended with a graduation ceremony where their parents and carers attended to share in their success.

Seven of our care experienced young people, who work with our Throughcare and Aftercare service, successfully completed a 'Passionate Young Leaders' programme, run by the 'Best of You' programme. These programmes are run over several sessions and have been commended by all young people who took part.

Criminal Justice Social Work Services

- 8.13 The Criminal Justice service is responsible for the assessment and supervision of offenders in the community. This is primarily achieved through the provision of reports for courts and supervision of Community Payback Orders (CPOs) imposed by the courts. The principles underpinning CPOs emphasise the benefits to the community in terms of paying back directly through unpaid work and/or other rehabilitative measures within a supervisory framework.

The demand for CJSW services has been sustained at a high level. The increase in CPOs noted in previous reports was sustained in 2016-17. In the same period there has been a significant increase in activity relating to the supervision of offenders released from custodial sentences. The number of offenders released from prison subject to social work supervision more than doubled in 2016-17. This is largely accounted for by courts using their powers to impose a short period of post custodial supervision (Supervised Release Orders) in relation to persons convicted of violent offences who would not otherwise be subject to such measures.

For a number of years the value of the criminal justice grant has reduced in relation the costs of delivering the service. Within this context the opportunity to achieve efficiencies has become progressively more challenging against a background in which the demands on the criminal justice workforce are increasingly complex in terms of the needs and risks.

The service has taken measures to accommodate the increase in demand including a recently concluded service re-design intended to enable a more flexible workforce to meet both volume and complexity of demand. However it should be noted that inevitably the combination of high demand and reducing budgets has had a direct impact on the performance of the service and our ability to meet timescales consistently when allocating court reports or enacting Unpaid Work placements due to the level of demand

Integrated Working – Learning Disability

- 8.14 Learning Disability Services continues to reflect the principles behind the creation of our Health & Social Care Partnership by integrating health and social care practice. Social care and health care staff continue to work side by side to provide, not only a holistic assessment of service users' needs, but also a similar approach to the implementation of care management and review in order to meet these needs. Emphasis is very much on an outcome based approach which encourages a more transparent and innovative approach to meeting the needs of service users and their carers. Some of our key developments are detailed below:

○ **Housing**

We are working with West Dunbartonshire Council Housing to develop a property in Dumbarton to develop a care and support placement for younger service users with LD who require flexible and tailored housing support. We are also working with the developer of a housing development on the site of the old St Andrew's school in Clydebank to identify several barrier free housing units for service users with more complex needs. This development is particularly relevant for those service users currently living out with West Dunbartonshire, to enable them to return to their local community to support them to return to their local area.

We are also working with a local housing support provider and a social housing provider to develop more suitable housing for existing service users in receipt of housing support services, within the new housing development at Dumbarton Harbour.

○ **Technology Enabled Care (TEC)**

We are collaborating with our housing support providers to make better use of the advantages in social care offered by increasing use of TEC. This will enable service users to receive their support in a more effective, accessible, personalised and less intrusive manner. We are currently reviewing sleepover arrangements and the exploration of TEC care as a new model for LD services. A work plan is in place to manage this development work going forward.

○ **Work Connect**

Work Connect is based in Levensgrove Park, is a specialist HSCP supported employment service for people with mental health issues, addictions and learning disability. In partnership with WDC Greenspace, it gives disabled or vulnerable people the safe space, tools and support to improve their quality of life through opportunities to learn and apply their skills and creativity, providing practical skills often used as a non-medical option, alongside existing health and care treatment and support, to improve health and wellbeing.

○ **Information Days**

Learning Disability Services continue to hold annual Information Days for service users and carers which showcase the wide ranges of activities and supports available locally. Feedback indicates that these events are widely appreciated as a means of informing service users and carers about the alternatives available. The dissemination of such information is especially important given the greater choice there is now about how supports are delivered and organised in relation to the principles of self directed support.

○ **Complex Needs**

The past 12 months has seen a continuation in the trend of an increase in service users with complex needs entering our services, particularly in transition from Children's Services. This has required significant review of how we can structure our services, particularly our building based ones (e.g. Dumbarton Centre and Housing Support) to meet the needs of a learning disability population with significantly higher physical, emotional, behavioural and mental health needs. We have also needed to develop services in order to meet the expanding needs of those on the autistic spectrum.

Transition

- 8.15 We are developing clearer transition processes for young people and their families moving from Children Services to Adult Services. Improvements have been introduced to streamline the process and in beginning the transition process at an earlier stage to allow for more robust care planning, simplifying the resource allocation process and identification of which area of adult service is best qualified to meet their needs. It is anticipated these changes will result in less anxiety and greater assurances for young people with additional support needs and their families regarding the nature of their support as they make the often difficult transition from children's to adult services.

Self-Directed Support

- 8.16 We continue to embrace the principles and requirements of the Social Care (Self-Directed Support) (Scotland) Act 2013 by ensuring service users and their families are fully informed of the range of options they have available in terms of the nature of the support they receive.

We recognise and are committed to supporting those who wish to take advantage of the opportunities that Self-Directed Support (SDS) provides. To support service users and families to understand our options, SDS is embedded in our assessment process across adult and children's services. Our Integrated Resource Framework continues to support indicative personal budgeting assessment. This framework supports fairness and equality across all individuals eligible for local authority funded support.

SDS provides opportunity for four options in deciding your own care: these being Direct Payment, Individual Service Fund, Local Authority arranging and organising your support or a mixture of any of the three options above.

Whilst the numbers of service users that have opted to take a Direct Payment option of SDS continue to be small, the total value of Direct Payments has risen steadily from £1,100,542 in 2014/15 to £1,496,153 in 2016/17. The expenditure on SDS Options 1 and 2 in 2015/16 has increased by 61% since 2013/14 and has also increased as a proportion of overall adult social care spend from 1.39% to 2.16% over the same time period.

We have taken cognisance of the recent Audit Scotland report which was recently presented to our Partnership Audit Committee and recognise that there is further improvement to be made in this area across children's and adult services.

Community Hospital Discharge Team

- 8.17 Our award winning integrated Community Hospital Discharge Team works with patients and carers in planning their discharge from the point of admission to hospital. Our Hospital Discharge Liaison Workers are based in hospital wards, supporting a smooth transition between acute and community services, providing planned discharge from hospital at the point a person is medically fit to return home. This can often involve a number of WDHSCP and partner services.

From 1st July 2016 targets for delayed discharge and methods of calculating delays were revised by the Scottish Government. Performance against the 72 hour target declined in February and March 2017 due to an increase in demand combined with a temporary decrease in capacity. However, the number of patients whose discharges were delayed beyond 3 days reduced back down to 5 in April 2017. By focusing on timely and appropriate hospital discharge the number of acute bed days lost to delayed discharge for West Dunbartonshire residents has reduced by 47% from 5,802 in 2014/15 to 3,047 in 2016/17.

Unscheduled Care

- 8.18 Our out of hours support in the community is increasingly used to reduce the need for emergency admission to hospital. While the number of unplanned acute bed days for older people aged 65 and over in 2016/17 has increased on the previous year, the overall trend is positive with a reduction of 11% between 2012/13 and 2016/17.

Critical to addressing unscheduled care has been on-going work and developments to shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when that is the best thing to do. To that end, during 2016/17 the

HSCP Partnership Board approved its commissioning objectives to improve unscheduled care for residents of West Dunbartonshire. At the heart of these comprehensive commissioning intentions is a commitment to invest, redesign and deliver an effective infrastructure of community services.

Care At Home

- 8.19 For many older people Care at Home provision is a crucial service that supports them to continue to live at home. West Dunbartonshire HSCP is ranked first in Scotland for the proportion of adults receiving any care or support who rated it as excellent or good in 2015/16 at 88%. The Scottish national figure has decreased from 84% in 2014/15 to 81% in 2015/16.

In addition the number of older people receiving a Telecare service has increased by 8.8% since 2012/13 to 2,394 in March 2017.

Acquired Brain Injury Service

- 8.20 Our Acquired Brain Injury Service Care Inspectorate inspection report published in 2017 was awarded gradings of 6 (Excellent) for the two themes inspected; Quality of Care and Support and Quality of Management and Leadership with the report noting the following strengths:

- 'A dynamic, expert service which put people affected by Acquired Brain Injury at the core of what it does'
- The contribution of the Brain Injury Engagement Network (BIEN) supporting inclusion and co-production;
- Extremely motivated and skilled staff;
- Excellent involvement at a national and strategic level.

Mental Health

- 8.21 West Dunbartonshire's Mental Health Services have made a positive impact on outcomes and waiting times for individuals. Enhanced access to Psychological Therapy programmes across the Mental Health community based services has led to clinically significant improved symptoms for local patients. By implementing a strategic approach to integrating resources across teams and supporting staff skills and development through peer mentoring, service users with anxiety, stress and depressions have been supported to improve their mental health. Since July 2016 we have consistently exceeded the national target of 90% of patients starting Psychological Therapies within 18 weeks of referral.

- **Dementia Friendly West Dunbartonshire (DFWD)**

WDHSCP and our partners understand that people living with dementia and their carers are experts in experiencing dementia and are often the best people to talk about it. DFWD is a community-led and multi-agency (statutory,

independent and third sector) initiative that has improved dementia awareness and support to people living with dementia in local communities. With the anticipated increase in numbers living with dementia in the community, this sustainable approach to supporting people in their homes, neighbourhoods and social networks is crucial.

In 2017 DFWD was recognised at the Annual Conference of Alzheimer's Disease International in April 2017 in Japan for its learning and good practice. West Dunbartonshire's Dementia strategy and implementation plan will be refreshed in 2017 reflecting the new Scottish Government's Dementia Strategy 2017-20.

Supporting People with Addictions

- 8.22 West Dunbartonshire HSCP Addictions Services support people to regain and sustain a stable lifestyle; access education, training and employment services, enabling individuals to participate in meaningful activities as members of their community; improve family and other relationships; access counselling services and provide support to families and children. The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services; underpins the development of our Addiction services supported by the Road to Recovery Strategy.

We continue to consistently meet the target of 90% of patients waiting no longer than 3 weeks for referral to appropriate drug or alcohol treatments: 92.7% were seen within 3 weeks and 99.8% within 5 weeks in 2016/17.

In May 2016, the Scottish Government Commissioned the Care Inspectorate to support all Alcohol and Drug Partnerships (ADPs) in Scotland to review their progress towards implantation of the national Quality Principles. Which support a holistic, recovery-focused partnership approach. The care Inspectorate reflected the high quality of effective services being delivered to meet the needs of clients in West Dunbartonshire.

People using the ADP's services tell us of the positive impact on their lives. Our ADP Annual User Satisfaction Survey 2017 indicates that the majority of service users were happy with services and felt their lives were better because of services provided. Service users felt they were treated with dignity and respect in all service areas.

Carers Act 2016

- 8.23 WDHSCP works in partnership with third sector organisations, Carers of West Dunbartonshire (adult carers), Y Sort-it (young carers) and West Dunbartonshire Community Volunteering Service (WDCVS) to provide carer services across West Dunbartonshire. This has seen a review and revalidation of West Dunbartonshire Carers Development Group to take forward implementation of the Carers Act 2016. This partnership approach

works to plan services, identify carers and focus resources to ensure adult and young carers are equal partners in the planning and delivery of care and support.

9. Planning for Change and Key Challenges

The Health and Social Care Standards 2017

9.1 In February 2016, the overarching principles for new national care standards were agreed by the Cabinet Secretary for Health, Wellbeing and Sport - namely:

- Dignity and respect
- Compassion
- Be included
- Responsive care and support
- Wellbeing

In June 2016 the Scottish Government formally launched the finalised new National Health and Social Care Standards which set out what we should expect when using health, social care or social work services in Scotland. They seek to provide better outcomes for everyone; to ensure that individuals are treated with respect and dignity, and that their basic human rights are upheld.

WDHSCP has welcomed these standards as positively reinforcing our existing commitment to robust quality assurance and clinical and care governance within the Strategic Plan.

Demography and Health Inequalities

9.2 West Dunbartonshire's Social and Economic Profile 2017 shows that we have seen relatively large increases in our share of the 20% most deprived data zones in Scotland, showing the biggest increase in relative deprivation from 2012. Our Strategic Needs Assessment reflects that we have high levels of people with long term and complex conditions, often linked to the history of heavy industry in the area, with related diseases affecting people at a relatively young age. Because of this, we are invariably experiencing high levels of demand for both health and social care services as delivered by the HSCP. Whilst we are committed to working together in shifting the balance of care and supporting a whole population approach to improved health and wellbeing we are also facing significant resource challenges in meeting this level of need, particularly within the current financial climate.

Financial Challenges

9.3 Social work services is very much a demand led service Annual exclusively in respect of the needs of older people and children as outlined above. As such many of the most vulnerable citizen's require a range of support needs and these can be fairly complex and therefore costly.

The Social Care budget remains under pressure, mainly due to the increased level of demands for services.

The HSCP is planning forward to achieve the required level of in-year savings which brings significant challenge, in addition to delivering a balanced position against budget for the current financial year. The Chief Officer continues to manage and review the budget across all service areas in conjunction with the senior management team.

In addition to demand as described above, there is also pressure in light of the economic uncertainty in the next few years which has an automatic impact on service delivery and in addition the more vulnerable citizens of West Dunbartonshire are inevitably feeling the effects of austerity measures especially with regards to the reform of the benefits system and the introduction of Universal Credit along with the restrictions to benefits for families with more than 2 children.

The HSCP as a whole provides significant front line services and support to the communities of West Dunbartonshire. It is important therefore in my role as Chief Social Work Officer, to continue to champion the protection of front line services to vulnerable communities wherever possible above all other back office functions. This applies both within the HSCP but also to the Council as a whole. If we are to improve the life chances of some of our most vulnerable children, families and adults in the years to come then we need to prioritise those services that impact directly on the lives of these people.

Jackie Irvine
Chief Social Work Officer
West Dunbartonshire Council and HSCP
September 2017

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP**Health & Social Care Partnership Board: 22nd November 2017**

Subject: Freedom of Information Policy**1. Purpose**

- 1.1** To present the Partnership Board with a proposed Freedom of Information Policy.

2. Recommendation

- 2.1** The Partnership Board is recommended to approve the new Freedom of Information Policy for the Partnership Board.

3. Background

- 3.1** The Freedom of Information (Scotland) Act 2002 (usually known as FOISA or FOI) aims to increase openness and accountability in government and across the public sector by making sure that people have the right to access information held by Scottish public authorities. This includes environmental information which is covered by the Environmental Information (Scotland) Regulations 2004 (known as the EIRs). The Act is overseen by the Scottish Information Commissioner.

- 3.2** Integration Authorities are a Scottish Public Authority for the purposes of FOI legislation. FOI and the EIRs therefore apply to all recorded information held by the West Dunbartonshire Health and Social Care Partnership Board (with the exception of personal information). Consequently, a local FOI Policy for the Partnership Board has been prepared for approval and then application (Appendix 1).

4. Main Issues

- 4.1** This Policy provides advice and guidance to staff that are responsible for handling FOI requests; and is also aimed at members of the public who want to understand their rights and know what to expect, under the Partnership Board's policy.
- 4.2** In light of the Partnership Board having delegated responsibility for the management oversight of the delivery of a wide range of services within Adult and Children's Social Care and Health Services, a FOI request may be more appropriately dealt with through either NHS Greater Glasgow and Clyde or West Dunbartonshire Council's FOI policies - unless it is a request concerned directly with statutory functions held by the Partnership Board.

5. People Implications

- 5.1** Managers are responsible for ensuring staff under their direction and control are aware of the freedom of information policies, procedures and guidance agreed and for ensuring that those staff understand and apply appropriately those policies, procedures and guidance in carrying out their day to day work.

6. Financial Implications

- 6.1** There are no financial implications associated with this report.

7. Professional Implications

- 7.1** There are no locality implications associated with this report.

8. Locality Implications

- 8.1** There are no locality implications associated with this report.

9. Risk Analysis

- 9.1** The Chief Officer is responsible for ensuring that the Partnership Board meets its obligations under this legislation, drawing on appropriate advice from within their Senior Management Team. This includes responsibility for reviewing operation of the Partnership Board's compliance with Freedom of Information legislation and for ensuring that the relevant policy is in place. FOI response performance will be reviewed quarterly by the Chief Officer and annually by the Partnership Board.

10. Impact Assessments

- 10.1** None required.

11. Consultation

- 11.1** None required.

12. Strategic Assessment

- 12.1** The approval and application of an effective and proportionate FOI Policy for the Partnership Board – alongside the existing policies of NHSGGC and the Council - supports the commitment to good governance and the delivery of the best possible quality of health and social care that is articulated within the Strategic Plan.

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West Dunbartonshire Health & Social Care Partnership.

Date: 06 November 2017

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Appendices: West Dunbartonshire Health & Social Care Partnership
Board Complaints Freedom of Information Policy

Background Papers: None

Wards Affected: All

West Dunbartonshire
Health & Social Care Partnership

**WEST DUNBARTONSHIRE
HEALTH & SOCIAL CARE
PARTNERSHIP BOARD**

Freedom of Information (FOI) Policy

Document Title:	WDHSCP Board - FOI Policy	Owner:	Head of Strategy, Planning & Health Improvement
Version No.	10	Superseded Version:	N/A
Date Effective:	22 nd November 2017	Review Date:	1 st April 2020

1. PURPOSE

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

1.2 The Partnership Board's:

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

1.3 The Partnership Board is a legal entity in its own right created by Parliamentary Order, following ministerial approval of its Integration Scheme (as per the Public Bodies [Joint Working] Act 2014). However, the Partnership Board has neither replaced nor assumed the rights or responsibilities of either the Health Board or the Council as the employers of the staff delivering integrated services; or for the operation of buildings or services under the operational remit of those staff.

1.4 The Freedom of Information (Scotland) Act 2002 (usually known as FOISA or FOI) aims to increase openness and accountability in government and across the public sector by making sure that people have the right to access information held by Scottish public authorities. This includes environmental information which is covered by the Environmental Information (Scotland) Regulations 2004 (known as the EIRs). The Act is overseen by the Scottish Information Commissioner, who has the power to issue enforcement notices and, if need be, initiate court proceedings to ensure compliance. Further advice and information can be found on the Scottish Information Commissioner's website at:

<http://www.itspublicknowledge.info>.

And you can read more about Scottish Law concerning Freedom of Information here:
<http://www.legislation.gov.uk/asp/2002/13/section/5>.

1.5 Integration Authorities are a Scottish Public Authority for the purposes of FOI legislation. FOI and the EIRs therefore apply to all recorded information held by the West Dunbartonshire Health and Social Care Partnership Board (with the exception of personal information).

1.6 This document details the required Freedom of Information Policy for the West Dunbartonshire Health & Social Care Partnership Board. It provides advice and guidance to staff that are responsible for handling FOI requests, but is also aimed at members of the public who want to understand their rights and know what to expect, under the Partnership Board's policy.

1.7 In light of the Partnership Board having delegated responsibility for the management oversight of the delivery of a wide range of services within Adult and Children's Social Care and Health Services, a FOI request may be more appropriately dealt with through either NHS Greater Glasgow and Clyde or West Dunbartonshire Council's

FOI policies - unless it is a request concerned directly with statutory functions held by the Partnership Board.

2. Our Commitment to Effective Governance

2.1 As expressed within both its Local Code of Good Governance and its approved Publication Scheme, the Partnership Board is committed to transparency and will favour disclosure of information whenever possible. This policy will demonstrate that commitment to work within the spirit of FOISA its related Regulations and Codes of Practice. This policy should be interpreted in conjunction with the Records Management, Information Sharing and Publication Scheme Policies that together provide the framework for governing recorded information. The Partnership Board commits to:

- Ensure that, where appropriate, information will be published through its publication scheme and on its website.
- Handle all requests promptly and within the legal timeframe.
- Fairly apply the public interest test in cases where a qualified exemption applies.
- Make its members aware that it is an offence to prevent disclosure by altering, defacing, blocking, erasing, destroying or concealing any record.
- Where valid exemptions apply to a FOISA (e.g. data protection) the Partnership Board will state the reasons why it has withheld all or part of the information.

3. Roles and Responsibilities

3.1 Overall responsibility and accountability for compliance with information legislation lies with the Chief Officer of the Partnership Board, reporting to the Partnership Board as a whole. Partnership Board Members may also be involved in considering complex information requests.

3.2 Given the narrow breadth of information 'controlled' by the Partnership Board, (see Publication Scheme), it is likely that, in many cases, that an initial FOI request may actually be more appropriately dealt with by either NHS Greater Glasgow & Clyde or West Dunbartonshire Council as 'data controllers' under their own FOI Policies.

3.3 Where a FOI request is submitted to the Integration Joint Board and it becomes apparent it is in relation to information technically held by West Dunbartonshire Council or NHS Greater Glasgow & Clyde, then the relevant policy and procedures for either would be more properly enacted and the request dealt with under the relevant policy. The applicant would be informed of this in writing.

3.4 The Chief Officer is responsible for ensuring that the Partnership Board meets its obligations under this legislation, drawing on appropriate advice from within their Senior Management Team. This includes responsibility for reviewing operation of the Partnership Board's compliance with Freedom of Information legislation and for ensuring that the relevant policy is in place. FOI response performance will be reviewed quarterly by the Chief Officer and annually by the Partnership Board.

3.5 The Chief Finance Officer (or nominated person) will generally oversee the independent review process, should the applicant be dissatisfied with the initial response provided by the Chief Officer.

3.6 Managers are responsible for ensuring staff under their direction and control are aware of the freedom of information policies, procedures and guidance agreed and for ensuring that those staff understand and apply appropriately those policies, procedures and guidance in carrying out their day to day work. Staff must know where to refer any issues on which they require guidance.

3.7 It is a criminal offence to destroy information that is subject to a FOI request.

4. Handling Requests for Recorded Information

4.1 Anyone can make a request for information held by the Partnership Board. Unless there are specific exemptions which apply to the information, this information should normally be provided within 20 working days; the 20 working day period starts when the Health and Social Care Partnership first receives the request, not when it reaches the correct personnel.

4.2 A request for information must be made in a permanent format, for example in writing or via email, cassette or video recording. The request must include the applicants name with an address or email address to which a response can be sent and should include a description of the information they are seeking.

4.3 It is not always the case, the applicant refers to FOISA within the terms of their request and they are not obliged to inform the Partnership Board why they want the information. They can also state a preference for how they wish the response to be sent.

4.4 It is up to the Chief Officer (on behalf of the Partnership Board) to determine if the request for information falls under FOISA legislation.

A request must be sent to:

**The Chief Officer,
West Dunbartonshire Health and Social Care Partnership Headquarters, Council
Offices, Garshake Road, Dumbarton, G82 3PU**

Or by email to: WDHSCP@west-dunbarton.gov.uk

4.5 An applicant will receive a written acknowledgement of their request (via email or post) detailing the deadline to which they should expect a response. A response should be issued as soon as possible and always within the 20 working day rule.

4.6 Where a request has been received but more information is required from the applicant to identify and locate the relevant information, the Chief Officer should approach the applicant for clarification as soon as possible.

4.7 As per section1(3) and 10(1)(b) of the Act the statutory 20 working days deadline will not start until sufficient clarification has been received from the applicant to allow the Chief Officer (on behalf of the Partnership Board) to identify and locate the requested information. See the Scottish Ministers Code of Practice here for further information:

<http://www.gov.scot/Resource/Doc/933/0109425.pdf>.

4.8 Once a written response has been received by the applicant, if they are unhappy with the response, they have the right to challenge the information provided and ask the Partnership Board to review their response. The Chief Finance Officer (or their nominated person) is responsible for undertaking the review on behalf of the Partnership Board, which will be followed by a second and independent response being sent to the applicant.

4.9 If after further correspondence, the applicant continues to be dissatisfied, they then have the right to appeal to the Scottish Information Commissioner who will decide if further investigation is necessary. The website address for the Scottish Information Commissioner can be found in the earlier section of this document.

5. What isn't a FOI request?

- 5.1 Telephone requests are not subject to FOISA.
- 5.2 A request for a service is not dealt with under FOISA. Instead these requests will be passed to the relevant service area to be dealt with through normal operations.
- 5.3 Requests for personal information either about themselves or about another individual (and they can prove they are acting as that person's representative), then the application should be handled under Subject Access Request legislation (Data Protection Act 1998). Subject Access Requests would fall within the policies of either West Dunbartonshire Council or NHS Greater Glasgow & Clyde, as the Partnership Board do not and will not hold personal data.
- 5.4 The Access to Health Records Act 1990 grants rights to certain individuals to see what has been written about a deceased person in a hospital and other health records. Access is available to the deceased patient's personal representative or to any person having a claim arising out of a patient's death. Again, this would fall within the relevant policy of NHS Greater Glasgow & Clyde, as the Partnership Board do not and will not hold such records.

6. Responding to a FOI Request – 20 Days

- 6.1 As already noted, the statutory timescale for responding to a FOI request is 20 working days. Working days are defined as Monday to Thursday 8:45 to 4:45 and Friday, 08:45 to 3:55 excluding bank holidays and weekends. All FOI requests will be responded to within the statutory period, regardless of staff absence or working patterns.
- 6.2 The 20 day period commences when the request is first received and must be date stamped by the Health and Social Care Partnership upon receipt. The FOI Request will be recorded in order to support formal reporting to the Information Commissioner. Suitable arrangements will be made to respond to FOI requests in the absence of the Chief Officer and relevant mailboxes monitored on a daily basis.
- 6.3 The 20 day period is 'stopped' when:
 - The information is sent to the applicant.
 - A fees notification/refusal notice is issued. Or.
 - Further clarification is required from the applicant to inform the response.

7. Publication Scheme

- 7.1 FOISA requires all public authorities to produce and maintain a publication scheme. A publication scheme sets out the following:
 - The Classes of information already available to the public.
 - Details of how the information can be obtained.
 - Its location.
 - Whether there is a charge for providing the information.
- 7.2 The Publication Scheme for the Partnership Board can be found here:
<http://www.wdhscp.org.uk/media/1703/wdhscp-board-publication-scheme-nov-16.pdf>
Any information made available through the Publication Scheme will be free of charge unless otherwise specified.

8. Charges

- 8.1 The Partnership Board may charge an appropriate fee for dealing with a specific request. This charge will be calculated in accordance with the statutory 'fees regulations'.
- 8.2 The Partnership Board can charge direct and indirect costs incurred in locating, retrieving and providing information.
- 8.3 Charging for time spent determining whether the information is held cannot be charged for, nor can a charge be levied for providing information in a particular format.
- 8.4 If costs exceed £600, the Partnership Board does not have to comply (section 12 of the Act) with the request.
- 8.5 Staff time can be charged for up to a maximum of £15 per hour. The fees regulations limit the chargeable amounts as follows:
- Up to £100 - no charge can be made.
 - £100 to £600 – first £100 deducted, the Partnership Board can charge 10% of this cost.
 - Over £600 - no obligation to provide information.
- 8.6 The cost for responding to a request should be calculated before the request is answered and within the 20 working day deadline. A fees notice will be issued and the applicants request only needs to be answered on payment of the fee. The Payment must be received within 3 months.

9. Exemptions and refusal to respond

- 9.1 The Partnership Board does not have to comply with information requests if the information is exempt under the provisions made in Sections 25 to 41 of the Act.
- 9.2 Exemptions will be applied on a case by case basis rather than applying on a blanket basis, (see Appendix 1 for a full listing of exemptions).
- 9.3 Exemptions may be applied to an entire request or part of a request. The Chief Officer or their deputy shall apply exemptions to responses as applicable. If necessary the application of exemptions will be discussed with West Dunbartonshire Council's Legal Services (as per its corporate support to the Partnership Board and the Chief Officer). There are two types of exemptions and these are outlined below.

10. Non - Absolute Exemptions

- 10.1 The 'public interest' test applies to determine if the public interest in disclosing the information outweighs the public interest in maintaining confidentiality. This includes commercial interests and personal information of third parties.

11. Absolute Exemptions

- 11.1 If an absolute exemption applies the Chief Officer (on behalf of the Partnership Board) will not release the information. Absolute exemptions include confidential material and information published elsewhere amongst others. The 'public interest' test does not need to be considered.

- 11.2 The Partnership Board will favour disclosure wherever possible. If applying an exemption it will inform the applicant and provide information on why the request has been refused.
- 11.3 If a request or part of a request is subject to an exemption, and is therefore being refused, the response will include a refusal notice. The refusal notice will include notice that the Partnership Board does or does not hold the required information, details of the exemption being claimed, including the appropriate section of the Act and an explanation of why the exemption applies. The notice will also include information about how to request a review or make an appeal to the Scottish Information Commissioner.
- 11.4 The Partnership Board is not obliged to comply with a request deemed to be vexatious or repeated (section 14 of the Act). The request log can be used to identify repeated or vexatious requests.
- 11.5 When applying the 'public interest' test, the Chief Officer (on behalf of the Partnership Board) will explain the reason(s) for claiming the public interest if applying the exemption outweighs the public interest in disclosure.

12. How the Partnership Board will respond

- 12.1 The Equality Act 2010 places a duty on public authorities to be sensitive to the requirements of applicants. For example, where reasonable, information should be provided in a format requested such as in large print, Braille, audio or recording or other languages.
- 12.2 A standard template will be used to provide the response from the Chief Officer of the Partnership Board.

13. Requesting a Review

- 13.1 If the applicant is dissatisfied with the way a request has been dealt with or is unhappy with the decision, they may request a review to be undertaken under FOISA.
- 13.2 The request for a review must also be in writing or in a permanent form, for example, email. The request for a review must be made no later than 40 working days following receipt of the response to the original request.
- 13.3 The applicant must explain what issue they are dissatisfied with, for example:
- The application of exemptions.
 - The handling of the request.
 - The fact that no response was received to the original request within the prescribed deadline of 20 working days.
- 13.4 The request should state the name of the applicant and an address (which can be an email address).
- 13.5 The Partnership Board does not have to conduct a review if the review request or the original request is deemed to be vexatious. In such instances, the Chief Finance Officer (or nominated person), on behalf of the Partnership Board, will explain this to the applicant and include information on their rights of appeal to the Scottish Information Commissioner.
- 13.6 The Chief Finance Officer (or nominated person), on behalf of the Partnership Board, has 20 working days within which to conduct and respond to the request for a review, from the date it was first received. The Chief Finance Officer (or

nominated person) will contact the applicant acknowledging their request for a review.

13.7 The Chief Finance Officer (or nominated person) will work with the Chair of the Partnership Board and consult with any staff involved in the original request. If required, the Chief Finance Officer (or nominated person) will obtain legal advice from a solicitor who was not involved in the original decision, either through West Dunbartonshire Council or NHS Greater Glasgow & Clyde.

13.8 The review process will be:

- Fair and impartial.
- Able to reach a different decision if appropriate.
- Straightforward and capable of reaching an outcome promptly.
- As per paragraph 66 of the Scottish Ministers Code of Practice the review will be handled by staff who were not involved in the original decision, where this is reasonably practicable.

13.9 The applicant can expect the following outcomes following a review:

- Confirmation of the original decision.
- The release of all or part of the information initially withheld.
- A finding that the Partnership Board did not follow the correct procedures for dealing with the request for information.

13.10 The Scottish Ministers' Scottish Ministers' Code of Practice under Section 60 provides valuable guidance and advice on dealing with review requests.

13.11 Following receipt of the outcome, applicants who continue to be dissatisfied with the Partnership Board's decision or the way in which their request was handled can appeal to the Scottish Information Commissioner. Applicants can appeal within six months from the date on which they received a response to their request for a review.

13.12 Requests for an independent review should be made in writing to the Scottish Information Commissioner:

Kinburn Castle, Doubledykes Road, St Andrews, Fife, KY16 9DS.

Or by email to: enquires@itspublicknowledge.info

14. Records Management and Monitoring

14.1 The Partnership Board will maintain a register of all requests made for information under the Act. Details of the applicant, dates, staff involved, exemptions applied will be collected along with other useful details.

14.2 A log shall also be kept of all review requests and appeals. Details of important dates, deadlines and staff involvement will be collated.

14.3 Monitoring reports will be reviewed quarterly by the Chief Officer and submitted to the Partnership Board (or its Audit Committee) annually to ensure compliance with the FOISA legislation and to address any areas for improvement.

14.4 The Chief Officer will make arrangements to ensure that the requirement to submit quarterly statistics to the Scottish Information Commissioner is fulfilled.

14.5 Records created under FOISA are retained in accordance with relevant Records Retention and Disposal Schedule. After the end of the relevant retention period, the records are destroyed by shredding.

15. Contact Us

15.1 For further advice or guidance on this document please contact:

West Dunbartonshire Health and Social Care Partnership Headquarters, Council Offices, Garshake Road, Dumbarton, G82 3PU

Or by email to: WDHSCP@west-dunbarton.gov.uk

Or by telephone: 01389 776833

Appendix 1 - Summary of FOISA Exemptions

Exemption.	Absolute.	Public Interest.	Substantial Prejudice.	Section of FOISA.
Information otherwise accessible.	Yes.	-	-	25
Prohibition on disclosure by other legislation.	Yes.	-	-	26
Confidential information obtained from a third person.	Yes.	-	-	36(2)
Court Records.	Yes.	-	-	37
Access to personal data about themselves.	Yes.	-	-	38
Information intended for future publication (within 12 weeks).	-	Yes.	-	27
Relations within the United Kingdom.	-	Yes.	Yes.	28
Formulation of Scottish administrative policy.	-	Yes.	-	29
Prejudice to the effect conduct of public affairs.	-	Yes.	Yes.	30
National security and defence.	-	Yes.	-	31
International relations.	-	Yes.	Yes.	32
Commercial interest and the economy.	-	Yes.	Yes.	33
Investigations by Scottish public authorities.	-	Yes.	-	34
Law enforcement.	-	Yes.	Yes.	35
Confidentiality of communication in legal proceedings (legal privilege).	-	Yes.	-	36(1)
Personal information about a third party.	-	Yes.	-	38
Health, safety and the environment.	-	Yes.	-	39
Audit functions.	-	Yes.	Yes.	40
Communications with the Royal household and the granting of honours.	-	Yes.	-	41

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP**Health & Social Care Partnership Board: 22nd November 2017**

Subject: Strategic Risk Register - Update**1. Purpose**

- 1.1 To present the updated Strategic Risk Register for the Health & Social Care Partnership.

2. Recommendation

- 2.1 The Partnership Board is recommended to approve the updated Strategic Risk Register as attached.

3. Background

- 3.1 Audit Scotland have emphasised that health and social care integration requires effective governance arrangements for the new joint bodies. Such governance arrangements include systems for managing risks.
- 3.2 The Health & Social Care Partnership Board Financial Regulations reflect the recommendations of the national Integrated Resources Advisory Group which confirms the responsibility of the Chief Officer to develop a local risk strategy and policy for approval by the Partnership Board. The Partnership Board approved the West Dunbartonshire Health & Social Care Partnership's Risk Management Strategy & Policy at its August 2015 meeting.
- 3.3 At the November 2015 meeting of the Partnership Board, the current strategic register for the Health & Social Care Partnership was considered and approved.
- 3.4 Following the planned and formal review of strategic risks by the Senior Management Team, an updated strategic risk register was presented in draft for discussion at the September 2017 meeting of the Audit Committee. That updated strategic risk register was endorsed by the Audit Committee for recommendation to the full Partnership Board, and is appended here for consideration and approval by the Partnership Board.

4. Main Issues

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

- 4.2** The Integration Scheme confirms that a key element of the required risk management process is the preparation, scrutiny, approval and then annual review of the annual strategic risk register for the Health & Social Care Partnership. The Chief Officer is responsible for ensuring that suitable and effective arrangements are in place to manage the risks relating to the Health & Social Care Partnership. The Chief Financial Officer is responsible for promoting arrangements to identify and manage key business risks, risk mitigation and insurance.
- 4.3** The attached Strategic Risk Register has been prepared in accordance with the aforementioned local Risk Management Policy & Strategy. The latter has recently been internally reviewed by the Senior Management Team and confirmed as still being fit-for-purpose in its current form. Similarly, in accordance with that Policy & Strategy, standard procedures are applied across all areas of activity within the Health & Social Care Partnership in order to achieve consistent and effective implementation of good risk management.
- 4.4** As per the Risk Management Policy & Strategy, *strategic risks* represent the potential for the Partnership Board to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risk. These are distinct from operational risks, which represent the potential for impact (opportunity or threat) within or arising from the activities of an individual service area or team operating within the scope of the Health & Social Care Partnership's activities.
- 4.5** The Chief Officer has responsibility for managing operational risks as those are more 'front-line' in nature and the development of activities and controls to respond to these risks can be led by local managers and team leaders. Operational risk registers are maintained by Heads of Service on behalf of the Chief Officer; and are the "building blocks" for the strategic risk register. Where a number of operational risks impact across multiple service areas or, because of interdependencies, require more strategic leadership, then these can be proposed for escalation to 'strategic risk' status for the Partnership Board (as is the case for two areas of risk identified with the strategic risk register).
- 4.6** The strategic risks included here were all included in the previous iteration of the strategic risk register, with the descriptions of instigating actions updated where necessary. There have been no strategic risks that have been removed. There has been one that has been added, i.e.:
- Failure to manage workforce pressures, recruitment demands and staff absence levels.

5. People Implications

- 5.1** Key people implications associated with the identified strategic risks identified are addressed within the *mitigating action* column of the draft Strategic Risk Register.
- 5.2** The local Risk Management Policy and Strategy affirms that risk management should be integrated into daily activities, with everyone involved in identifying current and potential risks where they work. Individuals have a responsibility to make every effort to be aware of situations which place them or others at risk, report identified hazards and implement safe working practices developed within their service areas.

6. Financial Implications

- 6.1** Key financial implications associated with the identified strategic risks identified are addressed within the *mitigating action* column of the draft Strategic Risk Register.
- 6.2** The local Risk Management Policy and Strategy affirms that financial decisions in respect of these risk management arrangements will rest with the Chief Financial Officer.

7. Professional Implications

- 7.1** Key professional implications associated with the identified strategic risks identified are addressed within the *mitigating action* column of the draft Strategic Risk Register.
- 7.2** The local Risk Management Strategy and Policy supports the regulatory frameworks within which health and social care professionals practice; and the established professional accountabilities that are currently in place within the NHS and local government. All health and social care professionals remain accountable for their individual clinical and care decisions.

8. Locality Implications

- 8.1** None

9. Risk Analysis

- 9.1** Audit Scotland have emphasised that health and social care integration requires effective governance arrangements for the new joint bodies. Such governance arrangements include systems for managing risks such as the preparation and maintenance of strategic risk registers.
- 9.2** It is the responsibility of Partnership Board to approve an appropriate Strategic Risk Register for the Health & Social Care Partnership that is prepared in accordance with the local Risk Management Policy & Strategy,

10. Impact Assessments

10.1 None required

11. Consultation

11.1 The Strategic Risk Register has been confirmed by the Health & Social Care Partnership Senior Management Team.

11.2 The Strategic Risk Register has been endorsed by the Audit Committee.

12. Strategic Assessment

12.1 The preparation, approval and maintenance of the attached Strategic Risk Register will prevent or mitigate the effects of loss or harm; and will increase success in the delivery of the Strategic Plan.

Author: Soumen Sengupta – Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Social Care Partnership.

Date: 06 November 2017

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Appendices: West Dunbartonshire Health & Social Care Partnership
Strategic Risk Register

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

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

HSCP Board Report (August 2015): Risk Management Policy & Strategy

HSCP Board (November 2016): Strategic Risk Register - Update

HSCP Audit Committee (September 2017): Draft Strategic Risk Register

Wards Affected: All

West Dunbartonshire Health & Social Care Partnership: STRATEGIC RISK REGISTER

Owner: Chief Officer

Status: Draft

Approval Date:

Review Date:

The West Dunbartonshire Health & Social Care Partnership (WD HSCP) Board, the Council and the Health Board purposefully seek to promote an environment that is risk 'aware' and strives to place risk management information at the heart of key decisions – and consequently take an effective approach to managing risk in a way that both address significant challenges and enable positive outcomes. The preparation and maintenance of this Strategic Risk Register is an important element of this. It has been prepared in accordance with the WD HSCP Risk Management Policy & Strategy, with pre-mitigation risks assessed as follows:

Consequence	Likelihood				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

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

Strategic risks represent the potential for the Partnership Board to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan: typically these risks require strategic leadership in the development of activities and application of controls to manage the risk. These are distinct from *operational risks*, which represent the potential for impact (opportunity or threat) within or arising from the activities of an individual service area or team operating within the scope of the Health & Social Care Partnership's activities. The Chief Officer is responsible for managing operational risks, as they will be more 'front-line' in nature and the development of activities and controls to respond to these risks can be led by local managers and team leaders. Where a number of operational risks impact across multiple service areas or, because of interdependencies, require more strategic leadership, then these can be proposed *for escalation* to 'strategic risk' status for the Partnership Board (identified in the register with an asterix*).

West Dunbartonshire Health & Social Care Partnership: STRATEGIC RISK REGISTER

Risk	Pre-Mitigation Assessment			Mitigating Action	Post-Mitigation Assessment			Risk Lead
	Likelihood	Consequence	Risk Grade		Likelihood	Consequence	Risk Grade	
1. Failure to deliver efficiency savings targets as approved by HSCP Board, including as a consequence of savings proposals implemented by other sections/divisions of WDC or NHSGGC and agree and operate within allocated budget.	5	4	Extreme	On-going process of managing and reviewing the budget by the Senior Management Team. A recovery plan will be implemented to address areas of significant in-year overspend. Savings options under review expected to be challenging – horizon scanning being undertaken with respect to delivery of Strategic Plan within context of both wider WDC and NHSGGC processes. Continue to work with corporate colleagues within WDC and NHSGGC and engage with forums/groups to identify proposals for financial savings and/or service redesign that may have a negative impact on HSCP services and/or budgets. Continue to work with NHSGGC and GGC-wide IJBs on bringing forward notification and approval of budget allocation, before the start of the financial year to allow for early identification of actual funding gap to be filled by efficiency savings.	4	4	Extreme	Chief Officer; and Chief Financial Officer

Risk	Pre-Mitigation Assessment			Mitigating Action	Post-Mitigation Assessment			Risk Lead
	Likelihood	Consequence	Risk Grade		Likelihood	Consequence	Risk Grade	
2. Failure of NHSGGC-wide MSK Physiotherapy Service to meet nationally determined four week waiting time target and impact on NHSGGC performance in relation to orthopaedic waiting time within Acute Division.*	5	3	Extreme	Text reminders for new and return appointments. Risk stratification process for back pain patients introduced. On-going work to review referral criteria; improve GP management of MSK conditions; and engage with orthopaedic specialty within Acute Division.	4	3	High	MSK Physiotherapy Manager
3. Failure to plan and adopt a balanced approach to manage the year-round unscheduled care pressures; and related business continuity challenges that are faced in winter.	4	4	Extreme	Develop and implement a WD HSCP unscheduled care plan for community services that addresses the 12 critical areas outlined in the national Preparing for Winter Guidance. Through locality arrangements, emphasise importance of general practices reviewing their business continuity plans.	2	4	High	Head of Community Health & Care
4. Failure to meet legislative compliance in relation to child protection.	3	5	High	Child Protection procedures are in place and overseen by the local Child Protection Committee. All child protection cases are audited regularly. Local arrangements reflected upon as part of internal audit exercise and (external) joint inspection of children and young people's services – learning taken on-board. Improvement Action Plan developed addressing identified areas for improvement. On-going work being undertaken to consider analysis and impact in demands increases over previous two years.	2	5	High	Head of Children's Health, Care & Criminal Justice Services

Risk	Pre-Mitigation Assessment			Mitigating Action	Post-Mitigation Assessment			Risk Lead
	Likelihood	Consequence	Risk Grade		Likelihood	Consequence	Risk Grade	
5. Failure to meet legislative compliance in relation to adult support and protection.	3	5	High	Adult Protection procedures are in place and overseen by the local ASP Committee. This includes approach to supporting vulnerable adults. Local adult support arrangements are subject to a bi-annual review process.	2	5	High	Head of Mental Health, Learning Disabilities & Addictions; and Head of Community Health & Care
6. Failure to deliver a sustainable solution to asbestos-related health & safety risks within fabric of Clydebank Health Centre.	4	4	Extreme	On-going repair and refurbishment expenditure on premises in the immediate to short-term. HSCP has led development of Outline Business Case for replacement Centre, prepared in compliance with Scottish Capital Investment Manual. Outline Business Case now formally submitted to Scottish Government Health Directorate Capital Investment Group for decision. Preparatory work in support of next phase of development has begun. Risk grade wont be altered until funding confirmed (i.e. once approval for Full Business Cases secured).	2	4	High	Head of Community Health & Care; and Head of Strategy, Planning & Health Improvement

Risk	Pre-Mitigation Assessment			Mitigating Action	Post-Mitigation Assessment			Risk Lead
	Likelihood	Consequence	Risk Grade		Likelihood	Consequence	Risk Grade	
7. Failure to moderate and contingency plan for flood risk for site of Dumbarton Health Centre (SEPA flood map identifies a 1:200 risk for this location).	3	4	High	Alternative accommodation identified to relocate staff and services in the event of a flood. Flood protection measures identified and documented to be employed as required. HSCP civil contingency and business continuity arrangements being developed in tandem with over-arching NHSGGC and WDC procedures.	2	4	High	Head of Community Health & Care
8. Failure to monitor and ensure the wellbeing of people in independent or WDC residential care facilities	3	4	High	Systems are in place to ensure that findings of external scrutiny (Care Inspectorate) processes are acted upon timeously. HSCP staff provide pro-active and constructive support to care facilities alongside leadership role of relevant WD HSCP operational managers. Regular reports on residential care facilities standards provided to Audit Committee.	2	4	High	Head of Community Health & Care; and Head of Strategy, Planning & Health Improvement
9. Failure to maintain a secure information management network so that confidentiality of information is protected from unauthorised disclosures or losses.	3	4	High	On-going data protection awareness sessions for staff, supported by continual reminders of the need to safeguard the data and information collected and stored in the course of delivering services and support.	2	4	High	Head of Strategy, Planning & Health Improvement
10. Failure to ensure that systems are in place to ensure that services are delivered by appropriately qualified and/or professionally registered staff.	3	4	High	Systems are in place to discharge this in line with NHSGGC policy & WDC requirements; and compliance with standards set by external scrutiny and registration bodies.	2	4	High	All Heads of Service

Risk	Pre-Mitigation Assessment			Mitigating Action	Post-Mitigation Assessment			Risk Lead
	Likelihood	Consequence	Risk Grade		Likelihood	Consequence	Risk Grade	
11. Failure to resolve delays in reporting by NHSGGC-wide Diabetic Screening Service following migration to new national software.*	3	3	High	Support to implement new software being provided by local and national IT specialists.	2	3	Moderate	Head of Community Health & Care
12. Failure to ensure that Guardianship cases are appropriately allocated to a supervising social worker for monitoring, support and review.	3	3	High	Have implemented a system which equally distributes cases across all social workers, monitored and managed by the Senior MHO. MHO arrangements will be subject to an internal audit review this year, with the findings used to strengthen arrangements.	2	3	Moderate	Head of Mental Health, Learning Disabilities & Addictions
13. Failure to manage workforce pressures, recruitment demands and staff absence levels.	3	3	High	Continued implementation of HSCP Workforce and Organisational Development Strategy and Support Plan, including succession planning. Staff absence and appropriate application of relevant organisational policies regularly reported on and routinely review by Senior Management Team and line managers; and also standing item for consideration at HSCP Joint Staff Forum meetings.	2	3	Moderate	All Heads of Service

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP**Health & Social Care Partnership Board: 22nd November 2017**

Subject: Climate Change Report**1. Purpose**

- 1.1 To present the Partnership Board with the Climate Change Report prepared on its behalf in accordance with the Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015 .

2. Recommendation

- 2.1 The Partnership Board is asked to approve the Climate Change Report for formal submission to the Scottish Government in advance of the 30th November deadline.

3. Background

- 3.1 The Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015, came into force in November 2015, requiring all public bodies classed as 'major players' to submit a climate change report to the Scottish Government using a standardised online template by 30 November each year.
- 3.2 Integration Joint Boards (IJBs) appear on schedule 1 within the Order as 'An integration joint board established by order under section 9(2) of the Public Bodies (Joint Working) (Scotland) Act 2014(c)'.
- 3.3. At its June 2017 meeting, the Audit Committee asked that the Head of Strategy, Planning & Health Improvement prepare a Climate Change Report for presentation and approval at a future meeting of the Partnership Board (report appended here).

4. Main Issues

- 4.1 Following dialogue with Scottish Government, Health Facilities Scotland and the Sustainable Scotland Network (SSN) involving the six HSCPs in the Greater Glasgow and Clyde area it has become clear that due to the nature of IJBs – and specifically the fact that they are not directly responsible for staff or capital estates, and locally do not directly procure services – very few areas of the standardised template are directly relevant to IJBs. HSCP contributions to the requirements of the Order will properly be captured within the distinct reports that the NHS Health Board and the Council are separately obliged to submit. It has also been accepted that a degree of proportionality should be

applied to the completion of the reports. The content of the appended report then consequently reflects this.

5. People Implications

5.1 None.

6. Financial Implications

6.1 None.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 The submission of a Climate Change Report is a statutory obligation for the Partnership Board as per the Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015.

10. Impact Assessments

10.1 None.

11. Consultation

11.1 None.

12. Strategic Assessment

12.1 The submission of a Climate Change Report supports the commitment of the Partnership Board to good governance and transparent public reporting.

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West Dunbartonshire Health & Social Care Partnership.

Date: 06 November 2017

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Appendices: Climate Change Report – West Dunbartonshire Health and Social Care Partnership Board (IJB)

Background Papers: Public Sector Climate Change Reporting – Scottish Government
<http://www.gov.scot/Topics/Environment/climatechange/publicsectoraction/publicsectorreporting>

Climate Change Reporting webpages
<http://www.keepsotlandbeautiful.org/sustainability-climate-change/sustainable-scotland-network/climate-change-reporting/>

Audit Committee (June 2017): Climate Change Reporting and Integration Joint Boards

Wards Affected: All

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APPENDIX 1

Required

PART 1: PROFILE OF REPORTING BODY

PART 2: GOVERNANCE, MANAGEMENT AND STRATEGY

PART 3: EMISSIONS, TARGETS AND PROJECTS

PART 4: ADAPTATION

PART 5: PROCUREMENT

PART 6: VALIDATION AND DECLARATION

Recommended Reporting: Reporting on Wider Influence

RECOMMENDED – WIDER INFLUENCE

OTHER NOTABLE REPORTABLE ACTIVITY

PART 1: PROFILE OF REPORTING BODY

1(a) Name of reporting body

West Dunbartonshire Health & Social Care Partnership Board

1(b) Type of body

Integration Joint Board

1(c) Highest number of full-time equivalent staff in the body during the report year

0

1(d) Metrics used by the body

Specify the metrics that the body uses to assess its performance in relation to climate change and sustainability.

Metric	Unit	Value	Comments
Other (Please specify in the comments)	other (specify in comments)	0	West Dunbartonshire Health & Social Care Partnership Board does not report on any performance in relation to climate change or sustainability.

1(e) Overall budget of the body

Specify approximate £/annum for the report year.

Budget	Budget Comments
167693000.00	This is the total budget allocation for the financial year April 2016 to March 2017. West Dunbartonshire Health & Social Care Partnership Board's budget consists of financial allocations and budgets delegated from West Dunbartonshire Council and NHS Greater Glasgow and Clyde, which the HSCP Board then delegates back to the Council and the Health Board with directions for them to deliver health and social care services through the Health & Social Care Partnership.

1(f) Report year

Specify the report year.

Report Year	Report Year Comments
Financial (April to March)	

1(g) Context

Provide a summary of the body's nature and functions that are relevant to climate change reporting.

The Public Bodies (Joint Working) Act (Scotland) 2014 sets out the arrangements for the integration of health and social care across the country. The Scottish Government-approved Integration Scheme for West Dunbartonshire details the 'body corporate' arrangement by which NHS Greater Glasgow & Clyde Health Board and West Dunbartonshire Council agreed to formally delegate health and social care services for adults and children to a third body, which is described in the Act as an Integration Joint Board. The Integration Joint Board for West Dunbartonshire is known as the West Dunbartonshire Health & Social Care Partnership Board.

The Health & Social Care Partnership Board is responsible for the operational oversight of West Dunbartonshire Health & Social Care Partnership (WD HSCP), which is the joint delivery vehicle for those integrated services delegated to it (except for any NHS acute hospital services, as these are managed directly by the Health Board). These arrangements for integrated service delivery are conducted within an operational service delivery framework established by the Health Board and Council for their respective functions, ensuring both those organisations can continue to discharge their retained governance responsibilities.

At the 17th August 2016 West Dunbartonshire Health & Social Care Partnership Board meeting, members approved the second HSCP Strategic Plan. Our Strategic Plan (2016-2019) sets out our commissioning priorities for the next three years – with a clear commitment to the delivery of effective clinical and care governance and Best Value. It has been shaped by our Annual Performance Report for 2015/16; our strategic needs assessment, which illustrates the growing complexity of need and demand within our diverse local communities; our active engagement with stakeholders at locality, community planning and national levels; and our understanding of the broader policy and legislative context.

West Dunbartonshire lies north of the River Clyde encompassing urban and rural communities. According to the National Records for Scotland, the 2015 population for West Dunbartonshire is 89,590; a decrease of 0.1 per cent from 89,710 in 2014. The population of West Dunbartonshire accounts for 1.7 per cent of the total population of Scotland. National evidence indicates that the population of West Dunbartonshire is aging, which is due to a combination of factors: that the number of births in the area is dropping; the number of people migrating to other council areas within the 15-44 age group is increasing; and the number of deaths registered annually is falling.

PART 2: GOVERNANCE, MANAGEMENT AND STRATEGY

2(a) How is climate change governed in the body?

Provide a summary of the roles performed by the body's governance bodies and members in relation to climate change. If any of the body's activities in relation to climate change sit outside its own governance arrangements (in relation to, for example, land use, adaptation, transport, business travel, waste, information and communication technology, procurement or behaviour change), identify these activities and the governance arrangements.

The accountability and responsibility for climate change governance in relation to the delivery of Council and Health Services lies with West Dunbartonshire Health & Social Care Partnership Board's partner statutory bodies i.e. West Dunbartonshire Council and Greater Glasgow and Clyde Health Board. These partners have governance and decision making structures in place to support sustainability planning and a range of climate change adaptations and improvements. Both these partners will submit Public Bodies Climate Change Duties Reports that will detail their arrangements.

With respect to NHS Greater Glasgow and Clyde: the Health Board has in place a Sustainability, Planning and Implementation Group, chaired by the director of Property Management who is also the Boards Sustainability Champion.

With respect to West Dunbartonshire Council: issues relating to climate change are predominantly reported to the Infrastructure Regeneration and Economic Development Committee or the Housing and Communities Committee.

2(b) How is climate change action managed and embedded by the body?

Provide a summary of how decision-making in relation to climate change action by the body is managed and how responsibility is allocated to the body's senior staff, departmental heads etc. If any such decision-making sits outside the body's own governance arrangements (in relation to, for example, land use, adaptation, transport, business travel, waste, information and communication technology, procurement or behaviour change), identify how this is managed and how responsibility is allocated outside the body (JPEG, PNG, PDF, DOC)

The accountability and responsibility for climate change governance in relation to the delivery of Council and Health Services lies with West Dunbartonshire Health & Social Care Partnership Board's partner statutory bodies i.e. West Dunbartonshire Council and Greater Glasgow and Clyde Health Board. These partners have governance and decision making structures in place to support sustainability planning and a range of climate change adaptations and improvements. Both these partners will submit Public Bodies Climate Change Duties Reports that will detail their arrangements.

With respect to NHS Greater Glasgow & Clyde: NHS Greater Glasgow and Clyde Sustainability Manager is responsible for sustainability and environmental issues. He provides professional support (including technical and managerial advice) to the Health Board to identify, plan, develop and implement strategies and policies in relation to climate change. He monitors the Health Boards Performance and NHS objectives for sustainable development and environmental management including performance reporting.

With respect to West Dunbartonshire Council: the Council's senior leadership team includes the Chief Executive, two Strategic Directors, a Chief Officer (HSCP), and twelve Strategic Leads who collaborate to oversee all of the Council's activities.

2(c) Does the body have specific climate change mitigation and adaptation objectives in its corporate plan or similar document?

Provide a brief summary of objectives if they exist.

Objective	Doc Name	Doc Link
West Dunbartonshire Health & Social Care Partnership Board does not have specific climate change mitigation and adaptation objectives. However reference is made to the objectives contained in the plans of West Dunbartonshire Council and NHS Greater Glasgow and Clyde.		

2(d) Does the body have a climate change plan or strategy?

If yes, provide the name of any such document and details of where a copy of the document may be obtained or accessed.

The accountability and responsibility for climate change governance in relation to the delivery of Council and Health Services lies with West Dunbartonshire Health & Social Care Partnership Board's partner statutory bodies i.e. West Dunbartonshire Council and Greater Glasgow and Clyde Health Board. These partners have governance and decision making structures in place to support sustainability planning and a range of climate change adaptations and improvements. Both these partners will submit Public Bodies Climate Change Duties Reports that will detail their arrangements. Please see associated documents within these partners reports.

2(e) Does the body have any plans or strategies covering the following areas that include climate change?

Provide the name of any such document and the timeframe covered.

Topic area	Name of document	Link	Time period covered	Comments
Adaptation	N/A			Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board
Business travel	N/A			Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board
Staff Travel	N/A			Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board
Energy efficiency	N/A			Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board

Fleet transport	N/A			Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board
Information and communication technology	N/A			Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board
Renewable energy	N/A			Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board
Sustainable/renewable heat	N/A			Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board
Waste management	N/A			Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board
Water and sewerage	N/A			Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board
Land Use	N/A			Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board
Other (state topic area covered in comments)	N/A			Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board

2(f) What are the body's top 5 priorities for climate change governance, management and strategy for the year ahead?

Provide a brief summary of the body's areas and activities of focus for the year ahead.

The accountability and responsibility for climate change governance in relation to the delivery of Council and Health Services lies with West Dunbartonshire Health & Social Care Partnership Board's partner statutory bodies i.e. West Dunbartonshire Council and Greater Glasgow and Clyde Health Board. These partners have governance and decision making structures in place to support sustainability planning and a range of climate change adaptations and improvements. Both these partners will submit Public Bodies Climate Change Duties Reports that will detail their arrangements.

2(g) Has the body used the Climate Change Assessment Tool(a) or equivalent tool to self-assess its capability / performance?

If yes, please provide details of the key findings and resultant action taken.

The accountability and responsibility for climate change governance in relation to the delivery of Council and Health Services lies with West Dunbartonshire Health & Social Care Partnership Board's partner statutory bodies i.e. West Dunbartonshire Council and Greater Glasgow and Clyde Health Board. These partners have governance and decision making structures in place to support sustainability planning and a range of climate change adaptations and improvements. Both these partners will submit Public Bodies Climate Change Duties Reports that will detail their arrangements.

2(h) Supporting information and best practice

Provide any other relevant supporting information and any examples of best practice by the body in relation to governance, management and strategy.

The accountability and responsibility for climate change governance in relation to the delivery of Council and Health Services lies with West Dunbartonshire Health & Social Care Partnership Board's partner statutory bodies i.e. West Dunbartonshire Council and Greater Glasgow and Clyde Health Board. These partners have governance and decision making structures in place to support sustainability planning and a range of climate change adaptations and improvements. Both these partners will submit Public Bodies Climate Change Duties Reports that will detail their arrangements.

PART 3: EMISSIONS, TARGETS AND PROJECTS

3a Emissions from start of the year which the body uses as a baseline (for its carbon footprint) to the end of the report year

Complete the following table using the greenhouse gas emissions total for the body calculated on the same basis as for its annual carbon footprint /management reporting or, where applicable, its sustainability reporting. Include greenhouse gas emissions from the body's estate and operations (a) (measured and reported in accordance with Scopes 1 & 2 and, to the extent applicable, selected Scope 3 of the Greenhouse Gas Protocol (b)). If data is not available for any year from the start of the year which is used as a baseline to the end of the report year, provide an explanation in the comments column.
 (a) No information is required on the effect of the body on emissions which are not from its estate and operations.

Reference Year	Year	Scope1	Scope2	Scope3	Total	Units	Comments
N/A							

3b Breakdown of emission sources

Complete the following table with the breakdown of emission sources from the body's most recent carbon footprint (greenhouse gas inventory); this should correspond to the last entry in the table in 3(a) above. Use the 'Comments' column to explain what is included within each category of emission source entered in the first column. If, for any such category of emission source, it is not possible to provide a simple emission factor(a) leave the field for the emission factor blank and provide the total emissions for that category of emission source in the 'Emissions' column.

Total	Comments – reason for difference between Q3a & 3b.	Emission source	Scope	Consumption data	Units	Emission factor	Units	Emissions (tCO2e)	Comments
0.0									N/A

3c Generation, consumption and export of renewable energy

Provide a summary of the body's annual renewable generation (if any), and whether it is used or exported by the body.

Technology	Renewable Electricity		Renewable Heat		Comments
	Total consumed by the organisation (kWh)	Total exported (kWh)	Total consumed by the organisation (kWh)	Total exported (kWh)	
Other					N/A

3d Targets

List all of the body's targets of relevance to its climate change duties. Where applicable, overall carbon targets and any separate land use, energy efficiency, waste, water, information and communication technology, transport, travel and heat targets should be included.

Name of Target	Type of Target	Target	Units	Boundary/scope of Target	Progress against target	Year used as baseline	Baseline figure	Units of baseline	Target completion year	Comments
N/A										N/A

3e Estimated total annual carbon savings from all projects implemented by the body in the report year

Total	Emissions Source	Total estimated annual carbon savings (tCO2e)	Comments
0.00	Electricity		N/A
	Natural gas		N/A
	Other heating fuels		N/A

Waste		N/A
Water and sewerage		N/A
Business Travel		N/A
Fleet transport		N/A
Other (specify in comments)		N/A

3f Detail the top 10 carbon reduction projects to be carried out by the body in the report year

Provide details of the 10 projects which are estimated to achieve the highest carbon savings during report year.

Project name	Funding source	First full year of CO2e savings	Are these savings figures estimated or actual?	Capital cost (£)	Operational cost (£/annum)	Project lifetime (years)	Primary fuel/emission source saved	Estimated carbon savings per year (tCO2e/annum)	Estimated costs savings (£/annum)	Behaviour Change	Comments
N/A											N/A

3g Estimated decrease or increase in the body's emissions attributed to factors (not reported elsewhere in this form) in the report year

If the emissions increased or decreased due to any such factor in the report year, provide an estimate of the amount and direction.

Total	Emissions source	Total estimated annual emissions (tCO2e)	Increase or decrease in emissions	Comments
0.00	Estate changes			N/A
	Service provision			N/A
	Staff numbers			N/A
	Other (specify in comments)			N/A

3h Anticipated annual carbon savings from all projects implemented by the body in the year ahead

Total	Source	Saving	Comments
0.00	Electricity		N/A
	Natural gas		N/A
	Other heating fuels		N/A
	Waste		N/A
	Water and sewerage		N/A
	Business Travel		N/A
	Fleet transport		N/A
	Other (specify in comments)		N/A

3i Estimated decrease or increase in the body's emissions attributed to factors (not reported elsewhere in this form) in the year ahead				
If the emissions are likely to increase or decrease due to any such factor in the year ahead, provide an estimate of the amount and direction.				
Total	Emissions source	Total estimated annual emissions (tCO2e)	Increase or decrease in emissions	Comments
0.00	Estate changes			N/A
	Service provision			N/A
	Staff numbers			N/A
	Other (specify in comments)			N/A

3j Total carbon reduction project savings since the start of the year which the body uses as a baseline for its carbon footprint	
If the body has data available, estimate the total emissions savings made from projects since the start of that year ("the baseline year").	
Total	Comments
	N/A

3k Supporting information and best practice
Provide any other relevant supporting information and any examples of best practice by the body in relation to its emissions, targets and projects.
Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

PART 4: ADAPTATION

4(a) Has the body assessed current and future climate-related risks?

If yes, provide a reference or link to any such risk assessment(s).

Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

4(b) What arrangements does the body have in place to manage climate-related risks?

Provide details of any climate change adaptation strategies, action plans and risk management procedures, and any climate change adaptation policies which apply across the body.

Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information. However, WD Health and Social Care Partnership Board will consider and discuss whether climate change risks/issues should be taken into account in future strategic service planning and development.

4(c) What action has the body taken to adapt to climate change?

Include details of work to increase awareness of the need to adapt to climate change and build the capacity of staff and stakeholders to assess risk and implement action.

Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

4(d) Where applicable, what progress has the body made in delivering the policies and proposals referenced N1, N2, N3, B1, B2, B3, S1, S2 and S3 in the Scottish Climate Change Adaptation Programme(a) ("the Programme")?

If the body is listed in the Programme as a body responsible for the delivery of one or more policies and proposals under the objectives N1, N2, N3, B1,B2, B3, S1, S2 and S3, provide details of the progress made by the body in delivering each policy or proposal in the report year. If it is not responsible for delivering any policy or proposal under a particular objective enter "N/A" in the 'Delivery progress made' column for that objective.

(a) This refers to the programme for adaptation to climate change laid before the Scottish Parliament under section 53(2) of the Climate Change (Scotland) Act 2009 (asp 12) which currently has effect. The most recent one is entitled "Climate Ready Scotland: Scottish Climate Change Adaptation Programme" dated May 2014.

Objective	Objective reference	Theme	Policy / Proposal reference	Delivery progress made	Comments
Understand the effects of climate change and their impacts on the natural environment.	N1	Natural Environment		N/A	Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.
Support a healthy and diverse natural environment with capacity to adapt.	N2	Natural Environment		N/A	Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.
Sustain and enhance the benefits, goods and services that the natural environment provides.	N3	Natural Environment		N/A	Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.
Understand the effects of climate change and their impacts on buildings and infrastructure networks.	B1	Buildings and infrastructure networks		N/A	Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.
Provide the knowledge, skills and tools to manage climate change impacts on buildings and infrastructure.	B2	Buildings and infrastructure networks		N/A	Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

Increase the resilience of buildings and infrastructure networks to sustain and enhance the benefits and services provided.	B3	Buildings and infrastructure networks		N/A	Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.
Understand the effects of climate change and their impacts on people, homes and communities.	S1	Society		N/A	Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.
Increase the awareness of the impacts of climate change to enable people to adapt to future extreme weather events.	S2	Society		N/A	Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.
Support our health services and emergency responders to enable them to respond effectively to the increased pressures associated with a changing climate.	S3	Society		N/A	Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

4(e) What arrangements does the body have in place to review current and future climate risks?

Provide details of arrangements to review current and future climate risks, for example, what timescales are in place to review the climate change risk assessments referred to in Question 4(a) and adaptation strategies, action plans, procedures and policies in Question 4(b).

Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

4(f) What arrangements does the body have in place to monitor and evaluate the impact of the adaptation actions?

Please provide details of monitoring and evaluation criteria and adaptation indicators used to assess the effectiveness of actions detailed under Question 4(c) and Question 4(d).

Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

4(g) What are the body's top 5 priorities for the year ahead in relation to climate change adaptation?

Provide a summary of the areas and activities of focus for the year ahead.

Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

4(h) Supporting information and best practice

Provide any other relevant supporting information and any examples of best practice by the body in relation to adaptation.

Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

PART 5: PROCUREMENT

5(a) How have procurement policies contributed to compliance with climate change duties?

Provide information relating to how the procurement policies of the body have contributed to its compliance with climate changes duties.

The West Dunbartonshire Health and Social Care Partnership Board (IJB) has not and does not as its usual practice procure services directly. Any procurement required by the Health and Social Care Partnership is undertaken through the arrangements and in accordance of the relevant policies of either West Dunbartonshire Council and NHS Greater Glasgow and Clyde (as appropriate). Both these bodies will submit a Public Bodies Climate Change Report that will address this. Please refer to these reports for this information.

5(b) How has procurement activity contributed to compliance with climate change duties?

Provide information relating to how procurement activity by the body has contributed to its compliance with climate changes duties.

The West Dunbartonshire Health and Social Care Partnership Board (IJB) has not and does not as its usual practice procure services directly. Any procurement required by the Health and Social Care Partnership is undertaken through the arrangements and in accordance of the relevant policies of either West Dunbartonshire Council and NHS Greater Glasgow and Clyde (as appropriate). Both these bodies will submit a Public Bodies Climate Change Report that will address this. Please refer to these reports for this information.

5(c) Supporting information and best practice

Provide any other relevant supporting information and any examples of best practice by the body in relation to procurement.

The West Dunbartonshire Health and Social Care Partnership Board (IJB) has and does not as its usual practice procure services directly. Any procurement required by the Health and Social Care Partnership is undertaken through the arrangements and in accordance of the relevant policies of either West Dunbartonshire Council and NHS Greater Glasgow and Clyde (as appropriate). Both these bodies will submit a Public Bodies Climate Change Report that will address this. Please refer to these reports for this information.

PART 6: VALIDATION AND DECLARATION

6(a) Internal validation process

Briefly describe the body's internal validation process, if any, of the data or information contained within this report.

The accountability for climate change governance in relation to the delivery of the delegated services remains with West Dunbartonshire Council and NHS Greater Glasgow and Clyde. Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information. However, this report and associated cover paper will be presented to the WD HSCP Partnership Board in November 2017 for approval prior to submission to Sustainable Scotland Network

6(b) Peer validation process

Briefly describe the body's peer validation process, if any, of the data or information contained within this report.

The accountability for climate change governance in relation to the delivery of the delegated services remains with West Dunbartonshire Council and NHS Greater Glasgow and Clyde. Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information. However, this report has been consulted on with colleagues across other HSCP's prior to submission.

6(c) External validation process

Briefly describe the body's external validation process, if any, of the data or information contained within this report.

The accountability for climate change governance in relation to the delivery of the delegated services remains with West Dunbartonshire Council and NHS Greater Glasgow and Clyde. Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

6(d) No validation process

If any information provided in this report has not been validated, identify the information in question and explain why it has not been validated.

Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

6e - Declaration

I confirm that the information in this report is accurate and provides a fair representation of the body's performance in relation to climate change.

Name	Role in the body	Date
Soumen Sengupta	Head of Strategy, Planning & Health Improvement	22-10-2017

RECOMMENDED – WIDER INFLUENCE

Q1 Historic Emissions (Local Authorities only)
 Please indicate emission amounts and unit of measurement (e.g. tCO2e) and years. Please provide information on the following components using data from the links provided below. Please use (1) as the default unless targets and actions relate to (2).
 (1) UK local and regional CO2 emissions: **subset dataset** (emissions within the scope of influence of local authorities):
 (2) UK local and regional CO2 emissions: **full dataset**:
Select the default target dataset
 N/A

Table 1a - Subset

Sector	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Units	Comments
													N/A

Table 1b - Full

Sector	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Units	Comments

Q2a – Targets
 Please detail your wider influence targets

Sector	Description	Type of Target (units)	Baseline value	Start year	Target saving	Target / End Year	Saving in latest year measured	Latest Year Measured	Comments
N/A									N/A

Q2b) Does the Organisation have an overall mission statement, strategies, plans or policies outlining ambition to influence emissions beyond your corporate boundaries? If so, please detail this in the box below.

The accountability and responsibility for climate change governance in relation to the delivery of the delegated services remains with West Dunbartonshire Council and NHS Greater Glasgow and Clyde. Please refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

Q3) Policies and Actions to Reduce Emissions

Sector	Start year for policy / action implementation	Year that the policy / action will be fully implemented	Annual CO2 saving once fully implemented (tCO2)	Latest Year measured	Saving in latest year measured (tCO2)	Status	Metric / indicators for monitoring progress	Delivery Role	During project / policy design and implementation, has ISM or an equivalent behaviour change tool been used?	Please give further details of this behaviour change activity	Value of Investment (£)	Ongoing Costs (£/ year)	Primary Funding Source for Implementation of Policy / Action	Comments
N/A										N/A			N/A	N/A

Please provide any detail on data sources or limitations relating to the information provided in Table 3

Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

Q4) Partnership Working, Communication and Capacity Building.
 Please detail your Climate Change Partnership, Communication or Capacity Building Initiatives below.

Key Action Type	Description	Action	Organisation's project role	Lead Organisation (if not reporting organisation)	Private Partners	Public Partners	3rd Sector Partners	Outputs	Comments
N/A									

OTHER NOTABLE REPORTABLE ACTIVITY

Q5) Please detail key actions relating to Food and Drink, Biodiversity, Water, Procurement and Resource Use in the table below.

Key Action Type	Key Action Description	Organisation's Project Role	Impacts	Comments
N/A				N/A

Q6) Please use the text box below to detail further climate change related activity that is not noted elsewhere within this reporting template

Refer to the Climate Change Reports from West Dunbartonshire Council and Greater Glasgow and Clyde Health Board for this information.

**WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE
PARTNERSHIP**

Health and Social Care Partnership Board: 22 November 2017

Subject: Audited Annual Accounts 2016/17

1. Purpose

- 1.1** To present the Health and Social Care Partnership Board with the Annual Audit Report, prepared by the HSCP Board's external auditors, Audit Scotland and the Annual Accounts for the year ended 31 March 2017.

2. Recommendations

2.1 The Board is recommended to:

- Note the previous recommendation of the HSCP Board of 23 August 2017 to remit the approval of the Annual Report and Accounts to the 20 September 2017 Audit Committee for the financial year 2016/17;
- Consider the contents of the Annual Report to the IJB and Controller of Audit for the financial year ending 31 March 2017; and
- Welcome the achievement of a qualification free set of HSCP Board accounts.

3. Background

3.1 The Annual Report and Accounts for the IJB were prepared in accordance with appropriate legislation and guidance. An overview of the process, legislative requirements and key stages were set out in the previous report of 23 August 2017.

3.2 The Annual Report prepared by the Board's external auditors, Audit Scotland, is attached at Appendix 1 and confirms that the Annual Report and Accounts are unqualified, meet legislative requirements, have no significant issues and confirm sound governance.

3.3 In addition to the above, a signed copy of the final 2016/17 Annual Accounts and Audit Certificate (ISA 260) is attached at Appendix 2.

4. Main Issues

4.1 The HSCP Board approved the Audit Committee to review the 2016/17 unaudited accounts prior to their submission to external audit and to approve the Annual Report and Accounts for final sign off before the statutory deadline of 30 September 2017.

- 4.2** During the audit there were some presentational and disclosure issues identified, mainly relating to the use of the new template approved by CIPFA/LASAAC and the requirements of the 2016/17 Accounting Code of Practice. These were adjusted for accordingly but made no impact on the reported overall surplus position. The HSCP Board had been successful in managing its expenditure within the income available for both health and social care, by achieving a surplus of £3.956m mainly related to unapplied Social Care Fund resources, which is held in reserve to support financial sustainability in future years.
- 4.3** There was a change to the split of total reserves between earmarked and unearmarked to reflect the decision of the HSCP Board on 23 August 2017. The £0.321m earmarked reserve for prescribing risk has been re-routed to cover the HSCP Board's £0.274m share of unachieved savings, with the £0.047m residual adding to the unearmarked reserves balance. These are reflected below in the reserves table extracted from the Annual Accounts.

Usable Reserve: General Fund

Balance as at 1st April 2015	Transfers Out 2015/16	Transfers In 2015/16	Balance as at 31st March 2016		Transfers Out 2016/17	Transfers In 2016/17	Balance as at 31st March 2016
£000	£000	£000	£000		£000	£000	£000
0	0	(301)	(301)	Integrated Care Fund	301	(555)	(555)
0	0	(275)	(275)	Delayed Discharge	191	(87)	(171)
0	0	(205)	(205)	GIRFEC NHS	30	0	(175)
0	0	(24)	(24)	GIRFEC Council	10	0	(14)
0	0	(46)	(46)	MSK Physio	46	0	0
0	0	(21)	(21)	Ophthalmology	21	0	0
0	0	(48)	(48)	Criminal Justice - transitional funds	48	(60)	(60)
0	0	(200)	(200)	DWP Conditions Management	16	0	(184)
0	0	0	0	TEC (Technology enabled care) project	0	(118)	(118)
0	0	0	0	Cluster lead funding	0	(26)	(26)
0	0	0	0	SMT Leadership development funding	0	(3)	(3)
0	0	0	0	Social Care Fund - Living Wage	0	(833)	(833)
0	0	0	0	Service Redesign and Transformation	0	(1,000)	(1,000)
				Physio waiting times initiative	0	(75)	(75)
0	0	0	0	CHCP 2015/16 Saving	0	(274)	(274)
0	0	(1,120)	(1,120)	Total Earmarked Reserves	663	(3,031)	(3,488)
0	0	(492)	(492)	Unearmarked	396	(1,984)	(2,080)
0	0	(1,612)	(1,612)	Total General Fund	1,059	(5,015)	(5,568)

4.4 The Annual Accounts of the IJB must be published by 31 October and any further reports by the External Auditor by 31 December immediately following the year to which they relate. These can be found on our website as required.

4.5 The Chief Financial Officer would like to extend thanks to colleagues from Audit Scotland for their advice and assistance during the audit of the accounts. Also to accountancy and finance staff within the partnership and both partner organisations, acknowledging the high quality, detailed work involved in the year end closure.

5. People Implications

5.1 None associated with this report.

6. Financial Implications

6.1 The HSCP Board achieved a surplus of £3.956m in 2016/17, which will be retained in accordance with the Integration Scheme and now holds cumulative reserves of £5.568m.

7. Professional Implications

7.1 None associated with this report.

8. Locality Implications

8.1 None associated with this report.

9. Risk Analysis

9.1 The HSCP Board has identified the requirement to develop a medium term financial plan to identify and help mitigate the risk of future funding gaps.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 This report has been completed in consultation with the HSCP Board's external auditor's Audit Scotland.

12. Strategic Assessment

12.1 This report is in relation to a statutory function and as such does not directly affect any of the strategic priorities.

Author: Julie Slavin – Chief Financial Officer,

Date: 8 November 2017

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Appendices: **Appendix 1** - Audit Scotland - Annual Audit Report 2016/17
Appendix 2 – 2016/17 Annual Accounts & ISA 260

Background Papers: Audit Committee June 2017 – Draft Unaudited Annual Accounts

Audit Committee September 2017 – Final audited Annual Accounts

Wards Affected: All

West Dunbartonshire IJB

2016/17 Annual Audit Report

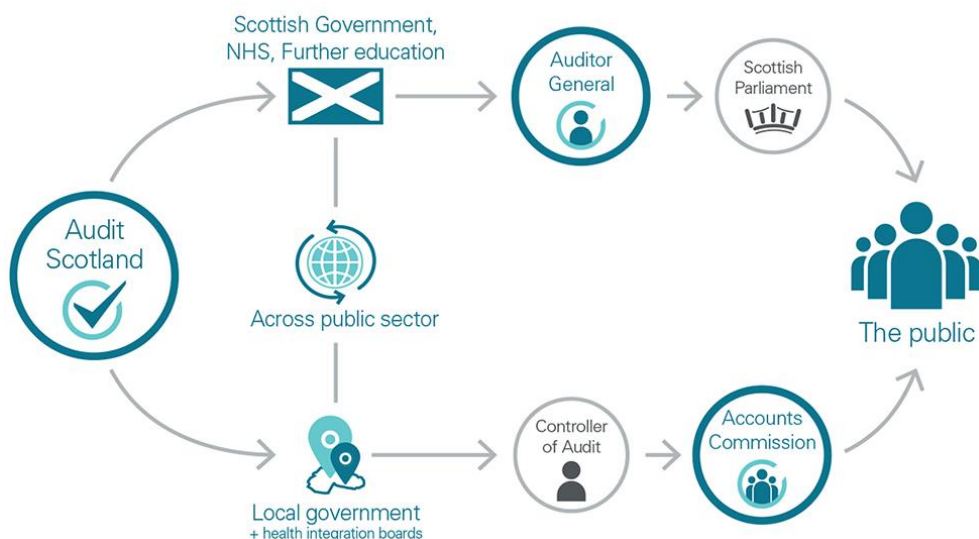


Prepared for the members of West Dunbartonshire IJB and the Controller of Audit
20 September 2017

Who we are

The Auditor General, the Accounts Commission and Audit Scotland work together to deliver public audit in Scotland:

- The Auditor General is an independent crown appointment, made on the recommendation of the Scottish Parliament, to audit the Scottish Government, NHS and other bodies and report to Parliament on their financial health and performance.
- The Accounts Commission is an independent public body appointed by Scottish ministers to hold local government to account. The Controller of Audit is an independent post established by statute, with powers to report directly to the Commission on the audit of local government.
- Audit Scotland is governed by a board, consisting of the Auditor General, the chair of the Accounts Commission, a non-executive board chair, and two non-executive members appointed by the Scottish Commission for Public Audit, a commission of the Scottish Parliament.



About us

Our vision is to be a world-class audit organisation that improves the use of public money.

Through our work for the Auditor General and the Accounts Commission, we provide independent assurance to the people of Scotland that public money is spent properly and provides value. We aim to achieve this by:

- carrying out relevant and timely audits of the way the public sector manages and spends money
- reporting our findings and conclusions in public
- identifying risks, making clear and relevant recommendations.

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Key messages

2016/17 annual accounts

- 1 The financial statements of West Dunbartonshire Integration Joint Board (WDIJB) for 2016/17 give a true and fair view of the state of its affairs and of its net expenditure for the year.
- 2 We have issued an unqualified independent auditor's report on the Annual Report and Accounts for 2016/17.

Financial management

- 3 WDIJB current budgetary process arrangements provide timely and reliable information for monitoring financial performance. However these arrangements should be strengthened by producing a year end report reconciling any differences between the budget reports and the unaudited accounts.
- 4 WDIJB achieved a surplus of £3.956 million. This is retained by the joint board in accordance with the integration scheme, to support financial management in future years.

Financial sustainability

- 5 WDIJB now holds cumulative reserves of £5.568 million. £3.488 million has been earmarked for specific purposes with the balance held as a contingency fund.
- 6 The Board approved the 2017/18 budget at their meeting on the 23 August 2017, almost six months into the financial year. This was due to delays in agreement of the health allocation to WDIJB.
- 7 WDIJB should develop medium to long term financial planning to mitigate the risk of future funding gaps and potential delays in agreeing funding allocations.

Governance and transparency

- 8 WDIJB has effective governance arrangements in place.
- 9 Internal audit arrangements and expectations need to be further clarified and formalised between the IJB and NHS Greater Glasgow & Clyde (NHSGGC).

Value for money

- 10 The Annual Performance Report was formally approved and submitted on 23 August 2017, missing the statutory publication deadline of 31 July 2017. However we note that the draft report was available through committee reports a week after the deadline and the Scottish Government had been made aware of this.

- 11** The IJB should continue to develop systems and processes to ensure that it can demonstrate that it is delivering Best Value by assessing and reporting on its arrangements to promote continuous improvement and value for money in service provision.

Introduction

1. This report is a summary of our findings arising from the 2016/17 audit of West Dunbartonshire IJB, hereby referred to as the 'WDIJB'. The report is divided into sections which reflect our public sector audit model.
2. The scope of our audit was set out in our Annual Audit Plan presented to the March 2017 special meeting of the Board. It comprises an audit of the annual accounts and consideration of the four audit dimensions that frame the wider scope of public sector audit requirements as illustrated in [Exhibit 1](#).

Exhibit 1 Audit dimensions



Source: Code of Audit Practice 2016

3. The main elements of our audit work in 2016/17 have been:
 - an interim audit of WDIJB's governance arrangements
 - obtaining service audit assurances from the auditors of NHS Greater Glasgow & Clyde (NHSGGC) and West Dunbartonshire Council (WDC)
 - an audit of WDIJB 2016/17 annual accounts.
4. WDIJB is responsible for preparing the annual accounts that show a true and fair view and, for establishing effective arrangements for governance, which enable them to successfully deliver their objectives.
5. Our responsibilities as independent auditor are established by the Local Government (Scotland) Act 1973, the [Code of Audit Practice \(2016\)](#), and supplementary guidance, and are guided by the auditing profession's ethical guidance.

6. These responsibilities include giving independent opinions on the financial statements, the remuneration report, the management commentary and the annual governance statement. We also review and report on the arrangements within the IJB to manage its performance, and use of resources. In doing this, we aim to support improvement and accountability.
7. Further details of the respective responsibilities of management and the auditor can be found in the [Code of Audit Practice \(2016\)](#) and supplementary guidance.
8. The weaknesses or risks identified in this report are only those that have come to our attention during our normal audit work, and may not be all that exist. Also, our annual audit report contains an action plan at [Appendix 1 \(page 21\)](#). It sets out specific recommendations, responsible officers and dates for implementation.
9. Communication in this report of matters arising from the audit of the annual accounts or of risks or of weaknesses does not absolve management from its responsibility to address the issues raised and to maintain an adequate system of control.
10. As part of the requirement to provide fair and full disclosure of matters relating to our independence, we can confirm that we have not undertaken non-audit related services. The 2016/17 audit fee for the audit was set out in our Annual Audit Plan and as we did not carry out any work additional to our planned audit activity, the fee remains unchanged.
11. This report is addressed to both the Board and the Accounts Commission and will be published on Audit Scotland's website www.audit-scotland.gov.uk.
12. We would like to thank all management and staff who have been involved in our work for their co-operational and assistance during the audit.

Part 1

Audit of 2016/17 annual accounts



Main judgements

The financial statements of the joint board for 2016/17 give a true and fair view of the state of its affairs and of its net expenditure for the year.

We have issued an unqualified independent auditor's report on the Annual Accounts for 2016/17.

Unqualified audit opinions

13. The annual accounts for the year ended 31 March 2017 were approved by the Board on 20 September 2017. We reported, within our independent auditor's report:

- an unqualified opinion on the financial statements;
- unqualified opinions on the remuneration, management commentary and the annual governance statement.

14. Additionally, we have nothing to report in respect of those matters which we are required by the Accounts Commission to report by exception.

Submission of annual accounts for audit

15. We received the unaudited financial statements on 14 June 2017, in line with our agreed timetable within our Annual Audit Plan.

16. Information on year-end balances for consolidation purposes was provided by WDIJB to NHSGGC by the 30 May 2017, in line with the agreed timetable.

17. The preparation of the WDIJB financial statements relies on the provision of timely and reliable information from the systems of WDC and NHSGGC. Assurances were received by the IJB's Chief Financial Officer from its host bodies confirming the completeness and accuracy of the information supplied.

18. The working papers provided with the unaudited annual accounts were of a good standard and finance staff, including the Chief Financial Officer, provided good support to the audit team which helped ensure the final accounts audit process ran smoothly.

Risks of material misstatement

19. [Appendix 2](#) provides a description of those assessed risks of material misstatement that were identified during the planning process which had the

The annual accounts are the principal means of accounting for the stewardship of its resources and its performance in the use of those resources.

greatest effect on the overall audit strategy, the allocation of resources to the audit and directing the efforts of the audit team. Also, included within the appendix are wider dimension risks, how we addressed these and conclusions.

Materiality

20. Materiality defines the maximum error that we are prepared to accept and still conclude that that our audit objective has been achieved. The assessment of what is material is a matter of professional judgement. It involves considering both the amount and nature of the misstatement.

21. Our initial assessment of materiality for the annual accounts was carried out during the planning phase of the audit and was reported in the Annual Audit Plan. We assess the materiality of uncorrected misstatements, both individually and collectively.

22. On receipt of the unaudited accounts we recalculated materiality and this is summarised at [Exhibit 2](#)

Exhibit 2

Materiality values

Materiality level	Amount
Overall materiality - This is the calculated figure we use in assessing the overall impact of audit adjustments on the financial statements. It was set at 1% of gross expenditure for the year ended 31 March 2017.	£1.8million
Performance materiality - This acts as a trigger point. If the aggregate of errors identified during the financial statements audit exceeds performance materiality this would indicate that further audit procedures should be considered. Using our professional judgement we have calculated performance materiality at 50% of overall materiality.	£0.91 million
Reporting threshold - We are required to report to those charged with governance on all unadjusted misstatements in excess of the 'reporting threshold' amount. This has been calculated at 1% of overall materiality.	£0.018 million

Significant findings

23. International Standard on Auditing (UK and Ireland) 260 requires us to communicate to you significant findings from the audit. These are summarised in [Exhibit 3 \(page 10\)](#). Where a finding has resulted in a recommendation to management, a cross reference to the Action Plan in [Appendix 1 \(page 21\)](#) has been included.

Agency Income and Expenditure

24. On behalf of all IJBs within the Greater Glasgow & Clyde (GGC) area, the WDIJB acts as the lead manager, or host, for a number of delegated services. Similarly other IJBs' within GGC area act as the lead manager, or host, for a number of delegated services on behalf of WDIJB.

25. According to the Code of Practice, by which the accounts of WDIJB are prepared, any transactions not relating to WDIJB should not feature within its financial statements.

26. For 2016/17 the payments that were made on behalf of the other GGC IJBs' (and the consequential reimbursement) are removed from the Comprehensive Income and Expenditure Statement (CIES). Similarly the payments that are made by the other IJBs on behalf of WDIJB (and the consequential reimbursement) are included in the CIES since this expenditure is incurred for the residents of West Dunbartonshire.

27. For 2015/16 there was no comparative data. Therefore in line with the Code of Practice we requested that management restate 2015/16 figures with the removal of the total cost of services hosted by WDIJB as there was no available cost data linking activity across all partnerships to expenditure.

28. The value of hosted services for the 9 months of 2015/16 was £5.128 million and when included the total "taxation and non-specific grant income" equals £118.865m which represents the actual funding for 2015/16.

Other findings

29. We identified a number of other presentational and disclosure issues in the draft accounts. These were discussed with management and were adjusted for and have been reflected in the audited financial statements.

Exhibit 3

Significant findings from the audit of the financial statements

Issue	Resolution
<p>1. Hospital Acute Services (Set Aside)</p> <p>A notional figure for the 'set aside' for hospital acute services under the control of WDIJB has been agreed with NHSGGC and included in the NHSGGC and WDIJB 2016/17 annual accounts. This is based on 2015/16 activities and the levels have been up-rated to reflect the 2016/17 position.</p> <p>As such the, the set aside sum disclosed within the 2016/17 annual accounts does not accurately reflect actual hospital use.</p>	<p>The Comprehensive Income and Expenditure Account in the annual accounts correctly incorporates the set aside costs.</p> <p>This is a transitional arrangement for 2016/17 which was agreed by the Scottish Government. Therefore this disclosure has been accepted for 2016/17.</p> <p>Action Plan (Appendix 1, point 1)</p>

Part 2

Financial management



Main judgements

Current budgetary process arrangements provide timely and reliable information to the Board. However these arrangements should be strengthened by producing a year end report reconciling any differences between the budget reports and the unaudited accounts.

No weaknesses in internal controls were identified by either host body systems which are used to process IJB transactions.

Financial management

30. Financial management is about financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively. It is the Board's responsibility to ensure that its financial affairs are conducted in a proper manner.

31. As auditors, we need to consider whether audited bodies have established adequate financial management arrangements. We do this by considering a number of factors, including whether:

- the Chief Financial Officer has sufficient status to be able to deliver good financial management
- standing financial instructions and standing orders are comprehensive, current and promoted within WDIJB
- reports monitoring performance against budgets are accurate and provided regularly to budget holders
- monitoring reports do not just contain financial data but are linked to information about performance
- WDIJB members provide a good level of challenge and question budget holders on significant variances.

32. The previous Chief Financial Officer retired in October 2016 and the current Chief Financial Officer has been in post from August 2016, therefore there was a sufficient handover period between the outgoing and incoming CFO.

33. WDIJB does not have any assets, nor does it directly incur expenditure or employ staff, other than the Chief Officer. All funding and expenditure for WDIJB is incurred by partners' bodies and processed in their accounting records.

34. Three budget monitoring reports were reported to the Board during 2016/17, in line with the number of Board meetings. During the course of the financial year, the position changed significantly from a deficit (£1.408 million) to a strong surplus

Financial management is about financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively.

(£2.774 million). This was mainly due to the unapplied Social Care Fund being omitted from earlier reports.

35. Budget monitoring reports for 2016/17 were submitted to the Board, with the unaudited accounts being submitted to the Audit Committee.

36. Following the year end, a report was taken to the May 2017 Board meeting which highlighted that since the March 2017 meeting the anticipated surplus for the year increased from £2.774 million to £3.112 million.

37. Subsequently the accounts which were taken to the June 2017 Audit Committee noted a year end surplus of £3.956 million. The variance was mainly due to the delay in the opening of the Dumbarton Care Home (£0.250 million) and an increase in the surplus from the Health Board (£0.396 million) which related to part achievement of 2016/17 savings in Learning Disability and Mental Health not approved until late in the financial year.

38. While we note that a verbal update was provided on the accounts, a report which reconciled the movements from the final outturn report to the accounts was not provided. This should be provided to the Board as part of their financial monitoring responsibilities as well as the Audit Committee so that they may sufficiently scrutinise and challenge any movements from outturn reports throughout the year.

[Action Plan \(Appendix 1, point 2\)](#)

Financial performance in 2016/17

39. The outturn is identified in [Exhibit 4](#). The underspend of £3.956 million has been retained by WDIJB with the reserves being apportioned between earmarked and contingency funds.

Exhibit 4 Budget Summary

IJB budget objective summary	Funding £m	Expenditure £m	Variance £m
NHS Greater Glasgow & Clyde (NHSGGC)	105.477	104.897	(0.580)
West Dunbartonshire Council (WDC)	62.216	58.840	(3.376)
Total Net Expenditure	167.693	163.737	(3.956)
Reserves retained by WDIJB comprised of:			
Earmarked Reserves – for health services	-	-	0.580
Earmarked Reserves – for social care services	-	-	1.835
Surplus from health services	-	-	0.000
Surplus from social care services)	-	-	1.541

Internal controls

40. WDIJB does not have any financial system of its own; instead it relies upon the financial system of its host bodies; NHSGGC and WDC to record all transactions.

The key financial systems which WDIJB relies upon include general ledger, trade payables, trade receivables and payroll.

41. As part of our audit approach we sought assurances from the external auditor of NHSGGC and WDC (in accordance with ISA 402) and confirmed there were no weaknesses in the systems of internal controls.

Part 3

Financial sustainability



Main judgements

WDIJB should develop medium to long term financial plans to demonstrate financial sustainability and support future developments.

Financial planning

42. WDIJB allocates the resources it receives from NHSGGC and WDC in line with the Strategic Plan. Due diligence was undertaken to consider the sufficiency of the 2016/17 budget and no issues were identified.

43. The budget for 2017/18 was approved by the Board at its meeting on 23 August 2017, almost six months into the financial year. The allocation from WDC was agreed at the March 2017 meeting of the Board, however the initial allocation from NHSGGC was rejected by WDIJB at that time due to the fact that the application of historic savings targets would bring the contribution from NHSGGC below 2016/17 cash levels. This means that till August 2017, the Board was operating without a fully approved budget.

[Action Plan \(Appendix 1, point 3\)](#)

44. There have been ongoing discussions between WDIJB and NHSGGC around the funding allocation. The Board has been made aware of these discussions and correspondence has been appended to the reports submitted to the Board, which has provided a transparent approach.

45. Currently there are no financial forecasts or savings plans which look beyond the current year. Therefore we conclude that there are no medium to long term financial plans in place. However we do note that this is something which the Chief Financial Officer was aware of at the start of the financial year and is something which the Chief Financial Officer is looking to progress through the Improvement Action Plan.

[Action Plan \(Appendix 1, point 4\)](#)

Reserves strategy

46. WDIJB is permitted to hold reserves under section 106 of the Local Government (Scotland) Act 1973. The integration scheme and the reserves policy set out the arrangements between the partners for addressing and financing any overspends or underspends. It highlights that underspends in an element of the operational budget arising from specific management action may be retained by the IJB to either fund additional in year capacity, or be carried forward to fund capacity in future years of the Strategic Plan. Alternatively, these can be returned to the partner bodies in the event of a windfall saving.

Financial sustainability looks forward to the medium and longer term to consider whether the body is planning effectively to continue to deliver its services or the way in which they should be delivered.

47. WDIJB was able to demonstrate that due to their specific management action, they secured additional turnover in mental health and learning disabilities in early response to implementing the 2016/17 approved savings. The finance reports highlighting this were written in consultation with host bodies.

48. Where there is a forecast overspend the partner bodies must agree a recovery plan to balance the budget

49. Reserves are an integral part of the medium and longer term financial plan of the IJB and its financial sustainability. A reserves policy was approved by the Audit Committee in January 2016. Reserves will be held by the IJB as both a contingency to mitigate the impact of unanticipated overspends and also to meet specific future commitments.

50. When determining the level of reserves to be held by the IJB, consideration was given to the strategic, operational and financial risks facing WDIJB in the medium term and the Board's overall approach to risk management. Based on the size and scale of the IJB, the Board has set a target level of general reserves at 2% of net expenditure. This is reviewed annually as part of the budget process and reported to the Board on 1 March 2017 and has remained at this level for 2017. Currently, 2% would equate to £2.83 million and therefore the unearmarked position within the accounts is within these parameters.

Efficiency savings

51. The IJB is required to make efficiency savings to maintain financial balance. In 2016/17 the IJB was expected to make efficiency savings of £2.424 million. The actual outturn position was £1.515 million. NHSGGC agreed to cover the shortfall of £0.909 million on a non-recurring basis.

52. For 207/18, savings required to be made from the Council are £2 million savings and this was fully met from the unallocated portion of the 2016/17 Social Care Fund recurring allocation.

53. For Health given the difficulties agreeing an opening budget allocation it was reported to the Board that WDIJB would cover the 1% pay award, apprentice levy and pensions recharge by imposing a 2% turnover target.

54. It is early to say whether that will be fully achieved but the August report did not highlight any concern at this stage.

Workforce planning

55. WDIJB relies on the workforce plans of the host bodies as IJB staff is employed by either WDC or NHSGGC. The IJB's Annual Performance Report, which was approved by the Board in August 2017, acknowledges the importance of workforce planning in WDIJB. This is reflected through integrated assessment process, shared planning arrangements, joint delivery of services and information sharing across community planning partners.

Part 4

Governance and transparency



Main judgements

WDIJB has effective governance arrangements in place that support the decisions by the Board.

There is currently no formal sharing protocol between the IJB and NHSGGC for the provision of Internal Audit Reviews.

The Board conducts their meetings in public and reports and minutes are available on their website.

Governance arrangements

56. The Board is responsible for the strategic planning, management and delivery of the health and social care services delegated to it in line with the Integration Scheme between its host bodies.

57. WDIJB has been fully operational since 1 July 2015. The Board has 22 members and is comprised of six voting members; equally split from both its partners. Non-voting members include a number of professional members and stakeholder representatives.

58. WDIJB is committed to ensuring the involvement of partner groups including community planning groups, the third sector, the independent sector and local communities. The Strategic Plan 2016-2019 and locality planning arrangements enable partners to engage in and support the delivery of the health and social care provision.

59. As stated on page five, we completed an interim audit of WDIJB's governance arrangements. We concluded that good progress has been made in establishing governance arrangements and its governance framework. Going forward WDIJB should continue to regularly review their arrangements to ensure arrangements are effective.

60. There was a requirement for the IJB to publicly report on their compliance against their Local Governance Code in 2016/17. While the Local Code has been completed, the review against this was not and therefore was not publicly reported. We note that WDIJB was aware of this requirement and has included this as an action for 2017/18 within their Annual Governance Statement. We also note that the review will be reported to the September Audit Committee.

[Action Plan \(Appendix 1, point 5\)](#)

61. Based on the work we have undertaken and knowledge of the WDIJB, we are satisfied that the governance arrangements in place at the IJB are sound and support governance and accountability.

Governance and transparency is concerned with the effectiveness of scrutiny and governance arrangements, leadership and decision-making and transparent reporting of financial and performance information.

Internal audit

62. Internal audit provides the IJB Board and Chief Officer with independent assurance on the IJB's overall risk management, internal control and corporate governance processes. The IJB's internal audit function is carried out by the internal audit department of West Dunbartonshire Council. During our planning stage, we carried out a review of the adequacy of the internal audit function and concluded that it operates accordance with the Public Sector Internal Audit Standards (PSIAS) and has sound documentation standards and reporting procedures in place.

63. To avoid duplication effort we place reliance on the work of internal audit wherever possible. In 2016/17 we did not place any formal reliance on internal audit reviews for the purpose of obtaining direct assurance for our financial statements work of WDIJB. However, we considered the work of internal audit to inform our wider dimension work. We reviewed internal audit's findings in relation to WDIJB's governance, performance and financial management arrangements. There were no issues identified by internal audit that would have an impact on our audit of the IJB's annual accounts.

64. The IJB's Chief Internal Auditor concluded in the 2016/17 internal audit annual report that reasonable assurance can be placed on the adequacy and effectiveness of WDIJB's systems of governance, risk and internal control. This conclusion was based on the Chief Internal Auditor's audit work carried out at WDC that related to the IJB. The internal auditor at NHSGGC, PricewaterhouseCoopers (PwC), concluded in the 2016/17 internal audit annual report that NHSGGC's systems of governance, risk management and control were generally satisfactory.

65. In 2015/16 we reported that there was no mechanism in place for PwC to consult with the Audit Committee of the IJB regarding the audit work they planned to carry out relating to the IJB, nor was there a protocol for PwC reports to be presented to the Audit Committee.

66. In late 2016 PwC agreed that only the annual audit plans and annual audit reports that they issue to NHSGGC would be shared with the IJB's Chief Internal Auditor and that they would not attend meetings of the IJB's Audit Committee. In order for Board members to properly discharge their governance responsibilities, the Audit Committee needs to receive copies of all relevant reports affecting the IJB from the internal auditors at NHSGGC.

[Action Plan \(Appendix 1, point 6\)](#)

Risk management

67. Risk management arrangements were initially drafted in May 2015 and subsequently revised and approved by the Board in November 2015. There is a commitment by WDIJB to review these annually and submit to the Board for approval. The most recent version was approved by the Board at their meeting on November 2016.

68. Based on our review of the evidence we concluded that the IJB has appropriate risk management arrangements which are subject to regular review by the board.

Transparency

69. Transparency means that the public, and in particular, local residents, have access to understandable, relevant and timely information about how the IJB is taking decisions and how it is using resources.

70. There is evidence from a number of sources which demonstrate the IJB's commitment to transparency. For instance, full details of the meetings held by WDIJB are available on their website. The committee papers and minutes of

meetings are also publically available and members of the public are permitted to attend and observe board meetings. Public notice of each meeting is given on the WDIJB website. Audit Committee meetings are also open to members of the public.

71. Overall, we concluded that the IJB conducts its business in an open and transparent manner.

Complaints handling

72. The Scottish Public Services Ombudsman (SPSO) issued guidance and a template to help IJBs develop an appropriate complaints handling procedure. The IJB's social work complaints handling policy and procedures, based on SPSO guidance, were approved by the Board at a meeting on 1 March 2017.

Standards of conduct and arrangements for the prevention and detection of bribery and corruption

73. The Board requires that all members must comply with the Standards in Public Life - Code of Conduct for Members of Devolved Public Bodies. In August 2016 the Board agreed to adopt the template Code of Conduct for Integration Joint Boards which had been produced by the Scottish Government.

74. Based on our review of the evidence we concluded that the IJB has effective arrangements in place for the prevention and detection of corruption and we are not aware of any specific issues that we need to record in this report.

Part 5

Value for money



Main judgements

The annual performance report did not meet the statutory deadline of 31 July 2017

The IJB should continue to develop systems and processes to ensure that it can demonstrate that it is delivering Best Value by assessing and reporting on its arrangements to promote continuous improvement and value for money in service provision.

Best Value

75. Local government bodies, including IJBs, have a statutory duty to make arrangements to secure Best Value, through the continuous improvement in the performance of their functions. The characteristics of a Best Value organisation are laid out in Scottish Government Guidance issued in 2004.

76. The audit findings included throughout this report, comment on arrangements that have been put in place by the Joint Board to secure Best Value in areas such as the financial position, financial management, governance and performance management arrangements. While there is evidence of elements of Best Value being demonstrated by the joint board, there is no mechanism for formal review. The Joint Board should have systems and processes to ensure that it can demonstrate that it is delivering Best Value by assessing and reporting on its arrangements to promote continuous improvement and value for money in service provision.

Value for money is concerned with using resources effectively and continually improving services.

[Action Plan \(Appendix 1, point 7\).](#)

Performance management

77. In order to achieve value for money WDIJB should have effective arrangements for scrutinising performance, monitoring progress towards their strategic objectives and holding partners to account.

78. The Strategic Plan identifies three strategic commissioning priorities that are linked to the Scottish Government's nine health and wellbeing outcomes, together with the six additional outcomes for children and community justice. These are:

- Supporting Children & Young People
- Supporting Adults & Older People
- Supporting Safe, Strong & Involved Communities

79. These commissioning priorities are then further broken down into eleven strategic priorities, which can be found detailed within the Strategic Plan.

80. The Board receives performance reports on a quarterly basis to update on progress against the proposed targets and measures, with narrative to describe progress and actions for improvement.

81. The measures and targets demonstrate the IJB's progress against the three strategic priorities set out in the Strategic Plan and take account of national core indicators for integration, local delivery targets and relevant Single Outcome Agreement (SOA) targets.

82. The Public Bodies (Joint Working) (Scotland) Act 2014 requires that an annual performance report is completed within four months of the year end (31 July 2017). The performance report did not meet this deadline; it was submitted to the Board meeting on 23 August 2017. However we note that the draft report was available within Committee Reports one week after the deadline and that the Scottish Government had been made aware of this. In addition, 2016/17 was the first required publication of the Annual Performance Report; however WDIJB issued a report in 2015/16 which covered most of the areas required by the guidelines.

[Action Plan \(Appendix 1, point 9\)](#)

83. Of the 43 key performance indicators reported, for the end of 2016/17, 23 performance indicators were demonstrating positive performance against target, 10 were showing as narrowly missing the target, 8 performance indicators had been missed (i.e. target missed by 15% or over) and 1 had no current data available.

National performance audit reports

84. Audit Scotland carries out a national performance audit programme on behalf of the Accounts Commission and the Auditor General for Scotland.

85. In December 2015, we published the first of three national reports looking at the integration of health and social care. In the report we recognised that The Public Bodies (Joint Working) (Scotland) Act 2014 introduced a significant programme of reform affecting most health and care services and over £8 billion of public money. The reforms are far reaching and have scope to address previous barriers to providing the right care for people closer to home. We also reported some significant risks to the success of health and social care integration. These included complex governance arrangements, difficulties in budget-setting and consequent delays in strategic planning. The scale of the change is significant and will not happen quickly. Therefore, we will carry out a second audit in 2018, now integration authorities are more established, to look at progress and to follow up on these risks. The audit will also examine changes to the system, including evidence for shifts in service delivery from acute to community-based and preventative services, and for impact on the lives of local people.

86. During 2016/17, we published a number of reports which are of direct interest to WDIJB. These are outlined in [Appendix 3](#) accompanying this report. WDIJB has satisfactory arrangements in place for considering and reviewing national reports including any locally agreed actions, as evidenced by the updates taken to the Audit Committee in respect of Audit Scotland's Social Work in Scotland 2016 and NHS in Scotland 2016 reports.

Appendix 1

Action plan 2016/17

2016/17 recommendations for improvement

Page no.	Issue/risk	Recommendation	Agreed management action/timing
11	<p>1. Hospital Acute Services (Set Aside)</p> <p>Arrangements for the sum set aside for hospital acute services under the control of WDIJB are not yet operating as required by legislation and statutory guidance.</p> <p>A notional figure was included in the accounts under a transitional arrangement agreed by the Scottish Government.</p> <p>Risk</p> <p>In future years the sum set aside recorded in the annual accounts will not reflect actual hospital use.</p>	<p>NHSGGC and WDIJB should establish processes for planning and performance management of delegated hospital functions and associated resources in 2017/18.</p>	<p>A working group has been formed with NHSGGC finance colleagues, CFOs and the Scottish Government to establish processes for planning, quantifying and performance management of delegated hospital functions and associated resources in 2017/18.</p> <p>Chief Financial Officer</p> <p>June 2018</p>
13	<p>2. Budget Monitoring</p> <p>There were differences in the figures reported to the Board in May and the surplus in the draft accounts reported to the Audit Committee in June.</p> <p>Risk</p> <p>Budget reports may not provide sufficient information to enable members to review performance and make the necessary decisions.</p>	<p>A report which reconciles any movements from the final outturn report to the accounts should be provided to the Board and Audit Committee.</p>	<p>Going forward, a year end summary report will be provided for the Board and Audit Committee.</p> <p>Chief Financial Officer</p> <p>June 2018</p>



Page
no.

Issue/risk

Recommendation

Agreed
management
action/timing

15	3. 2017/18 Budget The budget for 2017/18 was not approved till 23 August 2017, which means that the Board was operating without a fully approved budget for almost six months of the financial year. Risk Operating without a fully approved budget makes financial management and decision making more difficult and may negatively affect the quality of service delivery.	The Board should continue to ensure that budgets for future years are approved as a matter of urgency.	2017/18 Budget has been approved at the August 2017 Board Meeting. We will continue to ensure future budgets are agreed as a matter of priority. Chief Financial Officer June 2018
15	4. Medium to Long term Financial Plans There are no medium to long term financial plans in place. This is increasingly important as demand pressures increase, financial settlements continue to reduce and fundamental service redesign over a longer time frame becomes necessary. Risk WDIJB is not planning adequately over the medium to long term to manage or respond to significant financial risks. Services may be affected if their sustainability is not planned. I	A long term financial strategy (5 years +) supported by clear and detailed financial plans (3 years +) should be prepared Plans should set out scenario plans (best, worst, most likely).	This has been committed through further actions in our Annual Governance Statement and is now also included in our Improvement Action Plan as part of our review of the Local Code of Governance. Chief Financial Officer February 2018
17	5. Local Code Good Governance Arrangements The requirement in 2016/17 for the IJB to publicly report on their compliance with their Local Governance Code was not met. Risk WDIJB did not adopt the requirements of the Delivering Good Governance Framework in 2016/17.	WDIJB should review compliance against their Local Code and publicly report on this for 2017/18.	This has been included as part of the agenda for the September Audit Committee for approval from the Board. Going forward the annual review will form part of our draft annual accounts timetable. Chief Financial Officer and Senior Management Team September 2017 and to be reported in 2017/18 annual report and accounts

Page no.	Issue/risk	Recommendation	Agreed management action/timing
18	<p>6. Internal Audit</p> <p>The internal auditors of NHSGGC do not share copies of individual internal audit reports with the IJB or attend meetings of the IJB's Audit Committee.</p> <p>Risk</p> <p>Officers and Board members may be unable properly discharge their scrutiny and governance responsibilities.</p>	<p>The WDIJB should develop a protocol with the auditors to facilitate for all internal audit reports that affect the IJB are made available to its Audit Committee.</p>	<p>Discussions have commenced with the NSGGC Assistant Director of Finance. We will work to develop an agreement, if possible within the existing terms of contract between HNSGGC and PwC.</p> <p>Chief Internal Auditor and Chief Financial Officer</p> <p>June 2018</p>
20	<p>7. Value for Money</p> <p>While there is evidence of elements of Best Value being demonstrated by the joint board, there is no mechanism for formal review.</p> <p>Risk</p> <p>Opportunities for continuous improvement are missed.</p>	<p>The IJB should undertake a periodic and evidenced formal review of its performance against the Scottish Government Best Value framework</p>	<p>Work on developing links with Annual Performance Report data to demonstrate that in a climate of financial austerity targets are on track.</p> <p>Head of Strategy, Planning and Health Improvement and Chief Financial Officer.</p> <p>July 2018</p>
21	<p>8. Annual Performance Report</p> <p>The 2014 Regulations require that an Annual Performance Report be approved and submitted within four months of the financial year end this was not achieved for 2016/17 with the report being submitted on 23 August</p> <p>Risk</p> <p>Non compliance with statutory regulations which is required to be reported by auditors. In addition, late submission delays the ability of Board members to review performance and progress improvement actions.</p>	<p>The WDIJB should ensure the Annual Performance Report is approved and submitted within the deadline.</p>	<p>To seek approval from the Board to publish a draft of the Annual Performance Report by 31 July subject to Board approval at the next available meeting.</p> <p>Head of Strategy, Planning and Health Improvement</p> <p>July 2018</p>

Appendix 2

Significant risks identified during planning

The table below sets out the audit risks we identified during our planning of the audit and how we addressed each risk in arriving at our conclusion. The risks are categorised between those where there is a risk of material misstatement in the annual accounts and those relating our wider responsibility under the [Code of Audit Practice 2016](#).

Audit risk	Assurance procedure	Results and conclusions
Risks of material misstatement in the financial statements		
<p>1 Risk of management override of controls</p> <p>ISA 240 requires that audit work is planned to consider the risk of fraud, which is presumed to be a significant risk in any audit. This includes consideration of the risk of management override of controls in order to change the position disclosed in the financial statements.</p>	<p>Detailed testing of journal entries.</p> <p>Review of accounting estimates.</p> <p>Focused testing of accruals and prepayments.</p> <p>Evaluation of significant transactions that are outside the normal course of business.</p>	<p>Satisfactory written assurances were received from the external auditors of the council and health board regarding journal testing and accuracy, allocation and cut-off of Joint Board transactions.</p>
<p>2 Financial statements preparation</p> <p>The 2016/17 financial statements will require income, expenditure and year end balances to be agreed with West Dunbartonshire Council and NHS Greater Glasgow and Clyde. There is a risk that the procedures for agreeing the year end balances are not fully embedded and that the financial statements are not delivered to the agreed timescale and in the required format.</p>	<p>Continued engagement with officers prior to the accounts being prepared to ensure that the relevant information is disclosed and the timetable is met.</p> <p>Service auditor assurances will be obtained from the auditors of West Dunbartonshire Council and NHS Greater Glasgow and Clyde over the completeness, accuracy and allocation of the income and expenditure.</p>	<p>The required information was disclosed within the accounts and the financial statements were prepared in accordance with the Code.</p> <p>The timetable for reporting of inter partner balances was met.</p>
<p>3 Risk of fraud over expenditure</p> <p>The expenditure of the IJB is processed through the financial systems of West Dunbartonshire Council and NHS Greater Glasgow and Clyde. There is a risk that non</p>	<p>Gaining assurances from the auditors of the council and health board over the accuracy, completeness and appropriate allocation of the IJB ledger entries.</p> <p>Carry out audit testing to confirm the accuracy and</p>	<p>Satisfactory written assurances were received from the external auditors of WDC and NHSGGC regarding accuracy, allocation and cut-off of Joint Board transactions.</p>

Audit risk	Assurance procedure	Results and conclusions
IJB related expenditure is incorrectly coded to IJB accounts.	correct allocation of IJB transactions, and that they are recorded in the correct financial year.	





















Risks identified from the auditor's wider responsibility under the Code of Audit Practice

<p>4 Financial sustainability</p> <p>The board will need strong financial management and budgetary control to address the challenges and risks to future finances.</p>	<p>Review ongoing budget monitoring reports to ensure they accurately reflects the position of the partnership.</p> <p>Obtain evidence of remedial action being taken on areas of overspend</p>	<p>Overall, the board has improved and strengthened its financial management arrangements. The board should continue to address the issues and risks. These areas have been reported in the Action Plan to officers.</p>
<p>5 Chief Officer</p> <p>The incumbent Chief Operating Officer is due to retire in July 2017. Recruitment for a replacement has commenced however there is a risk that the replacement will not have sufficient time for a comprehensive handover of duties.</p>	<p>We will liaise with the current Chief Operating Officer throughout the recruitment process.</p>	<p>Satisfactory arrangements were put in place, with a crossover period between the incoming and outgoing Chief Operating Officer. This allowed for sufficient time for a comprehensive handover of duties.</p> <p>No issues identified.</p>

Appendix 3

Summary of national performance reports 2016/17



Month	Report Title	Report Title	Report Title
Apr			
May	 Common Agricultural Policy Futures programme: an update		
Jun	 South Ayrshire Council: Best Value audit report	 The National Fraud Initiative in Scotland	
Jul	 Audit of higher education in Scottish universities	 Supporting Scotland's economic growth	
Aug	 Maintaining Scotland's roads: a follow-up report	 Superfast broadband for Scotland: a progress update	 Scotland's colleges 2016
Sept	 Social work in Scotland	 Scotland's new financial powers	
Oct	 Angus Council: Best Value audit report	 NHS in Scotland 2016	
Nov	 How councils work – Roles and working relationships in councils	 Local government in Scotland: Financial overview 2015/16	
Dec	 Falkirk Council: Best Value audit report	 East Dunbartonshire Council: Best Value audit report	
Jan			
Feb	 Scotland's NHS workforce		
Mar	 Local government in Scotland: Performance and challenges 2017	 i6: a review	 Managing new financial powers: an update

IJB relevant reports

[The National Fraud Initiative in Scotland](#) – June 2016

[NHS in Scotland 2016](#) – October 2016

[Social work in Scotland](#) – September 2016

[Scotland's NHS workforce](#) – February 2017

West Dunbartonshire IJB

2016/17 Annual Audit Report

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West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Integration Joint Board

Commonly known as

West Dunbartonshire
Health and Social Care Partnership

Annual Accounts 2016/17

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MANAGEMENT COMMENTARY

INTRODUCTION

This publication contains the financial statements for the West Dunbartonshire Integration Joint Board (IJB), hereafter known as the Health and Social Care Partnership Board (HSCP Board) for the year ended 31 March 2017.

The Management Commentary provides an overview of the key messages in relation to the HSCP Board's financial planning and performance for the 2016/17 financial year and how this has supported the delivery of the its strategic priorities as laid out in its Strategic Plan 2016-2019. This commentary also outlines future challenges and risks which influence the financial plans of the HSCP Board as they deliver high quality health and social care services to the people of West Dunbartonshire.

The attached annual accounts have been prepared in accordance with current regulations and guidance.

The West Dunbartonshire Health and Social Care Partnership Board

The Public Bodies (Joint Working) Act (Scotland) 2014 sets out the arrangements for the integration of health and social care across the country. The Scottish Government approved Integration Scheme for West Dunbartonshire details the 'body corporate' arrangement by which NHS Greater Glasgow & Clyde Health Board (NHSGGC) and West Dunbartonshire Council (WDC) agreed to formally delegate health and social care services for adults and children (including criminal justice social work services) to a third body, which is described in the Act as an Integration Joint Board.

The Integration Joint Board (IJB) for West Dunbartonshire, commonly known as the West Dunbartonshire Health & Social Care Partnership Board (HSCP Board) was formally established on 1 July 2015.

The West Dunbartonshire Health and Social Care Partnership Board's:

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

The HSCP Board is responsible for the operational oversight of West Dunbartonshire Health & Social Care Partnership (WD HSCP), which is the joint delivery vehicle for those integrated services delegated to it (except for any NHS acute hospital services, as these are managed directly by the Health Board). Staff who work within the management of WD HSCP continue to be employed by either NHSGGC or WDC, retaining their respective terms and conditions. These arrangements for integrated service delivery are conducted within an operational service delivery framework established by NHSGCC and WDC for their respective functions, ensuring both those organisations can continue to discharge their retained governance responsibilities.

The range of functions and services delegated to the HSCP Board are detailed within the approved *Integration Scheme for West Dunbartonshire*, which can be viewed here:

<http://wdhscp.org.uk/media/1215/wdhscp-integration-scheme-may-2015.pdf>

The HSCP Board's Operations for the Year

The Act places a duty on the HSCP Board to create a "strategic plan" for the integrated functions and budgets that it controls. At its August 2016 meeting, the HSCP Board approved its second Strategic Plan, covering the three year period 2016 – 2019 (the maximum duration allowed by the legislation). This high-level strategic plan sets out the HSCP Board's commissioning priorities for that medium term period, with a clear commitment to the delivery of effective clinical and care governance and Best Value.

The HSCP Strategic Plan 2016 – 2019 can be viewed here:

<http://wdhscp.org.uk/media/1597/strategic-plan-2016-2019.pdf>

A full profile of West Dunbartonshire is set out in the Strategic Plan. Some of the key characteristics include the following:

- West Dunbartonshire lies north of the River Clyde encompassing urban and rural communities. According to the National Records for Scotland, the 2015 population for West Dunbartonshire is 89,590; a decrease of 0.1 per cent from 89,710 in 2014. The population of West Dunbartonshire accounts for 1.7 per cent of the total population of Scotland;
- Service delivery should reflect local population needs. In West Dunbartonshire there are two locality areas: Clydebank; and Dumbarton and Alexandria; and
- National evidence indicates that the population of West Dunbartonshire is aging due to a combination of factors; that the number of births within the area is dropping; the number of people migrating to other council areas within the 15 – 44 age groups is increasing; and the number of deaths registered annually is falling.

The substance of the Strategic Plan was shaped by the contents and response to the HSCP Board's first and well-received Annual Performance Report 2015/16.

The Strategic Plan reflects the HSCP Board's commitment to integration being community planning in practice, with its strategic commissioning outcomes articulated with respect to the three local *Community Planning Single Outcome Agreement* priorities that the WD HSCP has a key leadership role in locally:

- Supporting Children and Families.
- Supporting Older People.
- Supporting Safe, Strong and Involved Communities.

The HSCP Board receives a Public Performance Report at each meeting, which provides an update on progress in respect of key performance indicators and commitments. These can be viewed here:

<http://wdhscp.org.uk/about-us/public-reporting/performance-reports/>

The Act obliges all Integration Joint Boards to produce a Performance Report covering performance over the reporting year no later than four months after the end of that reporting year. The HSCP Board's second Annual Performance Report 2016/17 (i.e. for

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the same period as these annual accounts) was presented to its 23 August 2017 meeting for scrutiny. Thereafter it was made publicly available on the WDHSCP website; and submitted to NHS GGC, WDC, the local Community Planning Partnership Management Group and Scottish Government. As required by legislation the Annual Performance Report includes information on financial performance (in accordance with the national Finance Guidance for Health and Social Care Integration) and best value (with reference to the national Best Value Guidance for Local Authorities) and can be viewed here:

<http://www.wdhscp.org.uk/media/1850/hscp-annual-performance-report-2017.pdf>

Operational highlights for 2016/17 include:

- The HSCP's Community Hospital Discharge Team was a finalist at the 2016 Scottish Health Awards;
- The HSCP's Prescribing Support Team was recognised as the Self-Management Supporting Health and Social Care Partnership of the Year at the 2016 Health and Social Care Alliance Scotland Awards;
- The HSCP Care at Home Service was awarded the Scottish Association of Social Work (SASW) Award for 'Best example of collaboration in an integrated setting' as well as being finalists in the Team of the Year award at the national awards ceremony in March 2017;
- The HSCP's Residential Child Care Team at Burnside House won Residential Child Care Team of the Year Award at the Scottish Institute for Residential Child Care (SIRCC) Awards 2016;
- Practical completion of the new Crosslet House 70 bed residential care home (owned by WDC but managed by the HSCP as a delegated service) to replace the three current residential homes in the Dumbarton and Alexandria locality. This new, modern facility will truly transform the lives of its residents and their families;
- Further investment in social care services through the Scottish Government's £250m Social Care Fund. Our partnership share was £4.9m which was directed to: additional spend on expanding social care to support the objectives of integration by supporting people in their own home or a homely setting; and delivering the Scottish Living Wage to all adult social care workers; and
- Positive messages in 2015/16 Annual Audit Report published by our external auditors in September 2016 around effective financial management and financial sustainability in an increasingly challenging climate of public sector austerity.

Analysis of the Financial Statements and Financial Performance of HSCP Board

The Statement of Accounts contains the financial statements of the HSCP Board for the year ended 31 March 2017, which holds all of the expenditure and income associated with the operational delivery of services to the population of West Dunbartonshire. The requirements governing the format and content of local authorities' annual accounts are contained in The Code of Practice on Local Authority Accounting in the United Kingdom (the Code). The 2016/17 Accounts have been prepared in accordance with this Code.

The financial reporting responsibilities of the HSCP Board Chief Financial Officer include preparing financial statements which should reflect a "true and fair view" of the partnership's financial performance and financial position.

External auditors have a responsibility to provide an opinion on the financial statements, which will involve challenging and testing the unaudited accounts. The external audit findings and opinions may require some changes and adjustments being made before the accounts are approved by the HSCP Board on 20 September 2017.

Financial performance is an integral element of the HSCP Board's overall performance management framework, with regular reporting and scrutiny of financial performance at meetings of both the HSCP Board and its Audit Committee.

The key messages from our first full year of operation during the financial year 2016/17 are:

- On a total budget allocation of £167.693m from WDC and NHSGGC, including Set Aside and Hosted Services, we have ended the year with a surplus of £3.956m;
- This represents previously reported underspends in Social Care, mainly from unapplied Social Care Fund resources and planned for service underspends across Health Services to be held in reserve to mitigate any future budget volatility and underwrite the delivery of approved savings plans;
- This surplus will be added to the reserves brought forward from 2015/16 of £1.612m;
- These general fund reserves are categorised into earmarked reserves for specific projects, such as residential care home transformation or Technology Enabled Care project and unearmarked reserves which forms part of the HSCP Board's financial strategy and was established to better manage the risk of any future unanticipated events that may materially impact on the financial position of the HSCP Board;
- Approved savings of £0.993m relating to Social Care were delivered in line with the financial plan;
- Approved savings of £1.431m for Health Care were part delivered through Health Board collective savings plans and local savings plans. The balance of £0.909m was funded non-recurrently by Greater Glasgow and Clyde Health Board to allow the HSCP Board to approve savings options at the November 2016 meeting for implementation 1 April 2017;
- The cost of implementation of the Scottish Living Wage of £8.25/hr for all adult care workers from 1 October 2016 was calculated at a cost of £0.667m; and
- WD HSCP host MSK Physiotherapy Services and Retinal Screening for all partnerships within Greater Glasgow and Clyde Health Board. The net expenditure for these hosted services for 2016/17 was £6.064m and £0.766m respectively.

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The full year financial position for the HSCP Board can be summarised as follows:

1 April 2016 to 31 March 2017	West Dunbartonshire Council £000	Greater Glasgow & Clyde Health Board £000	Total £000
Funds Received from Partners	(62,216)	(105,477)	(167,693)
Funds Spent with Partners	58,840	104,897	163,737
Surplus in Year 2016/17	(3,376)	(580)	(3,956)

The HSCP Board's Strategy and Business Model

The Accounts Commission has stated that public bodies need to think differently about what they deliver: prioritising activities; redesigning services; and re-shaping their workforces. This is certainly the case in West Dunbartonshire, and just as true for the Health & Social Care Partnership as it is for other areas of public service. As committed to within the Integration Scheme and based on local engagement and feedback, a local Participation and Engagement Strategy was developed and approved in May 2016, that sets out the key principles and high level ways-of-working that the HSCP will apply in its relationships with stakeholders as an integral element of its mainstream strategy and business model. The Participation and Engagement Strategy can be viewed here:

<http://wdhscp.org.uk/media/1561/wdhscp-participation-and-engagement-strategy-2016.pdf>

In addition to the requirements set out within the Public Bodies (Joint Working) Act 2014, this Strategy takes due cognisance of other pertinent legislation, including:

- The Carer's (Scotland) Act 2016 which aims to ensure better and more consistent support for both adult and young carers so that they can continue to care in better health and to have a life alongside of caring.
- The Community Empowerment (Scotland) Act 2015 provides a legal framework that promotes and encourages community empowerment and participation; and outlines how public bodies will work together and with the local community to plan for, resource and provide services which improve local outcomes in the local authority area.
- The Children and Young People's (Scotland) Act 2014 which reinforces the United Nations Convention on the Rights of the Child; and the principles of Getting It Right for Every Child.
- The Community Justice (Scotland) Act 2016 which identifies Community Planning Partnerships as being the vehicle to bring partner organisations together to plan and deliver community justice outcomes.
- The Equality Act 2010, with its general duties to eliminate discrimination, harassment and victimisation; advance equality of opportunity between people who share a protected characteristic and those who do not; and foster good relations between people who share a protected characteristic and those who do not.

All of the above reinforce the stated core values of the HSCP Board i.e. protection; improvement; efficiency; transparency; fairness; collaboration; respect; and compassion. As expressed in this Strategy, these then underpin how the HSCP develops and delivers the local Strategic Plan and local services; and informs relationships with stakeholders, including service users, carers and communities; staff working within the HSCP, and Trade Unions; GPs, other NHS external contractors and acute clinicians; the

Third and Independent Sector; and Community Planning Partners. The HSCP has worked with stakeholders to create a tapestry of flexible opportunities to support pragmatic participation and engagement – and with the understanding that they are not set-in-stone but rather are dynamic processes that should and will evolve based on feedback, learning and changing circumstances.

The HSCP Board is also responsible for strategic planning for unscheduled care with respect to the population of West Dunbartonshire. In doing this, it is obliged to work closely with the NHSGGC as well the other Integration Joint Boards within the Greater Glasgow & Clyde area. This reflects the challenges presented by a combination of continuing shifts in patterns of disease to long term conditions; growing numbers of older people with multiple conditions and complex needs; and a pressurised financial environment. Critical to this is the on-going work and developments to shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when that is the best thing to do. Good quality community care should mean less unscheduled care in hospitals, and people staying in hospitals only for as long as they need specific treatment. At the same time, waste and variation in clinical practice need to be addressed, alongside promoting the reliable implementation of effective interventions. To this end, the HSCP Board approved at its 22nd March 2017 a set of comprehensive commissioning intentions for unscheduled care, reflecting a commitment to invest, redesign and deliver an effective infrastructure of community services. In doing this, it sets out initial commissioning directions for NHSGGC and its Acute Division; and a proposed improvement agenda for primary care, both of which emphasise the expectations of the Scottish Government's Chief Medical Officer to "Realise Realistic Medicine"¹. In accordance with Scottish Government's emerging indications with regards to measuring the impact of health and social care integration, the commissioning objectives express the following inter-connected areas for strengthening performance:

- Communication.
- Unplanned admissions.
- Occupied bed days for unscheduled care
- A&E performance.
- Delayed discharges.
- End of life care.
- Balance of spend across institutional and community services.

The Unscheduled Care Commissioning Intentions 2017 – 2020 can be viewed at:

<http://wdhscp.org.uk/media/1757/wdhscp-unscheduled-care-commissioning-march-2017.pdf>

¹ <http://www.gov.scot/Resource/0051/00514513.pdf>

Key Risks and Uncertainties

The HSCP Board Financial Regulations reflect the recommendations of the national Integrated Resources Advisory Group which confirms the responsibility of the Chief Officer to develop a local risk strategy and policy for approval by the Partnership Board.

The HSCP Board Financial Regulations can be viewed here:

<http://www.wdhscp.org.uk/media/1414/wd-hscp-board-financial-regulations-aug-2015.pdf>

The HSCP Board approved its Risk Management Strategy & Policy at its August 2015 meeting, which can be viewed here:

<http://www.wdhscp.org.uk/media/1415/wdhscp-risk-policy-and-strategy-august-2015.pdf>

Following the planned and formal review of strategic risks during 2016 by the Senior Management Team, an updated strategic risk register was presented in draft for discussion at the September 2016 meeting of the Audit Committee; and then presented to the HSCP Board for approval at its November 2016 meeting. That current strategic risk register – with mitigating activities specified – can be viewed here (item 9):

<http://wdhscp.org.uk/media/1669/hscp-document-pack-16-november-2016.pdf>

Some of key risks identified with mitigating actions in the HSCP Board Risk Register are:

Strategic Risk	Mitigating Action
Failure to deliver efficiency savings targets and operate within allocated budgets.	On-going process of managing and reviewing the budget by the Senior Management Team. A recovery plan will be implemented to address areas of significant in-year overspend. Savings options under review in 2016/17 expected to be challenging – horizon scanning being undertaken with respect to delivery of Strategic Plan within context of both wider WDC & GGC processes.
Failure of NHSGGC-wide MSK Physiotherapy Service to meet nationally determined four week waiting time target.	Text reminders for new appointments targeted introduction during autumn 2016. A risk stratification process for back pain patients is being introduced during autumn/winter 2016. Work stream being initiated to review referral criteria and improve GP management of MSK conditions, with reduction in risk grading dependent on HSCP Board approval of any proposed revisions.
Failure to deliver a sustainable solution to asbestos-related health & safety risks within fabric of Clydebank Health Centre.	On-going repair and refurbishment expenditure on premises in the immediate to short-term. Capital funding for new Clydebank Health & Care Centre has now been earmarked by Scottish Government, with HSCP having secured approved for Initial Agreement. Development work now underway to secure funding as per prescribed process. Risk grade won't be altered until funding confirmed (i.e. once approvals for Outline and Full Business Cases secured).

Ongoing financial austerity within the public sector coupled with short term funding allocations make financial planning in the medium term a complex endeavour for the HSCP

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Board's funding partners and impacts on the HSCP Board's decision making process on how to address funding reductions with the least impact to front line services.

Service redesign and shifting the balance of care are essential given the projected scale estimated funding reductions (3%-7%) and demographic challenges in the coming years. West Dunbartonshire HSCP was the second best performing in 2015/16 for percentage off adults supported at home who agreed that they are supported to live as independently as possible – 89% (Scotland 84%). The Strategic Plan and its associated commissioning intentions will inform the HSCP Board's Financial Plan around growing our community based services.

Moving into 2017/18 the HSCP Board will proactively address the funding challenges through a refresh of its medium term financial strategy, incorporating Scottish Government's 2017/18 funding directions to the funding partners, i.e. that:

- Health Boards' maintain budget allocation at 2016/17 cash levels; and
- Councils' restrict funding reductions to share of £80m in recognition of the addition £107m Social Care funding.

The HSCP Board will closely monitor progress delivering the of approved savings programmes through robust budget monitoring processes and regular meetings with all levels of budget holder. The HSCP Chief Office will develop further options through use of invest to save models and opportunities for team co-location (e.g. as part of WDC's investment in fit for purpose office accommodation and improved agile working strategy).

The HSCP Board will use reserves to both underwrite any unforeseen service volatility and to support service redesign to deliver sustainable, high quality health and care services to West Dunbartonshire communities.

More generally a range of wider issues presents some degree of uncertainty to the HSCP Board, particularly in terms of future planning relating to finance, the workforce and the scale and scope of the HSCP Board. Examples include:

- Potential reform(s) of NHS boards and local government;
- The national and local political landscape; and
- Impacts of Brexit, such as an unstable economic climate and uncertainty regarding the future employment rights of health and social care staff from EU countries.

As part of its commitment to a strong governance framework around regular and robust budget and performance monitoring and on-going assessment of risk, the HSCP Board and its senior officers will monitor such developments and will take appropriate action as required.

Marie McNair
HSCP Board Chair



Date: 20/09/17

Beth Culshaw
Chief Officer



Date: 20/09/17

Julie Slavin CPFA
Chief Financial Officer



Date: 20/09/17

STATEMENT OF RESPONSIBILITIES

Responsibilities of the Health and Social Care Partnership Board

The Health and Social Care Partnership Board is required to:

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

I confirm that these Annual Accounts were approved for signature at a meeting of the Audit Committee on 20 September 2017.

Signed on behalf of the West Dunbartonshire Health and Social Care Partnership Board

Marie McNair
HSCP Board Chair



Date: 20/09/17

Responsibilities of the Chief Financial Officer

The Chief Financial Officer is responsible for the preparation of the HSCP Board's Annual Accounts in accordance with proper practices as required by legislation and as set out in the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom (the Accounting Code).

In preparing the Annual Accounts, the Chief Financial Officer has:

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

The Chief Financial Officer has also:

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

I certify that the financial statements give a true and fair view of the financial position of the West Dunbartonshire Health and Social Care Partnership Board as at 31 March 2017 and the transactions for the year then ended.



Julie Slavin CPFA
Chief Financial Officer

Date: 20/09/17

REMUNERATION REPORT

Introduction

The Local Authority Accounts (Scotland) Regulations 2014 (SSI No. 2014/200) require local authorities and IJB's in Scotland to prepare a Remuneration Report as part of the annual statutory accounts.

It discloses information relating to the remuneration and pension benefits of specified WD HSCP Board members and staff. The information in the tables below is subject to external audit. The explanatory text in the Remuneration Report is reviewed by the external auditors to ensure it is consistent with the financial statements.

The HSCP Board does not directly employ any staff. All staff working within the HSCP are employed through either NHSGGC or WDC; and remuneration for senior staff is reported through those bodies. This report contains information on the HSCP Board Chief Officer and Chief Financial Officer's remuneration together with details of any taxable expenses relating to HSCP Board voting members claimed in the year.

Membership of the HSCP Board is non-remunerated; for 2016/17 no taxable expenses were claimed by members of the partnership board.

1. Health and Social Care Partnership Board

The voting members of the HSCP Board were appointed through nomination by Greater Glasgow and Clyde Health Board or West Dunbartonshire Council. Nomination of the HSCP Chair and Vice Chair post holders alternates, every 3 years, between a Councillor for WDC or a NHSGGC Health Board representative

The HSCP Board does not pay allowances or remuneration to voting board members; voting board members are remunerated by their relevant partner organisation.

The HSCP Board does not have responsibilities, either in the current year or in future years, for funding any pension entitlements of voting members. Therefore, no pension rights disclosures are provided for the Chair or Vice Chair. For 2016/17 no voting member received any form or remuneration from the HSCP Board as detailed in the table over.

Total Taxable HSCP related Expenses 2015/16	Voting Board Members 2016/17	Nominating Organisation	Total Taxable HSCP related Expenses 2016/17
Nil	Gail Casey (Chair)	West Dunbartonshire Council	Nil
Nil	Martin Rooney	West Dunbartonshire Council	Nil
Nil	Jonathan McColl	West Dunbartonshire Council	Nil
Nil	Allan Macleod (Vice chair)	NHS Greater Glasgow and Clyde	Nil
Nil	Heather Cameron	NHS Greater Glasgow and Clyde	Nil
Nil	Ros Micklem - Note 1	NHS Greater Glasgow and Clyde	Nil
N/A	Rona Sweeney - Note 2	NHS Greater Glasgow and Clyde	Nil

Note 1: Last Board meeting 25 May 2016 Note 2: Appointed to HSCP 17 August 2016 after nomination approved by NHSGGC Health Board

2. Senior Officers

The HSCP Board does not directly employ any staff. All staff working within the HSCP are employed through either NMSGC or WDC; and remuneration for senior staff is reported through those bodies.

Chief Officer

Under section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 a Chief Officer for the HSCP Board has to be appointed and the employing partner has to formally second the officer to the HSCP Board. The employment contract for the Chief Officer will adhere to the legislative and regulatory framework of the employing partner organisation. The remuneration terms of the Chief Officer's employment are approved by the HSCP Board.

The Chief Officer for the financial year 2016/17 (Mr Keith Redpath) was employed Greater Glasgow and Clyde Health Board; held an honorary contract with West Dunbartonshire Council; and was funded equally between the Health Board and the Council.

This report contains information on the HSCP Board Chief Officer's full year remuneration.

Other Officers

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

Total Earnings 2015/16 £	Senior Officers	Salary, Fees & Allowance £	Compensation for Loss of Office	Total Earnings 2016/17 £
102,741	K Redpath Chief Officer	107,436		107,436
	J Slavin (Start date 22/08/16) Chief Financial Officer	41,446 (FYE 67,920)		41,446
82,358	J Middleton (Retired 16/10/2016) Chief Financial Officer	43,596 (FYE 80,209)		43,596

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

The HSCP Board however has responsibility for funding the employer contributions for the current year in respect of the officer time spent on fulfilling the responsibilities of their role on the HSCP Board. The following table shows the HSCP Board's funding during the year to support officers' pension benefits. The table also shows the total value of accrued pension benefits which may include benefits earned in other employment positions and from each officer's own contributions.

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Senior Officers	In Year Pension Contributions		Accrued Pension Benefits		
	For year to 31/03/16 £000	For year to 31/03/17 £000		For year to 31/03/16 £000	For year to 31/03/17 £000
K Redpath Chief Officer	16	16	Pension	15	17
			Lump Sum	45	50
J Slavin (Start date 22/08/16) Chief Financial Officer	0	6	Pension	0	1
			Lump Sum	0	0
J Middleton (Retired 16/10/16) Chief Financial Officer	12	6	Pension	20	0
			Lump Sum	61	0

The officers detailed above are all members of the NHS Superannuation Scheme (Scotland). The pension figures shown relate to the benefits that the person has accrued as a consequence of their total public sector service, and not just their current appointment. The contractual liability for employer pension's contributions rests with NHS Greater Glasgow & Clyde. On this basis there is no pension liability reflected on the HSCP Board balance sheet.

Disclosure by Pay Bands

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

Remuneration Band	Number of Employees 31 st March 2016	Number of Employees 31 st March 2017
£55,000 -£59,999		
£65,000 -£69,999		
£80,000- £84,999	1	
£100,000 -£104,999	1	
£105,000-109,999		1

Marie McNair
HSCP Board Chair



Date: 20/09/17

Beth Culshaw
Chief Officer



Date: 20/09/17

ANNUAL GOVERNANCE STATEMENT

The Annual Governance Statement explains the HSCP Board's governance arrangements as it meets the requirements of the "Code of Practice for Local Authority Accounting in the UK" and reports on the effectiveness of the HSCP Board's system of internal control.

Scope of Responsibility

The HSCP Board is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively. The Strategic Plan 2016-2019 also commits to the delivery of effective clinical and care governance and Best Value.

To meet this responsibility the HSCP Board has established arrangements for governance of its affairs and facilitating the effectiveness of its functions, which includes arrangements for the management of risk. In discharging this responsibility, the Chief Officer has put in place arrangements for governance which includes a system of internal control. The system is intended to manage risk, to a reasonable level, to support the achievement of the HSCP Board's policies, aims and objectives. Reliance is also placed on Greater Glasgow and Clyde Health Board and West Dunbartonshire Council's systems of internal control that support compliance with both organisations' policies and promotes achievement of each organisation's aims and objectives, as well as those of the HSCP Board.

Delivering Good Governance in Local Government: Framework, published by CIPFA in association with Solace in 2007, set the standard for local authority governance in the UK. CIPFA and Solace reviewed the Framework in 2015 to ensure it remained 'fit for purpose' and published a revised edition in spring 2016. The new *Delivering Good Governance in Local Government: Framework (CIPFA/Solace, 2016)* applies to annual governance statements prepared for the financial year 2016/17 onwards.

West Dunbartonshire Council has recently approved and adopted a revised Local Code of Corporate Governance (the Local Code), which is consistent with the principles of the Chartered Institute of Public Finance and Accountancy (CIPFA) and the Society of Local Authority Chief Executives (SOLACE) Framework: *Delivering Good Governance in Local Government*. A copy of this Code is available from the Council website at:

<http://www.west-dunbarton.gov.uk/media/4312582/wdc-local-code.pdf>

A copy of Greater Glasgow and Clyde Health Board's annual review of its governance arrangements is available from the Health Board website at:

<http://www.nhsggc.org.uk/media/242657/item-07-governance-statement.pdf>

Any system of internal control can only provide reasonable and not absolute assurance of effectiveness.

The Governance Framework

The governance framework is comprised of systems and processes; culture and a set of values; by which the HSCP is directed and controlled. It enables the HSCP Board to monitor the achievements of the strategic objectives set up in its Strategic Plan.

The HSCP Board comprises of the Chair and five other voting members, nominated equally by either the West Dunbartonshire Council or Greater Glasgow and Clyde Health Board. There are a number of professional and stakeholder non-voting members including a Chief Officer appointed by the Board. As defined within the Integration Scheme the HSCP, “is the joint delivery vehicle for those integrated services delegated to the Integration Joint Board (except for NHS acute hospital services)”; and the Chief Officer is responsible for the operational management of said Health & Social Care Partnership.”

While the Delivering Good Governance in Local Government: Framework is written in a local authority context, most of the principles are applicable to the HSCP Board, particularly as legislation recognises IJBs as a local government body under Part VII of the Local Government (Scotland) Act 1973, and therefore subject to the local authority accounting code of practice.

The HSCP Board recently approved the adoption of a Local Code of Good Governance and considered the Sources of Assurance which describes and defines the main features of the governance framework. A review on the effectiveness of the sources of assurance has been carried out and an action plan for improvements will be submitted to the HSCP Board on 20 September 2017. A copy of the local code can be found on the WD HSCP website at (Item 9):

<http://www.wdhscp.org.uk/media/1789/hscp-31-may-document-pack-public-version.pdf>

The main features of the governance framework in existence during 2016/17 are described in the Local Code but are summarised below:

- The HSCP Board is formally constituted through the Integration Scheme agreed with our Council and Health Board partners and approved by Scottish Government;
- The HSCP Board’s second Strategic Plan 2016 – 2019 was approved by the Board on the 17 August 2016. It sets out the purpose, strategic vision and commissioning priorities for the next three years – with a clear commitment to the delivery of effective clinical and care governance and Best Value;
- The scope, authority, governance and strategic decision making of the HSCP Board and Audit Committee is set out in key constitutional documents including the integration scheme, scheme of delegation, terms of reference, code of conduct, standing orders and financial regulations;
- The Performance Management Framework commits to regular reporting on the delivery of outcomes as set out in the Strategic Plan. Building on the well received 2015/16 Report, the 2016/17 Annual Performance Report was approved at the HSCP Board on 23 August 2017 and each meeting of the HSCP Board receives a quarterly Public Performance Report, which has already been scrutinised by the Senior Management Team;

- The HSCP Board's approach to risk management has been scrutinised and endorsed by the Audit Committee through an update of the Strategic Risk Register, specifically for it to articulate to the anticipated effect on the level of risks as a result of the mitigating action specified. This revised version was subsequently approved by the HSCP Board in November 2016. This is further underpinned by operational risk registers maintained and reviewed by HSCP Heads of Service;
- HSCP Board's approval of Strategic Partnership Agreements with our voluntary organisation partners;
- The Reserves Policy was reviewed as part of the annual budget setting process and approved by the HSCP Board in March 2017;
- The HSCP Board follows the principles set out in COSLA's *Code of Guidance on Funding External Bodies and Following the Public Pound* for both resources delegated to the Partnership by the Health Board and Local Authority and resources paid to its local authority and health service partners;
- The HSCP Board has in place a development programme for all HSCP Board Members. The Senior Management Team has taken part in development sessions on resilience and maintaining high quality performance in preparation of the retirement of the Chief Officer. A performance appraisal process is in place for all employees and compliance reporting is a standing agenda item at the Clinical and Care Governance Group; and
- Effective scrutiny and service improvement activities are supported by the formal submission of reports, findings and recommendations by Audit Scotland, the external auditors, Inspectorates and the appointed Internal Audit service to the HSCP's Senior Management Team and the HSCP Board and Audit Committee.

The governance framework was in place throughout 2016/17.

The System of Internal Financial Control

The system of internal control is based on an ongoing set of processes designed to identify, prioritise and manage the risks facing the organisation. The system aims to evaluate the nature and extent of failure to achieve the organisation's policies, aims and objectives and to manage risks efficiently, effectively and economically. Any system of internal control can only provide reasonable and not absolute assurance of effectiveness.

The governance framework described operates on the foundation of internal controls, including management and financial information, financial regulations, administration (including segregation of duties), management supervision and delegation. Development and maintenance of these systems is undertaken by the Health Board and Council as part of the operational delivery of WD HSCP. During 2016/17 this included the following:

- Financial regulations and codes of financial practice;
- Comprehensive budgeting systems, including a formalised budget setting process;
- Regular reviews of periodic and annual financial reports that monitor service delivery and financial performance against the forecast of the integrated budget;
- Setting targets to measure financial and other performance;
- Clearly defined capital expenditure guidelines; and
- Formal project management disciplines.

The HSCP Board's financial management arrangements conform to the governance requirements of the CIPFA statement *The Role of the Chief Financial Officer in Local Government (2010)*. To deliver these responsibilities the Chief Financial Officer:

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- Must lead and direct a finance function that is resourced to be fit for purpose; and
- Must be professionally qualified and suitably experienced.

During 2016/17 the Health Board undertook a review of its Management Accounts function and in consultation with Chief Officers and Chief Financial Officers, formally delegated accountancy support to each of the six partner HSCP's. For WD HSCP the Chief Financial Officer now leads and directs a joint finance team which can continue to develop and refine integrated budgeting and monitoring processes.

From a review of disclosures made in the draft financial statements of NHSGGC and WDC, the HSCP Board has placed reliance on the individual Assurance Statements of Internal Financial Control and the Annual Audit Reports prepared by their own internal auditors. These reports highlight areas for improvement around internal controls and are reflected in the Council and Health Board's own Governance Statements.

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

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

Review of Effectiveness

The HSCP Board has responsibility for conducting, at least annually, a review of the effectiveness of its governance framework including the system of internal control. The review of the effectiveness of the framework is informed by the work of the Chief Officer and the Senior Management Team who have responsibility for development and maintenance of the governance environment; the annual report by the Chief Internal Auditor; and reports from Audit Scotland and other review agencies.

The review of the HSCP Board's governance framework is supported by a process within West Dunbartonshire Council and Greater Glasgow and Clyde Health Board. Within the Council each member of the Corporate Management Team presents an annual statement on the adequacy and effectiveness of control (including financial control), governance and risk management arrangements within their service area. Through the delegation of operational responsibility for the delivery of all social care services these statements were provided by the HSCP's Chief Officer and Senior Management Team. The responses to these are considered as part of the review of the HSCP and the Council's governance frameworks and areas for improvement are considered in "Further Actions" below. A similar process is in operation within the Health Board where Service Managers were provided with a "Self-assessment Checklist" to complete and return as evidence of review of key areas of the internal control framework.

The Chief Internal Auditor reports directly to the HSCP Board's Audit Committee on all audit matters, with the right of access to the Chief Officer, Chief Financial Officer and Chair of the Audit Committee on any matter. The Audit Committee operates in accordance with CIPFA's Audit Committee Principles in Local Authorities in Scotland and Audit Committees: Practical Guidance for Local Authorities. The Chief Internal Auditor undertakes an annual audit review to provide an independent opinion on the adequacy

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and effectiveness of the HSCP's Internal Financial Control. For 2016/17 the conclusion was "that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control".

Audit Scotland in their December 2015 report entitled "Health and Social Care Integration" recommended that Integration Joint Boards have high standards of effective governance. As part of the 2016/17 HSCP Board Audit Plan an audit was carried out on "Governance, Performance and Financial Management Arrangements" of the HSCP. The findings concluded that the systems examined are generally working effectively.

Governance Issues in 2016/17

The approval process for budget setting for NHSGGC and WDC follow different timetables. The council approved its 2016/17 annual budget on 24 February 2016, which included its budget allocation offer to the HSCP Board. The health board did not approve its budget until the 28 June 2016 and the budget allocation to the HSCP Board was not formally received until 5 July 2016.

This process was recognised as being unacceptable by both NHSGGC and the HSCP Board and efforts were made to rectify this for 2017/18 budget allocations. A budget allocation offer was received on 23 February 2017 and was formally presented to the HSCP Board on the 1 March 2017. This offer was not accepted on the basis that it did not meet the Scottish Government direction to maintain contribution at 2016/17 cash levels.

After significant commitment and partnership working with NHSGGC and the six IJBs' consensus was reached and a revised offer was accepted by the HSCP Board on 23 August 2017.

The uncertainty brought about by these delays impacted on the 2017/18 financial planning process and the possible utilisation of reserves (as detailed within these annual accounts) moving forward.

Whilst all operational and transactional governance issues are considered within our partners' governance frameworks the HSCP Board Audit Committee take an overview of all actions arising from both internal and external audit reports.

The Chief Internal Auditor's regular update reports to the HSCP Board Audit Committee have confirmed that there are no significant governance issues for 2016/17. However there is presently no formal mechanism in place for the internal audit service of NHSGGC to consult with the HSCP Board Audit Committee regarding planned audit work which could relate of impact on WD HSCP, nor is there a protocol for resulting audit reports to be shared. This will be taken forward and is acknowledged in "Further Actions" below.

Further Actions

To ensure continual improvement of the HSCP's governance arrangements the following actions have been agreed:

- Enhancement of the already robust budget monitoring processes by developing the functionality of Carefirst Financials in the production of full year commitment information;
- In partnership with the Council and Health Board continue to work with staff and their representatives through the Joint Staff Forum on reducing sickness absence rates across all services;

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- Developing management information in partnership with ISD to better inform strategic planning, financial and commissioning strategy and “measuring performance under integration” by way of 6 key measures laid down by the Ministerial Strategy Group for Health and Community Care;
- Internal Audit review of Social Work Tendering and Commissioning practices across services, with cognisance of the requirement to ensure that all adult social care workers are paid at the Scottish Living Wage rate; and
- Detailed review and scoring of local code, together with an improvement action plan will be presented to the 20 September 2017 HSCP Board Audit Committee, these include:
 - Developing a medium term financial strategy;
 - Develop a protocol with NHSGGC auditors to share internal audit report findings;
 - In partnership with NHSGGC, Scottish Government and GGC IJBs agree on a methodology that allows Set Aside resources to be quantified and reflect actual activity to comply with legislation on the use of this resource in shifting the balance of care; and
 - Strengthen the strategic planning process.

Assurance and Certification

Whilst recognising that improvements are required, as detailed above, it is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP Boards system of governance.

We consider the internal control environment provides reasonable and objective assurance that any significant risks impacting on our principal objectives will be identified and actions taken to mitigate their impact.

Marie McNair
HSCP Board Chair



Date: 20/09/17

Beth Culshaw
Chief Officer



Date: 20/09/17

West Dunbartonshire Health & Social Care Partnership

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COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT

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

2015/16 Gross Expend Restatement £000	2015/16 Gross Income Restatement £000	2015/16 Net Expend Restatement £000	West Dunbartonshire Integrated Joint Board Health & Social Care Partnership	2016/17 Gross Expend £000	2016/17 Gross Income £000	2016/17 Net Expend £000
Consolidated Health & Social Care						
24,736	(6,028)	18,708	Older People Residential, Health and Community Care	32,972	(7,183)	25,789
10,055	(519)	9,536	Homecare	13,786	(711)	13,075
1,927	(119)	1,808	Physical Disability	2,751	(242)	2,509
15,028	(1,546)	13,482	Children's Residential Care and Community Services (incl specialist)	19,881	(769)	19,112
1,560	(75)	1,485	Strategy Planning and Health Improvement	1,929	(78)	1,851
8,490	(1,130)	7,360	Mental Health Services - Adult & Elderly Community and Inpatients	11,085	(1,505)	9,580
2,555	(202)	2,353	Addictions	3,013	(154)	2,859
11,543	(602)	10,941	Learning Disabilities - Residential and Community Services	15,542	(379)	15,163
18,371	(780)	17,591	Family Health Services (FHS)	24,406	(988)	23,418
14,010	0	14,010	GP Prescribing	19,294	0	19,294
0	0	0	Hosted Services - MSK Physio Note 10	6,246	(182)	6,064
0	0	0	Hosted Services - Retinal Screening Note 10	770	(4)	766
(1)	0	(1)	Criminal Justice	3,742	(3,726)	16
3,512	(1,944)	1,568	HSCP Corporate and Other Services	1,536	(829)	707
244	0	244	IJB Operational Costs	254	0	254
112,030	(12,945)	99,085	Cost of Services Directly Managed by West Dunbartonshire HSCP	157,207	(16,750)	140,457
13,040		13,040	Set aside for delegated services provided in large hospitals Note 3	17,066	0	17,066
			Services hosted by other NHS GGC IJBS Note 3&10	13,292	(1,517)	11,775
			Services hosted by West Dunbartonshire IJB for other IJBS Note 3&10	(6,494)	231	(6,263)
			Assisted garden maintenance and Aids and Adaptions	702	0	702
125,070	(12,945)	112,125	Total Cost of Services to West Dunbartonshire HSCP	181,773	(18,036)	163,737
	(113,737)	(113,737)	Taxation & Non-Specific Grant Income (contribution from partners) Note 6		(167,693)	(167,693)
		(1,612)	(Surplus) or Deficit on Provisions of Services and Total Comprehensive (Income)/Expenditure			(3,956)

West Dunbartonshire Health & Social Care Partnership

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MOVEMENT IN RESERVES STATEMENT

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

Movement in Reserves During 2016/17	Unearmarked Reserves Balance £000	Earmarked Reserves Balance £000	Total General Fund Reserves £000
Opening Balance as at 31 March 2016	(492)	(1,120)	(1,612)
Total Comprehensive Income and Expenditure Increase /Decrease 16-17	(1,588)	(2,368)	(3,956)
Closing balance as at 31 March 2017	(2,080)	(3,488)	(5,568)

Movement in Reserves During 2015/16	Unearmarked Reserves Balance £000	Earmarked Reserves Balance £000	Total General Fund Reserves £000
Opening Balance as at 31 March 2015	-	-	-
Total Comprehensive Income and Expenditure Increase /Decrease 15-16	(492)	(1,120)	(1,612)
Closing balance as at 31 March 2016	(492)	(1,120)	(1,612)

BALANCE SHEET

The Balance Sheet shows the value of the HSCP Board's assets and liabilities as at the balance sheet date. The net assets of the HSCP Board (assets less liabilities) are matched by the reserves held by the HSCP Board.

2015-16 Restatement £000		Notes	2016-17 £000
1,612	Short Term Debtors	7	5,568
1,612	Current Assets		5,568
	Short Term Creditors	8	-
-	Current Liabilities		-
1,612	Net Assets		5,568
(492)	Usable Reserves: General Fund	9	(2,033)
(1,120)	Usable Reserves: Earmarked	9	(3,535)
(1,612)	Total Reserves		(5,568)

The unaudited accounts were issued on 22nd June 2017 and the audited accounts were authorised for issue on 20th September 2017.

Julie Slavin CPFA
Chief Financial Officer



20/09/17

NOTES TO THE FINANCIAL STATEMENTS

1. Significant Accounting Policies

1.1 General Principles

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

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

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

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

1.2 Accruals of Income and Expenditure

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

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

1.3 Funding

The HSCP Board is primarily funded through funding contributions from the statutory funding partners, WDC and NHSGGC. Expenditure is incurred as the HSCP Board commission's specified health and social care services from the funding partners for the benefit of service recipients in West Dunbartonshire.

1.4 Cash and Cash Equivalents

The HSCP Board does not operate a bank account or hold cash and therefore has not produced a cashflow statement for these annual accounts. Transactions are settled on behalf of the HSCP Board by the funding partners. Consequently the HSCP Board does not present a 'Cash and Cash Equivalent' figure on the balance sheet. The funding balance due to or from each funding partner, as at 31 March 2017, is represented as a debtor or creditor on the HSCP Board's Balance Sheet.

1.5 Employee Benefits

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

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

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

1.6 Provisions, Contingent Liabilities and Contingent Assets

Provisions are liabilities of uncertain timing or amount. A provision is recognised as a liability on the balance sheet when there is an obligation as at 31 March 2017 due to a past event; settlement of the obligation is probable; and a reliable estimate of the amount can be made. Recognition of a provision will result in expenditure being charged to the Comprehensive Income and Expenditure Statement and will normally be a charge to the General Fund.

A contingent liability is a possible liability arising from events on or before 31 March 2017, whose existence will only be confirmed by later events. A provision that cannot be reasonably estimated, or where settlement is not probable, is treated as a contingent liability. A contingent liability is not recognised in the HSCP Board's Balance Sheet, but is disclosed in a note where it is material.

A contingent asset is a possible asset arising from events on or before 31 March 2017, whose existence will only be confirmed by later events. A contingent asset is not recognised in the HSCP Board's Balance Sheet, but is disclosed in a note only if it is probable to arise and can be reliably measured.

1.7 Reserves

The HSCP Board's reserves are classified as either Usable or Unusable Reserves.

The HSCP Board's only Usable Reserve is the General Fund. The balance of the General Fund as at 31 March 2017 shows the extent of resources which the HSCP Board can use in later years to support service provision or for specific projects.

1.8 Indemnity Insurance

The HSCP Board has indemnity insurance for costs relating primarily to potential claim liabilities regarding HSCP Board member and officer responsibilities. Greater Glasgow and Clyde Health Board and West Dunbartonshire Council have responsibility for claims in respect of the services that they are statutorily responsible for and that they provide.

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

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

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

1.9 VAT

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

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

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

2. Accounting Standards Issued Not Yet Effective

For 2017/18, the Code requires the disclosure of information relating to the expected impact of an accounting change that will be required by a new standard that has been issued but not yet adopted. This applies to the adoption of the following new or amended standards within the 2017/18 Code:

- Amendment to the reporting of pension fund scheme transaction costs; and
- Amendment to the reporting of investment concentration.

It is not anticipated that the above changes will have a material impact on the information provided in the financial statements.

The Code requires implementation of these from 1 April 2017 and therefore there is no impact on the 2016/17 Statement of Accounts.

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3. Critical Judgements and Estimation Uncertainty

A critical judgement made in the Financial Statements relating to complex transactions is in respect of the values included for services hosted within West Dunbartonshire HSCP for other IJBs within the Greater Glasgow and Clyde area. At the end of the financial year an assessment of costs associated with activity for these services related to non-West Dunbartonshire residents is made and an appropriate share of the costs is removed from the accounts of West Dunbartonshire HSCP Board and transferred to those other IJBs. The costs removed are based upon budgeted spend such that any overspend or underspend remains with the hosting partnership.

The set aside resource for delegated services provided in large hospitals is determined by analysis of hospital activity and cost information. The value included in the accounts is calculated by NHSGGC using the average of activity data for each partnership population covering to 2013 to 2015 and 2014/15 cost data, uprated for 1% annual inflation for each year. In recognition of the significant joint work which requires to be undertaken to refine this calculation and allow NHSGGC and the six IJBs to meaningful set performance targets, 2016/17 expenditure value equalled the 2016/17 notional budget allocation.

4. Events After the Reporting Period

The Annual Accounts were authorised for issue by the Chief Financial Officer on 20th September 2017. Events taking place after this date are not reflected in the financial statements or notes. Where events taking place before this date provided information about conditions existing at 31st March 2017, the figures in the financial statements and notes have been adjusted in all material respects to reflect the impact of this information.

5. Expenditure and Income Analysis by Nature

West Dunbartonshire Health & Social Care Partnership Board Consolidated Health & Social Care Services	2015-16 £000	2016-17 £000
Employee Costs	41,912	69,697
Property costs	1,390	1,067
Transport	961	1,450
Supplies and Services	3,818	5,592
Payment to Other Bodies	29,683	40,128
Prescribing	16,369	23,435
Family Health Services	16,012	20,784
Capital Charges	580	0
Other - Direct Payments	1,288	1,835
Audit Fee	17	17
Assisted Garden Maintenance and Aids and Adaptations	0	702
Set Aside for Delegated Services Provided in Large Hospitals	13,040	17,066
Income	(12,945)	(18,036)
Taxation and non-specific grant income	(113,737)	(167,693)
Surplus on the Provision of Services	(1,612)	(3,956)

West Dunbartonshire Health & Social Care Partnership

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6. Taxation and Non-Specific Grant Income

The table below shows the funding contributions from the two partner organisations. The funding contribution from the NHS Greater Glasgow and Clyde Health Board shown above includes £17.066m in respect of 'set aside' resources relating to acute hospital and other resources. These are provided by the Health Board which retains responsibility for managing the costs of providing the services. The HSCP Board however has responsibility for the consumption of, and level of demand placed on, these resources.

Taxation and Non -Specific Grant Income	2015-16 Restatement £000	2016-17 £000
NHS Greater Glasgow and Clyde Health Board	(55,378)	(82,899)
West Dunbartonshire Council	(45,319)	(61,514)
NHS GGCHB Set Aside	(13,040)	(17,066)
Services hosted by other GGC IJBS *		(11,775)
Services hosted by West Dunbartonshire HSCP for other IJBS		6,263
Assisted garden maintenance and Aids and Adaptions		(702)
Total	(113,737)	(167,693)

*West Dunbartonshire HSCP Board was established on 1st July 2015 and integrated delivery of health and social care services commenced on this date. Consequently the 2016/17 financial year is the first fully operational financial year of the HSCP Board and the figures above reflect this. In accordance with the Code there is a requirement to restate 2015/16 figures with the removal of the total cost of services hosted by WDHSCP Board for MSK Physio and Retinal Screening as there is no available cost data linking activity across all partnerships to expenditure. The value of hosted services for the 9 months of 2015/16 was £4.556m and £0.572m respectively and when included the total "taxation and non-specific grant income" equals £118.865m.

7. Debtors

Short Term Debtors	2015-16 Restatement £000	2016-17 £000
NHS Greater Glasgow and Clyde Health Board	1,048	1,628
West Dunbartonshire Council	564	3,940
Total	1,612	5,568

8. Creditors

Short Term Creditors	2015-16 Restatement £000	2016-17 £000
NHS Greater Glasgow and Clyde Health Board	0	0
West Dunbartonshire Council	0	0
Total	0	0

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9. Usable Reserve: General Fund

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

- To earmark, or build up, funds which are to be used for specific purposes in the future, such as known or predicted future expenditure needs. This supports strategic financial management.
- To provide a contingency fund to cushion the impact of unexpected events or emergencies. This is regarded as a key part of the HSCP Board's risk management framework.

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

Balance as at 1st April 2015 £000	Transfers Out 2015/16 £000	Transfers In 2015/16 £000	Balance as at 31st March 2016 £000		Transfers Out 2016/17 £000	Transfers In 2016/17 £000	Balance as at 31st March 2017 £000
0	0	(301)	(301)	Integrated Care Fund	301	(555)	(555)
0	0	(275)	(275)	Delayed Discharge	191	(87)	(171)
0	0	(205)	(205)	GIRFEC NHS	30	0	(175)
0	0	(24)	(24)	GIRFEC Council	10	0	(14)
0	0	(46)	(46)	MSK Physio	46	0	0
0	0	(21)	(21)	Ophthalmology	21	0	0
0	0	(48)	(48)	Criminal Justice - transitional funds	48	(60)	(60)
0	0	(200)	(200)	DWP Conditions Management	16	0	(184)
0	0	0	0	TEC (Technology enabled care) project	0	(118)	(118)
0	0	0	0	Cluster lead funding	0	(26)	(26)
0	0	0	0	SMT Leadership development funding	0	(3)	(3)
0	0	0	0	Social Care Fund - Living Wage	0	(833)	(833)
0	0	0	0	Service Redesign and Transformation	0	(1,000)	(1,000)
				Physio waiting times initiative	0	(75)	(75)
0	0	0	0	CHCP 2015/16 Saving	0	(274)	(274)
0	0	(1,120)	(1,120)	Total Earmarked Reserves	663	(3,031)	(3,488)
0	0	(492)	(492)	Unearmarked	396	(1,984)	(2,080)
0	0	(1,612)	(1,612)	Total General Fund	1,059	(5,015)	(5,568)

West Dunbartonshire Health & Social Care Partnership

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10. Agency Income and Expenditure

On behalf of all IJBs within the NHSGGC area, the WD HSCP acts as the lead manager, or host for a number of delegated services. It commissions services on behalf of the other IJBs and recovers the costs involved. The payments that are made on behalf of the other IJBs' and the consequential reimbursement are removed from the Comprehensive Income and Expenditure Statement (CIES) since WD HSCP is not acting as principal in these transactions.

The net amount of expenditure and income relating to those agency arrangements is shown below. (Comparative data not available for 2015/16)

2015/16 Agency Expend £000	2015/16 Agency Income £000	2015/16 Net Exp £000		2016/17 Agency Expend £000	2016/17 Agency Income £000	2016/17 Net Exp £000
-	-	-	MSK Physio	5,486	(5,486)	0
-	-	-	Retinal Screening	681	(681)	0
-	-	-	Old Age Psychiatry	96	(96)	0
0	0	0	Services Hosted by WD HSCP Board for Other IJBs	6,263	(6,263)	0

Similarly, other HSCP's within GGC area act as the Lead Manager, or Host, for a number of delegated services on behalf of WD HSCP Board. The payments that are made by the other IJBs on behalf of WD HSCP Board and the consequential reimbursement are included in the comprehensive income and expenditure statement since this expenditure is incurred for the residents of West Dunbartonshire.

2015/16 Agency Expend £000	2015/16 Agency Services £000	2015/16 Net Exp £000		2016/17 Agency Expend £000	2016/17 Agency Income £000	2016/17 Net Exp £000
-	-	-	Podiatry	485	(485)	-
-	-	-	Primary Care support	373	(373)	-
-	-	-	Continence	311	(311)	-
-	-	-	Sexual Health	646	(646)	-
-	-	-	Learning Disability Tier 4	170	(170)	-
-	-	-	Mh Central Services	660	(660)	-
-	-	-	MH Citywide services	962	(962)	-
-	-	-	Oral Health	657	(657)	-
-	-	-	Addictions	1,096	(1,096)	-
-	-	-	Prison Healthcare	756	(756)	-
-	-	-	HC In Police Custody	177	(177)	-
-	-	-	General Psychiatry	3,393	(3,393)	-
-	-	-	Learning Disability	417	(417)	-
-	-	-	Old Age Psychiatry	1,672	(1,672)	-
-	-	-	Services Hosted by other NHS GGC IJB's	11,775	(11,775)	-

11. Related Party Transactions

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

Transactions with Greater Glasgow and Clyde Health Board

2015-16 Restatement £000		2016-17 £000
(73,546)	Funding Contributions received from the NHS Board	(99,965)
72,498	Expenditure on Services Provided by the NHS Board	99,385
(1,048)	Net transactions with NHS Board	(580)

Greater Glasgow and Clyde Health Board did not charge for any support services provided in the year ended 31st March 2017.

Balances with Greater Glasgow and Clyde Health Board

2015-16 £000		2016-17 £000
1,048	Debtors Balances: Amount Due from the NHS Board	1,628

Transactions with West Dunbartonshire Council

2015-16 £000		2016-17 £000
(45,319)	Funding Contributions received from the council	(61,514)
44,511	Expenditure on Services Provided by the council	57,884
244	Key management personnel	254
(564)	Net transactions with West Dunbartonshire Council	(3,376)

Balances with West Dunbartonshire Council

2015-16 £000		2016-17 £000
564	Debtors Balances: Amount Due from West Dunbartonshire Council	3,940

West Dunbartonshire Council did not charge for any support services provided in the year ended 31st March 2017.

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12. External Audit Costs

In 2016/17 the HSCP Board incurred the following fees relating to external audit in respect of external audit services undertaken in accordance with the Code of Audit Practice:

2015-16 £000		2016-17 £000
17	Fees payable	17

No other fees were payable for any other audit services.

INDEPENDENT AUDITOR'S REPORT

Independent auditor's report to the members of West Dunbartonshire Integration Joint Board and the Accounts Commission

This report is made solely to the parties to whom it is addressed in accordance with Part VII of the Local Government (Scotland) Act 1973 and for no other purpose. In accordance with paragraph 120 of the Code of Audit Practice approved by the Accounts Commission, I do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

Report on the audit of the financial statements

Opinion on financial statements

I certify that I have audited the financial statements in the annual accounts of West Dunbartonshire Integration Joint Board for the year ended 31 March 2017 under Part VII of the Local Government (Scotland) Act 1973. The financial statements comprise the Comprehensive Income and Expenditure Statement, Movement in Reserves Statement, Balance Sheet and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2016/17 (the 2016/17 Code).

In my opinion the accompanying financial statements:

- give a true and fair view in accordance with applicable law and the 2016/17 Code of the state of affairs of the West Dunbartonshire Integration Joint Board as at 31 March 2017 and of its surplus on the provision of services for the year then ended;
- have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2016/17 Code; and
- have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Basis of opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK and Ireland (ISAs (UK&I)). My responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of my report. I am independent of the West Dunbartonshire Integration Joint Board in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standards for Auditors, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the Chief Financial Officer for the financial statements

As explained more fully in the Statement of Responsibilities, the Chief Financial Officer is responsible for the preparation of financial statements that give a true and fair view in accordance with the financial reporting framework, and for such internal control as the Chief

Financial Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor’s responsibilities for the audit of the financial statements

My responsibility is to audit and express an opinion on the financial statements in accordance with applicable legal requirements and ISAs (UK&I) as required by the Code of Audit Practice approved by the Accounts Commission. Those standards require me to comply with the Financial Reporting Council’s Ethical Standards for Auditors. An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the circumstances of the West Dunbartonshire Integration Joint Board and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Chief Financial Officer; and the overall presentation of the financial statements.

My objectives are to achieve reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor’s report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK&I) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Other information in the annual accounts

The Chief Financial Officer is responsible for the other information in the annual accounts. The other information comprises the information other than the financial statements and my auditor’s report thereon. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon except on matters prescribed by the Accounts Commission to the extent explicitly stated later in this report.

In connection with my audit of the financial statements in accordance with ISAs (UK&I), my responsibility is to read all the financial and non-financial information in the annual accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Report on other requirements

Opinions on other prescribed matters

I am required by the Accounts Commission to express an opinion on the following matters.

In my opinion, the auditable part of the Remuneration Report has been properly prepared in accordance with The Local Authority Accounts (Scotland) Regulations 2014.

In my opinion, based on the work undertaken in the course of the audit:

West Dunbartonshire Integration Joint Board – Annual Accounts for the Year Ended 31st March 2017

- the information given in the Management Commentary for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with statutory guidance issued under the Local Government in Scotland Act 2003; and
- the information given in the Annual Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with the Delivering Good Governance in Local Government: Framework (2016).

Matters on which I am required to report by exception

I am required by the Accounts Commission to report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the auditable part of the Remuneration Report are not in agreement with the accounting records; or
- I have not received all the information and explanations I require for my audit; or
- there has been a failure to achieve a prescribed financial objective.

I have nothing to report in respect of these matters.



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20 September 2017

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP**Health & Social Care Partnership Board: 22 November 2017**

Subject: 2017/18 Budget Update and Financial Performance Report as at Period 6 (30 September 2017)**1.1 Purpose****1.2** To provide the Health and Social Care Partnership Board with:

- An update on the 2017/18 revenue budget position;
- An update on the financial performance as at period 6 to 30 September 2017;
- An update on the Scottish Living Wage extending to sleepovers; and
- An update on the 2018/19 budget setting process.

2.1 Recommendations**2.2** The HSCP Board is recommended to:

- Note the updated position in relation to budget movements on the 2017/18 allocation by WDC and NHSGGC;
- Note the progress of work around identification of Set-Aside budget resources and activity;
- Note that revenue position for the period 1 April 2017 to 30 September 2017 is reporting an overspend of £0.343m (-0.49%);
- Note the recommendations in 2016/17 Annual Accounts Report that if full resolution cannot be found within current budget resources then reserves may be utilised to smooth out cost pressures; and
- Note the update on the 2018/19 budget setting process and the potential level of savings required to be met.

3.1 Background**3.2 2017/18 Annual Revenue Budget Update****3.3** At the 23 August 2017 HSCP Board a letter dated 15 August 2017 from James Hobson, Assistant Director of Finance for Greater Glasgow and Clyde Health Board, detailing the 2017/18 budget allocation offer to the partnership, was tabled for the members' consideration.**3.4** After discussion and having heard the Chief Officer and Chief Financial Officer in further explanation of the letter and its impact on the annual revenue budget update report, the Partnership Board agreed to:

- approve the budget offer as it now satisfied the requirement to maintain budget at 2016/17 cash levels;
 - approve the application of £3.6m reduction in 2017/18 across all HSCPs by way of a recharge from NHSGGC for one year only; and
 - cover the HSCP Board's share of £0.274m with the redirection of the reserves earmarked for prescribing pressure no longer required.
- 3.5** With regards to the Set- Aside budget, in line with the 2016/17 "cash level" requirement this was notified as £17.066m, with the commitment from NHSGGC to work with COs, CFOs and Scottish Government to agree a clear methodology for both calculating budget resources aligned to HSCPs' and measuring activity across the 10 specialties specified within the legislation.
- 3.6** A working group has been convened and lists of measures and activity data are being considered. However NHS Scotland Chief Executives have expressed concern around the expectations of the Ministerial Steering Group that funding can be withdrawn from hospital budgets and transferred to IJBs when sustained reduction in unscheduled care demands are not yet fully evident.
- 3.7** This concern coupled with other issues around Integration governance and accountability is one the agenda items at the COSLA Health and Social Care Board October meeting. The HSCP Board will be apprised of further developments.
- 4.1** **2017/18 Financial Performance Revenue Expenditure as at Period 6 (30 September 2017)**
- 4.2** **Greater Glasgow and Clyde Health Board Allocation**
- 4.3** As referred to in 3.3 above the 15 August budget allocation letter detailed the HSCP Board's 2017/18 recurrent roll forward budget of £84.413m, further adjusted for budget changes up to period 3, including Social Care Fund, resulting in an adjusted budget of £86.519m
- 4.4** Since the previous reported budget the following budget adjustments have taken place from Period 3 to Period 6 revising the net expenditure budget to £87.834million.

	£000
Revised 2017/18 HSCP Opening Budget at Period 3	86,519

Additional Allocations of:

FHS GMS re SESP & DES Recharges - (Non-Recurring)	571
Prescribing Invest To Save - (Recurring)	231
Health Visitor Girfec Framework - (Recurring)	150
Scottish Government Veterans/Carers Funding - (Recurring)	140
Prescribing Base Budget - (Recurring)	93
Scottish Government Carers Information Strategy - (Non-Recurring)	78
SESP Funding from FHS (Diabetes & Eat Up) - (Non-Recurring)	70
Addictions - Public Health Hepc Bbv - (Non-Recurring)	26
MSK Physiotherapy from Acute - (Recurring)	5

Deductions of:

Complex Care Savings Target - (Recurring)	-49
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Revised 2017/18 HSCP Budget at Period 6	87,834
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4.5 West Dunbartonshire Council Budget Allocation

4.6 At the meeting of West Dunbartonshire Council on 22 February 2017, Members agreed the revenue estimates for 2017/2018, including a total net West Dunbartonshire Health & Social Care Partnership budget of £60.673m.

4.7 There have been further budget adjustments from Period 3 to Period 6 revising the net expenditure budget to £60.614 million. The main adjustment being an additional allocation from the council to cover the costs of implementing the cost of awarding all staff earning under £35,000 p.a. an annual pay increase of £350 and 1% for those over £35,000 per annum.

	£000
Revised 2017/18 HSCP Opening Budget at Period 3	60,659

Additional Allocations of:

Pay Award of £350 for salary < £35,000 - (Recurring)	205
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Deductions of:

Bridge Street Property Budgets to Regeneration - (Recurring)	-226
Training Budget Centralisation to Corporate - (Recurring)	-24

Revised 2017/18 HSCP Budget at Period 6	60,614
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4.8 Summary Position

4.9 The WDHSCP revenue position is reporting for the period 1 April to 30 September 2017 an overspend of £0.342m (-0.49%).

4.10 The Partnership's NHS Health Care budget is reporting a overall break even position and the Social Care budget is reporting a net overspend of £0.342m (-1.19%) for the same period.

4.11 The projected overspend of £0.570m (-0.38%) is based on figures presented as at 30 September 2017 and any known material variations.

4.12 The summary position is reported within the following table and the significant variances affecting the overall position reported above are highlighted within sections 4.13 to 4.21 of this report. Additional detailed breakdown of individual costs at care group level are reported in Appendix 1 of this report.

	Annual Budget	YTD Budget	YTD Actuals	Variance	Variance	Forecast	Full Year Variance	Variance
	£000's	£000's	£000's	£000's	%	Full Year	£000's	%
Health Care	92,181	43,465	43,465	(0)	0.00%	92,181	0	0.00%
Social Care	87,462	31,427	31,632	(205)	-0.65%	87,883	(421)	-0.48%
Expenditure	179,643	74,892	75,097	(205)	-0.27%	180,064		0.00%
Health Care	(4,347)	(2,285)	(2,285)	0	0.00%	(4,347)	0	0.00%
Social Care	(26,848)	(2,635)	(2,497)	(138)	5.22%	(26,699)	(149)	0.55%
Income	(31,195)	(4,920)	(4,782)	(138)	2.79%	(31,046)	(149)	0.48%
Health Care	87,834	41,180	41,180	(0)	0.00%	87,834	0	0.00%
Social Care	60,614	28,792	29,135	(343)	-1.19%	61,184	(570)	-0.94%
Net Expenditure	148,448	69,972	70,315	(343)	-0.49%	149,018	(570)	-0.38%

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.

4.13 Significant Variances – Health Services

4.14 The overall net position at 30 September 2017 is breakeven, this includes the previously approved application of both earmarked and unearmarked reserves to cover the HSCP Board's £0.274m share of the £3.6m and challenges meeting an elements of the 2016/17 savings (section 4.22 – 4.25 below) around staff restructuring and the cost of carrying displaced staff. It is anticipated that turnover savings targets agreed to meet pay inflation and apprentice levy pressure will be met. The key areas are:

- **Adult Community Services** – is reporting an overspend of £0.169m due to nursing costs for a specialist care package and EQUIPU pressure for aids provided at hospital discharge. This unfunded package was previously covered by staffing savings across services, however the application of a 2% turnover target to fund pay award and apprentice levy has closed off this option.
- **Mental Health – Adult Community and Elderly Services** is reporting an overspend of £0.027m. This is mainly due to vacancy slippage and delay in achieving 2016/17 workforce service redesign savings as anticipated employee retirements did not occur.
- **Planning and Health Improvement** - is reporting underspend of £0.083m mainly due to delay in application of discretionary funding commitments. Further information is required on level of non-recurrent funding anticipated.
- **Hosted Services – MSK Physiotherapy and Retinal Screening** – reporting underspends of £0.038m and £0.033m respectively. These are due to staff vacancies and maternity leave but with drives on waiting times initiative for both services should reduce as the year progresses.
- **Other Services** is reporting an underspend of £0.046m. This consists of some savings in non-pays budget and budget phasing and is projected to smooth out by the year end.

4.15 GP Prescribing for Partnerships in 2017/18

- 4.16** As reported to the 23 August HSCP Board there had been and continues to be significant work being undertaken by the Prescribing Efficiency Group to mitigate the 2017/18 inflationary cost and demand pressures on drugs.
- 4.17** The 2017/18 budget allocation from GGCHB maintained GP Prescribing budgets at 2016/17 “cash levels” and “risk sharing agreement”, where the Board continues to manage the budget collectively on behalf of all partnerships, would continue until the end of the financial year.
- 4.18** Therefore with risk sharing in place the budget position for the 6 HSCPs’ is shown as nil, however there are currently 4 partnerships reporting overspends based on prescription costs to July 2017, West Dunbartonshire HSCP is among them.
- 4.19** As at 31 July 2017 the overspend for WDHSCP is £0.050m and this is being investigated by the prescribing advisors. However there are likely to be many elements to the variance e.g. continuing pressure on drugs on short supply, off patent savings not as high as projected and efficiency programmes not yet fully implemented, making an estimation to the year end complex. However HSCPs’ will continue to work in partnership at reducing the potential year end cost to the health board.

4.20 **Significant Variances – Social Care Savings**

4.21 The net overspend position at 30 September 2017 is £0.343m (-0.49%). Although this is an increase in monetary terms from the £0.212m (-1.31%) overspend as at 30 June 2017, it is a reduction in % terms based on period 6 phased budgets. The key areas are:

- **Residential Schools** – is reporting an overspend of £0.073m mainly due to 2 new placements in secure residential schools and a delay in some young adults moving to throughcare. This is an extremely volatile budget and the childcare managers review alternatives to high cost placements on a weekly basis.
- **Community Placements** – is reporting a current overspend £0.110m due to the significant increase (30+) in the number of Kinship Care placements than originally budgeted. This is unlikely to be mitigated by the end of the financial year and will be reflected in 2018/19 budget pressures. Social Work Scotland networks have approached the Scottish Government to urge them to revisit funding allocated to these placements, equalised against payments to foster carers. Funding was only allocated based on 2014 placement levels with a commitment to re-visit if numbers significantly increased, as predicted by local authorities at the time.
- **Residential Accommodation for Older People** - is reporting a year to date overspend £0.167m for reasons previously reported. The delay in the opening of the new Dumbarton Care Home and the knock on impact of some double running costs. There is also an element of unidentified savings which was part of the original contribution to the revenue cost relating to borrowing and higher than anticipated staff cover costs due to staff absence for long term medical conditions. Significant work is being undertaken by the older people budget managers and human resources to minimise vacancies and absence covered by the use of overtime and agency staff.
- **Homecare** - is reporting an overspend of £0.152m mainly due to payments to external providers and a shortfall in income against budget, which is a continuation of a 2016/17 budget variance. To mitigate this pressure two new coordinators have been appointed who will review all current packages and scheduling efficiencies through the implementation of CM2000 and where possible move clients to our internal service.
- **Additional Support Needs Client Packages** – across clients with mental health issues, learning and physical disabilities there is a current underspend of £0.133m. This is mainly a result of the loss of a few clients and small increases in client contributions. However continued pressure from third sector and private providers to further enhance living wage commitments to help with retention of staff and the anticipated increase in demand in 2018/19 as young people with additional support needs transition into adult services will impact on future commitments.

4.22 Savings Performance to Date – Health

- 4.23** As previously reported, the Scottish Government direction to maintain 2017/18 budget allocations at 2016/17 cash levels resulted in the partnership having to find savings to mitigate the cost of pay inflation and apprentice levy costs of £0.465m. The HSCP Board approved the application of a 2% turnover target to be set against all staffing budgets and as indicated in section 4.14 above, at this stage in the financial year it is anticipated this will be achieved.
- 4.24** Coupled with this approved savings plan is the requirement to deliver on the approved 2016/17 savings of £0.955m which was covered non-recurrently by the Health Board in 2016/17. There is some uncertainty around the Mental Health service redesign and School Nurse Review also some of the other savings related to staff leaving the service are being covered by non-recurrent savings across the service (Appendix 2). The latest projections estimate that £0.140m may require to be drawn down from unearmarked reserves.
- 4.25** In addition to these previously reported savings there has been further pressure transferred in Period 6 in relation to a previously agreed target by Chief Officers in Complex Care bed reduction. The total saving across the 6 partnerships is £0.600m of which £0.049m applies to WDHSCP. Given the overspend in Adult Community Services, reported in 4.14 above, it is likely that is too may need to be covered in 2017/18 by reserves while a longer term solution is worked on.

4.26 Savings Performance to Date – Social Care

- 4.27** The approved budget allocation from West Dunbartonshire Council, detailed in sections 4.5 – 4.7 above, required the HSCP Board to identify savings of £2m in order to deliver on the current demand levels for services. The board approved that this was achieved by the application of uncommitted recurring 2016/17 Social Care Fund resources.

5.1 Update on Implementation of Scottish Living Wage (SLW) Commitment

- 5.2** As reported to the 23 August 2017 HSCP Board, throughout July and early August providers were issued with an offer to increase the unit cost day rate by 2.5%, which would cover the £0.20 increase to SLW of £8.45/hr, as well offer an element for sustainability. With regard to sleepovers, as guidance had yet to be received from Scottish Government, the offer was £7.57/hr which met both the NMW level and an element of sustainability as providers work with us on alternatives to service delivery.

- 5.3 The majority of providers have accepted however there are still some who are requesting further discussions, mainly around the offer for sleepovers and the uncertainty around future levels.
- 5.4 On the 19 October 2017 a joint letter was issued by the Scottish Government and COSLA (Appendix 3) confirming the Cabinet Secretary's decision to extend the payment of the SLW to sleepovers in 2018/19. At this point there is no indication on the level of additional funding which will be available to implement this commitment.
- 5.5 With this now confirmed all efforts will be made to finalise provider agreements for 2017/18 and calculate the potential additional costs, including for in-house employees. This will be run in parallel with the planned review on current sleepover levels and the possibility to make better use of technology to support clients with an assessed need.

6.1 **Housing Aids and Adaptations and Care of Gardens**

- 6.2 Housing Aids and Adaptations and Care of Gardens services for social care are also part of the HSCP Board total resource for 2017/18.
- 6.3 The budgets are currently held within West Dunbartonshire Council's – Regeneration, Environment and Growth Directorate and are managed on behalf of the HSCP Board. The 2017/18 budget based on existing resources for Care of Gardens is £0.500m and Aids and Adaptations is £0.250m (which includes the re-instatement of the £0.100m saving removed from the 2016/17 budget allocation) and provides a total resource of £0.750m.
- 6.4 The summary position for the period to 30 September 2017 is reported in the following table and reports an overall projected spend of £0.754m against the full year budget, resulting in a small overspend of £0.004m. However, management action will be expected to bring this back into line by the end of the financial year.

	Budget	Actual	Variance	Forecast
Care of Gardens	500,000	420,069	79,931	504,045
Aids & Adaptations	250,000	125,000	125,000	250,000
Total	750,000	545,069	204,931	754,045

7.1 **2017/18 Capital Expenditure**

- 7.2 The progress to date of the individual "live" schemes funded within the Health & Social Care Partnership is detailed below.

- 7.3** As previously reported to the Partnership Board, the Outline Business Case for the Clydebank Health and Care Centre was considered at the Scottish Government's Capital Investment Group (CIG) on 17 August and again on 19 September 2017.
- 7.4** As expected for a project of this size there was a series of questions and requests for further information which officers of the HSCP and NHSGGC responded to in early October. After further consideration CIG recommended approval and this was confirmed by letter (Appendix 4) from Paul Gray, Director General Health and Social Care and Chief Executive NHSScotland. The Full Business Case will now be worked up and the HSCP Board will be updated as it progresses.
- 7.5** As previously agreed by the HSCP Board there was agreement to provide funding of up to £0.250m for furniture and equipment for the new homes. The draft statement of final account is around £0.200m with some further analysis underway. A virement request was made to WDC on 30 August 2017 to transfer an underspend in 2016/17 Aids and Adaptations budget of £0.064m to fund the purchase of beds for the new care home, as historically this budget has been used to support care home purchases.
- 7.6** The elected members requested further information from the Chief Officer and this was provided to the council meeting on 25 October 2017 – extract below:

“The HSCP has both capital and revenue budget resources for the purchase of aids and equipment, required to maintain and facilitate people with an assessed need to remain in their own home or a homely setting.

The capital resource for Aids, Equipment and Adaptations is used for items such as specialist beds, stair lifts, walking aids, lifting equipment and Occupational Therapists assessment within clients' homes. It has also been used to purchase items of a capital nature for our care homes, including furniture and kitchen equipment. Therefore it is reasonable that the purchase of equipment i.e. Specialist beds for the new Dumbarton Care Home, could be charged to this budget.

This £0.064m reported slippage for 2016/17 was a combination of:

- £0.024m of capital slippage from 2015/16;*
- £0.021m of equipment originally charged to capital to redirected to HSCP revenue aids and equipment budget after a detailed analysis of expenditure incurred; and*
- £0.019m (2.9%) of new slippage on the total budget of £0.655m.*

Given the source of funding for the requested virement is an accumulation of minor slippage there is no detriment to the core budget allocation of £0.655m in 2017/18 with regards to waiting times and provision of essential equipment.”

- 7.7 After consideration of this additional information the virement request was approved.
- 7.8 Planning consent for the new Clydebank Care Home was agreed by WDC Planning Committee on 31st May 2017. This project is currently tracking an overspend on approximately £0.200m based on latest cost estimates, however this position will be reflected upon receipt of tender returns.
- 7.9 Further to Project Board meeting held on 6th September, the invitation to tender will be issued on 19 September with a closing date of 25 October 2017. However approaches were made by a couple of the potential bidders (5 preferred bidders identified at PQQ stage) for an extension to be granted.
- 7.10 After consideration by the Project Board an extension to 6 December 2017 was agreed with expectation that the extra time will mitigate the loss of potential bidders and get the best possible returns from this exercise and mitigate having to re-run the tender. Every effort will be made thereafter to compress the commercial and technical evaluations. The evaluators will require to block out time from 6 December to 22 December to protect the care home project and minimise the impact on the co-dependency dates with the Health Centre project. The Project Board will be required to compress the programme to do all possible to maintain the construction site start date in April 2018.
- 7.11 **Aids & Adaptations** – As reported above the underspend from 2016/17 of £0.064m was brought forward into 2017/18 with a request to be vired to the Care Homes project. At this stage full spend of the capital budget is anticipated.
- 7.12 The summary capital expenditure position is detailed in Appendix 5 and the significant variances affecting the overall position reported are monitored routinely as part of the Council's capital planning process.
- 8.1 Financial Challenges – Budget Setting Process 2018/19 – 2020/21**
- 8.2 West Dunbartonshire Council was presented with a refresh of its long term financial strategy on 25 October 2017. The strategy is reviewed annually and provides detailed analysis of issues for the next 3 financial years (2018/19 – 2020/21). The financial strategy aims to allow the Council to plan ahead and take appropriate action to maintain budgets within expected levels of funding.
- 8.3 The Strategic Lead - Resources reported the indicative funding gaps for 2018/19 to 2020/21 General Services ranging from more likely, best and worst position based on a variety of assumptions. The most likely scenario is expected gaps of £3.375m for 2018/19, £8.378m for 2019/20 and £14.254m (cumulative) remaining to be closed.
- 8.4 In order to meet the financial challenge for 2018/19 onwards, Strategic Leads, including the HSCP Chief Officer, have being asked to generate options for efficiencies and savings. For the HSCP Board the most likely scenario is that

the savings target allocated will take cognisance of the Scottish Government's commitment to deliver of its Health and Social Care Integration agenda by limiting the budget reductions that can be applied by its local authority partner. The 2017/18 local authorities were limited to adjust their allocations to Integration Authorities by up to their share of £80 million below the level of budget agreed in 2016/17. However this reduction was coupled with additional Social Care Funding to cover the increase to the Scottish Living Wage. As detailed above in section 5.3 there is no further information on what this is likely to be.

- 8.5** On this basis the funding reduction for the HSCP Board in 2018/19 could be £1.560m, before the addition of further pressures e.g. kinship care, residential schools and learning disability transitions, which could add another £1.5m to this opening savings target. This scenario, which equates to approximately 5% of the controllable Social Care budget, was presented to the Senior Management Team to produce savings options, which were presented to the HSCP Board voting members for discussion on 27 October 2017 and are subject to a separate report for the January Partnership Board.
- 8.6** The actual savings gap will not be confirmed with any certainty until the Scottish Government issues its budget settlement on 14 December 2017.
- 8.7** With regards to potential future funding settlements to the HSCP Board from NHSGGC, including their ability to fund pay award pressures, prescribing costs and demand pressures, will be dependent on the funding settlement from the Scottish Government and any specific directions attached to this.
- 8.8** The latest financial report to the Health Board projected a shortfall of £26m in 2017/18; however this is after taking account of £12.5m of one-off cash releasing savings.
- 8.9** For the purposes of calculating the funding gap for the HSCP Board in 2018/19, the likely scenario considers that, we will experience similar funding pressures around prescribing, without the safety net of the risk sharing arrangement, any pay award over 1% (due to the removal of the cap) may be funded by Scottish Government and unfunded cost pressures around specialist packages and equipment. This could equate to approximately £1.4m which equates to a 5% reduction on service budgets, excluding Family Health Services. As referred to in section 8.5 above savings options are subject to a separate report for a future meeting.

9.1 People Implications

- 9.2** None.

10.1 Financial Implications

10.2 Other than the financial position noted above, there are no other financial implications known at this time.

11.1 Professional Implications

11.2 None

12.1 Locality Implications

12.2 None

13.1 Risk Analysis

13.2 The main financial risks to the ongoing financial position relate to currently unforeseen costs and issues arising between now and the financial year end.

The main risks for 2018/19 are:

- Significant potential reduction to funding from both partner organisations as financial austerity continues to impact on their own funding strategies in the short to medium term;
- The removal of the 1% pay award cap and the cost pressures if unfunded; and
- The end of the risk sharing arrangement for GP Prescribing. As referred to above (section 4.17) the continuing cost of drugs on short supply, less than anticipated off-patent savings and prescribing efficiency programmes failing to realise full savings, will place significant cost pressures on HSCP Boards.

14.1 Impact Assessments

14.2 None

15.1 Consultation

15.2 This report has been provided to the Health Board Assistant Director of Finance and the Council's Head of Finance and Resources.

16.1 Strategic Assessment

16.2 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.

16.3 This report links to the strategic financial governance arrangements of both parent organisations.

Julie Slavin – Chief Financial Officer

Date: 8 November 2017

Person to Contact: Julie Slavin – Chief Financial Officer, Garshake Road,
Dumbarton, G82 3PU, Telephone: 01389 737311 e-mail julie.slavin@ggc.scot.nhs.uk

Appendices:

- Appendix 1 – Health and Social Care Financial Statement (P6 Budget report)
- Appendix 2 – Progress on 2016/17 Health Savings Performance
- Appendix 3 – Letter 19 October 2017 from Scottish Government and COSLA on SLW extension to Sleepovers
- Appendix 4 – Approval Letter Clydebank Health & Care Centre - October 2017 Paul Gray, Director General Health and Social Care and Chief Executive NHSScotland
- Appendix 5 – West Dunbartonshire Council - General Services Capital Programme

West Dunbartonshire Health & Social Care Partnership
 Financial Year 2017/18 period 6 covering 1 April to 30 September 2017

Appendix 1

	Annual Budget £000's	Year to date Budget £000's	Actual £000's	Variance £000's	Variance %	Forecast Full Year	Variance £000's
Health Care Expenditure							
Planning & Health Improvements	922	436	353	83	19%	822	100
Children Services - community	2,451	1,280	1,327	(47)	-4%	2,531	(80)
Children Services - specialist	1,588	794	829	(35)	-4%	1,658	(70)
Adult Community Services	9,653	5,048	5,217	(169)	-3%	9,933	(280)
Community Learning Disabilities	547	274	258	15	6%	547	0
Addictions	1,849	660	665	(5)	-1%	1,849	0
Men Health - Adult Inpatient	0	0	0	0	#DIV/0!	0	0
Mental Health - Adult Community	4,301	2,120	1,993	128	6%	4,301	0
Mental Health - Elderly Inpatients	3,124	1,587	1,742	(155)	-10%	3,124	0
Family Health Services (FHS)	24,865	12,890	12,890	0	0%	24,865	0
GP Prescribing	19,250	9,724	9,724	0	0%	19,250	0
Other Services	1,491	1,103	989	114	10%	1,211	280
Resource Transfer	15,161	4,075	4,075	0	9%	15,161	0
Hosted Services	6,981	3,475	3,404	71	2%	6,931	50
Expenditure	92,181	43,464	43,465	(0)	0%	92,181	0
Income	(4,347)	(2,285)	(2,285)	0	0%	(4,347)	0
Net Expenditure	87,834	41,180	41,180	(0)	0%	87,834	0

	Annual Budget £000's	Year to date Budget £000's	YTD Budget £000's	Variance £000's	% Variance	Forecast Full Year	Variance £000's
Social Care Expenditure							
Strategy Planning and Health Improvement	1,066	449	406	43	10%	980	86
Residential Accommodation for Young People	3,652	1,524	1,572	(48)	-3%	3,748	(96)
Children's Community Placements	3,472	1,575	1,713	(138)	-9%	3,748	(276)
Children's Residential Schools	637	589	661	(73)	-12%	782	(145)
Childcare Operations	3,867	1,579	1,579	0	0%	3,867	0
Other Services - Young People	3,996	1,439	1,406	33	2%	3,930	66
Residential Accommodation for Older People	7,519	3,002	3,227	(226)	-8%	7,974	(455)
External Residential Accommodation for Elderly	12,574	5,527	5,439	88	2%	12,399	175
Homecare	13,834	5,271	5,355	(85)	-2%	14,003	(169)
Sheltered Housing	1,948	671	646	25	4%	1,902	46
Day Centres Older People	1,214	405	423	(18)	-4%	1,250	(36)
Meals on Wheels	75	36	34	2	6%	71	4
Community Alarms	347	137	138	(2)	-1%	354	(7)
Community Health Operations	2,655	1,145	1,150	(5)	0%	2,665	(10)
Residential - Learning Disability	14,174	3,518	3,414	104	3%	13,967	207
Day Centres - Learning Disability	1,949	672	670	2	0%	1,946	3
Physical Disability	2,939	1,174	1,128	46	4%	2,847	92
Addictions Services	1,814	606	601	5	1%	1,804	10
Mental Health	3,850	1,160	1,134	26	2%	3,799	51
Criminal Justice	1,978	771	749	22	3%	1,934	44
HSCP - Corporate	3,902	182	187	(6)	-3%	3,913	(11)
Expenditure	87,462	31,428	31,632	(205)	-0.7%	87,883	(421)
Income	(26,848)	(2,635)	(2,497)	(138)	5%	(26,699)	(149)
Net Expenditure	60,614	28,793	29,135	(342)	-1.2%	61,184	(570)

	Annual Budget £000's	Year to date Budget £000's	Actual £000's	Variance £000's	Variance %	Forecast Full Year	Variance £000's
Consolidated Expenditure							
Older People Residential, Health and Community Care	35,985	15,969	16,274	(305)	-1.9%	36,548	(563)
Homecare	13,834	5,271	5,355	(85)	-1.6%	14,003	(169)
Physical Disability	2,939	1,174	1,128	46	3.9%	2,847	92
Children's Residential Care and Community Services (incl specialist)	19,663	8,779	9,087	(308)	-3.5%	20,264	(601)
Strategy Planning and Health Improvement	1,988	885	759	126	14.2%	1,802	186
Mental Health Services - Adult & Elderly							
Community and Inpatients	11,275	4,867	4,868	(1)	0.0%	11,224	51
Addictions	3,663	1,266	1,266	(0)	0.0%	3,653	10
Learning Disabilities - Residential and Community Services	16,670	4,463	4,342	120	2.7%	16,460	210
Family Health Services (FHS)	24,865	12,890	12,890	0	0.0%	24,865	0
GP Prescribing	19,250	9,724	9,724	0	0.0%	19,250	0
Hosted Services	6,981	3,475	3,404	71	2.0%	6,931	50
Criminal Justice	1,978	771	749	22	2.9%	1,934	44
Resource Transfer	15,161	4,075	4,075	0	0.0%	15,161	0
HSCP Corporate and Other Services	5,393	1,285	1,176	108	8.4%	5,124	269
Gross Expenditure	179,643	74,892	75,097	(205)	-0.3%	180,064	(421)
Income	(31,195)	(4,919)	(4,782)	(138)	2.8%	(31,046)	(149)
Total Net Expenditure	148,448	69,973	70,315	(342)	-0.49%	149,018	(570)

Appendix 2

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP				
HEALTH CARE SAVINGS OPTIONS 2016/17 - PROGRESS IN 2017/18				
Option	Full Year Effect value (£)	Achievable by 31/03/18 (£)	Recurring/Non-Recurring	Update from Budget Holders 25/10/17
<p>Addictions Services is an integrated team and as such any savings taken impact on the whole service. In order to deliver further savings would require a significant reduction in the level of service at a time when there is a significant increase in the demand. This proposal suggests a 6% saving of £ 63K</p> <p>The proposal would see a review of staffing with a focus on Band 7 posts . This is very challenging given GG&C has a no redundancy policy.</p>	63,000	63,000	Non-Recurring	The Band 7 posts remain and unlikely that a vacancy will arise before the end of the financial year. However the budget holders have identified across the Addictions budget. However the saving will roll forward to 2018/19 and add to proposed target.
<p>Review posts, skill mix and service delivery across the CMHT , PCMHT , OACMHT Crisis Team and Older Peoples Inpatient Service.</p> <p>Focus on a review Band 7 Posts across all service areas particularly band 7 posts managing small teams</p> <p>Review the skill mix required across all areas including inpatient areas</p> <p>Reduce on costs for Admin through reduction in skill mix and co location of teams</p>	246,178	190,000	Recurring - £90k and balance Non-Recurring	There has been significant work undertaken across both Adults and Older People, however there has not been significant staff movement in the required areas to fully implement saving recurrently. As above there has been some non-recurring solutions found to help in year target, however the shortfall will roll forward to 2018/19.
School Nursing Redesign	113,990	30,000	Non-Recurring	It is acknowledged that the review will not be fully implemented in 2017/18 and that any shortfall in savings target will have to be met from other non-recurrent sources. The addition of the 2% turnover target has made this difficult and it is likely that reserves will be required to be applied non-recurrently. Again this savings target will roll forward to 2018/19.
Delete Change Fund Manager post.	55,000	55,000	Recurring	Achievable from 01/04/17.
Reduce Accommodation Costs – Supplies and HLP.	2,000	2,000	Recurring	Achievable from 01/04/17.
Reduction in OOH nursing cover with redesign of cover arrangements	30,000	30,000	Recurring	Achievable from 01/04/17 through service redesign and skill mix.
Reduce on costs for Admin (night filer) costs through retirements and recruitment	34,000	34,000	Recurring	Achievable from 01/04/17 - post-holder retired and service redesign/skill mix achieved.
Redesign staffing model in Diabetic Retinal Screening Service - achieved through turnover of staff	31,000	31,000	Recurring	Achievable from 01/04/17.
Interim care beds	35,000	35,000	Recurring	Achievable from 01/04/17, however demand pressures continue to be
Review of project based funding	47,162	47,162	Recurring	Achievable from 01/04/17.
In order to deliver the required local savings target of £281,000 in 16/17 (this figure also includes the local workforce savings target of £61K), 8.3wte Physiotherapists (Bands 5 & 6) would be lost. This would have a significant impact on the quality of service provision and without further action, would increase waiting times. As any further increase in waiting times is not likely to be an acceptable or palatable option it is likely that the service would look for a Board decision on two main options for future service delivery.	220,123	220,123	Recurring	Achievable from 01/04/17.
Delete one currently vacant part-time (0.5WTE) Band 5 post (£18k FYE) and 50% reduction in non-pays budget (£13k),	30,942	30,942	Recurring	Achievable from 01/04/17.
Budget Reduction in relation to HQ Discretionary funding.	46,204	46,204	Recurring	Achieved in 16/17
TOTAL VALUE	954,599	814,431		
SHORTFALL	140,168			



19 October 2017

Dear Chief Officer

As part of the 2017/18 budget we said that we would undertake work to extend the Living Wage to sleepover hours. We have engaged with key stakeholders including health and social care partnerships, providers through CCPS and Scottish Care, and the workforce through Unison. We have identified the risks and challenges of extending the commitment to sleepovers, but believe these can be managed and addressed. **The Cabinet Secretary has decided that Living Wage will be extended to sleepovers during 2018/19.** This will provide time for commissioners and delivery partners to work together to ensure continuity of care to individuals and mitigate the risk of any adverse impact to the workforce.

Further discussion surrounding funding to support the implementation of this will continue and the detail of this will be confirmed as part of the 2018/19 Spending Review process.

Kind regards

A handwritten signature in black ink that reads "Geoff Huggins".

GEOFF HUGGINS
Scottish Government

A handwritten signature in black ink that reads "Paula McLeay".

PAULA McLEAY
COSLA



T: 0131-244 2790
E: dghsc@gov.scot

Jane Grant
Chief Executive
J B Russell House
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

16 October 2017

Dear Jane

Greenock and Clydebank Health and Social Care Centres – Outline Business Cases

The two Outline Business Cases above have been considered by the Health Directorates' Capital Investment Group (CIG) on 17 August and 19 September 2017. CIG recommended approval and I am pleased to inform you that I have accepted that recommendation and now invite you to submit a Full Business Case for both projects.

A public version of the document should be sent to Colin Wilson (Colin.Wilson@gov.scot) within one month of receiving this approval letter, for submission to the Scottish Parliament Information Centre (SPICe). It is a compulsory requirement within SCIM, **for schemes in excess of £5 million** that NHS Boards set up a section of their website dedicated specifically to such projects. The approved Business Cases/ contracts should be placed there, together with as much relevant documentation and information as appropriate. Further information can be found at http://www.scim.scot.nhs.uk/Approvals/Pub_BC_C.htm.

I would ask that if any publicity is planned regarding the approval of the business case that NHS Greater Glasgow and Clyde liaise with SG Communications colleagues regarding handling.

As always, CIG members will be happy to engage with your team during the development of the Full Business Case and to discuss any concerns which may arise. In the meantime, if you have any queries regarding the above please contact Alan Morrison on 0131 244 2363 or e-mail Alan.Morrison@gov.scot.

Yours sincerely

Paul Gray

APPENDIX 5

WEST DUNBARTONSHIRE COUNCIL						
GENERAL SERVICES CAPITAL PROGRAMME						
ANALYSIS OF PROJECTS AT RED ALERT STATUS						
MONTH END DATE				30 September 2017		
PERIOD				6		
Budget Details	Project Life Financials					
	Budget	Spend to Date		Forecast Spend	Forecast Variance	
	£000	£000	%	£000	£000	%
Replace Elderly Care Homes and Day Care Centres						
Project Life Financials	25,063	13,778	55%	25,263	200	1%
Current Year Financials	6,781	348	5%	481	(6,300)	-93%
Project Description	Design and construction of replacement elderly care homes and day care centres in Dumbarton and Clydebank areas					
Project Lifecycle	Planned End Date	31-Jan-19	Forecast End Date	30-Sep-19		
Main Issues / Reason for Variance						
<p>Dumbarton Care Home achieved practical completion on 28th April 2017 with retention due April 2018. Residents, day care users and staff are now using the new facility. Remaining budget of £0.112m required to slip into 18/19 for retentions and HSCP to reimburse capital budget for £200,000 expenditure on loose FF&E. Clydebank Care Home - Planning consent was granted on 31st May 2017 with conditions which are currently being monitored and discharged at the appropriate points. This project is currently tracking an overspend based on latest cost estimates, however this position will be reflected upon receipt of tender returns due in December 2017. Further to Project Board meeting held on 6th September, the invitation to tender was issued on 19th September 2017. It is anticipated that work will commence on-site by April 2018. Delay in achieving planning consent (linked to Masterplan Phase 1 which had to be determined first) and finalising more specific detail to tender (taking account of lessons learned from Dumbarton Care Home and site-specific matters and district heating) has subsequently changed the forecast end date. As a result of the amended timescale, forecast spend has been reduced in 17/18 and spend re-profiled into 18/19.</p>						
Mitigating Action						
September project board acknowledged tender issue date of 20th September. Consideration is being given by Officers to compress the tender evaluation period such that the contract can be awarded at earliest opportunity.						
Anticipated Outcome						
New Care home provision in Clydebank, currently anticipated to be £0.200m over budget and delayed by around 5 months.						
Special Needs - Aids & Adaptations						
Project Life Financials	719	67	9%	655	(64)	-9%
Current Year Financials	719	67	9%	655	(64)	-9%
Project Description	Reactive budget to provide adaptations and equipment for HSCP clients					
Project Lifecycle	Planned End Date	31-Mar-18	Forecast End Date	31-Mar-18		
Main Issues / Reason for Variance						
Virement requested at Council meeting on 30th August 2017 to move £0.064m to Dumbarton Elderly Care Home. Further information to be provided before Council reaches a decision on the virement request.						
Mitigating Action						
HSCP to provide further information to members with regards to request for virement.						
Anticipated Outcome						
Provision of adaptations and equipment to HSCP clients as anticipated						

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health and Social Care Partnership Board: 22nd November 2017

Subject: **Unscheduled Care (Winter) Plan 2017/18**

1. **Purpose**

1.1 To present the Health & Social Care Partnership Unscheduled Care (Winter) Plan for 2016/17.

2. **Recommendation**

2.1 The Partnership Board is recommended to approve the Unscheduled Care (Winter) Plan.

3. **Background**

3.1 The Scottish Government has produced planning guidance for winter 2017/18, recognising the additional pressures and business continuity challenges that are faced in winter.

3.2 NHS Health Boards are required to prepare winter plans with Scottish Government. The Scottish Government recognises the role of the Integration Joint Boards (IJB) in winter planning for each Partnership Area and the wider Health Board Area.

3.3 Across the six partnerships within the Health Board's area, the Chief Officers have all agreed that they will produce a winter plan for each of their areas; and that their teams will participate in the planning work across the wider NHS system which enables the delivery of effective unscheduled care.

3.4 Within West Dunbartonshire HSCP, the importance of having a plan and adopting a balanced approach to manage the additional unscheduled care pressures and business continuity challenges that are faced in winter has been recognised within the local Strategic Risk Register.

3.5 The Unscheduled Care (Winter) Plan for the 2017/18 period has been prepared and is attached for endorsement by the Partnership Board.

4. **Main Issues**

4.1 The national Preparing for Winter Guidance identified 12 critical areas for winter planning:

- Safe & effective admission / discharge continue in the lead-up to and over the festive period and also in to January.

- Workforce capacity plans & rotas for winter / festive period agreed by October.
- Whole system activity plans for winter: post-festive surge / respiratory pathway.
- Strategies for additional winter beds and surge capacity.
- The risk of patients being delayed on their pathway is minimised.
- Discharges at weekend & bank holiday.
- Escalation plans tested with partners.
- Business continuity plans tested with partners.
- Preparing effectively for norovirus.
- Communication plans
- Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

4.2 The local Strategic Risk Register identifies the development and implementation of a WD HSCP winter plan that addresses the 12 critical areas outlined in the national Preparing for Winter Guidance as a key mitigation action. The attached Unscheduled Care (Winter) Plan consequently has been developed to reflect that.

5. People Implications

5.1 Key people implications are addressed within the Unscheduled Care (Winter) Plan.

6. Financial Implications

6.1 The Scottish Government's funding in support of reducing delayed discharges is intended to support local capacity with respect to the additional challenges experienced at winter time. Increased NHS acute service activity over the winter period does contribute to demands on community services (e.g. hospital arranged homecare) – e.g. during 2014-15 there was a 14% increase in winter referrals – which has to be absorbed within the existing budgets for services.

7. Professional Implications

7.1 Scotland's Chief Medical Officer has encouraged NHS Boards to make sure all staff are vaccinated against seasonal flu, particularly front-line staff and those working in areas where patients might be at greater risk.

8. Locality Implications

8.1 The implementation of the Unscheduled Care (Winter) Plan will support business continuity challenges that are faced in winter at a locality level.

9. Risk Analysis

- 9.1** The importance of having a plan and adopting a balanced approach to manage the additional unscheduled care pressures and business continuity challenges that are faced in winter has been recognised within the local WD HSCP Strategic Risk Register

10. Impact Assessments

- 10.1** None required.

11. Consultation

- 11.1** None required.

12. Strategic Assessment

- 12.1** The preparation, endorsement and implementation of the attached Unscheduled Care (Winter) Plan is critical to the delivery of the Strategic Plan.

Author: Soumen Sengupta – Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Social Care Partnership.

Date: 06 November 2017

Person to Contact: Soumen Sengupta – Head of Strategy, Planning & Health Improvement, Garshake Road, Dumbarton. G82 3PU.
Telephone: 01389 737321
e-mail: soumen.sengupta@ggc.scot.nhs.uk

Appendices: West Dunbartonshire Health & Social Care Partnership
Unscheduled Care (Winter Plan) 2017/18

Background Papers: HSCP Board Report (November 2017): Strategic Risk Register

Wards Affected: All



West Dunbartonshire Health & Social Care Partnership

Unscheduled Care (Winter) Plan

2017/18

Introduction

The Scottish Government issued Guidance for Winter Planning in August 2017 to help ensure that Health and Social Care Partnerships are well prepared to provide safe and effective care for people using their service and ensure that effective levels of capacity and funding are in place to meet expected activity levels. West Dunbartonshire Health and Social Care Partnership Board recognise the importance of adopting a balanced approach to manage the additional unscheduled care pressures and business continuity challenges that are faced in winter.

This Unscheduled Care (Winter) Plan reflects that our winter planning is predominantly on-going activities which address unscheduled care demands all year round. Given the particular sessional pressures associated with winter, those activities can be augmented by strengthened and additional arrangements.

Health and Social Care Partnerships (HSCPs) have a critical role in enabling the delivery of effective unscheduled care. It has been agreed through the NHS GG&C whole system planning group that each HSCP will produce an operational unscheduled care plan with a particular focus on the winter period. These plans cover the community service aspects of the six essential actions:

- Delayed discharge.
- Measures to reduce admissions and attendances.
- Delivery of key service features including single point of access, Care Home support and Anticipatory Care.
- Continuity and resilience.
- Developing an agreed set of indicators to monitor performance.
- Planning with GPs for the two long bank holidays.

The Health and Social Care Partnership Board has recognised the importance of adopting a balanced approach to manage unscheduled care pressures and business continuity challenges that are faced in winter, as noted within its local Strategic Risk Register.

This Unscheduled Care (Winter) Plan identifies and addresses the local issues across the primary care and community services for which the West Dunbartonshire Health and Social Care Partnership (WDHSCP) is responsible, to support the NHS GG&C whole system planning as detailed above.

Our Winter Planning Group identify, address, and escalate actions, to ensure that service users receive safe, person centred, effective care to minimise unscheduled hospital admissions and reduce delays in discharges, specifically throughout the winter, and in particular, the festive period.

Given the particular sessional pressures associated with winter, the plan attached identifies those activities augmented during this period by identifying these arrangements in italics.

CORE TASKS	ACTIONS
<p>1. Business continuity plans tested with partners.</p>	<ul style="list-style-type: none"> • Business Continuity Plans (BCPs) are in place across HSCP services and shared with locality representatives. • Managers will regularly review their individual BCP service plans. • BCPs are embedded across community health and care services, and within our third and independent sector partners to ensure resilience at points of crisis. • <i>Links with West Dunbartonshire Council's winter planning arrangements to support the continuity of all partnership services throughout the winter period are well tested with support from the Council's Emergency Planning Team.</i> • All WDHSCP and independent sector care homes have detailed Winter Plans in place. These will continue to be reviewed and supported by WDHSCP Quality Assurance and Scottish Care, and shared and discussed at the WDC and Independent provider joint Care Home Managers' forum. • BCP across WDHSCP services and Carers of West Dunbartonshire are established to ensure resilience at points of crisis. • GP Practices and Pharmacies have BCPs in place that include a 'buddy system' should there be any failure in their ability to deliver essential services and alternative premises have been identified.

2. Escalation plans tested with partners.

- Escalation plans will be prepared and shared across services to ensure a whole system approach to implementing actions that minimise potential issues.
- An early alert system will enable GP practices to highlight unexpected increases in demand for appointments as a result of a particular illness or virus that put a strain on GP services. This will be completed more frequently where volume of activity escalates.
- Our Hospital Discharge team will provide staff during the weeks between the public holidays where a minimum of two staff are on duty. Additional capacity to respond to particular increases in service demand can be resourced from other social work teams if required.
- Commissioned services have emergency arrangements are in place and the Independent Sector Integration Lead has agreed to act as a link between the HSCP, the commissioning team , and Care Homes to share information and identify any issues that require to be escalated.

3. Safe & effective admission / discharge continue in the lead-up to and over the festive period and also into January.

1 Admission Avoidance

- Our Community Nursing teams use *Patient Status at a Glance* boards that are updated daily. The board displays details of vulnerable patients as well as patients with changing needs. The nursing teams have daily meetings to identify vulnerable patients and those at risk of admission. *The nurses will link with GPs to identify patients who may potentially be vulnerable during the long bank holidays.*
- Our Integrated Teams maintain a register of vulnerable people known to them living in the community. *The Social Work Out of Hours Standby Services have a copy of the information regarding these individuals to ensure appropriate supports can be provided if required out with office hours, including weekends and Public Holidays.*
- *Our Integrated Rehabilitation and Older Adults teams maintain a list of patients at risk of admission to assist in daily scheduling of visits during adverse weather periods.*
- Teams can access rapid day care assessment and community bases assessment within the rehabilitation team which offers same day access to service for patients referred by the GP before 4pm who are at risk of admission.
- Our early assessor service identifies patients who will be discharged and require Homecare services which we provide rapidly and will continue to provide including until close of play prior to public holidays.
- The Older Adults Mental Health Team has an in-hours duty system in place to provide urgent advice and input as appropriate. Out of hours referrals are directed to the Crisis Team
- Contracts with independent providers of Homecare services include monitoring their capacity for delivering services as commissioned.
- Locality Groups will continue to work in partnership with GPs, Acute Services, Independent Sector (including links with Care Homes), and Third Sector organisations (including Link Up, Marie Curie, and the Red Cross) to help people remain in their own homes, or homely setting, when it is safe to do so and to return them home safely on discharge.

2 Anticipatory Planning and Care

- Local intelligence and SPARRA information is used to identify patients at risk of admission. These patients are offered assessment and support from the Community Nursing service. Complete anticipatory care plans are uploaded by GP practices onto their electronic information system (eKIS). Additional nursing and social care capacity support high risk patients undertake single shared assessment and put in place supports which will maintain people at home. These include additional homecare, respite, nurse led beds in local care homes and step up/down placements.
- All patients with palliative and end of life care needs have an anticipatory care plan and electronic palliative care summary completed within EMIS which is shared with Acute Services and the Scottish Ambulance Service. Our extended Palliative Care Team (Nursing, Homecare and Pharmacy) provide additional support.
- Our community teams will ensure that people are reminded to order and collect their repeat prescriptions in advance of the festive period.
- Our Frailty Priority Project for people identified as frail uses the Dalhousie Clinical Frailty Scale following assessment and/or review ensuring ACPs are identifying relevant services.
- *Additional equipment and supplies are ordered and available for clinical staff.*
- *Our Homecare Services have access to 4x4 vehicles in the event of severe weather to ensure that they can reach vulnerable service users.*
- *The West Dunbartonshire Council Roads Department has agreed that a HSCP service manager can inform them of remote vulnerable service users who cannot be reached by car or foot during severe weather and actions will be taken to clear the road and enable access, thereby preventing a potential avoidable hospital admission. In addition, they will clear and grit access roads and parking areas around NHS health care facilities as a priority.*
- *Public information directing people to appropriate services will be made available through website links on the HSCP, WDC and relevant Third Sector websites. This will include “Know who to turn to” and NHS GG&C winter website link.*

	<p>3 Expediting Discharge from Hospital</p> <ul style="list-style-type: none"> • Our services are available via a single point of access and provide direct referral for occupational therapy, physiotherapy, nursing, social work, homecare and care at home, pharmacy team and step up/down beds. • Our hospital discharge team has an early assessor function to allow identification where possible prior to fit for discharge status and speedy assessment. • Dedicated mental health officer (MHO) staff provide support for adults with incapacity; and we provide multi-disciplinary post-discharge support. • Routine daily review of 13Za cases to ensure discharge is fast-tracked where the legal framework allows. • West Dunbartonshire HSCP has commissioned 10 NHS beds for access by Acute Services for patients delayed whilst awaiting legal powers and these will be active when resident medical officer (RMO) cover is advised by Acute Services.
<p>4. Strategies for additional winter beds and surge capacity.</p>	<ul style="list-style-type: none"> • The HSCP will respond where possible to support Acute Services in managing surge capacity. • <i>Our Hospital Discharge Team will provide services between the public holidays to support surge activity.</i> • Additional capacity to respond to particular increases in service demand can be resourced from the wider local teams if required. • <i>Additional care at home respite and nurse-led beds will be available over the period.</i>

5. Whole system activity plans for winter: post-festive surge.

- *The HSCP will contribute to the NHSGG&C whole system activity planning and ensure representation at winter planning groups.*
- The HSCP Chief Officer links with NHSGG&C Acute Division and other Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action.
- Situation reports (SITREPs) will be shared between the Community and Acute Services to inform escalation pressures.

6. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

The actions set out in this Winter Plan will be monitored and analysed to identify and potential improvements to inform future predictive modelling and planning.

Particular measures that will be monitored include:

- Bed days lost to delayed discharge.
- Bed days lost to delayed discharge for adults with incapacity (AWIs).
- A&E attendances.
- Emergency admissions all ages.
- Emergency Admission age 65yrs+.
- Emergency admissions age 75yrs+.
- Percentage uptake of flu vaccinations by staff.
- Percentage uptake of flu vaccinations by GP population.
- Referrals to Rapid Response and Rapid Assessment Link team.
- Referrals to Hospital Discharge Team and time to assessment and provided care.
- Demand and capacity on community services, including GP practices, and community health services.

A detailed rolling action log will be maintained and updated and reviewed monthly by the HSCP Senior Management Team.

A report analysing the activity, performance and pressures will be provided at the end of the winter planning period.

<p>7. Workforce capacity plans & rotas for winter / festive period agreed by October.</p>	<ul style="list-style-type: none"> • Service managers are responsible for determining that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity throughout the winter and during the festive period, and immediately following the four day holiday periods. • The WDHSCP's Workforce and Development Strategy 2015-18 and annual implementation plan will continue to prioritise the development of robust out of hours/unscheduled care services, through a skilled and capable integrated workforce
<p>8. Discharges at weekend & bank holiday.</p>	<ul style="list-style-type: none"> • Our Community Nursing service and Homecare service HSCP community teams provide a service 24 hours, 365 days per year inclusive of bank public holidays. • These teams, in partnership with Acute and Out of Hours Services, will support safe and effective hospital discharges during weekends and holidays.
<p>9. The risk of patients being delayed on their pathway is minimised.</p>	<ul style="list-style-type: none"> • Our single point of access (SPOA) will be fully resourced to accept referrals. • All referrals are assessed and allocated daily. • Patients identified by our early assessor team will have care packages in place timeously. • Access to rehabilitation and nursing services will be available throughout the period. • Our Homecare Services are managed alongside district nursing services and home based pharmacy support to ensure continuity of care post discharge.

<p>10. Communication to Staff & Primary Care Colleagues</p>	<ul style="list-style-type: none"> • The HSCP will ensure information and key messages are available to staff through communication briefs, team meetings and electronic links. • The HSCP will circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices. • The HSCP will collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP, Primary Care colleagues and NHSGG&C. • <i>Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet; and on the HSCP and Council websites. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The HSCP Clinical Director will re-enforce these messages to GP Practices.</i>
<p>11. Preparing effectively for Norovirus</p>	<ul style="list-style-type: none"> • All care homes have participated in action learning sets and have plans and processes in place to manage these. • Planning for norovirus will be included within BCPs of Care Home providers. In emergencies, there will be additional capacity available. • Information distributed to Care Homes will be shared by the Independent Sector Integration Lead.

12. Delivering Seasonal Flu Vaccination to Public and Staff

- Our Pandemic Flu Plan was agreed our Health and Social Care Partnership Board in 2017. This will be reviewed annually.
- All health care and homecare staff have been offered vaccination.
- All health care and homecare staff will be reminded to encourage elderly and vulnerable groups to attend their GP flu vaccination sessions. Information has been provided to community groups on the benefits of vaccination.
- Our Community Nursing Service will vaccinate those who the GPs identify as being housebound and consent to receiving the flu vaccination
- Health care staff are actively encouraged to be vaccinated, with local peer vaccination sessions will be provided in all Health Centres.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP**Health & Social Care Partnership Board: 22nd November 2017**

Subject: West Dunbartonshire Local Outcome Improvement Plan**1. Purpose**

- 1.1** To present the Partnership Board with the West Dunbartonshire Community Planning Partnership Local Outcome Improvement Plan 2017-2027.

2. Recommendation

- 2.1** The Partnership Board is recommended to endorse the West Dunbartonshire Local Outcome Improvement Plan 2017-2027.

3. Background

- 3.1** Since 2014 there has been significant progress and change in the development of community planning at both a local and national level. New legislation related to both Community Justice and Community Empowerment has changed the context for partnership working and places increased responsibilities on Community Planning Partnerships (CPPs).
- 3.2** The Community Empowerment (Scotland) Act 2015 requires each Community Planning Partnership (CPP) to develop and publish a local plan for improving, Local Outcome Improvement Plan (LOIP), by 1 October 2017. The West Dunbartonshire Local Outcome Improvement Plan 2017-2027 was approved at the September 2017 meeting of the local Community Planning Partnership Management Board. The Health & Social Care Partnership Board is a key partner on the Community Planning Partnership Management Board; and the Health & Social Care Partnership plays a lead role in driving forward the Community Planning Partnership's ambitions.

4. Main Issues

- 4.1** As per the Scottish Government's guidance, this LOIP has been designed by partners to be a high level and strategic document, setting out longer term aspirations for West Dunbartonshire. It contains a profile of the area; details of the strategic priorities and guiding principles; and information on governance and scrutiny of the LOIP itself.
- 4.2** The key outcome areas for the LOIP are as follows:
- Our local economy is flourishing
 - Our communities are safe
 - Our children and young people are nurtured
 - Our older residents are supported to remain independent

- Our residents are empowered.

4.3 Each of the 5 priority areas will be led by a Delivery & Improvement Group (DIG), building on and enhancing existing structures. Each DIG will put in place an action plan for delivery of the priorities and outcomes, reporting progress quarterly to Community Planning Partnership Management Board the in line with existing arrangements. The HSCP notably leads on two of the DIGs – i.e. our children and young people are nurtured; and our older residents are supported to remain independent.

4.4 The LOIP reinforces and supports the HSCP's own Strategic Plan. Key contributions that the HSCP has responsibilities for within the LOIP and the relevant DIG action plans will be reported to the HSCP Board within the body of both its quarterly Public Performance Reports and its Annual Public Performance Reports (as was the approach with respect to the predecessor CPP Single Outcome Agreement).

5. People Implications

5.1 No specific implications associated with this report.

6. Financial Implications

7.1 No specific implications associated with this report.

7. Professional Implications

7.1 No specific implications associated with this report.

8. Locality Implications

8.1 It should be noted that the Community Empowerment (Scotland) Act also requires CPPs to identify and develop locality plans – but that these localities are different from the localities that Integration Authorities have already been obliged to identify and develop working arrangements for as part of the Public Bodies (Joint Working) Scotland Act.

9. Risk Analysis

9.1 The LOIP is a requirement of the Community Empowerment (Scotland) Act 2015 and outlines the partnership commitment to improving outcomes for residents of West Dunbartonshire. Failure to deliver this strategic document would result have results in Community Planning Partners failing to comply with the legislation.

10. Impact Assessments

10.1 An EIA was carried out on the LOIP by the Council's Community Planning team.

11. Consultation

11. Consultation was carried out on the priorities and outcomes detailed within the LOIP by the Council's Community Planning team.

12. Strategic Assessment

12.1 The LOIP reinforces and supports the HSCP's own Strategic Plan.

Author: Soumen Sengupta - Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Care Partnership

Date: 06 November 2017

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Appendices: West Dunbartonshire Local Outcome Improvement Plan

Background Papers: West Dunbartonshire Community Planning Partnership Management Board (September 2017): Local Outcome Improvement Plan

Scottish Government Guidance – Community Empowerment Act Part 2:
<http://www.gov.scot/Resource/0051/00512027.pdf>

Wards Affected: All



Local Outcome Improvement Plan **2017-27**



Foreword

In my role as Chair of Community Planning West Dunbartonshire (CPWD), it is a pleasure to introduce the first West Dunbartonshire Plan for Place. It is important that we adopt a plan which focuses on the things that matter most across West Dunbartonshire but also recognises the differences in and diversity of our communities.

This plan builds on the achievements of previous Single Outcome Agreements and sets new aspirations and ambitions for the future focused on working with our citizens to improve outcomes for the communities of West Dunbartonshire. As a Council we recognise that our residents are our biggest stakeholders and must be fully involved in shaping West Dunbartonshire's future.

As a partnership we are committed to developing a West Dunbartonshire where all of our residents are:

Flourishing

Independent

Nurtured

Empowered

Safe

The Plan for Place also details our long term priorities and aspirations for improving outcomes for all citizens. We also detail the principles and values which underpin all of the work we do as a partnership and which will help achieve our objective of reducing inequality for the people of West Dunbartonshire.

Most importantly, this plan has been developed using feedback from our residents about what matters to them. It is truly a partnership plan, developed for and with the residents of West Dunbartonshire.

I am confident that together we can achieve these aspirations and deliver a West Dunbartonshire that's a great place to live, work and visit.



Councillor Jonathon McColl

Leader of West Dunbartonshire Council

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Your West Dunbartonshire, Your Place

This strategic outcome plan sets out the Community Planning West Dunbartonshire (CPWD) long term vision for 2017-2027. The plan builds on the Single Outcome Agreements that have gone before it, and reaffirms the partnership's shared vision of a West Dunbartonshire that's 'A great place to live, work and visit'.

This plan sets the context for outcome delivery over the next 10 years, detailing the vision and aspirations of the partnership and residents. It is the West Dunbartonshire plan for place, and has been adopted as the CPWD Local Outcome Improvement Plan. The plan details the 5 strategic priorities for delivery over the period 2017-2027 and the guiding and supporting principles which will allow delivery of the priorities. It provides a vision and focus, based on agreed local priorities, for partnership outcome improvement. Through this we will develop new ways of working, collaborative approaches, a focus on continuous improvement and robust governance and accountability frameworks.

Our strategic assessment, carried out during 2017, has informed the setting of the strategic priorities for the partnership. It provided an evidence base on which to assess current trends across outcomes for our residents, emerging issues and priority areas of concern for delivery over the next few years. The strategic assessment ensures that all partners have a shared understanding of context and needs for the diverse communities we serve.

This information, covering evidence and data from all community planning partners then translated into the 5 priority local outcomes adopted by CPWD:

- Our local economy is flourishing
- Our adults and older residents are supported to remain independent
- Our children and young people are nurtured
- Our residents are empowered
- Our communities are safe

At the core of this plan and the priorities adopted by CPWD is a commitment to tackling inequality. West Dunbartonshire is an area of multiple deprivation and it is critical that a focus on reducing inequality underpins all partnership activity in order to deliver on the aspiration of making West Dunbartonshire 'A great place to live, work and visit'.

Over a number of years the partnership has worked with the West Dunbartonshire Community Alliance, a strategic engagement body which supports the work of CPWD, to test and refine thinking on key priorities for the area. The Community Alliance is comprised of representatives from a range of community organisations representing geographical and interest communities.

To successfully deliver the aspirations and priority outcomes of the West Dunbartonshire plan for place it is critical that the variation of aspiration and need, and the diversity, of our different communities is recognised. In West Dunbartonshire we deliver a range of front line partnership activity through our Your

Community approach, focused on engagement, problem solving and capacity building.

Your Community allows the partnership to deliver at a local neighbourhood level, working with community organisations and residents in the 17 communities of West Dunbartonshire. This activity began in 2014/15 and is focused on supporting development of joint plans for each neighbourhood. These local place plans will act as locality plans, underpinned by a core of community led activity.

Your Community will support the delivery of locality plans, a new local level partnership plan to support delivery of this strategic place plan. Locality plans, a requirement of the Community Empowerment (Scotland) Act 2015, cover smaller areas and are focused more on those communities that will benefit more from improvement. These locality plans are being developed to target inequality of outcome at a local level, providing the context for transformation at a neighbourhood level. The plans will support a focus on targeted services where need is greatest, identifying new ways of working for and with communities. It is important to recognise however that locality plans will be focused on understanding differences in outcome at a local level and exploring approaches to reduce this outcome gap.

To ensure alignment and collaboration across all single agency plans it is critical that this West Dunbartonshire plan for place sets the strategic direction for outcome delivery in West Dunbartonshire. All partner strategies and plans will be aligned to the vision and aspirations set out in this plan.

Delivery of the aspirations and priorities set out in this plan falls to the five Delivery & Improvement Groups (DIGs), which report in to CPWD on action plans and activity to improve outcomes for all residents. The membership of these DIGs is drawn from the community planning partners, reflecting those agencies and services with the ability to deliver on the priorities detailed. Membership will change to reflect shifts in focus, and will also overlap to recognise the cross cutting nature of the priorities and outcome areas being progressed.

This strategic plan for place is underpinned by a range of supporting documents which provide data, context and mechanisms for delivery of the ambitions as outlined. Information, documents and links to these can be found on the Community Planning pages of the Council website at www.west-dunbarton.gov.uk

About West Dunbartonshire

West Dunbartonshire is a diverse area with a rich industrial heritage still evident in our local communities today. Across the three main settlements of Clydebank, Dumbarton and the Vale of Leven we see diversity from the densely populated urban centre of Clydebank to the more rural setting of the Loch Lomond and Trossachs National Park sitting in and beyond the northern edge of the Authority.

The CPWD strategic assessment carried out in 2017, builds on previous assessments and the annual social and economic profile of the area prepared by the Council. The assessment also utilises national publications and profiles such as the Improvement Service Community Planning Outcome Profiles (CPOP) and the Scottish Indices of Multiple Deprivation (SIMD). The full assessment can be found on the community planning pages of the Council website, however key data related to the population of West Dunbartonshire has been summarised in this section.

Population and Demographics

West Dunbartonshire has a population of 89,590, accounting for 1.7% of the total population of Scotland. The 19-29 years age group makes up only 17.4% of the population, compared to 18.2% of the Scottish population. West Dunbartonshire's total population has been falling over time as Scotland's has risen, linked to a steady decrease in the birth rate year on year.

Estimated Population – Age Group Split (WD) 2015

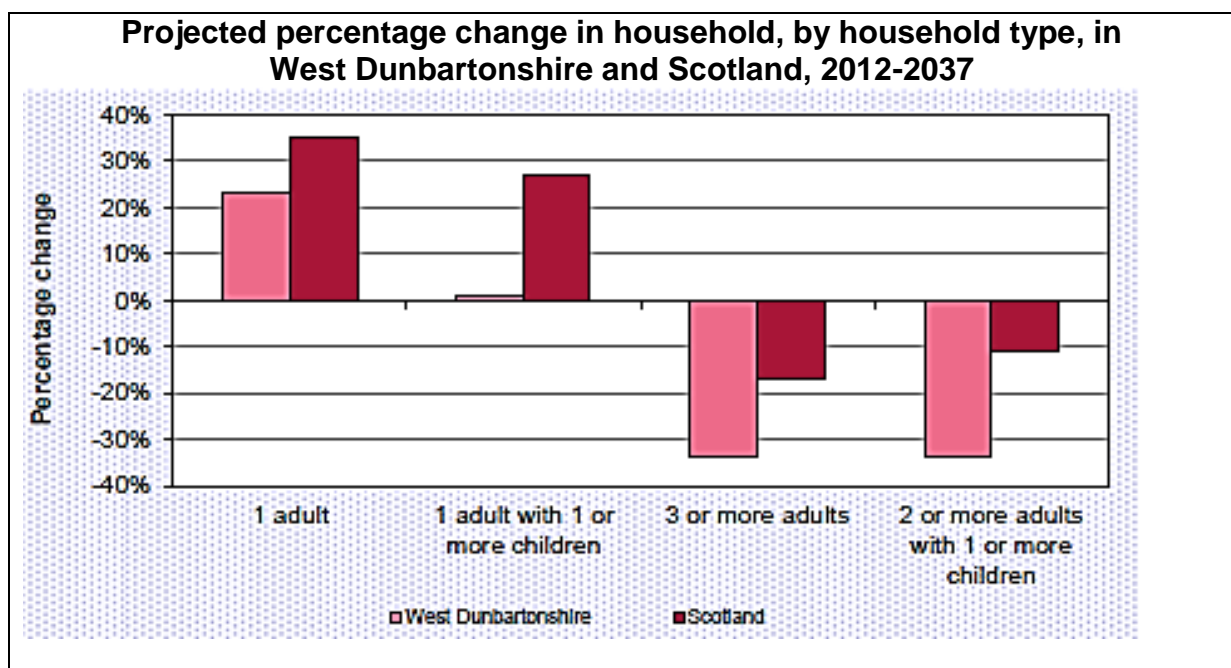


By 2039 the population of West Dunbartonshire is projected to be 83,690, a decrease of 6.7 % from 2014. Over the next 25 years, the age group that is projected to increase the most in West Dunbartonshire is 75+. This is the same as for Scotland as a whole. The population of under 16's in West Dunbartonshire is projected to decline by 12.1%.

Household Profile

The number of households in Scotland has been growing faster than the population. This is because more people are living alone and in smaller households. Average household size in Scotland fell from 2.21 people per household in 2005 to 2.17 in 2015.

West Dunbartonshire has around 45,056 dwellings; just less than 25% (10,748) of these homes are Council owned. Over the next 20 years it is estimated that households headed by 60-74 year olds will increase by 14%, and those headed by the 75+ age group are will increase in number by 70%. Similarly, the number of lone person households is projected to increase by 23%. Over the same period, the number of larger households is projected to fall, with the number of households of 2 or more adults with children decreasing by 34%.



Life expectancy

West Dunbartonshire has life expectancy rates that are statistically significantly worse than the Scottish average, with the second lowest life expectancy at birth of all Scottish Local Authorities.

Based on the most recent figures available (2013-2015) female is greater than male life expectancy), but both were lower than the Scottish average. Male life expectancy at birth in West Dunbartonshire is improving faster than female life expectancy.

Life expectancy at birth - WD



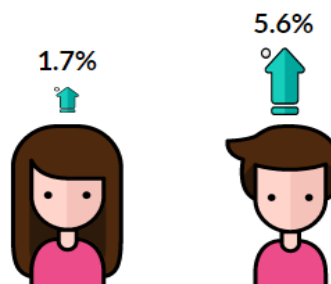
78.7 years



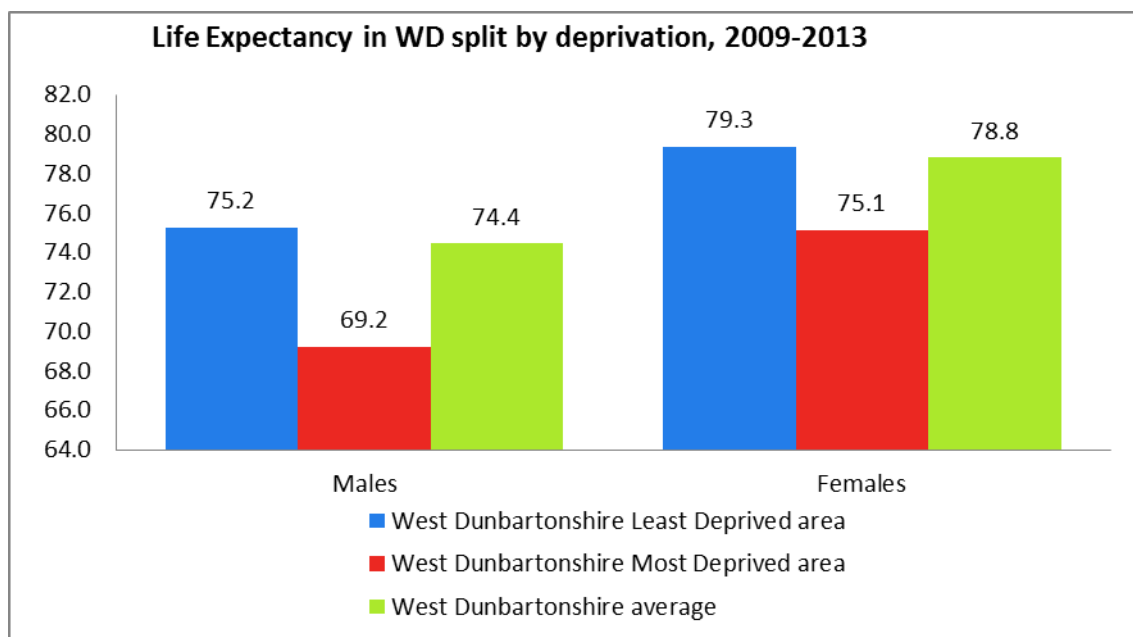
74.8 years

Females born in West Dunbartonshire in 2013-15 have the lowest life expectancy in Scotland. West Dunbartonshire females will live on average 4.8 years less than females in East Dunbartonshire 78.7 years compared to 83.5 years.

The overall picture however is showing some improvement, with the percentage change in life expectancy at birth in West Dunbartonshire improving by 5.6% for Males and 1.7% for females over the last 12 years.



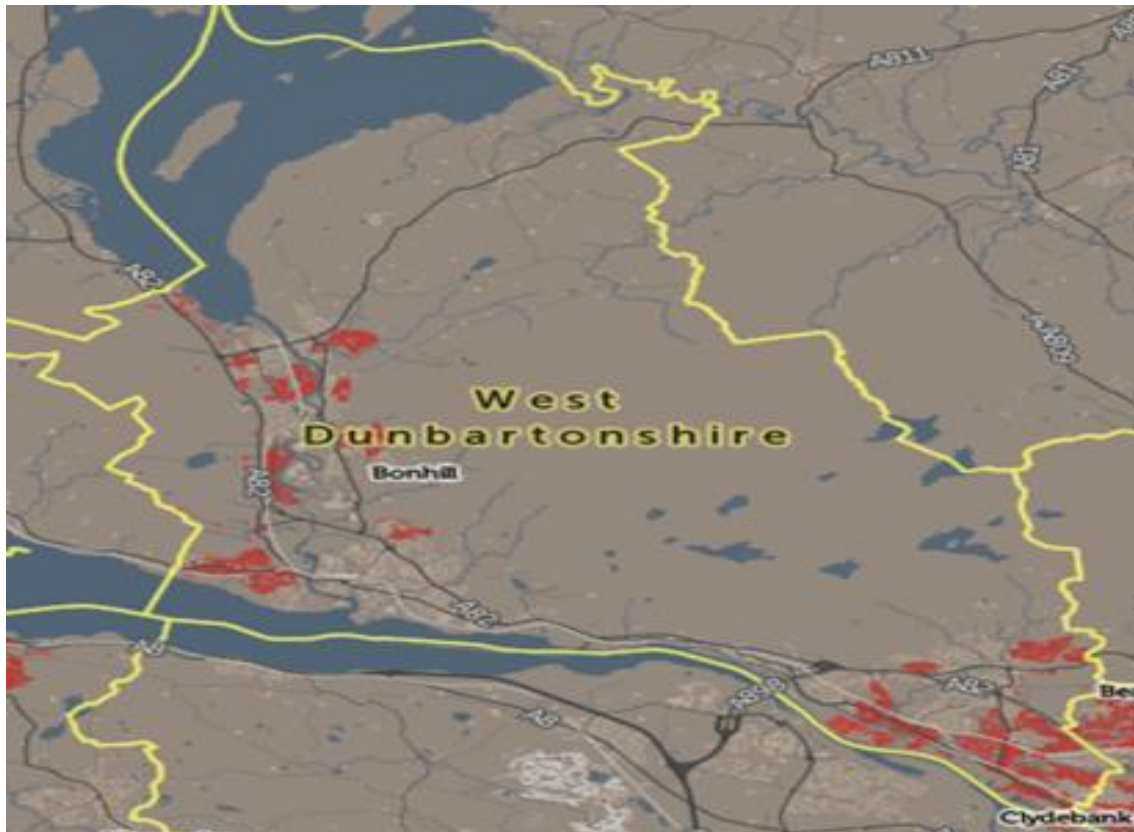
The effect that poverty has on life expectancy can be seen when comparing life expectancy rates in the least and most deprived areas of West Dunbartonshire. The chart below looks at life expectancy rates based levels of deprivation.



Deprivation

In the most recent review of multiple deprivation in Scotland, published in 2016, West Dunbartonshire’s share of the most deprived communities increased; the largest rate of increase in relative deprivation since the previous measurement in 2012.

The map below displays in red the small areas (datazones) within West Dunbartonshire that are ranked within the 20% most deprived in Scotland. West Dunbartonshire consists of 121 of these small area datazones. In 2016 the most deprived area in West Dunbartonshire is in South Drumry, Clydebank while the least deprived area is in Dumbarton.

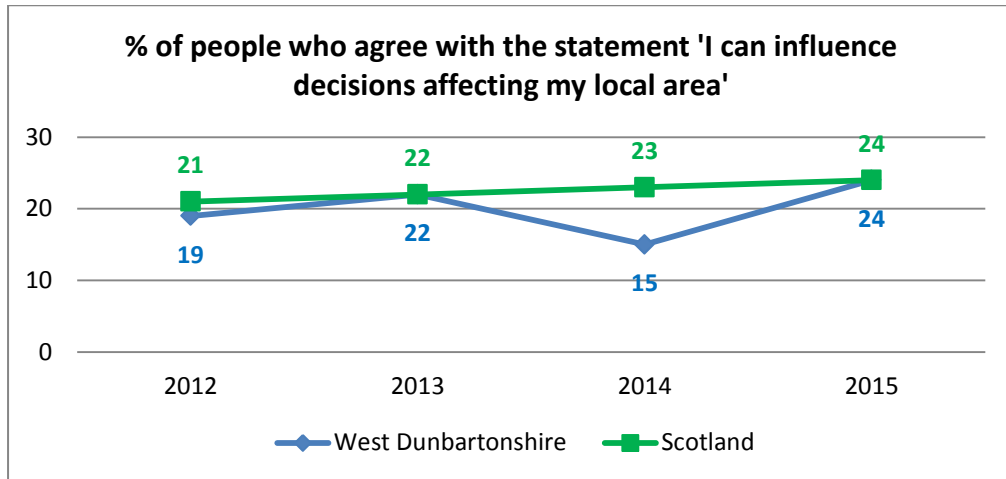


One of the most persistent and important challenges faced in West Dunbartonshire are inequalities between the health of people living in the most and least disadvantaged circumstance.

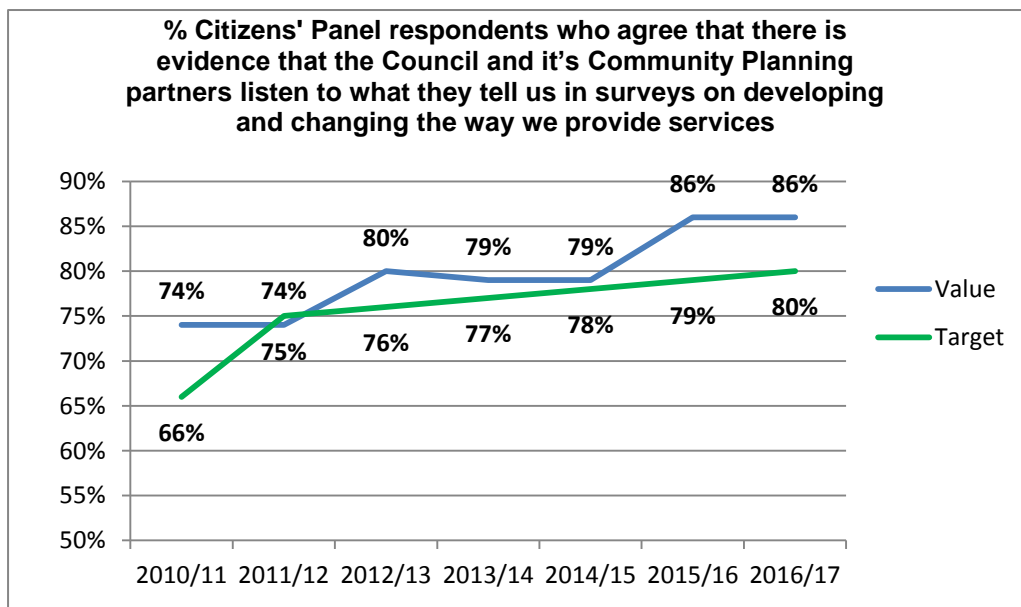
People experiencing disadvantaged life circumstances are more likely to develop a long term health conditions at an earlier age, experience more health problems during their lives and have shorter lives. A recent health publication highlight that West Dunbartonshire is worse than the national average across a range of mental health issues. Of most concern, where West Dunbartonshire is significantly worse than Scotland, are issues around problem drug use and risk taking behaviours.

Engagement & Influence

The 2015 Scottish Household Survey results show that the percentage of people who agree that they can influence decisions affecting their local area has increased and is in line with the Scottish average.



The percentage of Citizens' Panel respondents who agree that there is evidence that the Council and its Community Planning partners listen to what they tell us in surveys on developing and changing the way we provide services has increased to 86% in 2017 from 74% in 2011.



Our Strategic Priorities

CPWD is committed to improving outcomes for all residents in West Dunbartonshire, and values the focus on delivering locally through the Community Empowerment (Scotland) Act 2015. We recognise that improving outcomes requires a variety of different interventions and priorities based on the needs of our diverse communities, and that this is best planned and delivered at a local community level.

However it is also important that the focus locally is directed by the key priorities and outcome areas at a national level, set out through the national performance framework to ensure improved outcomes for all.

The five strategic priorities adopted for West Dunbartonshire are informed by the national performance framework and the previous six policy priorities detailed through the statement of ambition. They are not delivered in isolation, but build on a range of partner plans and strategies. A map of these strategies and plans can be found on the community planning pages of the Council website at www.west-dunbarton.gov.uk.



Priority Outcome Areas

In ensuring that the aspirations of the partnership are met in relation to the five strategic priorities adopted, CPWD has identified a number of outcome areas which will be the focus for partnership activity. Each Delivery & Improvement Group will be tasked with developing an annual action plan which progress activity across these outcome areas. Core performance measures and targets will be set for each of the five priorities and reported on an annual basis.

CPWD Strategic Priority	CPWD Outcomes
A Flourishing West Dunbartonshire	Our economy is diverse and dynamic creating opportunities for everyone
	Our local communities are sustainable and attractive
	Increased and better quality learning and employment opportunities
	Enhanced quality and availability of affordable housing options
An Independent West Dunbartonshire	Adults and older people are able to live independently in the community
	Quality of life is improved for our older residents
	Housing options are responsive to changing needs over time
A Nurtured West Dunbartonshire	All West Dunbartonshire children have the best start in life and are ready to succeed
	Families are supported in accessing education, learning and attainment opportunities
	Improved life chances for all children, young people and families
An Empowered West Dunbartonshire	We live in engaged and cohesive communities
	Citizens are confident, resilient and responsible
	Carers are supported to address their needs
A Safe West Dunbartonshire	Improved community justice outcomes ensure West Dunbartonshire is a safe and inclusive place to live
	All partners deliver early and effective interventions targeted at reducing the impact of domestic abuse
	Residents live in positive, health promoting local environments where the impact of alcohol and drugs is addressed
	Our residents are supported to improve their emotional and mental health and wellbeing

Our Guiding Principles

As a partnership, CPWD brings together key public bodies, communities, the voluntary sector and other key sectors to plan and deliver high quality, local and accessible services that are focused on improving lives for the people of West Dunbartonshire. In order to do that we set priorities for delivery, however we are also guided by a range of supporting principles which underpin and crosscut these priorities. In all that we do as a community planning partnership we will:

Adopt a preventative and early intervention approach

CPWD are committed to improving outcomes through a prevention and early intervention approach, which will reduce demand for services over time. All partners have committed their services to the outcomes detailed in this strategic plan for place and the documents, strategies and plans which underpin it. In delivering on these we will continue to take a partnership approach to identifying new ways of working and evidencing this decisive shift to a preventative approach. This includes our longstanding commitment to taking a determinants oriented approach to tackling health inequalities, focusing on those factors which have an impact on health such as housing and employment.

Ensure effective community engagement in the planning and delivery of local services

Meaningful and ongoing engagement with residents and community organisations is central to delivery of improved local outcomes. This commitment to engagement sits at the heart of the community planning approach taken in West Dunbartonshire. Your Community, a model of empowerment and service improvement led by resident engagement and feedback, allows CPWD to deliver in this ambition.

To ensure that residents and communities are fully engaged in the setting and delivery of priorities for West Dunbartonshire, in an inclusive and transparent way, CPWD will adopt an Engaging Communities Framework. This framework will enable ongoing engagement focused on communities of interest and of place.

Work with our communities to empower them and strengthen their voice

Through Your Community and regular engagement and dialogue with residents, at a very local level, the priorities outlined in this strategic place plan were tested and informed. This ongoing process of engagement will also be strengthened through the use of the National Place Standard as a mechanism for gathering views on a range of issues through the lens of local neighbourhoods.

A key approach driven through Your Community is the local delivery of participatory budgeting. CPWD intends to build on the existing community budgeting approach undertaken in West Dunbartonshire to ensure residents and communities have a greater say in how public funds are spent, supporting communities to identify and tackle local inequalities for themselves.

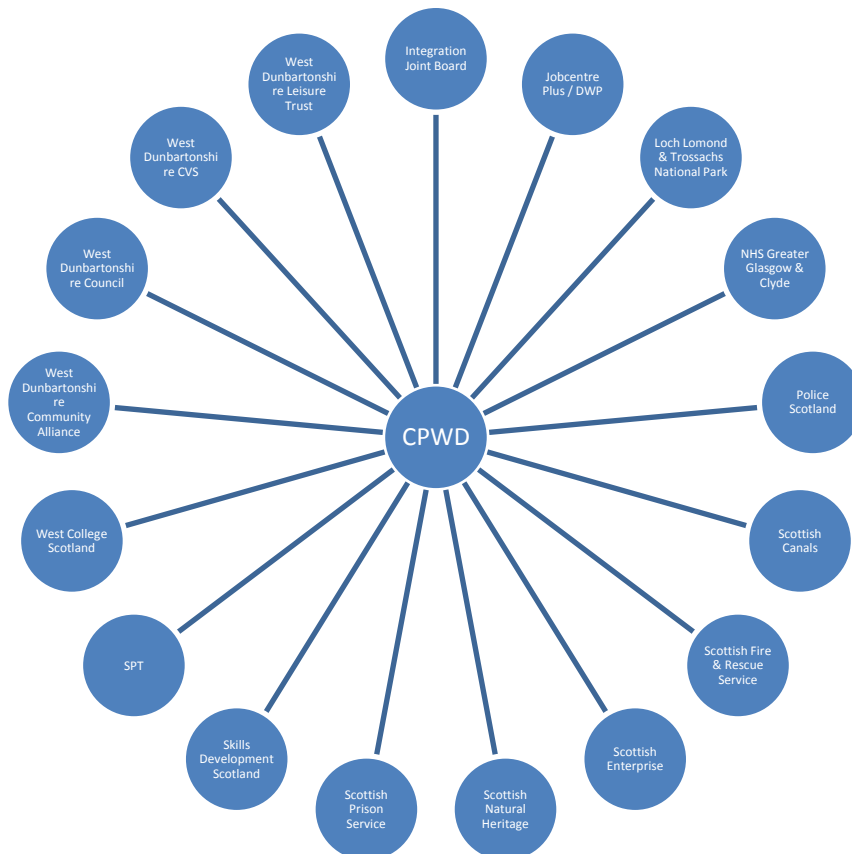
Promote equality and tackle inequality

At the core of the priorities and aspirations of CPWD is a commitment to promote equality and reduce the impact of inequality on our residents. We will continue to progress this equality agenda, recognising the vibrant diversity within our local communities and ensuring that the needs of residents are considered and planned for in an equitable way.

Through the Community Empowerment (Scotland) Act 2015 there has been an increased focus placed on reducing inequality of outcome, which means targeting the causes of inequality not the consequences. This links well and supports the CPWD commitment to a determinants led model to reduce health inequalities- this also looks at causes rather than consequences.

Governance and Scrutiny

This new CPWD plan for place, or Local Outcome Improvement Plan, is supported by robust governance, scrutiny and accountability arrangements across the partnership; providing strategic direction for delivery of improved outcomes across West Dunbartonshire. The partnership consists of:



Community Planning West Dunbartonshire will continue to set the strategic direction for community planning locally. Delivery of this strategic direction will fall to the Delivery & Improvement Groups, which lead on each of the 5 strategic priorities. These officer groups will develop action plans, building on existing plans and strategic at an agency and partnership level, which detail the actions they will undertake collaboratively to improve outcomes under each of the five strategic priorities.

The West Dunbartonshire Community Alliance is a strategic partnership group established to support CPWD in ensuring communities and local organisations within West Dunbartonshire are able to influence and scrutinise the work of CPWD. The Alliance brings together representatives from a range of organisations at neighbourhood, interest and user group level across West Dunbartonshire with the intention of identifying issues of common concerns and to highlight local priorities.

Performance Management and Reporting

It is critical that CPWD is able to focus on improvement and the difference being made through partnership working. This focus on performance is a fundamental element of public service reform and underpins a robust governance and scrutiny approach to community planning.

In delivering the West Dunbartonshire Plan for Place all partners will continue to jointly review progress and report annually on a range of performance measures. These core performance measures will be aligned to the range of national and local strategies and plans currently in place and reported on.

Each Delivery & Improvement Group will develop a strategic action plan detailing the activities and resources focused on their relevant strategic priority, reporting progress on this quarterly through CPWD. These groups will also report on the performance indicators relevant to evidencing progress on priorities on an annual basis.

If you have any questions or comments about this document please contact us at CommunityPlanningWD@west-dunbarton.gov.uk

Other formats

This document can be provided in large print, Braille or on audio cassette and can be translated into different community languages as required. If you would like this document to be provided in a different format please contact:

Corporate Communications
Council Offices
Garshake Road
Dumbarton G82 3PU
Tel: 01389 737000

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。
अनुरोध पर यह दस्तावेज़ अन्य भाषाओं में, बड़े अक्षरों की छपाई और सुनने वाले माध्यम पर भी उपलब्ध है
ਇਹ ਦਸਤਾਵੇਜ਼ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਵਿਚ, ਵੱਡੇ ਅੱਖਰਾਂ ਵਿਚ ਅਤੇ ਆਡੀਓ ਟੇਪ 'ਤੇ ਰਿਕਾਰਡ ਹੋਇਆ ਵੀ ਮੰਗ ਕੇ ਲਿਆ ਜਾ ਸਕਦਾ ਹੈ।
درخواست پر یہ دستاویز دیگر زبانوں میں، بڑے حروف کی چھپائی اور سننے والے ذرائع پر بھی میسر ہے۔



Community Planning Partner Duties

<p>Facilitate:</p>	
<p>Participate:</p>	
<p>Local & Co-opted Partners:</p>	

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 22nd November 2017

Subject: Workforce and Organisational Development Support Plan Update

1. Purpose

- 1.1 To present the Health & Social Care Partnership Workforce and Organisational Development Strategy Support Plan update for 2017 and revised support plan for 2018.

2. Recommendation

- 2.1 The Partnership Board is recommended to endorse the Workforce and Organisational Development Strategy update for 2017 and revised support plan for 2018.

3. Background

- 3.1 Members will recall that it is a responsibility within the Integration Scheme – and an action endorsed by the Partnership within its first Strategic Plan – that the Chief Officer develops a joint strategy and support plan for workforce and organisational development in relation to staff working within the HSCP on behalf of the Council and the Health Board.
- 3.2 The first integrated Workforce & Organisational Development Strategy 2015-18 - with a Support Plan 15-16 for the West Dunbartonshire Health & Social Care Partnership was endorsed by the Partnership Board on the 18th November 2015.

4. Main Issues

- 4.1 West Dunbartonshire has had the benefit of a strong local track record for joined-up workforce planning across health and social care services, coupled to a clear commitment to the principles of staff governance: i.e. that staff should be well informed; appropriately trained; involved in decisions which affect them; treated fairly and consistently; and provided with an improved and safe working environment.
- 4.2 The support plan has been developed to support the delivery of the overall Strategic Plan. A commitment was provided to the Partnership Board on 18th November 2015 that annual updates would be provided on the Support Plan for the lifetime of the Workforce and Organisational Development Strategy (2015-18).

4.4 It was agreed at the HSCP Partnership Board on 18th November 2015 that an annual update on the delivery of the support plan for 2015/16 would be reported annually to the Partnership Board for the lifetime of the Workforce and OD strategy.

5. People Implications

5.1 Effective workforce planning ensures that services and organisations have the necessary information, capability, capacity and skills to plan for current and future workforce requirements. This means planning a sustainable workforce of the right size, with the right skills and competences, which is responsive to health and social care demand and ensures effective and efficient service delivery across a broad range of services and locations.

6. Financial Implications

6.1 This Workforce and Organisational Development Strategy has been developed with an understanding of the financial environment that HSCP services are operating – both currently and anticipated in the future. It will be used to inform the wider financial planning activities for the HSCP and shape the future Strategic Plans.

6.2 The actions within the support plan 2018 will be delivered within the existing resources available to the HSCP.

7. Professional Implications

7.1 This Workforce and Organisational Development Strategy recognises the legal responsibility on the employing organisations to ensure that all of their respective staff working within the HSCP are appropriately registered.

8. Locality Implications

8.1 The implementation of the Workforce and Organisational Development Strategy and Support Plan will support the development of locality planning and working (e.g. through the sponsoring of Clinical and Care Governance Symposium)

9. Risk Analysis

9.1 It is a responsibility within the Integration Scheme – and an action endorsed by the Partnership within its first Strategic Plan – that the Chief Officer develops a joint strategy and support plan for workforce and organisational development in relation to staff working within the HSCP on behalf of the Council and the Health Board.

10. Impact Assessments

10.1 An Equality Impact Assessment (EIA) for the Workforce and Organisational Development Strategy 2015-18 was completed and found no negative impacts; and positive impacts specifically in relation to younger and older age groups.

11. Consultation

11.1 Service Teams across the HSCP were consulted as part of the development of the updated Workforce and Organisational Development Support Plan.

11.2 The local Joint Staff Partnership Forum have been consulted and informed about the updated support plan.

12. Strategic Assessment

12.1 The implementation of the support plan will support the overall delivery of the Strategic Plan.

Author: Serena Barnatt – Head of People & Change
West Dunbartonshire Health & Social Care Partnership.

Date: 6 November 2017

Person to Contact:

Serena Barnatt – Head of People & Change, Garshake Road, Dumbarton. G82 3PU.
Telephone: 01389 737566
e-mail: serena.barnatt2@ggc.scot.nhs.uk

Appendices: Workforce and Organisational Development Strategy & Support Plan 2017 and 2018.

Background Papers: Workforce and Organisational Development Strategy 2015-18 and Support Plan 2015-16.
<http://www.wdhscp.org.uk/media/1382/document-pack.pdf>

Wards Affected: All

West Dunbartonshire HSCP Workforce and OD Support Plan Annual Update

The HSCP agreed the following actions; these have been developed to respond to the previous priorities over the course of 2017 (so as to support the delivery of the overall HSCP Strategic Plan. This is not an exhaustive list of all of the workforce and organisational development activities that have been undertaken across and within service areas, but rather key actions of particular relevance to the delivery of the Strategic Plan. These actions address issues regarding the workforce where improvements are required or where planning is required to manage particular issues.

The HSCP has drawn upon expertise and combination of support from the Human Resource, Learning and Organisational Development functions of both the Council and the Health Board to deliver as much joint activity as possible, as well as activities which are delivered directly by specialist expertise from service areas.

The current HSCP Workforce and Organisational Development strategy covers 2015-18. As part of the process of developing the Workforce and Organisational Development Strategy it was agreed that a Support Plan would be developed and on an annual basis and progress would be reported along with a refreshed plan being provided for the following year. The Workforce and Organisational Development Strategy supports the delivery of HSCP Strategic Plan.

This document contains update on progress for 2017 along with a refreshed Workforce and Organisational Development Support Plan for 2018.

West Dunbartonshire HSCP Workforce and OD Support Plan 17 Progress Update

Primary Theme	Action	Lead	Update on Progress
Capable Workforce	Continuing to build on existing workforce and internal strategy to meet demands by training staff and explore opportunities to build capacity to meet increasing demands of MHO's amongst social care staff.	Head of Mental Health, Addictions & Learning Disabilities Head of Health & Community Care	<p>Rolling programme of training to assist with training.</p> <p>1 x individual currently undertaking training.</p> <p>2 x individuals completed training during 16/17.</p>
	Dementia champions will work with staff to further raise awareness of Dementia and available resources. Uptake will be monitored.	Head of Mental Health, Addictions & Learning Disabilities Head of Health & Community Care	<p>As part of Dementia Friendly West Dunbartonshire, Promoting Excellence training at Informed and Advanced levels are being delivered across staff groups within HSCP, Council and wider partners. This programme is led by CVS, Scottish Care and the HSCP with other partners including Police Scotland, Fire Scotland, Glasgow West College and RNIB.</p> <p>Cohorts of Dementia Champions have been trained by SSSC and are delivering the Informed and Advanced levels supported by a trained.</p>

Primary Theme	Action	Lead	Update on Progress
Capable Workforce	Dementia champions will work with staff to further raise awareness of Dementia and available resources. Uptake will be monitored.	Head of Mental Health, Addictions & Learning Disabilities Head of Health & Community Care	Dementia Ambassador supported by SSSC . Staffs across HSCP frontline and support services have been trained as well as WDC staff in housing services, working 4 u and wider HEEDs.
	Ensure PDPs in place across workforce.	All Heads of Service	Process for reporting on NHS KSF and PDP's in place in NHS and currently at 68% for KSF and 61% for PDP.(Aug 2017). Council have rolled out Be the Best Conversations and all staff are being managed in accordance with this process. For Social Work staff this is part of regular supervision sessions.
	Monitor and support registration status of staff.		Line managers have systems in place in accordance with registration polices
	Continue to support new agile technologies to assist the workforce, improve productivity and free up additional capacity from existing resource		Rolled out digital dictation , improved efficiency of Mental Health Services Development work completed on improving client records.

Primary Theme	Action	Lead	Update on Progress
Capable Workforce	Continue to support new agile technologies to assist the workforce, improve productivity and free up additional capacity from existing resource	All Heads of Service	Number of staff has been provided laptops to support new ways of working and offices of the future. Over 600 Care at Home staff issued with mobile phones as part of rollout of CM2000.
Capable Workforce	Continue to deliver on-going programme of data protection awareness sessions tailored to the staff working within the HSCP	Head of Strategy, Planning & Health Improvement	WDC has developed a Data awareness module on e Learn this year and staff will have to complete these annually. NHS Safe information handling. Learn Pro module completed every 3 years for NHS Staff. Newly recruited staff continue to attend the WDC IT Security and Data Protection awareness sessions held by Security Officer and Data Protection Officer.
Capable Workforce	Undertake a review of CM2000 post implementation	Head Of Health and Community Care	Roll out of CM 2000 fully implemented. External audit progressing actions.
	Update Staff Governance and Practice Governance Framework	Head of People & Change	Staff Governance and Practice Framework updated in partnership with Trade Union Colleagues and agreed through Joint Staff Forum.

Primary Theme	Action	Lead	Update on Progress
Capable Workforce	Continue to develop and implement CSE curricular programme across all secondary schools in line with Integrated Children's Service Plan Refresh. In addition to continue multiagency awareness sessions across the year.	Head of Children's Health, Care & Criminal Justice Services	CSE training sub group have delivered extensive training to multi-agency groups during 2016/17. Currently being evaluated.
	Develop Approaches to perpetrators of domestic abuse		SACRO have been successful in funding bid for this work. In early development stages
	To provide multiagency workshops post implementation for Getting It Right for Every Child, whilst practice beds in.		All completed in terms of Named Person service. Some further multi-agency development sessions are planned. Acknowledged through Joint Inspection that practice is well embedded across all services.
	Ongoing delivery of sexual health and relationship training for appropriate staff from HSCP and community planning partners working with looked after and accommodated children and young people.	Head of Strategy, Planning & Health Improvement	4 x Training Sessions successfully delivered and evaluated.
	Continue to support training through the Public Protection Co-ordinator and awareness of staff on Adult Support and Protection (ASP) Procedures	Head of Mental Health, Addictions & Learning Disabilities	Reviewed the current level of ASP training being undertaken to ensure this reflects the requirements of the Council.

Primary Theme	Action	Lead	Update on Progress
Capable Workforce	Deliver HSCP-wide Clinical and Care Governance Symposium, with invitations including NHS external contractors.	Head of Strategy, Planning & Health Improvement	Half-day Clinical & Care Governance Symposium organised and delivered in November 2016 at Clydebank Town Hall. Over 120 staff participated and feedback strongly positive. All material from the event made available to all on the HSCP website.
Sustainable Workforce	Create career pathways to encourage retention among key staff groups	All Heads of Service	1x Nurse in Addictions completed Nurse prescribing. 3 x Mental Health Practitioner Posts developed as part of psychological therapies 5x Support Workers developed in Learning Disability Care Academy working in partnership with Clydebank College to support placements in care at home and elderly residential care. All students who successfully complete the course are offered a guaranteed interview on our supply list.
	Encourage opportunities for Modern Apprenticeships; nursing internships; and volunteering		Modern Apprentices: 2 x Mental Health 10 x Community Care

Primary Theme	Action	Lead	Update on Progress
Sustainable Workforce	Build on existing capacity within the volunteer and third sector workforce while ensuring the maintenance of quality and standards of service.	Head of Strategy, Planning & Health Improvement	Developed and agreed Strategic Partnership Agreements with West Dunbartonshire CVS and Carers of West Dunbartonshire, which provide a framework for co-producing capacity and quality. External Inspection of Services for Children and Young People in West Dunbartonshire highlighted similar strong partnership working with third sector, notably Y-Sort-It.
Healthy Organisational Culture	Continue to Implement Health Working Lives programme of activities	Head of Strategy, Planning & Health Improvement	Work completed and Council and HSCP still hold Gold award. This work has been incorporated into Employee Well Being Group.
	Leads HSCP integrated Health & Safety Committee and oversee actions across services.	Head of People & Change	Group meets and has representation and input from Safety Reps from Trade Unions and management representation to cover all service areas. Learning shared across services through incident/Riddor reports. Key Actions for 16/17: NHS – Heads of Service/ to review and implement NHS GGC Action Plan following recent HSE inspection. WDC – roll out of Fig tree completed, which has improved reporting and analysis of trends.

Primary Theme	Action	Lead	Update on Progress
Healthy Organisational Culture	Implement staff absence action plan.	All Heads of Service	Action Plan agreed for HSCP and services working towards reducing absence.
	Roll out I Matter for NHS teams and explore if further roll out can be used for WDC staff.	Head of People and Change	I Matter have been rolled out for NHS Staff and integrated team, full roll out to be commencing by April 2018.
	Talent management and succession planning within the workforce to mitigate the impact of future skills loss associated with an ageing workforce profile	All Heads of Service	<p>Succession Planning is supported as part of Personal Development Discussions.</p> <p>Workforce trends and areas potential high risk are identified as part of annual workforce planning review for each HOS and appropriate interventions are discussed and agreed.</p> <p>Number of staff have completed or undergoing Leadership and management development activities to support Career Development to build skills and capability to meet current organisational requirements.</p>

Primary Theme	Action	Lead	Update on Progress
Healthy Organisational Culture	On-going support for HSCP Board members	Head of People and Change	Paper to HSCP Board in May 2017 outlining proposals for Board Development and induction. Senior OD Advisor working with Chief Officer to support Board development
	Ensure workforce changes associated with service redesigns are undertaken in compliance with HR policies and procedures	All Heads of Service	Criminal Justice Redesign completed and all staff in post. Crosslet House open and workforce changes were in accordance with policy and working in Partnership with Trade Unions.

West Dunbartonshire HSCP Workforce and OD Support Plan Priorities 2018

Primary Theme	Action	Lead
Capable Workforce	Continuing to build on existing workforce and internal strategy to meet demands by training staff and explore opportunities to build capacity to meet increasing demands of MHO's amongst social care staff.	Head of Mental Health, Addictions & Learning Disabilities/ Head of Health & Community Care
	Dementia champions will work with staff to further raise awareness of Dementia and available resources. Uptake will be monitored	
	Ensure PDPs in place across workforce.	All Heads of Service
	Monitor and support registration status of staff and progress any improvements from outcome of internal audit report.	
	Monitor and support SSSC registration of staff in Care at Home Service	Head of Health and Community Care
	Continue to deliver on-going programme of data protection awareness sessions tailored to the staff working within the HSCP	Head of Strategy, Planning & Health Improvement
	Consider further how to develop functionality of CM2000 and actions arising from external audit.	Head Of Health and Community Care

Primary Theme	Action	Lead
Capable Workforce	Update Staff Governance and Practice Governance Framework.	Head of People & Change
	Develop Approaches to perpetrators of domestic abuse	Head of Children's Health, Care & Criminal Justice
	Prepare and implement outcomes arising from information Sharing Bill in 2019, including implications from Part 4 and 5 and guidance associated with this.	
	Ongoing delivery of self harm and sexual health and relationship training for appropriate staff from HSCP and community planning partners working with looked after and accommodated children and young people.	Head of Strategy, Planning & Health Improvement
	Review of training and implementation of training for staff across the Council for Adult support and protection to be completed by Public Protection Officer.	Head of Mental Health, Addictions & Learning Disabilities.
Sustainable Workforce	Create career pathways to encourage retention among key staff groups	All Heads of Service
	Encourage opportunities for MAs; nursing internships; and volunteering	
	Build on existing capacity within the volunteer and third sector workforce while ensuring the maintenance of quality and standards of service.	Head of Strategy, Planning & Health Improvement
	Scope out analyse age profile of Childrens Residential workforce due to concerns about aging workforce.	Head Of Children's Health, Care & Criminal Justice Services

Primary Theme	Action	Lead
Healthy Organisational Culture	Contribute and implement actions from Council Employee Wellbeing Group.	All Heads of Service
	Lead HSCP integrated Health & Safety Committee and oversee actions across services.	Head of People & Change
	Implement HSCP staff absence action plan.	All Heads of Service
Effective Leadership and Management	Support teams with team development to support current or new ways of working	Head of People & Change
	Complete roll out of I Matter.	
	Talent management and succession planning within the workforce to mitigate the impact of future skills loss associated with an ageing workforce profile	All Heads of Service
	On-going support for HSCP Board members	Head of Strategy, Planning & Health Improvement
	Ensure workforce changes associated with service redesigns are undertaken in compliance with HR policies and procedures	All Heads of Service

**WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE
PARTNERSHIP BOARD AUDIT COMMITTEE**

At a Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit Committee held in Council Chamber, Clydebank Town Hall, Dumbarton Road, Clydebank, on Wednesday 20 September 2017 at 2.00 p.m.

Present: Allan MacLeod (Chair), Councillor Marie McNair (Vice Chair), Baillie Denis Agnew; Councillor John Mooney and Rona Sweeney.

Attending: Beth Culshaw, Chief Officer of the Health & Social Care Partnership; Julie Slavin, Chief Financial Officer; Jackie Irvine, Head of Children's Health, Care and Criminal Justice Services; Soumen Sengupta, Head of Strategy, Planning and Health Improvement; Colin McDougall, Chief Internal Auditor; Serena Barnatt, Head of People and Change; Peter Lindsay, Senior Audit Manager; Zahrah Mahmood, Senior Auditor and Zoe Maguire, Auditor (Audit Scotland); and Nuala Borthwick, Committee Officer (West Dunbartonshire Council).

Apologies: An apology for absence was intimated on behalf of Audrey Thompson.

Allan MacLeod in the Chair

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 Health and Social Care Partnership Audit Committee held on 22 June 2017 were submitted and approved as a correct record.

COMMITTEE ACTION LIST

A note of the Audit Committee's Action List was submitted for consideration and comment.

Having heard the Chair and the Chief Finance Officer in elaboration of the Action List, the Committee agreed to note the actions contained therein.

LOCAL CODE OF GOOD GOVERNANCE REVIEW

A report was submitted by the Chief Financial Officer advising of the outcome of the annual self-evaluation undertaken of the Health & Social Care Partnership's compliance with its Code of Good Governance.

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

- (1) to note the summary outcome of the recent self-evaluation process undertaken considering how the HSCP Board meets the approved Local Code of Good Governance;
- (2) to approve the improvement actions identified to strengthen compliance with the adopted Governance Framework principles;
- (3) that an additional column be added to the Annual Review of Code of Good Governance – Summary, detailed within Appendix 2 of the report, to include the total number of criteria per subsection for future reporting; and
- (4) to note that the Chief Officer would consider an external annual evaluation with participation from Board Members in future years.

KEY SOURCES OF ASSURANCE FOR INTERNAL AUDIT ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2017

A report was submitted by the Chief Internal Auditor presenting two key sources of assurance, from the Health and Social Care Partnership's partner organisations, that informed the Chief Internal Auditor's Annual Report for 2016/2017 for the Health and Social Care Partnership Board and supported the Governance Statement included in the 2016/17 Annual Accounts.

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

- (1) to propose to NHS Greater Glasgow and Clyde that a clause relating to information sharing be written into future procurement agreements with providers of audit services; and
- (2) to note the contents of the report.

AUDIT SCOTLAND: WEST DUNBARTONSHIRE INTEGRATED JOINT BOARD - DRAFT ANNUAL AUDIT REPORT 2016/17

A report was submitted by the Chief Financial Officer presenting the Annual Audit Report and Auditor's letter, for the audit of the financial year 2016/17, as prepared by the Health and Social Care Partnership Board's external auditors, Audit Scotland.

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

- (1) to note the contents of the Annual Audit Report to the Integrated Joint Board and the Controller of Audit for the financial year ended 31 March 2017;
- (2) to welcome the achievement of an unqualified report covering the HSCP Board's first full financial year;
- (3) to note the issues raised, recommendations and agreed management actions contained within the appendices to the report relating to the audited Annual Accounts;
- (4) that authority be delegated to the Chair of the HSCP Board, the Chief Officer and Chief Financial Officer to accept and sign the final 2016/17 Annual Accounts on behalf of the Partnership Board; and
- (5) to thank the Chief Financial Officer, her team and the team from Audit Scotland for their hard work in delivering the 2016/17 accounts closure process.

AUDITED ANNUAL ACCOUNTS 2016/17

A report was submitted by the Chief Financial Officer presenting the audited Annual Accounts for the year ended 31 March 2017 as delegated by the HSCP Board on 23 August 2017 and highlighting matters of interest.

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 audited Annual Accounts for 2016/17;
- (2) to acknowledge the work of the Chief Financial Officer and assistance from Audit Scotland in finalising the Partnership Board's Audited Annual Accounts; and
- (3) to note the contents of the report.

Note:- Peter Lindsay and Zahrah Mahmood, Audit Scotland left at this point in the meeting.

AUDIT PLAN PROGRESS REPORT

A report was submitted by the Chief Internal Auditor providing an update:-

- (1) on the planned programme of audit work for the year 2017/18 in terms of the internal audit work undertaken at West Dunbartonshire Council and NHS Greater Glasgow and Clyde that may have an impact upon the West Dunbartonshire Health and Social Care Partnership Board; and
- (2) on the agreed actions of the audit of the Partnership Board's Governance, Performance and Financial Management arrangements.

After discussion and having heard the Chief Internal Auditor in further explanation of the report and in answer to Members' questions, the Committee agreed to note the progress made in relation to the Audit Plan for 2017/18.

Note:- Rona Sweeney left the meeting during discussion of the above item of business.

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 & Health Improvement providing routine updates on the most recent Care Inspectorate assessments for one independent sector residential older peoples' Care Home located within West Dunbartonshire.

After discussion and having heard the Head of Strategy, Planning & Health Improvement in further explanation of the report and in answer to Members' questions, the Committee agreed to note the contents of the report.

Note:- Rona Sweeney returned to the meeting during consideration of the above item of business.

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

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

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

- (1) to note with slight concern the Care Inspectorate rankings for both Dunn Street Respite Service and Sense Scotland Supported Living Glasgow 1 Service with one remaining unchanged in a number of years and the other showing a consistent fall in grades;
- (2) that a report would be submitted to the next meeting, following engagement with the newly appointed Link Care Inspector, to provide re-assurance to Members on work being undertaken to improve grades at the above independent sector support services; and
- (3) to otherwise note the contents of the report.

CARE INSPECTORATE REPORTS FOR CHILDREN AND YOUNG PEOPLE'S SERVICES OPERATED BY WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

A report was submitted by the Head of Children's Health, Care and Criminal Justice providing a routine update on the most recent inspection report for Blairvadach Residential Children's House.

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

Note:- Rona Sweeney left the meeting during discussion of the above item of business.

CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S RESIDENTIAL CARE SERVICES OPERATED BY WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

A report was submitted by the Head of Community Health and Care Services providing a routine update on the most recent inspection report for one of the Council's Older People's Residential Care Home Services.

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

- (1) that a report with an action plan to improve Care Inspectorate grades at Mount Pleasant House would be presented to the next meeting of the Committee; and
- (2) to note the contents of the report.

DRAFT STRATEGIC RISK REGISTER

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

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

- (1) to note the content of the updated draft Strategic Risk Register; and
- (2) to endorse the updated draft Strategic Risk Register for onward recommendation to the West Dunbartonshire Health & Social Care Partnership Board at its next meeting on 22 November 2017.

AUDIT SCOTLAND – SELF DIRECTED SUPPORT 2017 PROGRESS REPORT

A report was submitted by the Head of Strategy, Planning and Health Improvement providing information on the recently published Audit Scotland progress report on Self-Directed Support.

The Head of Strategy, Planning & Health improvement was heard in further explanation of the report.

The Auditor, Audit Scotland was then heard in further explanation of the Audit Scotland Progress Report, as detailed within Appendix 1 to the report, and in answer to Members' questions.

Following discussion and having heard officers in answer to Members' questions, the Committee agreed:-

- (1) to note the findings of the Audit Scotland report on Self-Directed Support; and
- (2) to note the Partnership Board's intention to revise and update its existing Self-Directed Support Policy which will be reported to the Partnership Board upon completion.

The meeting closed at 15.45 p.m.

West Dunbartonshire Health & Social Care Partnership

Meeting: SMT Clinical & Care Governance Group

Date: 27 September 2017

Time: 9.30am

Venue: Managers' Meeting Room, Garshake Road

DRAFT MINUTE

Present: Beth Culshaw, Chief Officer (Chair)
Ken Ferguson, Clinical Director
Julie Lusk, Head of Mental Health, Addictions and Learning Disability
Lynnette Cameron, Clinical Risk Manager
Wilma Hepburn, Lead Nurse Adviser
Janice Miller, MSK Physiotherapy Lead
Soumen Sengupta, Head of Strategy, Planning and Health Improvement
Norman Firth, Partnership Manager, Criminal Justice
Jackie Irvine, CSWO, Head of Children's Health Care & Criminal Justice Services (for final 20 minutes of meeting)
Kate McLachlan (minute)

Apologies: Chris McNeill
Julie Slavin (Not required - no finance issues)

1. Welcome & Introductions

The chair welcomed the group and introductions were made.

2. Minute of Meeting Held on 26 July 2017 – attached

Minute accepted as an accurate record of the meeting.

3. Matters Arising

i. Clinical Incident Reporting – “Falls per Bed” (to be carried forward to next agenda)
Lynette advised that this report cannot but run until October, therefore this will be looked at in the November SMT Clinical and Care Governance meeting.

Lynette

ii. Feedback on Figtree training in Home Care

LF

Bring forward to next meeting.

Risk register – Soumen advised that the policy was being updated and that we are required to share our risk register with Greater Glasgow and Clyde. There have been recent discussions regarding the risk register being added to DATIX. Partnerships have previously been excluded, although Beth advised that some other

partnerships have adopted this practice.

BC

Homeless people

There has been a short life working group set up around homelessness. A lot of work has been done but this requires to be firmed up. Julie Lusk to speak to Jennifer MacMahon, Strategic Housing Officer. Julie will continue to feedback to group. **Action – Julie L.**

JL

Out of Hours Review

Ken Ferguson advised that the Output for the Out of Hours Service has been circulated by David Leese. There currently are 11 ideas with divided opinions all of which are still being discussed. Chris McNeill and Ken Ferguson are meeting with Dumbarton & Alexandria GPs on the 10 October 2017, to discuss the local situation and to see where we are at in terms of their thinking. There is a need to establish if there is a local commitment that would sit alongside Greater Glasgow & Clyde Out of Hours Service. **Action: KF.**

KF

4. Quality Assessment

- i. Clinical and Care Governance Report – attached

Soumen advised that we receive standard updates from the Care Inspectorate and in regard to in-house providers each Head of Service is responsible for bringing the grading system into their own Services.

Mountpleasant – Standing Items.

Ken asked what happens outwith Inspections in regard to what in-house policies we have to monitor services. Julie advised IOP Managers monitor and manage activity as this comes under their remit.

Ken asked how can this group be assured about this? Soumen advised that in terms of registered services, there is an external view held by the Care Inspectorate. With in-house services it is the in-house management who deal with this, for non-residential facilities, for example Learning Disabilities services, staff ensure quality assurance through the use of outcome measures. Beth asked how these outcomes are fed back into this group and how do we know the level of quality within in-house services. Ken suggested that we need an internal assurance group, he is not aware that anything comes directly to this group routinely with regard to reporting. Mary-Angela advised that she submits a quarterly report for clinical and care governance, and Julie Lusk does the same for Mental Health and Learning Disabilities Services.

ADP did a self evaluation last year and this was based on quality assurance. Another example is the mental health PSIF undertaking which linked in with Rosie Lawrence, Link Inspector and this is reported to Julie Lusk. Soumen advised that there is an action plan

from the Care Inspectorate for these services with timescales and dates that must be met.

Beth advised we need to spend time on this as the Audit Committee have raised questions about how external and internal services are brought together with regard to scrutiny of services.

Soumen and Julie noted that for external providers we don't have an arrangement in place other than Brian Gardner who regulates external agencies but he does not focus on this full time as he has other duties.

External reports – For service providers who score a grade 3: this requires to be reflected in the action plan and record what we are doing to improve this.

There is a meeting in the diary with our new Link Inspector, Stephen Rankin for the 7 November with Julie Lusk, Soumen and Jackie.

Residential Homes

Internal audits – with the process of self evaluation those strands all feed into our planning process on an operational level which links into the strategic plan. Questions raised by some members of group about where does feedback go and how does it get fed back here. The Chief Officers Group looks at aspects of this. Beth wants to close the loop in terms of feeding back any concerns to this group and to see where opportunities arise and to ensure that these links are being reviewed.

Beth asked in terms of external providers how are incidents reported. Julie noted that if anything happens in her own services, this would be reported to the care inspectorate and then internal audit.

Example, incident with various staff which raised ADP concern. Julie's team implemented an action plan after investigations. Mary Angela also advised that the Care Inspectorate would be the first port of call if anything happened in Care at Home service. This is a procuring function within WDC; we need to tease out what they are doing in regard to this. It was noted that our staff have an understanding of this and the procurement team will offer support. Ken is to come back with detail of how this will all fit together.

Action – Ken.

Infection control – Audits for hand hygiene. Beth asked what standard reports are there in terms of infection control – how do we ensure the social care staff are following guidelines. Wilma to feedback to group **Action: Wilma.**

Agenda item for next meeting – infection control (Wilma)

Janice noted that none of her team has had notification of overdue incidents. Lynette advised that MSK incidents may have been re-assigned to Glasgow City in error. Janice to email Alistair McKay, Clinical Governance to address this. **Action: Janice.**

There are a number of incomplete incidents Lynette advised that the Datix working group is dealing with overdue incidents and trying to reduce numbers. Marie Rooney sits on Datix user meeting for WDC. Staff needs to know that if they are wrongly re-assigned for incidents that they must report this for it to be rectified.

Beth asked about the running of DATIX reports, Lynette advised that clinical incidents reports run quarterly.

Action for next meeting – To have a list of outstanding overdue incidents. (agenda item)

Action - Beth asked for the Datix report for next SMT meeting. (agenda item)

SCI's mentioned in last report, there are now 4 incidents that are overdue, these are dated 2016. Marie Rooney has these at the moment. There are 2 outstanding.

Action: Julie and Marie.

– Julie to pick this report up with Marie Rooney as there have already been overdue issues.

Beth is keen to get this signed off as this is a matter of clinical risk. One was dealt with last week that should have been resolved a lot sooner as this does sit with the partnership and this group has the responsibility.

Julie Lusk spoke of a Bruce Street incident in which the union is now involved; she advised that a grievance will be coming in. Following a recent incident in the Rutherford Ward, Gartnavel Royal, Julie spoke to Dr Felix Kauye yesterday and Julie has put further questions to the ward. Paperwork has now been closed as this is now going for investigation. SCI paperwork closed. A rapid alert was submitted to Mags McGuire and Jennifer Armstrong.

Action: Lynette to check this as the rapid alert should be sent to the Chief Officer, HSCP. Beth wants the process checked as she also should have been notified. There is a very clear policy/link to SCI.

Action: ALL for everyone that they should look at the policy to ensure that this is strictly followed in terms of incidents.

5. Risk Management

- i. Partnership Infection Control Representation
Noted
- ii. Datix Bulletin
Noted
- iii. Datix Report
Noted

6. Service User Feedback

- i. Complaints Report

Soumen presented the report. Ken asked if we have a way

of identifying if an issue continues to arise as we need to ensure that any recurring incidents are captured. This is the responsibility of the Head of Service.
This will be flagged up to HOS to deal and discuss with integrated operations managers.

- ii. FOI Report
Soumen spoke to report. FOI related to the partnership board will be added into this. Soumen to check with Lorna regarding an outstanding FOI that Beth has not seen. **Action: Soumen/Lorna.**

7. Continuous Improvement

- i. Fire Training Update – e-mail attached

Serena sent a report regarding fire training stats to Beth that was not available at the meeting. Beth noted that staff need to be reminded to carry out this training. **Action: update on fire training from all HOS for next meeting.**

8. For Noting

- i. NICE Clinical Guidelines, Developmental follow-up of children and young people born preterm – e-mail attached
- ii. Mental Health Services Redesign (Glasgow City) Unscheduled Care Newsletter – attached

It would be useful to circulate a newsletter for people to be more familiar with this process. Julie L is on the main group; Marie and Fraser are on sub groups and are fully involved in this.

9. Standing Items

- i. Outstanding SCIs and SCRs - SBAR for completion attached

Norman spoke to the papers. There has been a report of an Injury to a child; the child is now in the care of the maternal grandmother. Family are known to Glasgow Social Services.
Norman notified care inspectorate as they require to be notified within 5 days of incidents. They will let Norman know by 20 October if they require any further information. Glasgow will be involved in the SCR.

Subject was released on bail last Thursday. This was alternated to Glasgow colleagues.

WDC did a brief initial review of this case and submitted back to the Care Inspectorate.

Norman will feedback to group any further developments and advised that we will support Glasgow in any investigations.
Action: Norman

Ken asked Lorna to circulate an SBAR template – only Norman's

has come back. Julie to fill out an SBAR form for ongoing incidents in her services. This is a one-off exercise to get all incidents up to date. **Action: Julie L.**

10. Social Work Standby

Norman discussed the Interim agreement – Glasgow is reviewing their overall services.

They are looking at how they link into HSCP services. Julie's concern for our staff in standby is significantly reduced, although we may not be getting the full service we are paying for due to this. Discussions are taking place in how many fully qualified staff they require to have on duty.

Jackie informed the group of an interim service level agreement but we have not made the final decision. Jackie has passed to our Legal colleagues who have advised that for a contract of this size it should be put out to Tender.

Lynne McKnight attended last Standby and feedback to Jackie who added some comments and sent back to Karen Donohue from Standby Service. Jackie advised that there needs to be a skill mix of professionals to take calls, this is still being discussed by Standby.

There is an issue regarding the quality of the information that we get back. Our costs have come down by 70k or 80k which we pay quarterly and this is adjusted according to our usage.

Beth asked for this to be a **key agenda item on the next SMT meeting. Beth, Julie and Jackie to discuss any issues there are and costs involved. We need to know the cost of an interim service so we need to be sighted on this – meeting to be arranged Action: Beth, Jackie & Julie L.**

Lorna/Kate to arrange meeting.

11. Review of Clinical and Care Governance

Meeting is arranged for 10 October with Julie, Jackie and Wilma with Ken. Ken doing background work on terms of reference with other HSCPs to gain a consistent approach with out of hours service. This will be fed back to the next SMT meeting in November. This will be fed back by email / circulations to other Heads of Service to feedback their comments. **Action: Ken. Agenda Item.** Lynnette to send terms of reference documents to Ken and to copy Beth in. **Action: Lynnette**

Ken informed the group of further discussion that is taking place regarding the review of services at Sandyford. There is talk of moving services from the Vale to Clydebank and then back to Glasgow City HSCP. Ken advised them that this should be discussed with West Dun HSCP.

Excellence in Care

Wilma is looking at developing this. Margaret Connolly is the rep in Glasgow. Wilma is to chair national working group in district nursing. Instead of Care Assurance, Excellence in Care will now be used.

Wilma will update at the next SMT meeting. This reports back to the national group and will be rolled out through Scotland. Wilma can feedback to the district nursing and possibly children and families. Standards and Indicators to be developed by September next year. Beth discussed the national overview and how this affects us locally. Indicators still have to be agreed for individual groups. **Action – Wilma.**

Standing items – Partnership Clinical Governance Group

Incidents. Concerns are being raised about patients being advised to drive to hospital when they are not fit to.

We need to discuss how we feed into this group as we don't submit a report from West Dunbartonshire. Clinical Director should feed into the Partnership Clinical Governance Group. SBAR information could be lifted and fed into this group. Ken is not available on a Thursday to attend this meeting. **Action – Ken.**

Date of Next Meeting

29 November 2017

West Dunbartonshire Health & Social Care Partnership

Meeting: Joint Staff Forum

Date: 17 October 2017

Time: 10.00am (Staffside pre meeting at 9.30am)

Venue: Committee Room 2, 1st Floor, Council Offices,
Garshake Road, Dumbarton

AGENDA

Item	Description	Action
1.	Welcome & Introductions	
2.	Minute of Meeting held on 18 July 2017 - attached	
3.	Minutes from Other Meetings for noting: a) APF Agenda - attached b) JCF Minute – to follow c) Employee Liaison Group Minute - attached	
4.	Matters Arising a) Update on Unison Learning Fund – Training Opportunities b) GP OOH	SB BC
5.	Service Updates: a) Children Services and Criminal Justice <ul style="list-style-type: none"> • School Nursing Review update • Pre-Five Immunisations b) Community Care <ul style="list-style-type: none"> • Ethical Care Charter update • Convenors Meeting (minute to follow) • Integrated Care Fund Meeting (minute to follow) c) Mental Health Learning Disability Addictions <ul style="list-style-type: none"> • Unscheduled Care Review • Learning Disability Management Review - attached 	Co'B CMcN JL
6.	Staff Governance- verbal update	SB
7.	Staff Relocations	BC
8.	Workforce and OD Support Plan update (paper attached)	SB
9.	Partnership Development Session (paper to follow)	DMc

10.	Standing Items: a) HSCP Board Meeting 22 November 2017 b) HR Report <ul style="list-style-type: none"> i) Discipline & Grievance Report – to follow ii) Attendance Management Report- to follow iii) Health and Safety - minute attached iv) Dignity at Work Survey NHS 	BC SB SB SB SB
11.	Finance Update	BC
12.	AOCB	
13.	Date of Next Meeting Proposed – 19 th December TBC	

ITEM 17(d)

West Dunbartonshire Health & Social Care Partnership

Meeting: HSCP Clydebank Locality
Date: 22nd August, 2017
Time: 10.00 – 12.00
Venue: Conference Room, Clydebank Health Centre

DRAFT MINUTE

Present :-

Name	Designation
Chris McNeil	Head of Community Health & Care Services
Dr. Alison Wilding	GP Red Wing (Chair)
Dr. Eddie Crawford	GP Orange Wing
Dr. Anthony Kearney	GP Old Kilpatrick Medical Practice
Lynne McKnight	Integrated Operations Manager Care at Home
Mary Angela McKenna	Integrated Operations Manager
Elaine Bowman	Prescribing Support Pharmacist
Dr. Neil Murray	GP Green Wing
Jacqueline Hardie	Practice Manager
Dr. Neil Chalmers	GP Yellow Wing
Kirsteen MacLennan	Integrated Operations Manager
Anna Crawford	Primary Care Development Lead
Dr. Ralph Cunningham	GP Blue Wing
Pamela Ralphs	Planning Manager, Acute
Dr. Arun Rai	GP Purple Wing
Patricia Rhodie	Integrated Operations Manager Addictions
Fiona Rodgers	Nursing Team Leader
Brian Polding Clyde	Development Officer

Apologies :-

Name	Designation
Maggie Ferrie	Practice Nurse
Jane McNiven	Practice Manager
Jackie Irvine	Head of Child Health, Care & Criminal Justice
Val Mclver	Senior Nurse
Marie Rooney	Integrated Operations Manager
Selina Ross	West Dunbartonshire Community Volunteer Services
Mags Simpson	Senior Nurse
Pamela McIntyre	Prescribing Lead

Item	Description	Action
1.	Welcome & Introductions	
2.	Minute of Meeting Held on 19th June 2017 Minutes of the meeting on 19 th June 2017 were approved by the group.	
3.	Mental Health & Addictions Workplans :- The Addictions Workplan was shared with the group and most actions complete. The Sub group will review the action plan at their next meeting. The SCI Gateway for information only referral is outstanding and P Rhodie is progressing. The recall of patients on some medications require review, this has to be added to the workplan. Mental Health workplan provided for information. Further update will be provided following the next Subgroup meeting.	AC
4.	Children's Services Workplan :- Workplan distributed at meeting. Group discussed the information around RCGP audit. J Irvine advised the good practice in this area will be highlighted within West Dunbartonshire and to Clinical Directors.	
5.	Older Peoples Workplan :- The Dalhousie frailty Scale is being used in Dumbarton & Alexandria. All practitioners are using this in over 65s (not effective in under 65). GPs are using for their patients 75 and over. Dalhousie read code on systems for GP Practices comes up as Canadian Clinical Frailty Score (38DW). A Crawford to share a copy of the Dalhousie Frailty Scale, and EMIS Template. Dalhousie information is sent monthly to GP practices. Frontline home carers will score patients/clients every six month using Dalhousie – assess results. GPs agreed to discuss Dalhousie model within their practices. C McNeill asked the group to provide her with their thoughts on how we can develop, Frailty, Anticipatory Care Planning across the HSCP by the end of September. C McNeill will use the feedback to inform the paper suggesting how the service can be developed. What resource would support practice in using this frailty model and how do we improve the service provided. M A McKenna agreed to provide an overview of the Frailty Work and the Dalhousie Scale at the next locality meeting.	AC
6.	Technology Enhanced Care Update :- <ul style="list-style-type: none"> Frailty A video to promote the use of the TEC safety equipment is in the final edit stages. Clients/ families being encouraged to use the Telecare equipment will be able to view videos in their own home. Clients are being encouraged to take the full suite of assessment tools initially with the opportunity to then assess which tools are of benefit to their needs.	Group MAK

Four packages installed at present to support clients at home. The service is exploring more opportunities with frontline staff to identify clients who would benefit from this service.

- **COPD**

The COPD Service has been experiencing problems with computer texting equipment which is being investigated with the service provider.

There are currently 20 patient's texting their oxygen saturations and an additional 38 patients have declined the text component of the service. The service is reviewing why patients decline to inform how they improve uptake.

7. New Clydebank Health Centre :-

The new health centre has been approved by the Capital Investment Group and approval from Scottish Government should be received soon.

The venture has move on to Stage 2 (meeting this afternoon 22.08.17). It is anticipated Stage 2 should take approximately 9 months. Then venture will go to planners for detailed planning consent.

There is an exhibition on 12th September 2017 in Clydebank Town Hall, providing information on the improvements to the roads into the Queens Quay site.

The care home on the Queens Quay site will start building within next 5 months.

8. Any Other Business :-

P Rhodie advised of the figures for drug related deaths in West Dunbartonshire, it was noted that there was an increase of one since 2015. In other areas this increase was higher.

9. Date of Next Meeting

- Tuesday 24th October, 2017.

West Dunbartonshire Health & Social Care Partnership

Meeting: Dumbarton and Alexandria Locality Group
Date: 1 September 2017
Time: 10.00 am
Venue: Seminar Room, Vale Centre for Health and Care

DRAFT MINUTE

Present:

Saied Pourghazi	-	GP - Levenside Practice (Chair)
Fiona Wilson	-	GP, Oakview
Marjorie Johns	-	Planning Manager Acute
Kathryn McLachlan	-	GP, McLachlan Practice
Jane Young	-	GP – Dumbarton HC
Gillian Bonar	-	Practice Manager
William Wilkie	-	Lead Optometrist
Lynne McKnight	-	IOM, Care at Home
Jennifer Perry	-	GP, Dumbarton HC
Pamela Macintyre	-	Prescribing Lead
Jane Cumberland	-	Practice Manager
Alison Walsh	-	GP – Lennox Practice
Neil Mackay	-	GP – Bank Street Practice
Kelly Connor	-	Nurse Team Leader – WD
Fraser Downie	-	IOM, Mental Health, RRC
Kirsteen Maclennan	-	IOM – Hospital Discharge Team
Chris McNeill	-	Head of Health Care Service
Anna Crawford	-	Primary Care Development Lead
Mary Angela McKenna	-	IOM, Older Peoples Team
Lesley Traquair	-	Minutes

Apologies: John Kerr, Selena Ross, Yvonne Milne, Mags Simpson

Item	Description	Action
1.	Welcome & Introductions Julie opened the meeting and apologies were noted.	
2.	Minute of Meeting Held on 23 June 2017 <ul style="list-style-type: none"> • Page 3 – Item 7 – Pamela advised that the Technology Enabled Care Report was not yet available but hoped to be able to circulate next week. • Page 4 – AOB – A. Crawford to follow up on the distribution list of ‘Know Who to Turn To’ poster. C. McNeill questioned the feasibility of putting the posters up on the walls in health centres. 	PMacl AC

- 3. Matters Arising**
Optometry Update
W. Wilkie met with the Sensory Impairment Team when it was agreed to set up Network meetings in the evenings. A presentation was done on all the services available and discussion had on how Optometry issues could be integrated into this. William asked that any issues should be sent to him. William working on a development paper and C. McNeill agreed to take to the Heads of Service meetings. William discussed his plans to introduce the frailty scale and Dalhousie system to the Optometrists.
- ALL**
CMcN
- 4. Cluster Update Report**
Key Priorities
- McMillan finishes in October. Three modules completed and another hoped to be finished by end of October/November.
 - Frailty focussing on coding – not set at the moment.
 - Looking at epilepsy and chronic disease to see if this can be streamlined for all practices. Dr. S. Pourghazi to organise a teaching forum to look at new areas for the future. C. McNeill stated she had some HSCP funding available but will be guided by the Scottish government targets.
 - Local arrangements with ambulance service being piloted in Clydebank.
 - Proposals to avoid home visits with possibility of expanding nursing team for more immediate care. C. McNeill stressed the need to capture money early and it is hoped to put additional resources into this.
 - Hoping to look at house visits when people present unwell and map A&E attendance against attendance at GP.
 - C. McNeill asked that this be discussed further at next Cluster Meeting whilst funding is still available. Chris asked for GP feedback before next cluster meeting.
 - Gerontology Nurses not doing anything different from our own nurses, just more of them with more accessibility.
 - C. McNeill to draft outline for paper in October.
- SP**
GP's
CMcN
- 5. Frailty Work Plan**
- Dr. Wilson asked that practices continue to code patients over 75 with frailty Scotland focus.
 - Looking at potential of using clinics to capture people. A. Crawford shared figures. Need to focus on looking at patients with score of 6 and 7 and more in depth care planning for these patients. Kevin Rankine, (new care fund nurse) has started this process with patients recommended by Dr. Wilsons practice. Hope to bring model back to the next frailty meeting on 26 September and start roll out to other practices and professionals. Focus for next meeting is to look at people lower down the scale. Hope to pilot going down route of e-frailty index.
 - A. Crawford advised she would circulate the Living Well in
- AC**

Communities paper to the team which will incorporate the newly appointed Care Fund Nurse (Kevin Rankin). It is hoped to expand this work focusing on activities. A. Crawford AC to put the offer to Clydebank.

6. COPD Work Plan Update

- Dr. Young presented a summary of the work plan information.
- Suzanne Adams, COPD Liaison Nurse from secondary care has advised patients on her caseload who become palliative would be highlighted to the GP and DNs. She will continue to support and visit these patients in the community as needs indicated. These patients should be on palliative register, no clear cut pathways.
- Looking for an accurate list of people on oxygen – some discrepancies.
- No clear pathway for replacing broken nebulisers out of hours. Protocol to be put in place.
- Need to refer more patients onto technology project.
- Pulmonary Rehab – very few referrals. Practice Nurses to be reminded to refer patients. Local community pharmacies referring into pulmonary rehab.
- Smoke Free Service to feed in work being done around COPD patients.
- Few technical issues around e-mailing in referral forms. This requires to be promoted further.

7. Technology Enabled Care (COPD and Frailty)

- P. Macintyre stated that last month only one person had been recruited on the technology project. Continue to have difficulties with the programme and texting. Patients less keen on texting. Looking at identifying suitable people, currently offered to 42 people.
- Looking at creating a video for COPD patients giving instructions on how to use the technology. This to be organised in the next two weeks. P. Macintyre discussed how this can be communicated around different areas (community and hospital staff)
- Work being carried out to evaluate patients who can be offered this.
- Hospital discharge is the main source of referrals.
- Looking at developing a technician role to work with the equipment and advise on the best piece of equipment required. Waiting to hear back from Scottish Government if we can use some of the funding available to recruit to this post.
- Developing a questionnaire pack to look at why patients are declining this technology.

8. Local Engagement Network

- G. Murphy will present to the next LENS meeting looking at adults with physical disabilities.

- First session planned for 5 September 2017. Discussion around “Tell us about Your Engagement with WD”
- Second session planned for 12 September 2017 – looking at emotional touch points.
- Update to be done at next locality meeting in November.

9. Any Other Business

- F. Downie, Integrated Operations Manager at Riverview Resource Centre discussed the Mental Health Emergency Out of Hours Referral Pathway for Dumbarton, Vale of Leven and Helensburgh for assessing people who might require hospital admission and putting a care plan in place. Paper circulated for information.

Fraser advised that if there was immediate risk of suicide this would generally be a police call but his team would be happy to manage the situation with them. CPN's available who rotate into the system and liaise with PCMTs.

A lot of work being carried out on distress models and how we can manage this better. Also work being carried out on pathways into the older adult service and putting a robust 24 hour service in place.

Dr. J. Young spoke about pressures encountered around patients of part time GPs if they have already been seen by another GP beforehand. Fraser to raise the question.

- C McNeill to speak to Dr. K. Ferguson regarding his engagement with clusters and locality meetings.

CMcN

10.

Date of Next Meeting

Friday, 3 November 2017 in the Seminar Room, Vale Centre for Health and Care.

- Business Meeting – 8:45 am
- Main Meeting – 10.00 am

Meeting dates 2018

- 12 January 2018
- 9 March 2018
- 11 May 2018
- 13 July 2018
- 14 September 2018
- 9 November 20

Venue to be advised.

West Dunbartonshire Local Engagement Network
Physical Disability/Adults with Complex Needs
Service Providers and Service User Workshops
September 2017

The Chair of the Local Engagement Network (LEN) welcomed everyone to the Local Engagement Network sessions before the HSCP Head of Strategy, Planning and Health Improvement gave an overview presentation.

The first session began with providers/service users being asked to consider:
What could be done to facilitate better engagement between providers and the HSCP?

Responses from Service Providers:

- It's frustrating when we do a good piece of work and funding ends...what happens next
- We have done good work in West Dunbartonshire and taken it to other areas I think the elephant in the room is money. Money is also a problem for statutory services as well.
- We are working with a lot of young people who are doing course after course at college without moving on. They need a social life; we have really good interaction with the HSCP and hope it will continue as we are having success working with our client group
- It is easy for us to get people out and about and engaged if their funding allows us. We make the best with what we've got
- It would be good to know more of what's available. The team are flexible with resources so people can participate.
- Services out there are good at what they do and engage appropriately. Adult Care Team has gone back to basics, "what can we do for service users," the team know what's out there, linking in with specialist services.
- When we find something that works, how do we embed it?

- How can we build up stimulants to take things forward? Services help people up but what can families do to help? Instead of doing things to service users how can we rehabilitate using their networks to the point of independence.
- People have peaks and troughs especially if they have a degenerated disease, services have to be flexible so good relationships are important
- How can we develop mutual support further?
- There is work being done in transition of a child moving to adult services... should adult services be getting to know the children from the age of 14? Should adult team worker be the transition worker to the child?
- Transitions – managing expectations, if it's not working who do we go to; is there a named worker.
- A young person goes for physiotherapy because their parents take them they don't want to be there, what does this achieve?
- We need to work with groups of young people, sharing strategies with peer learning volunteering.
- Some people are getting things done to them we need to say to service users here are a few possibilities.
- How can you plan for years? We have regular reviews with service users and yearly reviews with social worker.
- Sometimes we do things off the cuff... it could be a one off' we are flexible and just run with it. We probably couldn't plan for 12 months because people change. Some people have moved onto work or volunteering but some people don't want to move on.
- Are we flexible enough with you?
- Sometimes the social workers doesn't listen to service user, sometimes we are fire blankets.
- Care management can be good but it's all or nothing, there can be an imbalance.
- We have 16 service users with 16 different services, how do you know what to do for 30 hours, it depends on the service user wants to do.
- We have one service user with a brain injury and other issues; he used to be a chef, we have worked with him and he has learnt how to cook again and is moving on.
- Working with West Dunbartonshire HSCP has been fantastic the team got what we were doing.

- Sometimes the Social Worker was not 100% sure what we were doing.

Service Providers were asked why they chose to attend the session?

Responses from Service Providers

- Why not? We are providing a service that the HSCP are paying for and we can learn from each other.
- I have more links with social work in West Dunbartonshire than other areas.
- Working in WD is less stressful, I see it as a partnership not a divide. We know who to contact
- Feedback is key from organisations and people.
- Customer contact, care management and good awareness of providers are shared around the team.
- To look at transitions; adults may have received more provision when they were in children services and this can be seen as a negative - we need to look at the positives of going into adulthood.
- Expectation that this is not just a one off, we need to consider all aspects from childhood to adulthood.
- Chatting with providers is useful as we need to know how to demonstrate good use of public money.
- As a team we want to engage with everybody, we getting an understanding of service providers, we know what you can offer.
- We want to have a relationship with service providers so we can develop services for the service user.
- It is also about supporting your team
- Instead of saying we need XYZ we need to start with we have this client what can we do – conversations like this help
- If we have the right network we should be just phoning people to have formal and informal conversations.

For the Service users' session we used Emotional Touchpoint cards and service users were asked to choose a card to sum up their views on community services they receive.

Service Users Emotional Touchpoints Responses:

- Supported: services and groups I attend make me feel supported not worthless
- Respected: I feel respected now I've become a volunteer.
- Comfortable: the services I receive and the environment I live in make me feel comfortable.
- Frustrated: I'm frustrated because I feel I'm getting the run around trying to sort out Self Directed Support (SDS).

Service users were asked questions about their experiences:

Can you tell us what professionals you see and how you access them?

- Doesn't matter to me what professional I see, but the ones I do see are excellent.
- Basically just my GP and social worker, things have got much better recently. I was put in touch with the West End project and it's been great. We have a good say in what happens in the project.
- I see my social worker, its okay.
- I see a social worker and physiotherapist from the Falls Team; the social worker had general knowledge but not much specific knowledge of physical disability. Its pot luck who you get through to, it's very sketchy.
- Asking for SDS (Self Directed Support)... I know what I need, the assessed need is not being matched. I've got the same social worker as my husband. I don't know what else is available, having information about a specific condition would be helpful and what's available for it.
- I haven't tried accessing information from the HSCP website. I wouldn't know where to start not everyone has access to the internet.

What does support look like for you? (including SDS)

- My family and the groups I go to give me support.
- I get SDS and use it to get out and about on a Friday and Saturday, it works really well.
- I'm just frustrated with the way I'm getting messed about.

- Well supported from family, met a lot of new people and I've started going to the swimming.

What works well, what doesn't and what would you change if you could?

- Being part of a group works well; activities let you forget all your worries, I wouldn't change a thing, we support each other.
- I'm quite happy, I wouldn't change anything either with the support I get from my family and the groups I attend.
- The group are fantastic because they do what you want to do and not what they want.
- SDS works well for my husband as he can chose what he wants and employs his own worker. I don't think they see me as independent as they try and attach me to some of my husband's hours. I think they are trying to postpone until I'm 65.

Summing up the sessions, it was agreed that all parties were happy for shared learning and training across service providers and service users. A small number of invited participants were unable to attend due to capacity issues but they would be followed up after the sessions.

The Chairs of the LEN thanked everyone for their input to the sessions, noting the levels of activity and involvement highlighted. Information and contact details were given to participants looking to follow up issues identified.

